Obregon v New York & Presbyt. Hosp.
2012 NY Slip Op 30681(U)
March 19, 2012
Supreme Court, New York County
Docket Number: 110782/08
Judge: Joan B. Lobis
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SCANNED ON 3/21/2012

[* 1]

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

PRESENT: LOBIS, Justice — PART 6

LOUIS RAPHAEL NATAN -v- OBREGON, NY PRESBYTERIAN HOSPITAL

INDEX NO. 110782/08

MOTION DATE

MOTION SEQ. NO. 2

MOTION CAL. NO.

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

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-12
Answering Affidavits — Exhibits	13-16
Replying Affidavits	17

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

FILED
MAR 20 2012
NEW YORK
COUNTY CLERK'S OFFICE

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION & ORDER

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

Dated: 3/19/12

JOAN B. LOBIS, J.S.C.

Check one: ☑ FINAL DISPOSITION ☐ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

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

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

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LOUIS RAPHAEL NAJAR OBREGON, Individually and as Administrator of the Estate of ROBERTO NAJAR deceased,

Plaintiff,

Index No. 110782/08

-against-

Decision and Order

THE NEW YORK AND PRESBYTERIAN HOSPITAL, IGOR OUGORETS, M.D. and SOUMITRA R. EACHEMPATI, M.D.,

Defendants.

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FILED
MAR 20 2012
NEW YORK
COUNTY CLERK'S OFFICE

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

Defendants[1] The New York and Presbyterian Hospital ("NYPH") and Soumitra R. Eachempati, M.D., move, by order to show cause, for summary judgment pursuant to C.P.L.R. Rule 3212. Plaintiff Louis Raphael Najar Obregon opposes the motion.

This action, sounding in medical malpractice, lack of informed consent, and wrongful death, relates to medical care that the moving defendants provided to plaintiff's decedent Roberto Najar, a 19-year old man who was struck by an automobile as a pedestrian on May 24, 2006. Mr. Najar was initially hospitalized at St. Vincent's Medical Center ("SVMC") with major head and brain trauma. At SVMC, an emergency left-sided decompressive craniectomy was performed to address brain swelling. After two days, Mr. Najar was transferred to NYPH. He arrived at NYPH in a coma and on mechanical ventilation. On the day of his admission to NYPH, Dr. Eachempati performed an exploratory laparoscopy and inserted a gastrostomy tube ("G-tube") so that Mr. Najar

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[1] Igor Ougoretz, M.D. s/h/a Igor Ougorets, M.D., was never served with the complaint and has not appeared, although he was deposed.

[* 3]

could receive nutrients; feedings were commenced through the G-tube on May 27, 2006. Over the next two months, Mr. Najar's care was complicated by pneumonia and continued swelling of the brain. On June 8, he underwent a right-sided craniectomy. On June 14, Dr. Eachempati performed a tracheostomy to facilitate long-term mechanical ventilation. On July 18, surgeons placed a shunt to drain excess cerebrospinal fluid from the ventricles in Mr. Najar's brain and inserted a plate to replace the bone removed during the right-sided craniectomy. However, ten days later, Mr. Najar developed hydrocephalus and ventriculitis, and his surgeons removed the right-sided plate and shunt. He was diagnosed with a multi-drug resistant Klebsiella pneumoniae bacterial infection.

The records reflect that on July 30, 2006, Mr. Najar vomited a yellowish liquid while receiving a feeding through the G-tube and his tube feedings were temporarily discontinued and replaced with intravenous total parenteral nutrition ("TPN") feedings. His surgical team, on which Dr. Eachempati was an attending physician, was made aware of the problem. On July 31, Mr. Najar's G-tube was found out of the stoma and was reinserted. On August 1 and 2, large amounts of brown, serous drainage were observed around the G-tube site, and his physicians were made aware. Mr. Najar's physicians made attempts to use larger G-tubes, but the drainage kept reoccurring. Repeated abdominal imaging studies over August 2 and 4 indicated a non-obstructed gas pattern and no obstruction in the small intestine. By August 7, it was noted that the skin around the G-tube was showing signs of breakdown. G-tube feedings were again discontinued and replaced with TPN feedings. On August 10, Dr. Eachempati performed surgical intervention to address a gastrocutaneous fistula at the insertion site. He removed the G-tube; resected the tissue near the insertion site and closed the site; closed the stomach with staples; and performed a jejunostomy to

[* 4]

place a J-tube to deliver feedings directly into the small intestine. He also inserted an orogastric tube (through the mouth and into the stomach) to decompress the stomach and allow air and excess fluid to exit the stomach. During this procedure, adhesions were noted between the stomach and interior wall of the abdomen; the adhesions were lysed.

