Guerrieri v Tsiamtsiouris

2011 NY Slip Op 31003(U)

April 5, 2011

Supreme Court, Nassau County

Docket Number: 12114/08

Judge: Denise L. Sher

Republished from New York State Unified Court System's E-Courts Service.
Search E-Courts (http://www.nycourts.gov/ecourts) for any additional information on this case.

This opinion is uncorrected and not selected for official publication.

[* 1]

SCAN

SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK

PRESENT: HON. DENISE L. SHER
Acting Supreme Court Justice

ANNA MARIA GUERRIERI as Administratrix of the Estate of ANTONIO GUERRIERI, Deceased, and ANNA GUERRIERI, Individually,

Plaintiffs,

- against -

THEOFANIS TSIAMTSIOURIS, M.D., NEIL R. BERCOW, M.D., NEIL R. BERCOW, M.D., P.C., RALPH MASTRANGELO, M.D., ROBERT SIEFRING, R.P.A., and ST. FRANCIS HOSPITAL, ROSLYN, NEW YORK,

Defendants.

TRIAL/IAS PART32
NASSAU COUNTY

Index No.: 12114/08
Motion Seq. Nos.: 03, 04, 05
Motion Dates: 11/15/10
12/07/10
12/22/10

The following papers have been read on these motions:

	Papers Numbered
Notice of Motion (Seq. No. 03), Affirmation and Exhibits	1
Notice of Motion (Seq. No. 04), Affirmation and Exhibits and Memorandum of Law	2
Notice of Motion (Seq. No. 05), Affirmation and Exhibits	3
Affirmation in Opposition and Exhibit	4
Reply Affirmation and Exhibits	5
Reply Affirmation and Exhibit	6
Reply Affirmation	7

Upon the foregoing papers, it is ordered that the motions are decided as follows:

The motion by defendants Theofanis Tsiamtsiouris, M.D. ("Dr. Tsiamtsiouris"), Neil R. Bercow, M.D. and Neil Bercow, M.D., P.C. ("Dr. Bercow") for an order, pursuant to CPLR §

3212, granting them summary judgment dismissing the complaint against them is denied.

The motion by defendant Ralph Mastrangelo, M.D. ("Dr. Mastrangelo") for an order, pursuant to CPLR § 3212, granting him summary judgment dismissing the complaint against him is granted.

The motion by defendants Robert Siefring, R.P.A. ("P.A. Siefring") and St. Francis Hospital, Roslyn, New York ("Hospital") for an order, pursuant to CPLR § 3212, granting them summary judgment dismissing the complaint against them is determined as provided herein.

Plaintiffs in this action seek to recover damages for lack of informed consent, medical malpractice and the wrongful death of Antonio Guerrieri ("Antonio"). Antonio died at defendant Hospital on March 7, 2007, within twenty-four (24) hours of defendant Dr. Bercow's surgical placement of a permanent pacemaker. It is not disputed that defendant Dr. Bercow lacerated Antonio's left subclavian vein and punctured his left lung during that surgery, which caused internal bleeding, and that, despite the placement of a test tube to drain the fluid accumulating in Antonio's chest and the attempt by non-party Dr. Fernandez to surgically repair Antonio's lacerated vein and punctured lung, Antonio died. The cause of death listed by the coroner on Antonio's death certificate is "Hemorrhage. Due to: perforation of left subclavian vein and left lung with pacemaker wire placed to treat heart block with bradycardia on March 5, 2007, status post attempted surgical repair March 6, 2007. Other Significant Conditions: Atherosclerotic cardiovascular disease with heart failure."

Antonio had been hospitalized since February 17, 2007, during which time he was treated by the defendants Dr. Tsiamtsiouris, Dr. Mastrangelo and P.A. Siefring for an obstructed bowel and irregular heartbeat including tachycardia, bradycardia and atrial fibrillation.

[* 3]

Plaintiffs allege that the defendants improperly administered medications, i.e., negative chronotropes, in an attempt to regulate Antonio's heartbeat which lowered his heart rate to the point of bradycardia and heart block which necessitated the placement of a pacemaker. They also allege that defendant Dr. Bercow erred in failing to attempt a second surgical insertion of a temporary transvenous pacemaker via an alternative route before placing the permanent pacemaker and in failing to timely and properly diagnose and treat Antonio's post-operative bleed. Finally, they allege that the administration of Heparin to which Antonio had a history of allergies was negligent and contributed to Antonio's death because he developed Heparin-Induced Thrombocytopenia ("HIT") which contributed to his post-operative bleed.

