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| <b>Daugharty v Marshall</b>  |
| 2007 NY Slip Op 33162(U)   |
| October 4, 2007  |
| Supreme Court, Rensselaer County   |
| Docket Number: 0210767/2007  |
| Judge: George B. Ceresia   |
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STATE OF NEW YORK  
SUPREME COURT

COUNTY OF RENSSELAER

PATRICIA A. DAUGHARTY, Individually and as Executrix of the  
Estate of JAMES P. GLEASON, Deceased,

Plaintiff,

-against-

ROBERT MARSHALL, M.D., PARTNERS IN FAMILY MEDICINE, JORGE  
CONSTANTINO, M.D. and CAPITAL CARDIOLOGY ASSOCIATES,

Defendants.

All Purpose Term

Hon. George B. Ceresia, Jr., Supreme Court Justice Presiding

RJI: 41-0426-2004 Index No. 210767

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**DECISION/ORDER**

George B. Ceresia, Jr., Justice

In this wrongful death action premised on medical malpractice, defendants Robert Marshall, M.D. and Partners in Family Medicine (Marshall defendants) and defendants Jorge Constantino, M.D. and Capital Cardiology Associates (Constantino defendants) concurrently move pursuant to CPLR 3212 for an order granting each of them summary judgment dismissing the complaint. The plaintiff Patricia A. Daugharty, individually and as Executrix of the estate of James P. Gleason, opposes both motions (in one submission).

This action arises from the treatment James P. Gleason (decedent) received from the Marshall and Constantino defendants from June 2000 until his death on March 15, 2002. The gravamen of plaintiff's complaint is that defendants failed to properly diagnose and treat decedent's complaints of, inter alia, abdominal pain. The plaintiff alleges that, had the decedent been properly diagnosed and treated, the defendants would have discovered that decedent suffered from an ongoing disease process in the gastrointestinal tract, which plaintiff contends caused decedent's death. Plaintiff also asserts that defendants failed to timely refer decedent to a gastroenterologist and, once recommended, failed to follow-up to ensure decedent was evaluated by such a specialist.

In a motion for summary judgment in a medical malpractice action, the moving physician "is 'required to establish a prima facie entitlement to judgment as a matter of law by tendering sufficient, competent, admissible evidence demonstrating the absence of any genuine issue of fact'" (Torns v Samaritan Hosp., 305 AD2d 965, 966 [3d Dept 2003],

quoting Toomey v Adirondack Surgical Assn., 280 AD2d 754, 754 [3d Dept 2001]). Moreover, this burden “can be met by the submission of affidavits and/or depositional testimony and medical records which rebut plaintiff’s claim of medical malpractice with factual proof” (Suib v Keller, 6 AD3d 805, 806 [3d Dept 2004], quoting Horth v Mansur, 243 AD2d 1041, 1042 [3d Dept 2003]). Further, “[t]he affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment 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” (id., quoting Tomey v Adirondack Surgical Assn., supra at 755). Once such a showing is established, the burden shifts to plaintiff to rebut it by establishing “a departure from accepted medical practice, as well as a nexus between the alleged malpractice and plaintiff’s injury.’ Moreover, ‘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 a defendant physician’s summary judgment motion” (Passero v Puleo, 17 AD3d 953, 954 [3d Dept 2005], quoting Grzelecki v Sipperly, 2 AD3d 939, 941 [3d Dept 2003]).

In support of their motion, the Marshall defendants submitted, inter alia, an affirmation from Robert Marshall, M.D. In that affirmation, Dr. Marshall affirmed he is a New York licensed physician who is Board Certified in Family Practice. Dr. Marshall noted that he treated decedent from 1998 through 2001 for such conditions as, inter alia,

“hypertension and hypertension cardiomyopathy, coronary artery disease, diabetes, aortic insufficiency, COPD, complete heart block with pacemaker, severe arthritis, CHF, pancreatitis, cholecystectomy, left ventricular wall motion abnormality and prostate problems” (Marshall Affirmation, ¶ 5). Dr. Marshall noted that decedent also received care from defendant Constantino – a cardiologist.