Over the next four days, Mr. Najar had a post-operative fever, elevated white blood cell counts, and continued drainage. He had a nondistended, flat soft abdomen until August 14, when the abdomen was noted to be distended and taut. Additionally, he had expressed emesis (vomited) and continued to have drainage from the orogastric tube. Later on August 14, Mr. Najar had a medium sized bowel movement and afterward his abdomen was described as soft and non-tender. Even later in the evening on August 14, it was noted that Mr. Najar's abdomen was mildly distended. The plan was to stop J-tube feedings until the morning, in order to conduct an obstruction x-ray series.

At approximately 6:12 a.m. on August 15, 2006, Mr. Najar underwent a bedside abdominal x-ray, which indicated an indistinct bowel gas pattern and no observed obstruction. At approximately 6:30 a.m., Mr. Najar arrested and was resuscitated. After he was resuscitated, his abdomen was noted to be distended, firm, and rounded, with no audible bowel sounds. At approximately 9:00 a.m., Mr. Najar had a bowel movement. At approximately 10:00 a.m., his bladder pressure was noted to be elevated, which is indicative of elevated intra-abdominal pressure and possible abdominal compartment syndrome. Dr. Eachempati suspected abdominal compartment syndrome, and performed an exploratory laparotomy at approximately noon that day. Dr.

Eachempati observed an edematous bowel, consistent with abdominal compartment syndrome, and a small perforation along the staple line of the previous gastrectomy. He sutured the perforation and placed a decompressive gastrostomy tube in a separate part of the stomach, and left the abdomen open to allow for swelling to subside and promote healing. On August 23, 2006, Dr. Eachempati attempted to close the abdominal wound from the August 15 surgery. He observed an abscess in the small bowel, which was evacuated. He observed leakage at the J-tube site and another perforation in the small bowel. He resected part of the bowel, which had active inflammation and ischemia. A culture of the peritoneal fluid was negative for bacteria or fungi.

Throughout his hospitalization, Mr. Najar was consistently described as being in a stupor as a result of the traumatic brain injury he experienced during the accident. He required mechanical ventilation and tube feedings. After the accident, he never again spoke or communicated meaningfully, although he was able to open his eyes and move his arms somewhat. On September 1, 2006, Mr. Najar went into cardiogenic shock and was pronounced dead following unsuccessful resuscitation efforts. The autopsy report indicates that Mr. Najar died from multiple complications of blunt impacts of the head, torso, and extremities, with fractures and visceral injuries.

Plaintiff alleges that defendants were negligent in failing to recognize and treat Mr. Najar's apparent bowel obstruction. Plaintiff's allegations primarily focus on what is denoted as the "terminal month" of Mr. Najar's hospitalization. By this motion, defendants argue that the evidence supports a prima facie finding that their care and treatment of Mr. Najar was at all times appropriate and within accepted standards of medical care, and that none of the alleged departures proximately

[* 6]

caused Mr. Najar's injuries or death. Plaintiff maintains that issues of fact exist as to whether defendants failed to diagnose a gastrointestinal obstruction.

As established by the Court of Appeals in Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) and Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 (1985), and as has recently been reiterated by the First Department, it is "a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that [he or she] is entitled to judgment as a matter of law." Ostrov v. Rozbruch, ___ A.D.3d ___, 2012 N.Y. Slip Op. 22, **9-10 (1st Dep't January 3, 2012), citing Winegrad, 64 N.Y.2d at 853. In order to establish entitlement to summary judgment in a medical malpractice case, a physician must demonstrate that s/he did not depart from accepted standards of practice or that if there was a departure, it did not proximately cause the patient's injury. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). "When medical malpractice forms the basis of a wrongful death action, in establishing that he/she did not proximately cause the injuries alleged to have caused plaintiff's death, a defendant establishes prima facie entitlement to summary judgment as to the wrongful death action as well." Id. Once a movant meets this burden, it is incumbent upon the opposing party to proffer evidence sufficient to establish the existence of a material issue of fact requiring a trial. Ostrov, at **10, citing Alvarez, 68 N.Y.2d at 324. In medical malpractice actions, expert medical testimony is the sine qua non for demonstrating either the absence or presence of material issues of fact pertaining to departure from accepted medical practice or proximate cause.

