

**Labarbara v Mount Sinai Beth Israel Med. Ctr.**

2020 NY Slip Op 31325(U)

May 8, 2020

Supreme Court, Kings County

Docket Number: 513648/2015

Judge: Genine D. Edwards

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At Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, located at 360 Adams Street, Brooklyn, New York, on the 8th of May 2020.

P R E S E N T:

HON. GENINE D. EDWARDS,

Justice.

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CARMELA LABARBARA, as Administrator of the ESTATE OF STEVE LABARBARA, individually,

Index No. 513648/2015

Plaintiff,

**DECISION/ORDER**

-against-

Motion Sequence: 3

MOUNT SINAI BETH ISRAEL MEDICAL CENTER  
BROOKLYN, MOUNT SINAI BETH ISRAEL  
MEDICAL CENTER MANHATTAN,

Defendants.

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In an action to recover damages for medical malpractice and wrongful death, defendants Mount Sinai Beth Israel Brooklyn s/h/a Mount Sinai Beth Israel Medical Center Brooklyn (“MSBI Brooklyn”) and Mount Sinai Beth Israel Medical Center New York (“MSBI

Manhattan”) moved for summary judgment dismissing the complaint in its entirety. Plaintiff opposed the motion.

## **BACKGROUND<sup>1</sup>**

Decedent developed a cut, the size of a quarter, which was red in color, on the lower portion of his left leg and for which he treated with over-the-counter Neosporin, for approximately one to two weeks before April 13, 2014. The cut did not heal and remained an open wound. On April 13, 2014, decedent was transported, via ambulance, to the emergency department of MSBI Brooklyn in critical condition for respiratory distress. He was disoriented with an altered mental status, had a temperature of 100.4, heart rate of 128, blood pressure of 183/109, with oxygen saturation of 82%, and a finger stick of 317. He had intercostal retractions, decreased inspiration/expiration throughout his entire chest and marked respiratory distress with wheezing in his right lung fields. Upon physical examination, he was documented to have abdominal distention, bilateral edema, stasis dermatitis and chronic cellulitis. MSBI Brooklyn suspected sepsis and initiated sepsis protocol.

Decedent was intubated and sedated and admitted to the Intensive Care Unit ("ICU"). He was given broad-spectrum antibiotics, Vancomycin and Ceftriaxone, and another antibiotic, Doxycycline. He was also administered Heparin, an anticoagulant, Lasix, a diuretic used to reduce extra fluid or edema in patients with congestive heart failure, and sedatives. Labs, including blood and urine cultures, were obtained. The urine culture revealed no growth and an MRSA culture from the nose was negative. The initial blood cultures were

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<sup>1</sup> In general, see the Notice of Motion/Exhibits; Affirmation in Opposition/Exhibits.

positive for group B streptococcus, a type of bacterial infection. An infectious disease consultation determined that the likely cause of decedent's infection was left lower cellulitis.

Decedent's leg cellulitis resolved by April 17, 2014, but his fever persisted. MSBI Brooklyn was unable to identify the source of the fever. On April 21, 2014, MSBI Brooklyn determined that decedent needed a tracheostomy. The antibiotic Aztreonam was added to his regimen. By April 22, 2014, MSBI Brooklyn thought decedent could have a medication related fever because some antibiotics cause same. As a result, on April 25, 2014, Vancomycin was discontinued. The fever, however, persisted.

On April 27, 2014, a fiber optic bronchoscopy was conducted, which showed normal respiratory flora and again no source of infection could be identified. On April 28, 2014, decedent was transferred to MSBI Manhattan because it had the capability to perform, prior to a tracheostomy, a cardiac catheterization. Upon discharge from MSBI Brooklyn, decedent's diagnoses included shortness of breath, streptococcal septicemia, acute respiratory failure, bronchopneumonia, acute myocardial infarction, atrial flutter and atrial fibrillation, hypotension, COPD, elevated cholesterol, diabetes, and acute renal failure.

From April 28, 2014 to April 30, 2014, MSBI Manhattan did not administer any antibiotics to decedent because there was no documented infection despite the fever. On April 29th, labs were obtained. On April 30th, Dr. Dennis Karter, an infectious disease specialist, examined decedent. His impression was that decedent had a high-grade fever

with an unclear source. He ordered repeat cultures. Antibiotics, Vancomycin and Aztreonam, were resumed, and the antifungal medication, Caspofungin was added.