All of the defendants seek summary judgment dismissing the complaint against them. Defendant Dr. Tsiamtsiouris was Antonio's private attending cardiologist, defendant Dr. Bercow was Antonio's private attending cardio-thoracic surgeon and defendant Dr. Mastrangelo was Antonio's private attending internist. Defendant P.A. Siefring was an employee of defendant Hospital who assisted Dr. Patetsios during a surgical procedure.

The facts pertinent to the determination of these motions are as follows:

Antonio was a seventy-eight (78) year old man had been chronically ill for years prior to his admission to the hospital on February 17, 2007. His history included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, peripheral vascular disease, chronic anemia and post repair of an abdominal aortic aneurysm. He had been either hospitalized or in a rehabilitation facility for the majority of time between November 2006 and February 2007.

Antonio was admitted to defendant Hospital on November 13, 2006, with difficulty

breathing and chest discomfort. His general surgeon, Dr. Patetsios, performed a surgical repair of an abdominal aorta aneurysm which had increased in size. He was given Heparin prophylactically to guard against deep vein thrombosis at Dr. Patetsios' recommendation. It was discontinued on December 13, 2006 because Antonio might have developed HIT. On December 15, 2006, Antonio developed a large bowel obstruction and underwent a cecostomy creation with the insertion of a percuntaneous endoscip grastrostomy. He was discharged on January 6, 2007, but he was readmitted with a fever. He was diagnosed with chronic obstructive pulmonary disease via a chest x-ray and he was admitted to rule out pneumonia and a viral syndrome. He remained hospitalized and on antibiotics until January 12, 2007. He was readmitted again on January 20, 2007 with shortness of breath and anemia. He received cell transfusions and a hematology study was performed which revealed that he had anemia with an onset of leukopenia. Monitoring for a bone marrow transplant was put in place. Inappropriately low erythropoietin levels which stimulates the formation of red blood cells was diagnosed and Procrit was recommended. His hemoglobin/hematocrit improved sufficiently to permit his discharge on January 20, 2007.

Antonio was admitted to the hospital again on February 17, 2007 under the auspices of his private doctor, non-party general surgeon Dr. Patetsios, with complaints of neck pain, chest pain, back pain, nausea, labored breathing and thirst. He had no output from his ostomy for the previous 12-18 hours. Dr. Patetsios admitted him for a bowel obstruction which necessitated the closure of his cecostomy. A consult by defendant thoracic surgeon Dr. Tsiamtsiouris was requested but, since he was on vacation, Dr. Madrid of his practice provided one. Defendant Dr. Mastrangelo's practice via his partner, non-party Dr. Linden, gave medical clearance for that procedure that day. Heparin prophylaxis 5,000 units subcutaneous every twelve (12) hours was

begun on the day that Antonio was admitted, however, it was discontinued after three doses due to a "questionable allergy to Heparin." On February 21, 2007, atrial fibrillation and an abnormally low heartbeat were noted. Defendant Dr. Tsiamtsiouris prescribed Cardizem.

Defendant P.A. Siefring assisted non-party Dr. Patetsios in the surgery to close Antonio's cecostomy on February 22, 2007. At his Examination Before Trial ("EBT"), defendant P.A. Siefring testified that after reviewing Antonio's admission history which indicated "allergies, none;" his medication reconciliation form which had "no known allergies" checked off; and his pre-operative check which noted that Antonio had "no known allergies" and discussing it with the pharmacist, he prescribed subcutaneous Heparin 5,000 units every 12 hours for Antonio that day as a prophylaxis against deep vein thrombosis which was administered through March 2, 2007. Heart medications Enalapril and Cardizem were also prescribed.

Defendant Dr. Mastrangelo first saw Antonio post-operatively on February 23, 2007. He recommended a transfusion. Defendant P.A. Siefring evaluated Antonio post-operatively along with Dr. Patetsios on February 24, 2007. Defendant Dr. