Gambacorta v Giordano
2020 NY Slip Op 30776(U)
March 11, 2020
Supreme Court, New York County
Docket Number: 805368/14
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11

---------- X Index No.: 805368/14

THEODORE GAMBACORTA,

Plaintiff,

-against-

CHRISTOPHER GIORDANO, M.D., RON CHAY, M.D.,
MICHAEL CHILL, M.D., PETER FREYLINGHUYSEN, M.D.,
and STATEN ISLAND UNIVERSITY HOSPITAL,

Defendants,

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JOAN A. MADDEN, J.:

In this medical malpractice action, defendant Ron Chay, M.D. moves for summary judgment dismissing the complaint and all cross claims against him (motion sequence no. 005), and defendant Staten Island University Hospital (SIH) separately moves for summary judgment dismissing the complaint and all cross claims against it (motion sequence no. 007).[1] Plaintiff opposes both motions.[2]

Background

In this medical malpractice action, plaintiff alleges that defendants departed from accepted medical practice by failing to properly diagnose and treat plaintiff's spinal column infection, including by using antibiotics, during his admission to SIH from January 13 to January

[1]Motion sequence nos. 005 and 007 are consolidated for disposition.

[2]Defendant Dr. Peter Freylinghuysen, M.D. separately moved for summary judgment (motion sequence no. 006). Defendants Christopher Giordano, M.D. and Michael Chill, M.D. also moved for summary judgment under motion sequence no. 007. These motions were unopposed and by separate orders dated August 29, 2019, the court granted the motions.

27, 2014, and that as a result plaintiff suffered various injuries including severe cognitive impairment.[3]

Plaintiff was admitted to SIH through its emergency department during the early morning hours on January 13, 2014, with complaints of severe back, spine and bilateral flank pain, as well as burning skin pain.[4] Plaintiff reported intermittent back pain for a month, radiating to the right and left upper quadrants, and that during the previous three days, the pain had gotten worse. Dr. Chay, who is board certified in internal medicine and nephrology, admitted plaintiff to the hospital by telephone and accepted the care of plaintiff while he was at SIH (Chay EBT at 28-29). Dr. Chay testified that he had an arrangement with plaintiff's primary care physician, Dr. Zafaranloo, that he would cover Dr. Zafaranloo's medicine in-patients at SIH (Id at 23-24). Dr. Chay described admission process at SIH, testifying that "..after a patient is triaged and worked up in the Emergency Room and they decide a patient needs to have an inpatient admission, they usually then contact either a hospitalist group or the primary care physician to accept that patient and take over care of their inpatient responsibilities...In my case, I was covering for Dr. Zafaranloo. So they then contact me." (Id at 28-29). After accepting plaintiff as a patient, Dr. Chay ordered neurology and infectious disease consultations (Id at 31-35). Plaintiff testified that the first time he met Dr. Chay a few hours after his admission to SIH, and that Dr. Chay told him

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[3]The other departures alleged by plaintiff in his bill of particulars, including, inter alia, that defendants departed in mis-diagnosing plaintiff's condition as a paraspinal hematoma; by failing to perform a biopsy; by failing to order further testing; and by failing to appreciate the significance of plaintiff's presentation; and by failing to ensure plaintiff was hospitalized for further treatment, are deemed abandoned as they are not supported by plaintiff's expert's opinion.

[4]Unless otherwise specified, the following facts are based on plaintiff's medical records at SIH during his admission there.

he was assisting Dr. Zafaranloo who did not come to the hospital (Plaintiff's EBT at 137).

A CT scan performed on the date of plaintiff's admission revealed an irregular soft tissue density mostly anterior to the right of the T7-T8 disc space. The impression was that diskitis/osteomyelitis was the most likely possibility. On January 14, an MRI with contrast was performed and was interpreted by Dr. Lynne Voutsinas, who informed the medical resident that there was an abnormal signal in the T7 and T8 vertebral bodies which was consistent with diskitis/osteomyelitis. Dr. Voutsinas wrote that the plaintiff could have either a bacterial or granulomatosis (tubercular) infection, and that the anterior paraspinal soft tissue mass was consistent with an abscess. As plaintiff had a history of a periodontal abscess, a dental consultation was done on January 16, which was ruled out as the source of the bacteria.

The infectious disease consultant, Dr. Neville Mobarakai, saw plaintiff on January 14, and did not recommend starting antibiotics. On January 15, Dr. Mobarakai wrote a note that a fine needle aspiration was planned and antibiotics should be held until the results of the study of the specimen was obtained. On the afternoon of January 15, a fine needle aspiration was performed, and the cytological smears from the withdrawn thoracic paraspinal fluid were interpreted as negative for malignant cells but consistent with paraspinal abscess. Culture of the paraspinal abscess was reported to have "growth of skin flora." Prior to plaintiff's discharge from the hospital, the final culture of the specimen was read as negative for aerobic or anaerobic bacteria.

On January 17, it was noted on plaintiff's chart that any organisms had still not been identified and plaintiff should be kept off antibiotics. Vital signs remained stable and the patient was afebrile. On January 18, plaintiff had pain not relieved by Dilaudid overnight, with nausea

and heartburn, but felt better that morning. The medicine attending called in a pain management physician who adjusted the pain medications. On January 19, the patient felt better and the white count was 9.4. The resident's note that day, and the subsequent medical residents' notes consistently state that the CT and MRI had indicated or suggested plaintiff had osteomyelitis, but noted that the cultures had not grown anything.

On January 21, Dr. Mobarakai recommended that as the cultures were negative a repeat aspiration should be considered, and on January 22, he wrote that no antibiotics should be given until an organism was identified. After it was determined that it was unlikely that a good specimen would be obtained from the back, it was decided that the site should be approached from the front and, on January 24, 2014, a surgery was performed by cardiac surgeon, Dr. Jon Nabagiez, to obtain a pleural biopsy specimen. Dr. Nabagiez wrote that the procedure had led him to have "no suspicion of infection," and the pathology report revealed no evidence of an abscess.

On January 25, the general surgery attending indicated that if the preliminary culture was negative, then the patient would be sent home with antibiotics with the culture results to be followed as an outpatient. On January 26, Dr. Nabagiez wrote that patient denied back pain, and that the patient could be followed up in the office in two weeks. Dr. Chay saw plaintiff on his discharge date and wrote in his chart that he was doing well. He dictated the discharge summary that day and signed it the following day. The discharge diagnoses were paraspinal hematoma, diabetes coronary artery disease, and status post hematoma evacuation. The CT had shown T7 - T8 diskitis. Plaintiff was to take Percocet as needed and otherwise continue his usual medications, and was to contact his personal physician within a week. Dr. Chay testified that at

the time of discharge, "there was concern for osteomyelitis and diskitis. The plan was for him to be discharged and to follow-up with Dr. Zafaranloo, who was going to set him up with a spine specialist, which I believe he had seen within 72 hours upon discharge to help further manage the case as an outpatient due to the complexity of the situation." (Chay EBT at 105).

On the date he was discharged, plaintiff, who testified that after the medication wore off the pain was intense, contacted Dr. Zafaranloo, who recommended Dr. Frelinghuysen, a spine specialist, who receives his medical records from SIH (Plaintiff's EBT at 62-63,65). On January 30, 2014, plaintiff saw Dr. Frelinghuysen, a spinal surgeon and his note reveals he was aware of the possibility that infection in spinal column. (Dr. Frelinghuysen's medical records). A further MRI of the thoracic spine was reviewed by Dr. Frelinghuysen on February 13, 2014, and found to reveal like diskitis and osteomyelitis of the T7 and T8 bones and a fluid collection posterior to the bones at that level compressing cord (Id). His impression was diskitis, osteomyelitis, and epidural abscess with thoracic myelopathy (Id). The patient's neurological condition had deteriorated and Dr. Frelinghuysen recommended an immediate hospital admission for work-up and urgent surgery (Id).

