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

PRESENT: LOBIS Justice PART 6

JANET NARVAEZ

-v-

ALLAN STEWART, M.D.,

INDEX NO. 113058/08

MOTION DATE 5/24/11

MOTION SEQ. NO. 2

MOTION CAL. NO.

The following papers, numbered 1 to 22 were read on this motion to/for summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-19
Answering Affidavits — Exhibits	20-21
Replying Affidavits	22

Cross-Motion: ☐ Yes ☑ No

Upon the foregoing papers, it is ordered that this motion decided in accordance with accompanying decision and order.

FILED

JUL 27 2011

NEW YORK
COUNTY CLERK'S OFFICE

Dated: 7/22/11

J.S.C.

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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JANET NARVAEZ, as Administratrix of the Estate of FREDDIE MONTALVO, deceased, and JANET NARVAEZ, individually,

Plaintiff,

-against-

ALLAN STEWART, M.D., MICHAEL BOWDISH, M.D., CHARLES MARBOE, M.D., ANGEL RODRIGUEZ, M.D., CHRISTOPHER NDU IROBUNDA, M.D. and NEW YORK PRESBYTERIAN- THE UNIVERSITY HOSPITAL OF COLUMBIA AND CORNELL,

Defendants.

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Index No. 113058/08

Decision and Order

JOAN B. LOBIS, J.S.C.:

Motion Sequence Numbers 002 and 003 are consolidated for disposition. In Motion Sequence Number 002, defendant Allan Stewart, M.D., moves for summary judgment dismissal of the claims against him pursuant to C.P.L.R. Rule 3212. Inasmuch as plaintiff's claims against New York-Presbyterian Hospital ("NYPH") s/h/a New York Presbyterian- The University Hospital of Columbia and Cornell sound in vicarious liability for the acts of Dr. Stewart, in Motion Sequence Number 003, NYPH brings a motion for summary judgment predicated on Dr. Stewart's motion. Plaintiff Janet Narvaez, individually and as the Administratrix of the Estate of Freddie Montalvo, deceased, opposes the two motions.

This action sounding in medical malpractice and wrongful death arose out of treatment rendered to Mr. Montalvo between August 23, 2007 and his death on November 26, 2007. On August 23, Mr. Montalvo presented to the emergency department of NYPH with complaints of chest pain and tachycardia. An echocardiogram demonstrated that Mr. Montalvo had a bicuspid

aortic valve with moderate to severe aortic stenosis and moderate aortic regurgitation. He was scheduled to undergo surgery with Dr. Stewart.

On August 28, 2007, Dr. Stewart performed the scheduled surgery on Mr. Montalvo, which included an aortic root replacement with reimplantation of an artificial valve, hemiarch replacement, an epicardial maze procedure, and ligation of the left atrial appendage. Dr. Stewart testified at his examination before trial ("EBT") that he did not observe signs of infection at the aortic root site during the surgery. Mr. Montalvo's white blood cell count was within normal limits throughout this first admission to NYPH. He did not have a fever, except for a transient fever on the first day after the operation. Cultures of blood drawn on August 30, 2007, were negative for growth.

Specimens removed during the procedure were sent for pathological analysis. The pathology studies of the aortic root valve were reported by former co-defendant[1] Charles Marboe, M.D., on August 30, 2007. The native aortic valve tissue had signs of acute and healing endocarditis. An addendum to the report, dated September 6, 2007, indicated that the aortic valve specimen was analyzed using Gram and Gomori methenamine-silver stains and no organisms were identified. The addendum also reported that one specimen had "an additional focus of degeneration of the valve with necrosis of fibrous tissue, fibrinous exudates, infiltrates of neutrophils, and also healing with granulation tissue." Dr. Stewart testified at his EBT that "infiltrates of neutrophils"

[1] Plaintiff has discontinued her action against Michael Bowdish, M.D., Charles Marboe, M.D., Angel Rodriguez, M.D., and Christopher Ndu Irobunda, M.D.

indicates inflammation. Dr. Marboe testified at his EBT that the inflammation of the endocardium of the native aortic valve was consistent with tissue degeneration, and that there was no evidence to conclude that the tissue was positive for infective endocarditis. On September 2, 2007, Mr. Montalvo was discharged with instructions to follow up with a cardiologist and with Dr. Stewart in six weeks. It is uncontested that Dr. Stewart did not review the pathology report before Mr. Montalvo was discharged on September 2, 2007. Dr. Stewart testified that even had he reviewed the pathology report, he would not have treated Mr. Montalvo any differently.

On September 10, 2007, Mr. Montalvo was seen by Christopher Irobunda, M.D., a cardiologist. Mr. Montalvo complained of a slight cough and chest wall discomfort. All other pertinent aspects of the examination and blood work were within normal limits. On September 16, 2007, Mr. Montalvo was seen by Angel Rodriguez, M.D., an internist. There were no documented complaints at the September 16 visit.

On September 24, 2007, Mr. Montalvo returned to NYPH via ambulance with a fever of 102.1 degrees Fahrenheit and complaints of chills and shortness of breath. Blood work revealed an elevated white blood cell count and blood cultures indicated Gram-positive cocci, Streptococcus mitis, and Streptococcus salivarius. Mr. Montalvo became unresponsive in the early morning of September 25, 2007; he was transferred to the intensive care unit and intubated. On September 26, 2007, a transesophageal echocardiogram showed vegetation on the prosthetic aortic valve. Mr. Montalvo was diagnosed with probable prosthetic valve endocarditis and started on a course of antibiotics. On September 27, 2007, magnetic resonance imaging revealed that Mr. Montalvo had

a massive stroke with septic emboli. Mr. Montalvo went into a coma, from which he never recovered, and died on November 26, 2007.

Plaintiff's essential allegation against Dr. Stewart is that he departed from the standard of care in failing to timely diagnose and treat Mr. Montalvo's endocarditis. She alleges that Dr. Stewart failed to review the August 28, 2007 pathology report and appreciate the presence of endocarditis in that report; failed to prescribe the appropriate antibiotics to treat the endocarditis; and allowed the endocarditis to progress to such an extent that Mr. Montalvo could not recover. She further alleges that Dr. Stewart failed to communicate with the other medical professionals caring for Mr. Montalvo, and failed to arrange for a timely infectious disease consultation.

Dr. Stewart contends that there are no issues of fact that his treatment of Mr. Montalvo was within accepted standards of medical care, and that there was no departure from accepted medical practice that proximately caused Mr. Montalvo's injuries or death. 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 A.D.3d 204, 206 (1st Dep't 2010) (citations omitted). To satisfy that burden, the defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Id. If the defendant makes a prima facie showing, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues

of fact which require a trial of the action." Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) (citation omitted). Specifically, in a medical malpractice action, a plaintiff opposing a summary judgment motion

> must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries. . . . In order to meet the required burden, the plaintiff must submit an affidavit from a physician attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged.

Roques, 73 A.D.3d at 207 (internal citations omitted).

In support of his motion for summary judgment, Dr. Stewart submits an affirmation from Richard Fried, M.D., who affirms that he is a physician licensed to practice medicine in New York and board certified in internal medicine and infectious diseases. Dr. Fried states that he has reviewed the pleadings, plaintiff's expert disclosures, the deposition transcripts of all parties, NYPH's records, the records of Drs. Stewart, Rodriguez, and Irobunda, and the Medical Examiner's records. He opines, to a reasonable degree of medical certainty, that Dr. Stewart's care was within accepted standards of medical care and that there was no departure that was a substantial factor in Mr. Montalvo's injuries or death. Dr. Fried contends that plaintiff's allegation that the infectious endocarditis that Mr. Montalvo had on September 24, 2007, was present during the first admission is without basis. In Dr. Fried's opinion, Mr. Montalvo did not have infectious endocarditis during his first admission to NYPH from August 23 through September 2, 2007. He notes that Mr. Montalvo had no signs of infection upon his admission on August 23, 2007 and he had a consistently normal white blood cell count and temperature. The fever on the first day after the operation is typical, in Dr. Fried's opinion, and does not indicate infection or warrant a consultation by an

infectious disease specialist or treatment with antibiotics. The cultures of Mr. Montalvo's blood on August 30, 2007, were negative for bacterial or fungal infection. Further, Dr. Stewart testified that he saw no evidence of infectious endocarditis during the surgery. Dr. Fried opines that there was no reason to suspect that Mr. Montalvo had an infection during the first admission based on his clinical signs and test results.