Dr. Marshall affirmed that, on June 21, 2002, decedent reported to him during an office visit that “over the past year, he had experienced four to five episodes of lower abdominal pain, developing through his chest and lasting for about ten to fifteen minutes and was associated with diaphoresis, passing when at rest” (id. at ¶ 7). Dr. Marshall noted that, on that date, decedent’s “abdomen was soft and non-tender. It was my assessment that [decedent] was experiencing a possible increase in his cardiomyopathy with possible ischemic disease. . . . Lab tests were ordered including liver function tests, which were found to be normal” (id.). At decedent’s next visit on September 13, 2000, Dr. Marshall affirmed that decedent did not complain of abdominal pain but, rather, had concerns of nocturia.

Again, on December 13, 2000 and January 10, 2001, Dr. Marshall noted that decedent reported experiencing abdominal pain, which was relieved with nitroglycerine (see id. at ¶¶ 9-10). On March 2, 2001, Dr. Marshall affirms that decedent noted he underwent a cardiac catheterization the previous week. At that visit, decedent presented with prostate problems. Further, at that visit, Dr. Marshall reviewed Dr. Constantino’s February 21, 2001

report which stated that his office would schedule an appointment for decedent to be evaluated by a gastroenterologist. Thereafter, Dr. Marshall affirms that, on April 30, 2001, decedent had no abdominal complaints and, on May 29, 2001, decedent noted one episode of chest pain relieved with nitroglycerine. At the May 29, 2001 visit, Dr. Marshall notes that decedent's abdomen was soft and non-tender and liver function tests were normal. Again, Dr. Marshall noted that, at decedent's visit of August 29, 2001, decedent reported feeling fine, his abdomen was soft and non-tender, and liver function tests were normal. Dr. Marshall noted that, on October 30, 2001, decedent's last office visit with him, decedent reported feeling good and noted that alcohol did not interest him anymore. Dr. Marshall further noted that decedent

“described abdominal pain he had approximately 2 weeks earlier as feeling like prior gall bladder attack but continued to be relieved with nitroglycerine. . . . My physical examination revealed a non-tender abdomen . . . My continued assessment of [decedent's] intermittent abdominal complaints were that they were likely symptoms of abdominal anginal. . . . [Decedent's] liver function tests were again found to be normal” (*id.* at ¶ 16).

Dr. Marshall explained that on January 21, 2002, decedent “presented to the Emergency Room at Samaritan Hospital with complaints of a three-day history of lower abdominal pain” (*id.* at ¶ 17). He also noted that liver function tests revealed elevated liver enzymes and an exploratory laparotomy revealed “extensive adhesions and inflammation from a perforation that was a few days old” (*id.*). Further, Dr. Marshall noted: “[D]ecedent was admitted to Samaritan Hospital where he had a difficult course and eventually developed sepsis and multi-system organ failure. He also had progressive weakness, kidney

failure and then a gastrointestinal bleed. Following referral to Hospice, [decedent] died on March 15, 2002" (id. at ¶ 18).

Dr. Marshall opined that his care of decedent "did not deviate from accepted standards of care at any time" (id. at ¶ 19). Dr. Marshall explained:

"[Decedent's] infrequent and sporadic episodes of 15 minutes of vague abdominal pain that he reported occurring a couple of times a year did not warrant aggressive treatment or evaluation under the circumstances then and there existing. These include his normal liver enzymes, normal CBC, stable weight, negative rectal examinations and negative stool specimens, negative findings on physical exam including lack of tenderness, and the patient's description of the discomfort and the fact that he never presented for evaluation because of these vague complaints. [Decedent] merely mentioned his complaints during some routine visits. Additionally, he reported relief of his symptoms with nitroglycerine" (id. at ¶ 20).

Dr. Marshall also indicated that both he and Dr. Constantino "felt that there was progressive cardiovascular disease in this elderly diabetic and that abdominal anginal (mesenteric ischemia) was consistent with his clinical course" (id. at ¶ 21).

Dr. Marshall further opined that decedent's "intermittent complaints of abdominal discomfort did not require ordering an extensive workup or consultation" (id. at ¶ 23). Dr. Marshall also concluded that, as of December 2001, decedent's "abdominal complaints seemed to have resolved or at least markedly diminished to the point where he reported feeling fine, had gained weight and had a benign abdominal examination" (id. at ¶ 25). Further, Dr. Marshall noted that, when decedent reported he stopped drinking, he interpreted this as positive step since Dr. Marshall had advised him to stop (see id. at ¶ 26). Dr. Marshall also opined that decedent's "vague episodes of pain were not related to or

predictive of the acute and catastrophic abdominal complaints with which [decedent] presented to Samaritan Hospital emergency room in January, 2002" (*id.* at ¶ 27). Dr. Marshall further opined that decedent "suffered from an acute condition in January of 2002 that was completely unrelated to his complaints in October 2001, his last visit in my office. It is also my opinion that my care and treatment of [decedent] fully comported with accepted standards of care at all times" (*id.* at ¶¶ 28-29).

Further, Marshall defendants submitted, *inter alia*, Dr. Marshall's deposition testimony, in which he testified consistently with his submitted affirmation discussed above. At that deposition, Dr. Marshall testified that he assumed that decedent had been referred to a gastroenterologist since he had received a consultation note from Dr. Constantino stating such. Dr. Marshall also testified that he did not attach any clinical significance to the fact that decedent had stopped drinking since decedent had stopped drinking on and off over a period of ten years. Further, Dr. Marshall testified that he was comfortable with his possible diagnosis of mesenteric ischemia to explain decedent's reported abdominal pain especially since Dr. Constantino appeared to agree with the diagnosis and "when the gastroenterologist wrote in the chart that he thought it was mesenteric ischemia" (Snyder Affidavit, Exhibit F at 78).

As to the Constantino defendants motion, they submitted, *inter alia*, the affidavit of Dr. Constantino, who is a New York licensed physician and Board Certified in Cardiology and Internal Medicine. In that affidavit, Dr. Constantino averred that decedent was "an

elderly gentleman with multiple medical problems, including emphysema, coronary artery disease, a pacemaker, and a previous history of gallbladder disease,” who Dr. Constantino had followed regarding decedent’s cardiovascular issues since the mid-1990s (Constantino Affidavit at ¶ 6 [McFarland Affidavit, Exhibit I]). Dr. Constantino explained that, on June 7, 2000, decedent reported some prior episodes of abdominal discomfort. In response, Dr. Constantino noted that he conducted an abdominal exam and “found that the patient’s abdomen was benign without any masses or tenderness” (id. at ¶ 8). Dr. Constantino further noted: “This was significant because it indicated to me that the patient was not experiencing any acute problem at the time” (id.). Dr. Constantino further explained:

“As the patient had no abdominal complaints at that time, and the abdominal examination was normal, I noted the complaints and the results of my examination in my office note, copied the primary care physician on the note, and focused my investigation and treatment on the patient’s cardiac issues” (id. at ¶ 9).

Dr. Constantino averred that he next saw decedent in December 2000, at which time decedent reported continued intermittent abdominal discomfort, indicating it was relieved with an inhaler. Dr. Constantino explained that he believed “the complaints might be related to [decedent’s] chronic obstructive pulmonary disease” (id. at ¶ 10). Dr. Constantino opined that his “care and treatment of [decedent] at both of these visits was appropriate in all respects and [he] completely fulfilled [his] responsibilities as [decedent’s] cardiologist” (id. at ¶ 11).

Dr. Constantino noted that, in January 2001, decedent underwent a stress test, which

was abnormal. Decedent returned to Dr. Constantino's office in February 2001, reporting continued intermittent abdominal pain with loss of appetite and weight loss (see id. at ¶ 12). Dr. Constantino noted that he "recorded the symptoms in my office note, and indicated that [he] would refer the patient for a GI evaluation" (id.). Dr. Constantino also recommended decedent undergo a cardiac catheterization and copied these notes to the primary care physician (see id.). Decedent underwent the catheterization on February 27, 2001.

Dr. Constantino next saw decedent in April 2001, at which Dr. Constantino averred decedent reported his appetite improved and he gained weight. Dr. Constantino noted: "While [decedent] described some intermittent abdominal discomfort like 'gas type pain', his abdominal examination was benign, with no masses, tenderness, hepatomegaly or palpable aneurysm" (id. at 14). At decedent's June and December 2001 visits, Dr. Constantino averred that decedent had no abdominal complaints and was feeling fine.

Dr. Constantino opined that, regarding plaintiff's allegations that he deviated from accepted standards of care by not following-up on his February 2001 consult recommendation, such claims lack merit (see id. at ¶¶ 16-17). Dr. Constantino further noted that, while he was called to treat decedent's cardiovascular issues and he understood the primary care physician was following decedent with regard to his abdominal complaints, he did address the symptoms and recommended a referral for what may have been decedent's gastrointestinal issue (see id. at ¶¶ 18-19). Dr. Constantino opined: "However, and more importantly, [decedent's] abdominal complaints resolved after that February 2001 visit, to

the point where a gastroenterology consult was not longer indicated” (id. at ¶ 20). Dr.

Constantino further explained:

“As indicated in my notes and at my deposition, my concern was ‘triggered’ at that February visit due to the patient’s reports of a loss of appetite and weight. While I still thought that his symptoms might be cardiac in nature, these new symptoms made me question whether there was a more worrisome problem occurring and thus prompted the GI referral.

“While plaintiff is correct i[n] claiming that I did not pursue that referral, or “push” for the plaintiff to see a gastroenterologist, it is my opinion that my decision in that respect was completely appropriate because the patient’s symptoms resolved.

“When I next saw the patient in April, he reported that his appetite was improving and that he had started to gain weight. His abdominal symptoms had diminished, and by June he had no abdominal complaints at all and was continuing to do well” (id. at 21-23).

Dr. Constantino further opined that he “was associating [decedent’s] issues with mesenteric ischemia, which is not a serious problem, and is not uncommon in a patient with long-standing vessel disease. This type of problem does not need to be ‘addressed’ as it is not life-threatening, rather appropriate treatment consists of monitoring the situation and perhaps making medication changes” (id. at ¶ 24). Dr. Constantino noted that “the fact that the patient had no symptoms for several months prior to January 2002 reveals that the vague, intermittent complaints in early 2001 were in no way the cause of, or related to, the patient’s 2002 hospitalization” (id. at 28). Dr. Constantino concluded: “It is my opinion that [decedent] suffered from an acute condition in 2002, that was entirely unrelated to [decedent’s] 2001 abdominal complaints” (id. at ¶ 29).

The Constantino defendants also submitted the affidavit of John Nolan, M.D., a New York licensed physician who is Board Certified in Internal Medicine and Cardiology. Upon review of decedent's medical records from Dr. Constantino, Dr. Marshall, Dr. Eglow and Samaritan Hospital, along with his review of the pleadings and deposition transcripts, Dr. Nolan opined that "all of the claims against [the Constantino defendants] lack merit, and that Dr. Constantino's care and treatment of this patient did not deviate from accepted standards of care at any time" (Nolan Affidavit at ¶ 3). Dr. Nolan noted that decedent was an elderly gentleman with several medical problems. Further, Dr. Nolan explained that Dr. Constantino, as the treating cardiologist, "was in charge of [decedent's] cardiovascular health" and that decedent "was concurrently treating with a primary care physician who was generally responsible for managing his overall health" (*id.* at ¶ 8). Dr. Nolan further explained that cardiac patients often describe "epigastric pain, such as described by [decedent] here, which is later determined to be cardiac in nature" (*id.* at ¶ 10).

After highlighting the treatment Dr. Constantino provided to decedent, Dr. Nolan opined that no basis exists for plaintiff's claim that Dr. Constantino should have followed up on the recommendation for a GI consult (*see id.* at ¶¶ 15-16). First, Dr. Nolan explained that it was not Dr. Constantino's responsibility since that would fall on the primary physician once notified of such recommendation by Dr. Constantino's consultation note (*see id.* at ¶ 17). Second, Dr. Nolan noted that, "even if Dr. Constantino did not assume some responsibility for following this issue by making the referral, there was no deviation in not

ensuring that the patient followed through with it because the patient's abdominal issues resolved" (id. at ¶ 18).

Further, Dr. Nolan opined: "As the patient's abdominal complaints clearly resolved, and the patient was not present with any acute abdominal issues, Dr. Constantino did not deviate from accepted standards of care by not pressing [decedent] to see a gastroenterologist and associating his vague, intermittent complaints with ischemia" (id. at ¶ 22). Dr. Nolan also opined that, since decedent made no further abdominal complaints after April 2001 and reported feeling fine for the next 8-9 months, "[t]here is no basis to plaintiff's claims that the patient's hospitalization in 2002 was the result of the patient not having been treated for non-acute abdominal complaints in early 2001" (id. at ¶ 27). Dr. Nolan concluded: "It is my opinion that Dr. Constantino's treatment of [decedent] was appropriate in all respects, and conformed to accepted standards of medical care at all times" (id. at ¶ 28).

The Constantino defendants also submitted the affidavit of Dr. Richard MacDowell, a New York licensed physician, who is Board Certified in Surgery and a Clinical Associate Professor of Surgery at Albany Medical Center. Dr. MacDowell reviewed decedent's medical records from Dr. Constantino, Dr. Marshall, Dr. Eglow, and Samaritan Hospital, in addition to the pleadings, deposition transcripts and plaintiff's expert response. Dr. MacDowell opined that "the claims against all of the defendants lack merit, as this patient suffered from an acute condition in January 2002 that was in no way related to any

symptoms experienced by [decedent] in early 2001" (MacDowell Affidavit at ¶ 5 [McFarland Affidavit, Exhibit L]). Significantly, Dr. MacDowell noted:

"The fact that [decedent's] symptoms were relieved with these medications is very important, as it is a clear indication that the doctors were not dealing with a significant gastrointestinal pathology. Had the patient been suffering from an ongoing serious abdominal issue, such as chronic peptic disease, the abdominal symptoms certainly would not have been relieved with the use of such medications. Patients experiencing such a problem usually present with localized pain under the rib cage or right under the bottom of the sternum or breast bone, followed by significant pain in that area or in the right upper quadrant. This patient was not suffering from such problems, and instead only reported intermittent abdominal pain of very short duration" (*id.* at ¶ 9).

Dr. MacDowell further opined that decedent's reports of intermittent abdominal pain, with a negative abdominal examination, was not indicative peptic ulcer disease but "were more consistent with mesenteric ischemia" (*id.* at ¶¶ 12, 18). Dr. MacDowell also opined that decedent "did not present with a single symptom to suggest chronic peptic disease or perforation at any of the visits in 2000 or 2001" (*id.* at ¶ 19). Dr. MacDowell concluded:

"It is my opinion, to a reasonable degree of medical certainty, that the cause of [decedent's] acute abdominal event in January 2002 was a new problem and was not related to the periodic abdominal complaints made by the patient in early 2001. Especially where, upon admission to the hospital in 2002, [decedent] reported a history of abdominal pain for 3 days, and presented with nausea, vomiting, severe abdominal pain, abdominal tenderness and shortness of breath – all indicators of an acute attack.

"It is therefore my opinion that both Dr. Constantino's and Dr. Marshall's treatment of the patient was appropriate in all respects, and conformed to accepted standards of medical care at all times" (*id.* at ¶¶ 24-25).

The Constantino defendants also submit copies of Dr. Constantino's deposition transcripts, in which Dr. Constantino testified consistent with his above-discussed affidavit.

In addition, the Constantino defendants also submitted various medical records related to decedent.

Here, both the Marshall defendants and the Constantino defendants have established their prima facie entitlement to judgment as a matter of law (Torns v Samaritan Hosp., *supra* at 966 [quoted case omitted]). Both sets of defendants have presented detailed affidavits, along with deposition testimony and medical records, demonstrating that their actions neither deviated from the acceptable standards of care nor were a proximate cause of decedent's death (see Suib v Keller, *supra* at 806). For instance, their submissions demonstrate that the failure of the physicians to either refer or follow-up on a referral of decedent to a GI specialist did not deviate from the appropriate standard of care in light of decedent's intermittent complaints of abdominal pain and the negative findings upon physical examination by both physicians, as well as negative lab testing results. In addition, the submissions indicate that decedent was suffering from other health issues, which explained the differential diagnosis that both physicians arrived upon for decedent.

Although the record and expert submissions show some disagreement as between Dr. Marshall and Dr. Constantino as to who was responsible for either referring decedent to a GI specialist or following-up on such a referral, this dispute is not determinative here. As the submissions indicate, all the experts agree that such a referral was no longer necessary as decedent's symptoms had resolved months prior to his admission to Samaritan Hospital and his eventual death.