Plaintiff was admitted to Lenox Hill Hospital where spinal surgery was performed February 14, 2014, and Dr. Frelinghuysen arranged for plaintiff's treatment with antibiotics based on positive cultures for with streptococcus milleri.

Dr. Chay moves for summary judgment, arguing that he provided appropriate and timely care and treatment to plaintiff during his admission at SIH, and called in appropriate specialists including in infectious disease, interventional radiology, cardiothoracic surgery, neurosurgery and general surgery, as well as experts in pain management and cardiology, and relied on their

decisions and recommendations as to the treatment of plaintiff, and that no departure by him proximately cause plaintiff's alleged injuries. In connection with causation, Dr. Chay asserts that the presence of an injury is insufficient to demonstrate malpractice. Moreover, he asserts that at the time of discharge, Dr. Chay appropriately referred the patient back to his primary care physician who promptly referred the patient to a spinal surgeon for further out-patient assessment and care.

In support of his motion, Dr. Chay submits the affidavit of Dr. William Mandell, M.D., who is board certified in internal medicine and infectious disease, and states that he has reviewed Dr. Chay's deposition transcript, plaintiff's deposition transcript and the relevant medical records. Dr. Mandell opines that Dr. Chay did not depart from any standards of care with regard to plaintiff's treatment and that he appropriately relied on a series of sub-specialists to guide the care of the plaintiff and deferred to their expertise.

With respect to plaintiff's allegation that Dr. Chay departed from the standard of care by failing to properly diagnose and treat plaintiff's diskitsis/osteomyelitis and by failing to perform an adequate differential diagnosis, Dr. Mandell states that:

> Prior to Dr. Chay accepting the admission of the patient, the Hospital staff had blood work done, and there had been a consultation by a general surgeon. A CT was done which revealed likely diskitis osteomyelitis, and a soft tissue mass. The correct diagnosis was within the differential even before the plaintiff was Dr. Chay's patient.... At all times through the remaining admission, Dr. Chay considered osteomyelitis/diskitis to be within the differential, as reflected in his own notes, the notes of the residents working under his supervision, and his care of the patient. Even after the procedure performed by Dr. Nabagiez, the notes continued to evidence the concern as to osteomyelitis/diskitis raised by the imaging, the patient continued to be followed by the infectious disease specialist, and the discharge plan provided for further evaluation as an out-patient.

Dr. Mandell opines that "Dr. Chay appropriately relied on other physicians to obtain a specimen for culturing and biopsy. In particular, he called upon specialists in infectious disease, neurosurgery, interventional radiology, and cardiothoracic surgery in the effort to do so. It was appropriate for Dr. Chay to rely on their expertise as to how a specimen might be best obtained. The diagnosis of osteomyelitis/diskitis was maintained throughout the admission, but could not be confirmed because of the difficulty obtaining an appropriate specimen."

As for the alleged departure in failing to prescribe antibiotics, Dr. Mandell opines that "Dr. Chay relied on the advice of an infectious disease specialist as to the use of antibiotics under the circumstances herein, as was appropriate for him to do. Prescription of antibiotics could have had the effect of masking the evidence of the on-going infection, and in any event the prescription or ordering of antibiotics in the circumstances herein was outside of his field of expertise. It was appropriate that no antibiotics were prescribed, by Dr. Chay or anyone else."

As for the alleged departure in discharging plaintiff, Dr. Mandell states that the decision "was approved by Dr. Nabagiez on January 26, and Dr. Chay (who was managing plaintiff's medical condition, and who saw him on both January 26 and January 27, before the discharge) [and][t]he plan was for the patient to be followed as an out patient." He opines that "the plan was appropriate under the circumstances...[n]ote that cultures were still pending, and the infectious disease physician, who saw the patient on the day of discharge, did not raise any concerns about the plan that there would be further out-patient workup, as set forth in the prior notes."