In support of defendants' motion, they submit an affirmation from Ronald J. Simon, M.D., who sets forth that he is a physician licensed to practice medicine in New York and board certified in surgery and surgical intensive care. He states that in reaching his opinions, he reviewed the medical records from SVMC and NYPH; plaintiff's bills of particulars; and the deposition testimony of plaintiff, Dr. Eachempati, and Dr. Ougorets. Dr. Simon opines that the care provided to Mr. Najar at NYPH was in keeping with accepted standards of care and did not proximately cause his cardiac arrest or death. He notes that Mr. Najar suffered a substantial brain injury from the motor vehicle accident. He states that infection in a compromised patient such as Mr. Najar, in an ICU setting, with the injuries and interventions described above, is a known complication, and opines that Mr. Najar was properly treated with antibiotics and other interventions to address the infections. Dr. Simon points out that by August 2, 2006, Mr. Najar had lost 66 pounds, and that the bloody drainage around the skin insertion site of the G-tube reflected the loss of a tight seal of the stomach wall around the G-tube where it enters the stomach. He also notes that Dr. Eachempati observed a gastrocutaneous fistula during the August 10, 2006 surgery to remove the G-tube, which Dr. Simon opines is consistent with metabolic compromise and erosion of tissue around the gastric entry site in a chronically and severely ill patient. He opines that with these findings, it was appropriate to attempt to utilize larger G-tubes, but after two attempts at larger G-tubes, it was clear that the G-tube was no longer a viable option, and it was proper to hold G-tube feedings and start TPN feedings. Dr. Simon sets forth that TPN (intravenous) feedings are not ideal for long-term feeding, thus defendants' decision to insert a J-tube was proper and appropriate. He states that Dr. Eachempati's decision to resect (remove) the compromised tissue from around the G-tube insertion site and to close that entry site with staples was proper and in accordance with accepted standards of care. He

[* 8]

further opines that it was appropriate to use the orogastric tube with suction to decompress the stomach and drain stomach contents thereafter.

Dr. Simon opines that Mr. Najar's clinical course from August 11-13, after the J-tube was placed, was stable and unremarkable. By August 13, it was appropriate to discontinue orogastric suctioning of the stomach contents in favor of straight orogastric tube drainage in preparation for the eventual removal of the orogastric tube. Further, on August 14, it was appropriate to call for a surgical consult because there was increased drainage of the stomach contents, emesis, and one entry of a taut, distended abdomen at 8:00 a.m., even though three subsequent entries that day reflected no abdominal distension. Dr. Simon states that Mr. Najar had stable vital signs within normal limits, and the fact that he passed a bowel movement did not suggest a bowel obstruction or ileus (decreased bowel motility or peristalsis). Additionally, an abdominal x-ray on August 15 did not demonstrate any frank obstruction or edema substantial enough to be consistent with abdominal compartment syndrome. Ultimately, when Dr. Eachempati performed the exploratory procedure, he did not identify a bowel obstruction. Regardless, Dr. Simon opines that even if there had been a bowel obstruction, it would not have caused Mr. Najar's arrest.

Dr. Simon opines that the substantial abdominal distension that occurred after Mr. Najar arrested on August 15, 2006, was consistent with the interventions (administration of large volumes of fluids and cardiopulmonary resuscitation) undertaken to resuscitate Mr. Najar. He states that peritoneal inflammation and perforation at the suture line in the stomach are consistent with resuscitative efforts. However, he further states that perforation at the suture line in the stomach

could have occurred even without resuscitative efforts, because of the compromised tissue around the G-tube insertion site of this chronically and severely ill patient.

Dr. Simon further asserts that the August 23, 2006 surgery to attempt to close the abdomen was appropriate; that the abscess, leakage, and perforation were identified and repaired, and were consistent with a metabolically compromised patient; and that it was appropriate to leave the abdomen open given evidence of continuing intra-abdominal edema. Dr. Simon opines that even though Mr. Najar arrested and died on September 1, 2006, his care was in keeping with accepted standards of care. Dr. Simon opines that Mr. Najar was properly supported and treated for his continuing medical issues, and that his death was not caused by any departure from accepted standards in that continuing care. He sets forth that in a patient as severely and chronically ill as Mr. Najar, the etiology of events such as cardiac arrest are frequently multifactorial and attributable to the underlying chronic and severe illness in the absence of any specific clear mechanism of arrest.

