To commence the statutory time for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

FILED AND ENTERED
ON 5/12/2014
WESTCHESTER COUNTY CLERK

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER
PRESENT: HON. SAM D. WALKER, J.S.C.

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ETNIK NEZAJ

Plaintiff,

-against-

Index No. 835/11
DECISION & ORDER
Motion Sequence 5

JONATHAN ZVI BERKOWITZ, BENJAMIN MAX BERNSTEIN, EDWARD BRIAN JARVIS, WESTCHESTER MEDICAL CENTER A/K/A WESTCHESTER COUNTY HEALTH CARE CORPORATION,

Defendants.

----------x

FILED
MAY 12 2014
TIMOTHY C. IDONI
COUNTY CLERK
COUNTY OF WESTCHESTER

The following papers numbered 1 through 32 were received and considered in connection with the above-captioned matter:

PAPERS	NUMBERED
Notice of Motion/Affirmation/Exhibits A-S	1-21
Affirmation in Opposition/Exhibits A-D	22-26
Reply Affirmation	27-30
Affidavit of Angelo T. Scott, M.D.	31
Affidavit of David S. Wolkstein, M.D.	32

Defendants Benjamin Max Bernstein ("Bernstein") and Edward Brian Jarvis ("Jarvis") move by Notice of Motion for summary judgment pursuant to CPLR § 3212 on the issues of both liability and proximate cause, and directing the clerk to enter judgment in favor of the moving Defendants and dismissing the Plaintiff's complaint with

prejudice.

This is a medical malpractice action arising from two emergency room visits to Westchester Medical Center on March 11 and 12, 2010. Plaintiff alleges that Defendants failed to detect and diagnose an infection of Methicillin-resistant Staphylococcus Aureus ("MRSA"), which the Plaintiff claims was present on March 11 and 12, 2010, and which led to a prolonged hospitalization followed by out patient and in patient rehabilitation. Plaintiff also alleges that he developed Septic Arthritis as a result of the MRSA infection, which damaged the cartilage in Plaintiff's hip and Plaintiff required hip surgery as a result. This motion is supported by the expert affirmations of Dr. Gregory Mandell, board certified in internal medicine/infectious disease medicine and Dr. Gregory Mazarin, board certified in emergency medicine. In opposition, the Plaintiff offered expert affidavits from Dr. Angelo T. Scott, Diplomat of the American Board of Infectious Diseases and Internal Medicine, and Dr. David S. Wolkstein, Diplomat of the American Board of Orthopedic Surgery.

Plaintiff commenced this action by filing a Summons and Complaint on or about June 7, 2011 and an Amended Summons and Complaint on or about August 30, 2011. Defendant Berkowitz appeared on October 14, 2011, and Defendants Bernstein and Jarvis appeared on January 20, 2012. Discovery was completed to include service of Verified and Supplemental Verified Bills of Particulars as well as depositions and a Note of Issue was filed on September 23, 2013. Both Plaintiff and Defendants have served Expert Disclosures.

Plaintiff, a twenty-six-year-old male went to Westchester Medical Center on March 11, 2010. He was triaged at 2:31 P.M. in a wheelchair complaining of a

productive cough, generalized weakness, night sweats, chills and watery stools for three days. He had no history of medical illness, but was a smoker. Plaintiff was febrile and tachycardic. He weighed 300 pounds and complained of body aches rated at 5/10. Defendant, Bernstein was the attending physician that day. According to Bernstein's notes, the Plaintiff reported a fever, chills, sweats, muscle aches, general fatigue, weakness, cough and poor appetite. He also had a cough productive of sputum but no blood or shortness of breath. Bernstein stated that the Plaintiff was in mild distress with dry mucous membranes. He also stated that there were no other abnormal physical findings. A chest x-ray was obtained which was normal. The Plaintiff was also fed two liters of fluid intra venously.