SIH also moves for summary judgment, arguing that it cannot be held vicariously liable

for the acts or omissions of Dr. Chay, an attending private physician, or Dr. Mobarakai, the non-employee infectious disease specialist who treated plaintiff at SIH, and submits affidavit of Mary Beth Springstead, its Associate Executive Director of Human Resources at SIH. Ms. Springstead states that "[i]n January 2014, Neville Mobaraki [sic], M.D. was a voluntary attending physician with certain privileges at Staten Island University Hospital [and that] Neville Mobarakai was not, and has never been, an employee of Staten Island University Hospital."

Plaintiff opposes the motions by Dr. Chay and SIH, asserting there are triable issues of fact as to whether defendants deviated from the standard of care in failing to treat plaintiff with antibiotics during his admission and SIH, and whether such deviations were a proximate cause of plaintiff's injuries. As for SIH, plaintiff argues that it is vicariously liable for care and treatment provided by Dr. Chay as plaintiff did not specifically seek his care and treatment, and based on alleged departures by Dr. Mobarakai.[5]

In support of his opposition, plaintiff submits an affidavit from an expert whose identity is redacted and who is licensed to practice medicine in the State of New Jersey, and is specializes in infection disease and internal medicine. Plaintiff's expert states that his opinion is to a reasonable degree of medical certainty and based on a review of the pleadings. the deposition transcripts of the parties, the relevant medical records and the physician affirmations in support of the subject summary judgment motions.

Plaintiff's expert states that there was "overwhelming evidence of diskitis and osteomyelitis in [plaintiff] who was never given IV antibiotics, in spite of the fact that a PICC

[5] At oral argument, plaintiff clarified that its claims against SIH are based on the acts and omissions of both Dr. Chay and Dr. Mobarakai, but not those of SIH's employee Dr. Nabagiez, the cardiac surgeon who treated plaintiff.

line had been inserted in anticipation of such treatment." With respect to the evidence of diskitis and osteomyelitis, the expert points to plaintiff's complaints of back pain, which persisted intermittently for a month, and the results of the CT scan and MRI taken at SIH indicating diskitis and/or osteomyelitis as a likely diagnosis. With respect to the fluid taken from the fine needle aspiration, plaintiff's expert states that "paraspinal fluid revealed histiocytes and inflammatory cells consistent with abscess ...[and that] culture of the paraspinal abscess was reported to have 'growth of skin flora' [and that] [a]ny growth must be considered abnormal in a situation where all the other tests indicated infection...[and that] [n]egative cultures do not rule out infection."

The expert opines that in light of these circumstances, Dr. Chay and SIH "deviated from accepted standard of medical care in discharging [plaintiff] without antibiotic treatment and abscess drainage and to omit such treatment when [plaintiff] was hospitalized." The expert also opines that "[t]he standard of care requires the paraspinal abscesses be drained and that diskitis and osteomyelitis be treated with six or more weeks of appropriate antibiotics [and that][w]hen cultures are negative or equivocal, and all other studies indicate osteomyelitis and diskitis, treatment should be empirical in order to cover all of the likely organisms, with clinical, radiological and laboratory follow up to evaluate the effectiveness of the treatment."

As for causation, plaintiff's expert notes that plaintiff "was discharged on January 27, 2014, and did not receive treatment until February 14, 2014, when Dr. Frelinghuysen assumed responsibility for his care; performing surgery on February 14, 2014 and arranged for appropriate antibiotics based on positive cultures with streptococcus milleri, an oral organism." The expert opines that "during the more than 19 day delay in appropriate treatment resulting from the

deviations at [SIH], [plaintiff's] spinal infection became more extensive resulting in spinal cord compression with neurological deficits and the need for extensive neurological procedures" The expert further opines that "[h]ad the patient been appropriately treated at [SIH] with empirical antibiotics and drainage of the paraspinal abscess, it is highly probable that he would not have required an open neurological procedure, would not have developed cord compression with neurological deficits and would not have had the permanent injuries and disabilities described at [plaintiff's] deposition."

In reply, Dr. Chay argues, *inter alia*, that plaintiff has not adequately demonstrated causation as plaintiff has failed to establish that the relevant organism would have been "covered" by empiric antibiotics and notes that the culture slip from the specimen obtained on February 14, 2014 lists the antibiotics to which the organism was sensitive and plaintiff's expert does not claim these antibiotics would have been used as part of empiric therapy.

In reply, SIH, argues that plaintiff has not overcome its burden of demonstrating that SIH is vicariously liable for Dr. Chay or the infectious disease physician Dr. Mobarakai who is not mentioned in plaintiff's opposition, and notes the plaintiff did not challenge the affidavit from its Human Resources representative stating that Dr. Mobarakai is not an employee of SIH and that the hospital did not control the manner or method of Dr. Mobarakai's treatment of plaintiff.

Discussion

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 AD3d 204,

206 (1st Dept 2010). To satisfy this burden, a 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 The expert opinion relied on by defendant must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dept 2010). A defendant's expert opinion must also "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

Here, Dr. Chay has made a prima facie showing entitling him to summary judgment based on the opinion of his expert that Dr. Chay did not depart from the applicable standard of care in his treatment of plaintiff in that he appropriately relied on specialists in obtaining a culture and in deciding not to prescribe antibiotics during plaintiff's hospitalization and after his discharge, and the discharge plan was appropriate under the circumstances, and that any asserted departure was not a proximate cause of any injury to the plaintiff.

As Dr. Chay has met his burden, the burden shifts to plaintiff "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 NY2d 320, 324-325 (1986). Specifically, in a medical malpractice action, this requires that a plaintiff opposing a defendant's summary judgment motion "submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact… 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 defendant['s]... summary judgment motion." Id.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 AD3d 303, 307 (1st Dept 2007) (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation... the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 NY2d 542, 544 (2002). On the other hand, "[t]he law is well settled that when competing experts present adequately supported but differing opinions on the propriety of the medical care, summary judgment is not proper." (See Rojas v. Palese, 94 AD3d 557 (1st Dept 2012).

In this case, the court finds that plaintiff has met this burden based on his expert's opinion that in light of evidence that plaintiff was suffering from diskitis and osteomyelitis, even though the cultures were negative or equivocal, it was a departure from the standard of care to fail to treat plaintiff with empirical antibiotics, and drainage of the paraspinal abscess, and such departure allowed plaintiff's spinal infection to become more extensive, and in the absence of such departure it is "highly probable" that plaintiff would not have required an open neurological procedure, would not have developed cord compression with neurological deficits and would not have had the permanent injuries and disabilities.

Furthermore, while Dr. Chay's expert opines that Dr. Chay properly relied on specialists, including the infection disease physician, with respect to the care and treatment of plaintiff, the court notes that the issue of whether Dr. Chay owed a duty to plaintiff despite his referral of

certain aspects of plaintiff's treatment to specialists, "is a question for the court, and generally not an appropriate subject for expert opinion." Dallas-Stephenson v Waisman, 39 AD3d at 307 (internal citations omitted). Although "the duty of a physician may be limited to those medical functions undertaken by the physician and relied upon by the patient...the question is whether the physician owes a duty under the circumstances of a particular scenario." Burtman v. Brown, 97 AD3d 156, 161-162 (1st Dept 2012)(internal citations and quotations omitted). In this case, Dr. Chay's day-to-day involvement in plaintiff's care and treatment subjects him to potential liability even though he referred certain aspects of such care and treatment to specialists. See Mandel v. New York County Public Administrator, 29 AD3d 869, 870-871 (2d Dept 2006)("...liability may be imposed where referring physician was involved in decisions regarding diagnosis and treatment to such an extent as to make them his or her own negligent acts")(internal citations and quotations omitted).