Where, such as here, defendants have "demonstrated entitlement to summary

judgment, a ‘plaintiff must adequately rebut that showing by establishing a departure from accepted medical practice, as well as a nexus between the alleged malpractice and [decedent’s] injury’” (Grzelecki v Sipperly, supra at 941, quoting Rossi v Arnot Ogden Med. Ctr., 268 AD2d 916, 917 [3d Dept 2000], lv denied 95 NY2d 751; see Merritt v Saratoga Hosp., 298 AD2d 802, 804 [3d Dept 2002]). In addition, “‘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 a defendant physician’s summary judgment motion’” (Grzelecki v Sipperly, supra at 941, quoting Alvarez v Prospect Hosp., 68 NY2d 320, 325 [1986]).

In this instance case, plaintiff submitted an affidavit of Dr. Maxwell M. Chait, a New York licensed physician who is Board Certified in Internal Medicine and Gastroenterology. Dr. Chait averred that he reviewed decedent’s medical records from Dr. Constantino, Dr. Marshall, Dr. Eglow and Samaritan Hospital, along with the pleadings, plaintiff’s expert response, deposition transcripts, and defendants’ expert affidavits submitted on this motion. Dr. Chait first noted that “mesenteric ischemia is a significant and potentially life threatening disease and, if suspected, needs to be evaluated,” which he notes was not done in this case (Chait Affidavit at ¶ 6).

Also, Dr. Chait notes that Dr. Marshall “never documented any effort to engage in a differential diagnosis and indeed failed to seriously consider any cause for [decedent’s] continuing abdominal complaints other than the possibility of mesenteric ischemia” (id. at ¶ 7). Dr. Chait suggested that “mesenteric ischemia is a less common cause in a patient such

as [decedent] with his continuing abdominal complaints. The more likely causes of his abdominal complaints given his history and risk factors, would be gastrointestinal problems including gastroduodenal ulcers and biliary tract disease,” which Dr. Chait notes were the conditions that were ultimately diagnosed when decedent presented at Samaritan Hospital (id. at ¶ 8). Dr. Chait explained decedent “had numerous medical conditions which predisposed him to gastroduodenal peptic ulcer diseases. Further, he had a history of aspirin use and NASID use, which are known causes of ulcers” (id. at ¶ 10). Thus, Dr. Chait concluded that, as to Dr. Marshall, he deviated from good and accepted medical practice by failing to consider any other causes, other than mesenteric ischemia, for decedent’s abdominal pain since there was no documented basis for that diagnosis (see id. at ¶ 12).

Moreover, Dr. Chait noted that this possible diagnosis was never confirmed, which good and accepted medical practice would mandate. Further, Dr. Chait averred: “Nitroglycerin relieves spasm and as such, it can and does relieve spasms caused by bile duct stones which we know [decedent] was suffering from” (id. at ¶ 13). Dr. Chait also opined that decedent’s complaints of abdominal pain were the responsibility of Dr. Marshall to follow and not the treating cardiologist. Dr. Chait also averred that, after reading Dr. Constantino’s February 21, 2001 note, “[i]t was incumbent upon [Dr. Marshall] to make an inquiry” of decedent regarding that note (id. at ¶ 20). Further, Dr. Chait opined that it “was a serious lapse of judgment and a deviation from the standard of care by a primary care physician” not to follow up on the GI referral and the GI complaints (id. at ¶ 21).

After reviewing each of decedent’s visits with Dr. Marshall, Dr. Chait opined, with

a reasonable degree of medical certainty, that decedent

“was suffering from long standing gastroduodenal peptic ulcer disease and from a common bile duct gall stone. Given the size of the stone and the nature of the ulcerative disease at the time of his admission in January of 2002, it is my belief that he suffered these conditions probably from the point of his first complaints in June of 2000, but most certainly by early 2001. Further it is clear that a referral at any time, up to and through this last visit with Dr. Marshall, to a gastroenterologist would have found the peptic ulcer disease and the huge common bile duct stone and that [decedent’s] life would have been saved” (id. at ¶ 23).