In opposition to defendants' motion, plaintiff submits an affirmation from a physician (name redacted) licensed to practice medicine in New York and board certified in internal and critical care medicine. The expert states that s/he reviewed the NYPH records; the deposition testimony of Drs. Eachempati and Ougorets; and Dr. Simon's affirmation. Plaintiff's expert opines that the medical care provided to Mr. Najar indicates a failure to recognize and treat the symptoms of an apparent bowel obstruction early in the course of the adverse abdominal events. The expert states that there were three possible causes of the obstruction: ileus, adhesions, or abdominal compartment syndrome. Plaintiff's expert sets forth that there were gastrointestinal

complications -- emesis and persistent bloody drainage—between July 30 and August 10, 2006. The expert opines that emesis and drainage were evidence of an ongoing obstruction, which likely began on July 30, when Mr. Najar vomited. The expert sets forth that persistent drainage of gastrointestinal secretions through the gastrostomy stoma, despite discontinuing the enteral tube feedings, should have raised a suspicion for a bowel obstruction and should have prompted an evaluation for bowel obstruction and decompression of the upper gastrointestinal tract through the G-tube or the orogastric tube, but that action was only taken on August 10. Plaintiff's expert opines that the failure to take action prior to August 10 was a departure from accepted care and treatment, and that the ongoing departure allowed the obstruction to persist and contribute to a steady increase in abdominal pressure over ten (10) days. The expert opines that the unattended progression of the bowel obstruction caused the fistula, and that leakage of the fistula lead to diffuse peritonitis and septicemia from Klebsiella, which in turn progressed to severe sepsis, multiorgan failure, and death. Plaintiff's expert opines that the constellation of Mr. Najar's symptoms after August 10—fever, elevated white blood cell counts, vomiting, decreased urine output, and drainage—suggested severe sepsis with progressive multiorgan failure, which was later confirmed by the growth of Klebsiella pneumoniae from blood cultures.

Defendants argue that plaintiff's expert's opinion is conclusory, is not based on evidence in the record, and fails to address Dr. Simon's assertions. They point out that the records between July 30 and August 10, 2006, lack any reference to clinical evidence of an obstruction. They further point out that plaintiff's expert fails to explain how the fistula caused discharge outside the body at the site where the feeding tube entered the body. Additionally, defendants point out that

plaintiff's expert fails to provide any statement of the mechanism by which the conclusory trail of events—bowel obstruction, causing fistula, causing peritonitis and septicemia, causing multiorgan failure and death—allegedly led from one to the other with reference to the clinical evidence in the record. Defendants point out that plaintiff's expert fails to address Dr. Simon's opinion that the leakage from around the gastric feeding tube was attributable to the breakdown of tissues at the tube site after two months of being in place in a medically compromised patient; fails to address the radiological studies performed during the time period in question that did not reveal the presence of a bowel obstruction; and fails to address the lack of clinical presentation of a bowel obstruction, including the indications on Mr. Najar's chart that he continued to pass bowel movements.

Defendants have made out a prima facie case for summary judgment in their favor by tendering an expert's opinion, supported by evidence in the records, that defendants did not depart from the standard of care in treating Mr. Najar. Dr. Simon provides reasons consistent with Mr. Najar's condition as to why the discharge was occurring, why the fistula occurred, and why the G-tube ultimately failed over the time period between July 30 and August 10, 2006. There are also a number of radiological studies in the medical chart from July 30 to August 10, 2006, which indicated that there was no evidence of a bowel obstruction. Defendants have demonstrated that they did not fail to diagnose a bowel obstruction. In opposition, plaintiff fails to raise a trial issue of fact because his expert's affidavit is conclusory and vague and does not address the facts in the record or Dr. Simon's opinions regarding same. Plaintiff's expert states that the purported bowel obstruction likely began on July 30, 2006, as evidenced by emesis, and continued until August 10, 2006, as evidenced by the G-tube drainage. Plaintiff's expert fails to address Dr. Simon's opinion

that the G-tube drainage and the gastrocutaneous fistula occurred because of an inability to achieve a proper seal between the G-tube and Mr. Najar's tissue due to weight loss and metabolic compromise. Plaintiff's expert also opines that the leakage through the G-tube should have prompted further investigation as to whether the was a bowel obstruction, but fails to address the multiple abdominal studies taken between July 30 and August 10, 2006, showing that there was no evidence of a bowel obstruction. Finally, even assuming that a gastrointestinal obstruction did occur between July 30 and August 10, 2006, except in a conclusory manner, plaintiff's expert fails to explain how that obstruction caused the gastrocutaneous fistula that led to the patient's downward spiral into sepsis and death.

Additionally, defendants argue that a cause of action for failure to obtain informed consent does not lie here because plaintiff's claim is that defendants failed to diagnose a condition and have not particularized any invasive procedure. Plaintiff fails to rebut or even address this argument in his papers. Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is granted in its entirety, the complaint is dismissed against The New York and Presbyterian Hospital ("NYPH") and Soumitra R. Eachempati, M.D., and the Clerk is directed to enter judgment accordingly.

Dated: March 19, 2012

ENTER:

JOAN B. LOBIS, J.S.C.

FILED

MAR 20 2012

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