As for Dr. Chay's assertion that plaintiff's expert did not raise an issue of fact as to causation as his expert did not opine that the use of empirical antibiotics would have effectively eliminated the organism which was eventually identified, such assertion is unavailing as the court finds that plaintiff's expert has sufficiently demonstrated the nexus between plaintiff's injuries and the failure to treat plaintiff with empirical antibiotics, which he opined would cover likely organisms and would have been followed up with clinical, radiological and laboratory tests to evaluate the effectiveness of the antibiotic treatment.

The next issue to be addressed by the court is whether SIH can be held vicariously liable for any departure by Dr. Chay and/or Dr. Morabakai. In general, a hospital may not be held liable for the malpractice of an independent physician, including when the physician is retained

by the plaintiff. See Hill v. St Clare's Hosp., 67 NY2d 72, 79 (1986). "Nor is affiliation of a doctor with a hospital ... not amounting to employment, alone sufficient to impute the doctor's negligent conduct to the hospital or facility." Id. At the same time, "vicarious liability for malpractice on the part of nonemployee physicians may be imposed... on a theory of ostensible or apparent agency [by estoppel]." St. Andrews v. Scalia, 51 AD3d 1260, 1261, 1262 (3d Dept 2008)); see also Malcolm v. Mount Vernon Hospital, 309 AD2d 704, 705-706 (1st Dept 2003), lv dismissed 2 NY3d 793 (2004). "In the context of a medical malpractice action the patient must have reasonably believed that the physicians treating him or her were provided by the hospital or acted on the hospital's behalf." Dragotta v. Southampton Hosp., 39 AD3d 697, 699 (2d Dept 2007). "In the context of evaluating whether a doctor is the apparent agent of the hospital, a court should consider the attendant circumstances...to determine if the patient could properly believe that the physician was provided by the hospital." Sampson v. Contillo, 55 AD3d 588, 590 (2d Dept 2006)(internal citations and quotations omitted)

Under this standard, SIH has made a prima facie showing that it cannot be held vicariously liable for any malpractice by Dr. Chay, as the record shows that he was not an employee of the hospital and that plaintiff was informed by Dr. Chay that he was treating him through an arrangement with plaintiff's primary care physician, and plaintiff does not controvert this showing.

As for Dr. Mobarakai, SIH submits evidence that he is not its employee but "a voluntary attending physician," with certain privileges at the hospital, and that Dr. Chay called Dr. Mobarakai in as a consult. With respect to plaintiff's awareness of Dr. Mobarakai's relationship with the hospital, however, SIH fails to meet its burden of showing plaintiff "could not have

reasonably believed that [Dr. Mobarakai] was acting at the hospital's behest." Chapman v. Tovar, 170 AD3d 518, 518 (1st Dept 2019); see also Malcolm v. Mount Vernon Hospital, 309 AD2d at 706 (affirming trial court's denial of summary judgment to defendant hospital in the absence of a showing that plaintiff "could not have reasonably believed that [the defendant doctor] was acting the hospital's behest")(internal citation and quotation omitted). This conclusion is supported by evidence that Dr. Mobarakai regularly saw plaintiff during his admission to SIH, was not plaintiff's private physician, and did not have a prior relationship with plaintiff.

Accordingly, summary judgment is denied as to SIH to the extent it may be held vicariously liable for departures of Dr. Mobarakai in failing to treat plaintiff with antibiotics during his admission at SIH.[6]

Conclusion

In view of the above, it is

ORDERED that the motion for summary judgment by defendant Dr. Chay is denied; and it is further

ORDERED that the motion for summary judgment by defendant SIH is granted except to the extent that plaintiff's claims seek to hold it vicariously liable for departures of Dr. Mobarakai in failing to treat plaintiff with antibiotics during his admission at SIH; and it is further

ORDERED that the parties shall appear on March 26, 2020 at 11:30 am in Part 11, room 351, 60 Centre Street for a pre-trial conference.

DATED: March 11, 2020

J.S.C.

[6]While plaintiff's expert does not specifically allege that Dr. Mobarakai departed from accepted medical practice, the expert's opinion that SIH departed in failing to treat plaintiff with antibiotics during his admission at SIH is sufficient given Dr. Mobarakai's role in this regard.