Dr. Fried avers that Mr. Montalvo had no signs of clinical infectious endocarditis when he presented to Dr. Irobunda on September 10, 2007, or Dr. Rodriguez on September 16, 2007. Dr. Fried notes that blood drawn on September 10, 2007, indicated a normal white blood cell count and there was no fever on either presentation. However, when Mr. Montalvo returned to NYPH on September 24, 2007, he did have clinical signs of infection, i.e., a history of fever and chills, an elevated temperature, and an elevated white blood cell count. Additionally, the blood cultures on the second admission were positive for Streptococcus. Dr. Fried opines that during the second admission, with the aforementioned presentation of signs and symptoms of infection, an infectious disease consultation was properly called for and Mr. Montalvo was appropriately treated with antibiotics, but that there was no reason to treat Mr. Montalvo with antibiotics prior to the second admission.

Dr. Fried opines that the degeneration and acute and healing endocarditis on the pathology report are consistent with inflammation without infection, which is further supported by the fact that the Gram and Gomori stains for the same specimen were negative for any infection. Dr. Fried contends that the finding of inflammatory cells on pathology described as endocarditis does

not warrant a diagnosis of infectious endocarditis, and that given the lack of evidence to support a diagnosis of infectious endocarditis, it was appropriate for Dr. Stewart to discharge Mr. Montalvo with directions to follow-up in six weeks.

Dr. Stewart has met his burden in showing that he did not depart from the standard of care and did not proximately cause Mr. Montalvo's death by submitting an expert affirmation that addresses plaintiff's essential allegations in her pleadings. Basically, Dr. Stewart's expert sets forth in a detailed, nonconclusory fashion, that even in light of the fact that Dr. Stewart never reviewed the pathology report, there was no evidence of infectious endocarditis during the first admission and no reason to administer antibiotics prior to the second admission. Accordingly, the burden shifts to plaintiff to rebut Dr. Stewart's prima facie showing of entitlement to summary judgment.

Plaintiff argues that issues of fact preclude granting Dr. Stewart summary judgment. She claims that his failures to review the pathology report, to call for an infectious disease consultation, and to administer intravenous antibiotics constitute departures from good and accepted medical practice and were substantial factors in causing Mr. Montalvo's injuries and subsequent death. In support of her argument that issues of fact remain, plaintiff submits an affirmation from a physician (name redacted) licensed to practice medicine in New York who sets forth that he/she is an internist with knowledge of infectious disease. The expert bases his/her opinion on Mr. Montalvo's medical records, the autopsy report, the parties' deposition testimony, and Dr. Stewart's motion. It is plaintiff's expert's opinion, within a reasonable degree of medical certainty, that Dr. Stewart's failure to review the pathology report, order an infectious disease consultation, and

administer intravenous antibiotics constituted departures from good and accepted medical practice under the circumstances. The expert further maintains that these departures were substantial factors in causing Mr. Montalvo's injuries and premature death. The expert sets forth that endocarditis can present with a nonspecific constellation of symptoms, including fever, fatigue, weight loss, and malaise. Some cases present with acute symptoms such as high fever, chills, and elevated white blood cell counts. Other cases present with "a paucity of nonspecific symptoms such as cough, fatigue, poor appetite and/or weight loss extending over a period of several weeks or even months." Plaintiff's expert contends that blood culture results positive for bacteria are the best diagnostic tool for determining whether a patient has endocarditis, but echocardiographic visualization of lesions on the heart valve or pathological examination may also lead to a diagnosis of endocarditis even in the absence of positive blood cultures. Plaintiff's expert states that the "visualization of acute and healing endocarditis of the native aortic valve" in the pathology report was "unequivocal evidence for endocarditis." The expert avers that "'healing' does not indicate that the infection was resolving; rather, it indicates that there were scattered areas of active inflammation adjacent to other scattered areas of scarring . . . [which is] indicative of an active ongoing infection." Further, the "infiltrating neutrophils" and other histologic features described in the addendum to the pathology report indicates to plaintiff's expert that an active infection of the aortic valve was present at the time the native valve was removed; the prosthetic valve was, therefore, placed into an infected surgical bed and also became infected. Plaintiff's expert opines that Dr. Stewart's statements that he did not visualize infected tissue during the surgery are irrelevant, because it is impossible for the naked eye to visualize microorganisms; the only reliable way to identify infection is through pathologic analysis.

Plaintiff's expert sets forth that untreated endocarditis is a fatal condition, but with

appropriate medical therapy, cure rates range from 85% to 95%. Depending on the extent of the disease, intravenous antibiotics for two to six weeks are a necessary component of appropriate medical therapy; surgical intervention to replace the valve is sometimes also appropriate, but plaintiff's expert contends that surgery alone is never sufficient to cure the infection. The expert maintains that the endocarditis reported in the pathology report required consultation with an infectious disease specialist and treatment with intravenous antibiotics; he/she opines that Dr. Stewart's failures to call for such consultation or administer such antibiotics were departures from good and accepted medical practice. Plaintiff's expert opines that had Dr. Stewart reviewed the pathology report in accordance with standard medical practice, he would have recognized the endocarditis and arranged for the infectious disease consultation and treatment with antibiotics. The expert opines that Dr. Stewart's testimony that he would not have altered Mr. Montalvo's course of treatment even had he reviewed the pathology report "only highlights [Dr. Stewart's] lack of appreciation of the disease process and why intravenous antibiotic therapy was needed." The expert opines that had Dr. Stewart requested an infectious disease consultation, appropriate measures to treat and cure the endocarditis would have been undertaken; alternatively, had Dr. Stewart administered a course of antibiotics, Mr. Montalvo's endocarditis would have been "successfully treated and cured before the development of septic emboli, the complications from which [Mr. Montalvo] ultimately died." Plaintiff's expert sets forth that his/her opinion that intravenous antibiotic therapy would have successfully treated Mr. Montalvo's endocarditis is supported by the fact that this treatment did eventually cure the endocarditis once it was started during Mr. Montalvo's second admission to NYPH; blood cultures were positive for bacteria upon his admission but negative after the antibiotics were administered. However, the treatment was too late to prevent the

development of emboli. Plaintiff's expert contends that Dr. Stewart's departures allowed the disease to progress to such a point that Mr. Montalvo lost all chance for recovery. The expert opines, to a reasonable degree of medical certainty, that had antibiotics been started during the first admission to NYPH, the prosthetic valve infection would have been cured and Mr. Montalvo would not have died from the endocarditis.

Plaintiff's expert's affirmation is sufficient to rebut Dr. Stewart's showing of entitlement to summary judgment. While Dr. Fried opines that there was no evidence of infectious endocarditis during the first admission, plaintiff's expert sets forth in a detailed, nonconclusory manner that infectious endocarditis was present on the pathology report and that, despite the clinical signs indicating no infection was present, it is the standard of care to both review pathology reports and either call for an infectious disease consultation or start a course of antibiotics upon a finding that endocarditis is present in the pathology report. Essentially, one expert maintains that clinical presentation and blood work are the only tests required to rule out endocarditis, while the other expert maintains that a pathological examination is also required to rule out endocarditis. Plaintiff's expert's opinion conflicts with Dr. Fried's conclusion that the pathology report did not indicate infectious endocarditis, and that there was no reason to treat Mr. Montalvo with antibiotics during the first admission to NYPH. It also conflicts with Dr. Fried's conclusion that nothing that Dr. Stewart did or did not do proximately caused Mr. Montalvo's death. It is well-established that "[c]onflicting expert affidavits raise issues of fact and credibility that cannot be resolved on a motion for summary judgment." Bradley v. Soundview Healthcenter, 4 A.D.3d 194 (1st Dep't 2004). Summary judgment is denied as to Dr. Stewart, and as NYPH's motion is predicated on Dr.

Summary judgment is denied as to Dr. Stewart, and as NYPH's motion is predicated on Dr. Stewart's motion on a theory of vicarious liability, summary judgment is denied as well as to NYPH. Accordingly, it is hereby

ORDERED that the motions on Motion Sequence Numbers 002 and 003 are denied; and it is further

ORDERED that the parties shall appear for a pre-trial conference on August 23, 2011, at 9:30 a.m., prepared to pick trial dates.

Dated: July 22, 2011

JOAN B. LOBIS, J.S.C.