On May 1, 2014, decedent appeared awake and his mental status seemed improved, however, later that day, he was in respiratory distress and had a high fever despite the administration of broad-spectrum antibiotics and antifungal medication. Decedent's fever continued on May 2, 2014. A tracheostomy was performed.<sup>2</sup> He was non-verbal, and his mental status declined. The antibiotic Doxycycline was once again added to his drug regimen. A brain MRI was performed. The impression was as follows:

secretions and mucosal thickening are seen within bilateral maxillary sinuses, ethmoid sinus, frontal sinus and sphenoid sinus and there is fluid within bilateral mastoid cavities and within nasopharynx. These findings were presumably related to intubation. However, the contents of the sphenoid sinus and to a lesser extent the frontal sinus and maxillary sinuses demonstrated restricted diffusion raising concern for bacterial or fungal superinfection.<sup>3</sup>

Between May 4, 2014 to May 6, 2014, the results of the tests returned. The venous blood was negative, the stool was negative, the parasite smear was negative, and the blood culture was negative.<sup>4</sup> The urine was positive for pseudomonas and the bronch culture was positive for Herpes Simplex, Type I.<sup>5</sup> Decedent's antibiotics were changed. Polymyxin B was added, and Vancomycin was stopped. Then Polymyxin B was switched to Amikacin and Aztreonam was switched to Cefepime. Acyclovir, an antiviral medication used to treat HSV-1, was given.

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<sup>2</sup> Affirmation in Opposition to Motion, Exhibit A, pg. 36.

<sup>3</sup> Affirmation in Opposition to Motion, Exhibit A, pg. 33.

<sup>4</sup> Dr. Karter EBT, pg. 21, lines 2-12.

<sup>5</sup> Dr. Karter EBT, pg. 21, lines 13-16.

After the results of the MRI came back, Dr. Karter did not have a high index of suspicion that decedent had a bacterial or fungal superinfection. Instead, he believed decedent's sinusitis was related to prolonged intubation and pseudomonas pneumonia was the likely cause of the fevers. However, on May 7, 2014, Dr. Karter requested an ear, nose and throat (ENT), sinus evaluation to assess the findings on the MRI.<sup>6</sup>

On May 8, 2014, ENT physician, Dr. John Naughton, examined decedent for "any sign of sinus disease, bacterial or fungal."<sup>7</sup> After a physical examination and a nasal endoscopy of decedent,<sup>8</sup> he found no signs of infection, including a fungal superinfection. With respect to the MRI impression, Dr. Naughton stated that "MRI findings of a fungal superinfection would include findings of necrotic tissue,"<sup>9</sup> which was not indicated on the decedent's MRI. Moreover, he stated that the "diagnosis of sinusitis is clinical, not radiological."<sup>10</sup>

Following the ENT consultation, decedent's condition continued to deteriorate and on May 10, 2014 he died. The final diagnosis was STEMI, ST-Elevated Myocardial Infarction, and septic shock. An autopsy was not performed on decedent per his family's request.

## PROCEDURAL HISTORY

Plaintiff Carmela LaBarbara, as the administrator of the estate of Steve LaBarabara, commenced this action on November 9, 2015. Defendants filed an answer on November 25, 2015. A verified bill of particulars was filed on January 5, 2016 and a supplemental bill of

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<sup>6</sup> Dr. Karter EBT, pg. 36, lines 6-8.

<sup>7</sup> Dr. Naughton EBT, pg. 15, lines 16-19.

<sup>8</sup> Dr. Naughton EBT, pg. 17, lines 24-25; pg. 18, lines 2-18.

<sup>9</sup> Dr. Naughton EBT, pg. 21, lines 10-24.

<sup>10</sup> Dr. Naughton EBT, pg. 21, lines 10-24.

particulars was filed on May 31, 2019. The verified bill of particulars, alleged that defendants departed from good and accepted standards of medical care as follows:

- Failure to diagnose and treat a bacterial or fungal superinfection causing sepsis and ultimately death.
- Failure on May 2, 2014 and May 3, 2014, to perform a differential diagnosis for, decedent's persistent fevers and MRI findings of "secretions and mucosal thickening seen throughout the sinuses and mastoid cavity," which should have revealed a fungal superinfection.
- Failure to confirm the radiological diagnosis of fungal superinfection.
- Failure to timely obtain an emergent Ear, Nose and Throat (ENT) consultation in order to biopsy and culture the sinuses.
- Failure to perform an endoscopic examination of the sinuses.
- Failure to perform a biopsy, culture or aspiration on any of the sinuses even after determining that the May 2, 2014 MRI of the brain revealed diffuse acute sinusitis.
- Failure to perform cultures, aspirations of secretions for microbiological studies and surgical debridement of the necrotic and infected sinus tissues.
- Failure to immediately start intravenous Amphotericin B on May 2, 2014 and May 3, 2014 in order to treat decedent's nosocomial infection.<sup>11</sup>

After discovery was completed and a note of issue filed, the defendants served the instant motion for summary judgment.