As to Dr. Constantino, Dr. Chait noted that “Dr. Constantino’s medical negligence and deviations from the standards of care are of an entirely different nature than Dr. Marshall’s” (id. at ¶ 26). Dr. Chait observed that, although Dr. Constantino suggested a gastroenterological referral, he never followed up with it. Dr. Chait opines:

“While under ordinary circumstances it would be appropriate for a cardiologist or any other specialist to refer a patient back to his primary care physician for abdominal complaints, Dr. Constantino chose not to. It was a deviation from accepted standards to not follow-up on this. Had he done so at any point after his February 21, 2001 office visit, the unfortunate outcome of the gastroduodenal peptic ulcer disease and common bile duct stone would have been prevented” (id. at ¶ 30).

In reply, both sets of defendants adopt each other’s submissions and both contend that Dr. Chait’s affidavit is insufficient as a matter of law to raise a question of fact and defeat defendants’ motions for summary judgment. The Marshall defendants contend that Dr. Chait failed to state specifically what medical tests should have been performed or to explain why Dr. Marshall’s reliance on statements by decedent that nitroglycerin relieved his symptoms was significant. Further, the Marshall defendants contend that Dr. Chait failed to explain the significant of decedent’s symptoms and what record evidence Dr. Chait

relied upon reaching his ultimate conclusions. The Constantino defendants contend that Dr. Chait failed to adequately explain why he concluded that follow-up regarding Dr. Constantino's recommendation that decedent see a GI specialist would have prevented decedent's death.

As to the Constantino defendants, this Court agrees that plaintiff's submissions are insufficient to raise a material issue of fact to preclude summary judgment as to these defendants (see Grzelecki v Sipperly, supra at 941). Dr. Chait's affidavit failed to address the opinion asserted by the Constantino defendants' experts that decedent's abdominal issues resolved 8-9 months prior to decedent's 2002 hospitalization and, thus, follow-up on Dr. Constantino's recommendation that decedent be evaluated by a GI specialist was no longer medically necessary.

As to the Marshall defendants, this Court also agrees that plaintiff's submissions are insufficient to raise a material issue of fact as to preclude summary judgment as to these defendants (see id.). Dr. Chait's affidavit failed to address key factors that were the basis for the differential diagnosis relied on by both defendant doctors. For instance, Dr. Chait did not address the results of both defendant doctors' physical examinations of decedent regarding his complaints of abdominal pain. Undisputed record evidence establishes that those exams revealed that decedent's abdomen was non-tender and soft to the touch. As evidenced by all defendants' expert and treating physician submissions, these physical exam results were significant in both Dr. Marshall and Dr. Constantino operating under a differential diagnosis of mesenteric ischemia. Further, Dr. Chait did not address that Dr.

Constantino operated under the same differential diagnosis, which affirmed Dr. Marshall's differential diagnosis. In other words, there was some confirmation from another physician – decedent's cardiologist – who was also treating decedent, knew his history, heard similar intermittent complaints of abdominal pain, and also had the same results upon examining decedent's abdomen.

In addition, Dr. Chait failed to address cardiovascular issues with which decedent presented during the relevant time period, and how such issues affected Dr. Marshall's conclusions. As undisputed in the record, during the period of treatment at issue in this action, decedent underwent a catheterization procedure, which appeared to be related to some of the abdominal issues raised by decedent. Moreover, decedent never presented at either defendant doctor's office with an abdominal issue but merely mentioned the abdominal pains at intermittent visits during the relevant time period. Accordingly, since these significant factors were not discussed by Dr. Chait, plaintiff's submissions fail to rebut the prima facie showing by defendants to defeat defendants' motions for summary judgment (see Kean v Community Gen. Hosp., 195 AD2d 910, 912 [3d Dept 1993], lv denied 83 NY2 752 [1994]).

Finally, there is no merit to plaintiff's argument that the Noseworthy doctrine (Noseworthy v City of New York, 298 NY 76 [1948]) applies here. Pursuant to that doctrine,

“a party who has died or is incapacitated as a result of alleged negligent acts of a defendant is held to a lesser burden of proof in establishing his or her right to recovery.” The rationale is that the decedent is not available to

describe the occurrence and that it is unfair to permit the defendant, who has knowledge of the facts, to benefit by standing mute.’ The rule, however, has no application where the plaintiff and the defendant have equal access to the facts surrounding the decedent’s death” (Orloski v McCarthy, 274 AD2d 633, 634 [3d Dept 2000], lv denied 95 NY2d 767 [quoted cases omitted]; see Holiday v Huntington Hosp., 164 AD2d 424, 427 [2d Dep 1990]).

