

Shecter v Fuster

2009 NY Slip Op 31746(U)

July 29, 2009

Supreme Court, New York County

Docket Number: 117019/04

Judge: Joan B. Carey

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

PRESENT: Honorable Joan B. Carey
Justice

PART 29

CELIA SHECTER, as Executrix of the
Estate of EDWIN SHECTER, Deceased,
and CELIA SHECTER, Individually,

INDEX NO. 117019/04

Motion Sequence No.: 1

Plaintiff,

-v-

VALENTIN FUSTER, M.D.,

Defendants.

FILED
JUL 30 2009
COUNTY CLERK'S OFFICE
NEW YORK

The following papers, 1- 15, were read on this motion by defendant Valentin Fuster, M.D. for summary judgment dismissing the complaint as asserted against it.

Notice of Motion - Affidavits - Exhibits
Affirmation in Opposition - Affidavits - Exhibits
Replying Affirmation -

<u>Papers Numbered</u>	
1-11	_____
12-14	_____
15	_____

Cross-Motion: Yes No

Edwin Shecter first presented to the office of Valentin Fuster, M.D. for a cardiovascular examination on November 11, 1992.¹ He was complaining of shortness of breath and was found to have atrial fibrillation. Dr. Fuster performed a thallium perfusion imaging exercise test, which showed moderate exercise tolerance and no indication of ischemia. This test, however, revealed a dilated left ventricle with multiple perfusion defects with no redistribution. In June of 1993, Mr. Shecter underwent a successful electrical cardioversion to address his atrial fibrillation, which was performed by Dr. Jay Curwin. Thereafter, from 1993 to 1998, Dr. Fuster continued to follow the patient on an annual basis. Despite a history of considerable heart disease, it appears that during this period Mr. Shecter remained stable from a cardiovascular perspective. At or around April 1998, Mr. Shecter began to complain of shortness of breath on a regular basis. In June of 1999, Mr. Shecter required the insertion of a transvenous pacemaker to address the recurrence of atrial fibrillation.

¹ It is noted that prior to treating with Dr. Fuster, Mr. Shecter had triple coronary artery bypass surgery on June 1, 1988, due to a history of myocardial infarction, and onset of anginal chest pain.

On April 8, 2003, Mr. Shecter presented to Dr. Fuster to obtain cardiovascular clearance for an inguinal herniorrhaphy. A cardiac PET scan was performed which revealed, *inter alia*, left and right ventricular enlargement and severe overall dysfunction. Notwithstanding, the PET scan report stated that “[t]here was only minimal stress-inducible mid-inferior ischemia, of little clinical significance.” Although Dr. Fuster noted that Mr. Shecter had an ejection fraction close to 20%, and a tendency for cardiac failure, Mr. Shecter was found to be stable from a cardiovascular point of view, and cleared for the surgery. Mr. Shecter underwent an uneventful herniorrhaphy with Marlex mesh at Mount Sinai Hospital on April 11, 2003. During the procedure, he was sedated and given regional anesthesia in the left groin. It does not appear that Mr. Shecter experienced any cardiac problems or issues during the procedure or in the immediate post-operative period.

On or about May 14, 2003, about one month after the hernia surgery, Mr. Shecter presented to the emergency department at Helene Fuld Medical Center, with a shortness of breath and was found to be hypotensive with positive cardiac enzymes. He was transferred to St. Francis Medical Center where he was found to be in cardiogenic shock with hypoxemia and worsening renal function. An emergency angioplasty was performed on Mr. Shecter. Notwithstanding, his condition continued and on May 17, 2003, Mr. Shecter was transferred to New York Presbyterian Hospital. He subsequently died on June 17, 2003.

Plaintiffs commenced the instant medical malpractice action against the defendant, Dr. Fuster, with the filing of a summons and complaint on or about January 18, 2005. Plaintiff alleges that on or about April 2003, Dr. Fuster failed to perform or recommend cardiac catheterization, cardiac angiography, coronary artery bypass grafting, and/or heart transplantation, thereby failing to prevent decedent’s myocardial infarction that resulted in his death on June 17, 2003. Discovery has been completed, a note of issue/certificate of readiness has been filed, and this action is now ready for trial. Dr. Fuster presently moves for summary judgment, dismissing the complaint.