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<sup>11</sup> Verified Bill of Particulars.

## LAW

“A [defendant who moves] for summary judgment dismissing a complaint alleging medical malpractice must establish, prima facie, either that there was no departure from accepted standards of medical care or that any departure was not a proximate cause of the plaintiff’s injuries.” *Schwartzberg v. Huntington Hospital*, 163 A.D.3d 736, 81 N.Y.S.3d 118 (2d Dept. 2018) quoting *Mackauer v. Parikh*, 148 A.D.3d 873, 49 N.Y.S.3d 488 (2d Dept. 2017). See *McAlwee v. Westchester Health Associates, PLLC*, 163 A.D.3d 549, 80 N.Y.S.3d 401 (2d Dept. 2018). To sustain the burden, the defendant “must address and rebut any specific allegations of malpractice set forth in the plaintiff’s bill of particulars.” *Mackauer*, 148 A.D.3d 873.

“In opposition, a plaintiff must submit the affidavit of a[n expert] physician attesting to a departure from good and accepted practice, and stating the physician’s opinion that the alleged departure was a competent producing cause of the plaintiff’s injuries.” *Shectman v. Wilson*, 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept. 2009). See *Burns v. Goyal*, 145 A.D.3d 952, 44 N.Y.S.3d 180 (2d Dept. 2016) (“Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause.”). Once the expert establishes “his or her knowledge of the relevant standards of care, he or she need not be a specialist in the particular area at issue to offer an opinion.” *Leavy v. Merriam*, 133 A.D.3d 636, 20 N.Y.S.3d 117 (2d Dept. 2015). However, “[g]eneral allegations that are conclusory, [speculative, or] unsupported by competent evidence tending to establish the

essential elements of medical malpractice are insufficient to defeat the motion for summary judgment.” *Keun Young Kim v. Lenox Hill Hosp.*, 156 A.D.3d 774, 67 N.Y.S.3d 53 (2d Dept. 2017). See *Shectman*, 68 A.D.3d 848 (“A plaintiff cannot rebut a defendant physician’s showing that he or she was not negligent and defeat a motion for summary judgment by offering an expert’s affidavit containing general allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice.”).

### ANALYSIS

Here, defendants established their prima facie entitlement to judgment as a matter of law by submitting expert affirmations from Dr. Michael Setzen, board certified in otolaryngologist, Dr. Lana Lustbader, board certified in internal medicine, critical care medicine, and hospice and palliative care, Dr. Bruce Farber, board certified in internal medicine and infectious diseases, and Dr. Gordon Sze, board certified in diagnostic radiology, who opined, *inter alia*, that decedent did not have a fungal superinfection and that the treatment rendered by defendants did not deviate from accepted medical care or proximately cause decedent’s sepsis and subsequent death. See *Keane v. Dayani*, 178 A.D.3d 797, 114 N.Y.S.3d 93 (2d Dept. 2019); *Simpson v. Edgehill*, 169 A.D.3d 737, 93 N.Y.S.3d 399 (2d Dept. 2019).

In opposition, plaintiff did not address defendants’ prima facie showing that MSBI Brooklyn did not deviate from accepted standards of medical care.<sup>12</sup> Nor did plaintiff address

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<sup>12</sup> Plaintiff’s Attorney *Affirmation in Opposition* only alleges that Dr. Karter and MSBI Manhattan departed from accepted standards of medical care.

defendants' prima facie showing that defendants did not fail to diagnose and treat a bacterial superinfection. Thus, plaintiff failed to raise a triable issue of fact against MSBI Brooklyn and as to any allegations of failure to diagnose and treat a bacterial superinfection.

Before this Court is the viability of plaintiff's remaining claims against defendant MSBI Manhattan. Plaintiff submitted an expert affidavit from a board certified internal medicine and infectious diseases doctor, who opined that decedent's "clinical history of persistent fevers notwithstanding broad spectrum antibiotics (which are known to promote fungal infection), signs and symptoms and findings on examination, and most importantly, the May 2nd MRI results were all consistent with a fungal sinus infection,"<sup>13</sup> the most likely fungal pathogens being *Mucor* or *Aspergillus* ssp, and that defendants did not diagnose or workup decedent for such. Plaintiff's expert also opined that:

with a patient who has an infection and fever of unknown cause, to provide effective treatment it is incumbent upon the patient's medical providers to recognize [the] risks for fungal infection, attempt to identify the pathogen or pathogens causing the infection, including specimen (sinus, nasal, throat, lungs) staining and cultures, obtaining biomarkers for fungal infection (including but not limited to serum or lung galactomannan, Beta-D-glucan, specific serum fungal IGG antibody titers) and initiate broad spectrum antifungal medication awaiting both test results and monitor results to treatment. If testing is unobtainable, then initiating broad spectrum antifungal treatment empirically as soon as possible with Amphotericin B or liposomal Amphotericin is the standard of care and is considered first choice (not Caspofungin) for invasive fungal infections since it broadly covers yeast, mucor and other molds.<sup>14</sup>