At 3:15 P.M. the Plaintiff was still febrile (T: 101, BP: 132/80, HR: 120, RR: 16, 99%). He was given 30 mg of Toradol intravenously. By 5:00 P.M. his vital signs had normalized (T: 98.8, BP: 130/70, HR: 80, RR: 20, 99%). His symptoms had improved and when he was checked again later, he was feeling better and was able to ambulate. He was discharged with Moltrin, 800 mg (every 8 hours) and instructed to follow up with his private doctor within two days. The final diagnoses were weakness and influenza. He was provided with pre-formulated instructions for influenza. No blood was sent for laboratory analysis on this visit.

Plaintiff returned to Westchester Medical Center the following afternoon, March 12, 2010, at 2:02 P.M. On this visit, he was complaining of a productive cough with weakness. He was afebrile (T: 97.8, BP: 119/73, HR: 110, RR:20, 100%). His pain was initially rated 3/10 but was later recorded as high as 10/10. Jarvis was the attending Physician that day. The Plaintiff reported a cough, runny nose, fever and muscle aches for four days. On the previous visit, Plaintiff was diagnosed with the flu. He returned to

the hospital because the Moltrin was not adequately treating his muscle aches. He was suffering from fatigue, even though he does not have a history of fatigue. His exam was unremarkable except for mild distress. He was given two (2) Percocets and was advised to follow up in the clinic in 3-4 days. He was diagnosed with the flu and given a prescription for thirty Percocets. He was once again given pre-formulated instructions for the flu and released.

Plaintiff was taken to Montefiore North Hospital by ambulance four days later, on March 16, 2010 at 7:59 P.M. In triage he described intermittent fevers for the past two weeks with moderate decrease in oral intake and urinary output. He reported vomiting, diarrhea, and coughs with green sputum. His condition had gotten worse since his last visit to Westchester Medical Center with continued intermittent fever, vomiting and diarrhea. He had also begun hallucinating after starting Percocet on March 12th. He had generalized body and neck pain with movement and was "not making sense."

On admission, Plaintiff was perspiring profusely, and restless with jaundiced skin. He was also disoriented at times. His vital signs were significant for hyperthermia and Tachycardia (T: 95.0, BP: 125/50, HR: 126, RR: 22, 100%). He had been having intermittent altered mental status for a couple of days. When examined, he was oriented, but jaundiced, tachycordic, and his elbows and ankles were both mildly swollen. He was in mild respiratory distress with a pustular lesion on the left arm and tender lesions on the ankle, left elbow and right hand. An intravenous line was inserted and blood was drawn for testing. The results of the blood test revealed that the Plaintiff had MRSA. By this time he was in intensive care where he was administered a broad spectrum of antibiotics. He also received five liters of fluid but had minimal urine output. He also received several units of blood and he required one dialysis session after which

his kidney function began to return to normal.

An abnormal echocardiogram led to the Plaintiff being transferred to Albert Einstein Hospital where fluid removed from his pericordia sac grew out MRSA. An orthopedic consult on March 23rd. for ruling out septic arthritis of the right knee, left shoulder and right foot resulted in the Plaintiff confirming discomfort in all four extremities to include soreness and weakness. Plaintiff denied any pain localized to a specific joint or joints and stated that he had no history of joint pain in the past. After completing the exam showing full range of motion in both hips, the physician concluded there was no evidence of septic arthritis of any major synovial joints. Plaintiff's final diagnosis was MRSA endocarditis and he was treated with antibiotics. He was released from the hospital on April 8th and transferred to Bay Park Center for Nursing and Rehabilitation. At this time there was no diagnosis of septic arthritis.

Plaintiff continued to recover from the MRSA infection with no recurrent signs of infection. However, Plaintiff continued to complain of general muscle weakness which was initially attributed to deconditioning secondary to a long hospital course. He was prescribed Percocet but the pain did not resolve. He reported that the pain was exacerbated with movement but improved with medication. By this time he was ambulating with the aid of a walker or a cane. He continued to complain of "large joint" aches and pains and was prescribed Percocet. On September 10, 2010, he began complaining of pain in his left hip and on October 29, 2010, he was referred for an x-ray. Plaintiff did not get an x-ray but returned on January 6, 2011, complaining of an "aching" pain in his left hip and knee which resolved if he rested for more than an hour.

On January 10, 2011, Plaintiff underwent a bilateral x-ray of his hips, including the pelvis. The x-ray revealed degenerating joint disease at the hips, mild on the right

and moderate on the left. He continued to complain of sharp shooting pain in his entire left side since 2010. A musculoskeletal examination notes full range of motion with no synovitis or effusions. He was advised to lose weight and prescribed Calcium, Vitamin B-12 and Vitamin D. Plaintiff continued to complain of left knee and left hip pain and was noticed to have decreased range in motion during the musculoskeletal examination. On March 23, 2012, he was diagnosed with avascular necrosis of the left hip. He was referred to the Department of Orthopedic for possible hip replacement but he did not followup unitl November 13, 2012. By this time he complained of severe pain in his left hip. A comparison x-ray revealed significant degenerative changes of the left hip with joint space narrowing on the right side. He was diagnosed with severe left hip arthritis and mild right hip arthritis and referred to the Department of Orthopedic Surgery for further evaluation.

Plaintiff was evaluated for left hip replacement verses resurfacing. He was assessed with end-stage osteonecrosis of the left hip with severe osteoarthritis and was advised that he would undergo hip resurfacing unless findings during the surgery revealed that he needed total hip replacement. Plaintiff did undergo hip resurfacing and his postoperative evaluation indicates that he is recovering well. In April 2013 he was reported to be walking with a cane and asking to go back to work and he is continuing to undergo physical therapy.

A party on a motion for summary judgment must assemble affirmative proof to establish his entitlement to judgment as a matter of law. *Zuckerman v. City of N.Y.*, 49 N.Y.2d 557, 427 N.Y.S.2d 595, 404 N.E.2d 718(1980). Furthermore,"the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence

of any material issues of fact," *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324(1986). To demonstrate its entitlement to relief the moving party must come forward with evidentiary proof that establishes the absence of any material issues of fact. *McDonald v. Mauss*, 38 A.D.3d 727, 728 (2d Dept 2007). Only when such a showing has been made must the opposing party set forth evidentiary proof establishing the existence of a material issue of fact. See, e.g., *Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 (1985).

In a medical malpractice action, the Appellate Division, relying on *Alvarez*, has repeatedly stated that a defendant physician seeking summary judgment must make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby, and, in opposition, "a plaintiff must submit evidentiary facts or materials to rebut the defendant's prima facie showing, so as to demonstrate the existence of a triable issue of fact," *Stukas v. Streiter,* 83 A.D.3d 18 (2d Dept 2011) citing *Alvarez at* 68 N.Y.2d 320 (1986). Typically, the moving party's prima facie case is established by affidavits or affirmations submitted by expert medical professionals and the opposing party can only show genuine issues of material facts by offering their own expert medical testimony countering that of the moving party, *Kambat v. St. Francis Hosp.,* 89 N.Y.2d 489, 496 (1997).

In support of his summary judgment application, the Defendant cites *Graziano v. Cooling,* 79 A.D.3d 803 (2d Dept. 2010) where the Court in granting summary judgment held that plaintiff's affidavits failed to raise a triable issue of fact. "For example, the plaintiff expert did not assert that the plaintiff exhibited key symptoms such as photophobia and neck stiffness, or other 'cardinal signs,' which would have led to a

diagnosis of meningococcal meningitis prior to the afternoon of September 29, 2004. The plaintiff's expert also did not assert that any further testing was indicated at the time that Cooling examined the plaintiff." Id at 805. Therefore, there was no support for the expert's conclusory and speculative statement that the plaintiff would have been diagnosed and begun treatment sooner if not for Cooling's alleged deviations from the recognized standard of care, *Dixon v Freuman*, 175 AD2d 910, 911 (1991).