“[T]he remedy of summary judgment is a drastic one, which should not be granted when there is any doubt as to the existence of a triable issue or where the issue is even arguable, since it serves to deprive a party of his day in court.” Byrnes v. Scott, 175 AD2d 786 [1st Dept. 1991], quoting Gibson v. Am. Export, 125 AD2d 65 [1st Dept. 1987]. Initially, “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 Hospital, 68 NY2d 320 [1986]; see also Winegrad v. New York Univ. Med. Center, 64 NY2d 851 [1985]; Zuckerman v. City of New York, 49 NY2d 557 [1980]. A failure by the movant in demonstrating, *prima facie*, its entitlement to judgment as a matter of law requires the denial of summary judgment, regardless of the sufficiency of the opposing papers. See Alvarez v. Prospect, *supra*; Winegrad v. New York Univ. Med. Center, *supra*. Where a *prima facie* showing of entitlement to judgment as a matter of law has been properly demonstrated, the burden then shifts to the party opposing the motion to produce evidence that establishes the existence of material issues of fact which require a trial in the action. See Alvarez v. Prospect, *supra*; Zuckerman v. City of New York, *supra*.

In support of his motion, Dr. Fuster relies upon, *inter alia*, the expert affidavit of a physician who is board certified in internal medicine, cardiovascular disease, and nuclear medicine. Based upon the expert’s review of Mr. Shecter’s medical records as well as documents relating to the instant litigation, *i.e.*, deposition transcripts and bill of particulars, the expert opined that Dr. Fuster was not negligent in his medical treatment of Mr. Shecter. Dr. Fuster’s expert expressly sets forth that “the care rendered by Dr. Fuster to Mr. Shecter at all times adhered to the standards of care.” He further states that “the care provided by Dr. Fuster

was not the proximate cause of Mr. Shecter's death."

Dr. Fuster's expert opines that Dr. Fuster was not required to perform a cardiac catheterization and angiogram prior to the time of Mr. Shecter's hernia surgery or at any time during his treatment of Mr. Shecter. The expert explains that a cardiac catheterization and angiogram is an invasive procedure and "is only recommended if the clinical symptoms and non-invasive tests suggest that there is active ischemia present." According to the expert, since the non-invasive PET scan revealed no active ischemia, cardiac catheterization and angiogram was unnecessary. Dr. Fuster's expert further opines that the standard of care did not require Dr. Fuster to perform a coronary artery bypass graft (CABG) prior to the hernia surgery or at any time during his care of Mr. Shecter. He states that "[a] repeat bypass in a patient like Mr. Shecter bears a mortality rate of greater than 20%. In the absence of compelling symptoms or non-invasive tests documenting ischemia, recommending a bypass would have been absolutely contraindicated." The expert also sets forth that Dr. Fuster was not required to consider a heart transplant because "the standard of care would generally prohibit a cardiac transplantation in a 76-year-old man." As result of the foregoing opinions, Dr. Fuster's expert finds that Dr. Fuster adhered to the standard of care in treating Mr. Shecter from 1992 through 2003.

Additionally, Dr. Fuster's expert opines that the care rendered by Dr. Fuster was not the proximate cause of Mr. Shecter's death. The expert sets forth that Mr. Shecter had a history of cardiac issues and "was vulnerable to decompensation and death from 1992 forward." According to the expert, Dr. Fuster's treatment of Mr. Shecter contributed to his ability to sustain a relatively normal lifestyle, despite the poor condition of his heart. The expert also sets forth that Dr. Fuster properly assessed Mr. Shecter's ability to tolerate the hernia surgery, pointing out the fact that Mr. Shecter underwent the hernia surgery without any complications. The expert states that "[t]he absence of cardiac complications during the surgery and in the immediate post-operative period is evidence that Mr. Shecter was able to withstand the procedure from a cardiovascular perspective." The foregoing affidavit is sufficient to make a *prima facie* showing of entitlement to judgment as a matter of law, demonstrating the absence of any material issues of fact with respect to the adequacy of the medical treatment provided by Dr. Fuster (see Sulb v. Keller, 6 AD3d 805 [3rd Dept. 2004]; Juba v. Bachman, 255 AD2d 492 [2d Dept. 1998]; see also Alvarez v. Prospect Hospital, *supra*). The burden, therefore, shifts to plaintiffs to come forward with evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial in the action (see Alvarez v. Prospect, *supra*; Zuckerman v. City of New York, *supra*).

In opposition to Dr. Fuster's motion, plaintiffs submitted, *inter alia*, the expert affidavit of a physician, who specializes in the practice of cardiology and is board certified in internal medicine and sub-certified in cardiovascular disease. Based on a review of Mr. Shecter's medical records, as well as documents relating to the instant litigation, *i.e.*, deposition transcripts and bill of particulars, plaintiffs' expert concludes that Dr. Fuster departed from the accepted standards of medical practice and these departures substantially contributed to Mr. Shecter's injuries and premature death. Plaintiffs' expert states that "the decedent, Edwin Shecter, died due to complications of an acute overwhelming myocardial infarction experienced on or about May 14, 2003, due to severe coronary artery occlusion." The expert sets forth that:

"the signs and symptoms of worsening shortness of breath, progressive edema, declining ejection fraction and worsening congestive heart failure in a patient whose last (and only) coronary artery arteriogram had been performed fifteen years prior to death in conjunction with coronary artery bypass grafting, who presented for clearance for non-emergency hernia surgery, required the performance of another coronary artery arteriogram. While the PET scan did not reveal significant ischemia

after chemical stress induced by the injection of dipyridamole, the fact that the maximum heart rate achieved was only 70 rendered this finding of very limited reliability as to the inducibility of ischemia. Whether or not Dr. Fuster chose to perform a PET scan initially, under the circumstances described above, a follow-up coronary artery arteriogram should have been performed."

Plaintiffs' expert acknowledges that coronary arteriography is not a risk-free procedure, but stresses that the risk of death from a myocardial infarction due to undetected coronary artery occlusion outweighs the risk of performing the procedure. Plaintiffs' expert notes in his affidavit that the reocclusion of Mr. Shecter's saphenous vein coronary bypass grafts that were performed fifteen years prior was predictable, as it occurs in a majority of such grafts of that age.

Plaintiffs' expert adds "that even aside from the clinical scenario of clearance for non-emergency hernia surgery," Dr. Fuster should have performed a repeat coronary artery arteriogram on Mr. Shecter no later than one year before Mr. Shecter's terminal myocardial infarction in May of 2003. According to plaintiffs' expert, such procedure should have been performed "given that Mr. Shecter's shortness of breath, edema and congestive heart failure began to worsen at this time, given that the ejection fraction had been steadily declining over ten years and due to significant risk that previously placed saphenous vein grafts had reoccluded." With respect to causation, plaintiffs' expert states that had a timely coronary artery arteriogram been performed, Mr. Shecter's coronary artery occlusions would have been discovered, allowing for the performance of elective coronary artery bypass grafting, which would have prevented the fatal myocardial infarction.

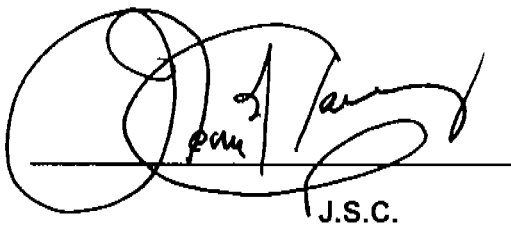
Based upon the conflicting expert affidavits submitted by the parties, issues of fact and credibility exist in connection with whether Dr. Fuster departed from good and accepted medical practice in the treatment of Mr. Shecter, and whether such departures were a substantial factor in causing injury to plaintiff. Such issues cannot be resolved on this motion for summary judgment (see Bradley v. Soundview Healthcenter, 4 AD3d 194 [1st Dept. 2004]; Morris v. Lenox Hill Hosp., 232 AD2d 184 [1996]). Accordingly, the instant motion for summary judgment is denied.

Based on the foregoing, it is hereby

ORDERED that this motion by defendant Valentin Fuster, M.D. for summary judgment dismissing the complaint is denied, and the complaint; and it is further

ORDERED that counsel for all remaining parties are to appear before the court on September 17, 2009, at 9:30am, at 60 Centre Street, room 228, Part 29, for a pre-trial conference.

Dated: 7/29/2009



J.S.C.

Check one: FINAL DISPOSITION

NON- FINAL DISPOSITION

Check if appropriate: DO NOT POST

REFERENCE

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