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<sup>13</sup> Plaintiff's Expert Affirmation, Para 9, Sub-para e.

<sup>14</sup> Plaintiff's Expert Affirmation, Para 9, Sub-para f.

Failure to diagnose and workup the fungal superinfection prolonged decedent's persistent fevers and was the proximate cause and substantial factor in causing decedent's sepsis and ultimate death.<sup>15</sup>

Plaintiff's expert affidavit, which relied, in part, upon facts contradicted by the record, was speculative and conclusory, including on the issue of proximate cause. See *Kane v. Ausubel*, 44 A.D.3d 717, 843 N.Y.S.2d 656 (2d Dept. 2007); *Wagner v. Parker*, 172 A.D.3d 954, 100 N.Y.S.3d 280 (2d Dept. 2019) ("An expert opinion that is contradicted by the record cannot defeat summary judgment."). Contrary to the expert's assertions, the record was devoid of any indication that decedent had any type of fungal superinfection, including *Mucor* or *Aspergillus* ssp. The record showed that defendants suspected possible septic shock when decedent was admitted to MSBI Brooklyn. Numerous tests were conducted before and after decedent's left leg cellulitis resolved. Tests were repeated at MSBI Manhattan to ascertain the cause of decedent's persistent fevers. Plaintiff was treated with broad spectrum antibiotics and the antifungal medication, caspofungin. Following the findings on the MRI, decedent was clinically examined by Dr. Naughton, who after an endoscopy, found no signs of a fungal superinfection. He stated that a fungal superinfection would not cause mucosal thickening<sup>16</sup> and like defendants' experts, that the findings on the MRI were consistent with prolonged intubation and not a fungal superinfection, which is identifiable on an MRI as black necrotic tissue. Dr. Naughton also stated that a fungal superinfection would

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<sup>15</sup> Plaintiff's Expert Affirmation, Para 9, Sub-para w.

<sup>16</sup> Dr. Naughton deposition, pg. 30, lines 5-12.

Q: Can mucosal thickening be caused by [a] fungal superinfection? . . .

A: No. A fungal superinfection would not cause mucosal thickening. It would cause mucosal necrosis and death . . . .

not exist without clinical signs and symptoms,<sup>17</sup> which decedent did not have. Plaintiff's expert did not rebut these specific assertions. Indeed, neither Dr. Naughton's May 8, 2014 examination of decedent nor his deposition testimony was even addressed by plaintiff's expert.<sup>18</sup> Consequently, this Court finds that plaintiff failed to establish a triable issue of fact.

Based upon the foregoing and after oral argument, it is

ORDERED that the motion of defendants Mount Sinai Beth Israel Brooklyn s/h/a Mount Sinai Beth Israel Medical Center Brooklyn ("MSBI Brooklyn") and Mount Sinai Beth Israel Medical Center New York ("MSBI Manhattan") for an order, pursuant to CPLR 3212, granting summary judgment dismissing the complaint as against them is GRANTED, and it is

ORDERED that defendants' counsel shall serve a copy of this order with notice of entry upon the plaintiff's counsel and shall file an affidavit of said service with the Kings County Clerk.

ENTER:

*Genine D. Edwards*

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Hon. Genine D. Edwards

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<sup>17</sup> Dr. Naughton EBT, pg. 30, lines 5-12.

Q: Can you have an ongoing fungal superinfection notwithstanding the absence of clinical signs and symptoms?

A: No.

Q: Can the clinical signs and symptoms resolve before the infection is resolved?

A: Absolutely Not.

Q: It works the other way around?

A: This bacterial superinfection, which is acute invasive fungal sinusitis, is extremely aggressive and often fatal quickly, and so if there was a concern on May 2 and six days later there is still no finding consistent with acute invasive fungal sinusitis, that would be effectively ruled out.

<sup>18</sup> The Court notes that Dr. Naughton was deposed on November 7, 2019, after defendants filed the summary judgment motion. Plaintiff's expert affirmation is dated November 8, 2019.