The Defendant also cited *Forrest v. Tierney,* 91 A.D.3d 707 (2d Dept. 2012), where the court held that summary judgment was warranted because "the plaintiffs' expert's affirmation was conclusory and speculative, and failed to address the specific assertions on defendants' experts. For example, the plaintiffs' experts did not contradict the defendants' expert's opinion that Forrest did not exhibit symptoms requiring hospitalization on December 31, 2004." Forrest himself testified at his deposition that he did not follow the aftercare instructions provided to him by the defendants to follow up with the pulmonary and critical care specialist at Mercy within three days. Therefore, there was no support for the expert's conclusory and speculative statement that Forrest's claimed injuries were caused or worsened by the defendants' alleged deviations from the recognized standard of care.

The Defendant contends that in both cases, the patients exhibited signs and symptoms consistent with a viral syndrome, and gave no indication of any bacterial infection. Therefore, the standard of care did not require the emergency room physician on the first presentation to identify a bacterial infection, which did not manifest itself until later in time after the plaintiff experienced significant changes in his physical condition. Defendants argue that in the instant matter, the Plaintiff presented to the emergency

room at Montefiore on March 16, 2010 different symptoms as he presented to the emergency room at Westchester Medical Center. In other words, his symptoms on March 16th were completely different when compared to March 11th and 12th.

However, in the cases cited by the Defendants the summary judgment was granted because the Plaintiffs' experts did not raise triable issues of fact leaving the inference that had they properly rebutted the Defendants' claims, summary judgment would not have been granted. Here, the expert affidavits offered by the Plaintiff contradict the Defendants' expert opinions and detailed the specific symptoms requiring hospitalization and further evaluation of the Plaintiff by the Defendants on March 11th. and 12th. Here, the Plaintiff offers conflicting non-speculative expert opinions. Moreover, [w]here the parties offer conflicting expert opinions, issues of credibility arise requiring jury resolution, *Colao v. St. Vincent's Med. Ctr.,* 65 A.D.3d 660 (2d Dept. 2009). It is the Plaintiff's contention that had the Defendants conducted the requisite medical tests consistent with the symptoms presented by the Plaintiff in the emergency room on March 11th. and March 12th, that the appropriate treatment would have been administered preventing the deterioration of the Plaintiff's condition.

The Plaintiff's expert opined within a reasonable degree of medical certainty that had the diagnostic tests been performed on March 11th. and March 12th., including a blood test, a stool test, complete blood count inclusive of white cell count and a comprehensive metabolic panel, the Plaintiff would not have suffered from the severe injuries caused as a result of the delayed diagnosis of the bacterial infection that the Defendants failed to diagnose. Defendants seem to imply that failure to conduct laboratory studies did not deviate from the acceptable standard of care and cite,

Morales v. New York City Health and Hospitals Corporation, 111 A.D.3d 436, 974 N.Y.S.2d 408 (1st Dept. 2013). However, in *Morales*, the Court opined that "the standard of care in treating infants with fever who otherwise looked well had changed with the advent of vaccine, which now prevent most infections that used to be of concern to emergency medicine staff." Here, the symptoms presented by the Plaintiff at the emergency room on March 11th. and March 12th. were not as clear cut to rule out ordering of certain tests. Moreover, based upon Westchester Medical Center records, lab reports were considered but were just not ordered. The Defendants have failed to make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby. Therefore, the Defendants' motion is denied.

With respect to the issue of proximate cause, according to the Defendants' expert, it was impossible to say whether the MRSA infection was present on March 11th. and March 12th. and it is also impossible to speculate what a blood test or cultures would have shown had one been conducted. However, the same tests that could have been performed on March 11th. and March 12th. were performed on March 16th. and the results were consistent with a bacterial infection and negative for influenza. The Plaintiff's expert opined that Plaintiff's symptoms on both March 11th, and 12th when he presented to the Emergency Department of Westchester Medical Center with body aches, tachycardia, chills, fatigue, weakness, night sweat, a productive cough, and loose watery stool for three days duration, were more than enough evidence to conclude that Plaintiff was suffering from an MRSA bacterial infection at that time.