Further, the Noseworthy doctrine only applies “to such factual testimony as a decedent might have testified to, had he lived” (Feltus v Staten Island Hosp., 285 AD2d 445, 447 [2d Dept 2001]).

Here, plaintiff seeks application of the doctrine in two instances. In the first instance, plaintiff seeks an inference that there was not a definitive correlation of relief of all of decedent’s abdominal complaints from his use of nitroglycerine. Plaintiff contends that this is only fair given the ambiguity in the medical records regarding decedent’s statement’s regarding his use of nitroglycerine and his abdominal complaints. In the second instance, plaintiff seeks an inference that it was Dr. Constantino’s negligence that resulted in the referral to a GI specialist never occurring. First, all parties have access to the same medical records in which decedent’s statements regarding his use of nitroglycerine were recorded (see Feltus v Staten Island Hosp., supra). Second, decedent could not have testified regarding the alleged negligence of the defendant doctors in failing either to diagnose and treat him or refer him to a GI specialist (see Tan v St. Vincent’s Hosp. & Med. Ctr., 294 AD2d 122, 123 [1<sup>st</sup> Dept 2002]; see also Stewart v Olean Med. Group, P.C., 17 AD3d 1094, 1096 [4<sup>th</sup> Dept 2005]; Casey v Tan, 255 AD2d 900, 901 [4<sup>th</sup> Dept 1998]). Accordingly, the Noseworthy doctrine is not applicable.

As to the parties' remaining arguments, the Court has reviewed them and finds them to be without merit.

Accordingly, it is

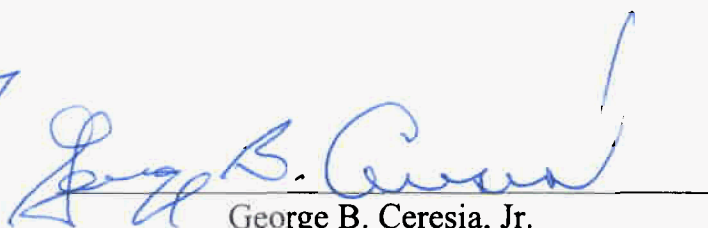
**ORDERED** that the motion for summary judgment dismissing the complaint by defendant s Robert M. Marshall, M.D. and Partners in Family Medicine is granted; and it is further

**ORDERED** that the motion for summary judgment dismissing the complaint by defendants Jorge Constantino, M.D. and Capital Cardiology Associates is granted; and it is further

**ORDERED** that the complaint is dismissed in its entirety.

This shall constitute the decision and order of the Court. All papers are returned to the attorney for defendants Robert Marshall, M.D. and Partners in Family Medicine, who is directed to enter this Decision/Order without notice and to serve all attorneys of record with a copy of this Decision/Order with notice of entry.

Dated: OCTOBER 4, 2007  
Troy, New York

  
George B. Ceresia, Jr.  
Supreme Court Justice

Papers Considered:

1. Notice of Motion by defendants Jorge Constantino, M.D. and Cardiology Associates dated February 15, 2007;

2. Affidavit of Mandy McFarland, Esq., sworn to February 15, 2007, with accompanying Exhibits A-L (including the Affidavit of Jorge Constantino, M.D., sworn to February 13, 2007 [Exhibit I]; the Affidavit of John Nolan, M.D., sworn to February 13, 2007 [Exhibit K]; and the Affidavit of Richard MacDowell, M.D., sworn to February 13, 2007 [Exhibit L]).
3. Notice of Motion by defendants Robert Marshall, M.D. and Partners in Family Medicine dated February 16, 2007;
4. Affirmation of Robert Marshall, M.D. affirmed February 16, 2007, with accompanying Exhibit A;
5. Affidavit of Lauren M. Snyder, Esq., sworn to February 16, 2007, with accompanying Exhibits A-G;
6. Affidavit of Jonathan Fairbanks, Esq., sworn to June 4, 2007, with accompanying Exhibits 1-13;
7. Affidavit of Maxwell M. Chait, M.D., sworn to June 4, 2007, with accompanying Exhibit;
8. Reply Affidavit of Mandy McFarland, Esq., sworn to June 8, 2007;
9. Reply Affidavit of Lauren M. Snyder, Esq., sworn to June 15, 2007.