In support of their claim for lack of proximate cause, the Defendants rely on

Foster-Sturrup v. Long, 95 A.D.3d 726, 945 N.Y.S.2d 246 (1st Dept. 2012), which states that "to sustain a cause of action for medical malpractice, a 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 plaintiff's injury." In *Foster-Sturrup*, which involved failure to diagnose the plaintiff's ectopic pregnancy, the blood test administered by the hospital on March 23 revealed a human chrionic gonadotropic (hCG) level of 436 units which indicated a very early pregnancy. The testimony suggested that had the test been conducted nine days earlier when the plaintiff first saw the doctor her hCG level would have been between 0 and 20, and based upon those low levels the standard of care would not have required an ultra sound for another four weeks since the embryo would not have been visible for another four weeks. Here again, the Defendant's expert's affirmation was conclusory and did not address the prima facie showing in the detailed affirmation of the defendant's expert justifying the granting of summary judgment. Moreover, it is clear that had the doctor conducted an untrasound, it would not have assisted in his diagnosis of her ectopic pregnancy. This is clearly distinguishable from the case presented here.

The facts here are incongruent with *Foster-Sturrup.* In this case the Plaintiff's experts raised issues asserting that key symptoms such as body aches, tachycardia, chills, fatigue, fever, productive cough, loose water stools should have led to a diagnosis of bacterial infection when Plaintiff presented to Westchester Medical Center on March 11th and March 12th and prior to the afternoon of March 16, 2010 when Plaintiff entered Montefiore Hospital with renal failure, multi organ failure and sepsis. Plaintiff's experts clearly assert that further testing such as blood work, chem. profile,

CBC (complete blood count), stool test, and even rapid influenza A and B tests were indicated at the time that Plaintiff was examined by Defendants. This is clearly supported by the records and not speculation. Therefore, there is ample support for the experts' statements that the plaintiff would have been diagnosed and begun treatment sooner if not for Defendants' alleged deviation from the recognized standard of care, *Dixon,* 175 A.D.2d 910, 911 (1991).

It follows, therefore, that a doctor may be liable only if the doctor's treatment decisions do not reflect his or her own best judgment, or fall short of the generally accepted standard of care, *Davis v Patel*, 287 A.D.2d 479, 480 (2d Dept. 2001); *Ibguy v State of New York*, 261 A.D.2d 510 (2d Dept. 1999). The Court finds that in view of the symptoms presented by the Plaintiff and the abnormal findings noted by the Defendants on March 11th and 12th., there are clearly questions of the judgment exercised by the Defendants and whether or not their treatment decision fell short of the general accepted standard of care. The question of proximate cause is therefore a matter for a jury to decide.

With respect to the Plaintiff's experts' assertion that failure on the part of the Defendants to correctly diagnosed Plaintiff's septic arthritis and/or bacteremia resulted in septic hip, which caused Plaintiff to undergo a left hip resurfacing raises questions of fact for a jury to determine. Also, on the question of whether or not the Defendants violated their own Emergency Department policy and procedure for diagnostic testing, etc., that also raises questions of fact for a jury to decide.

The Defendants' application for summary judgment is denied.

The parties are directed to appear before the Settlement Conference Part,

914-824-5350 on July 1 2014 at 9:30am in Courtroom 1600 for a settlement conference. To the extent any relief requested in Motion Sequence 5 was not addressed by the Court, it is hereby deemed denied. The foregoing constitutes the Opinion, Decision and Order of the Court.

Dated: White Plains, New York
May 5, 2014

HON. SAM D. WALKER, J.S.C.

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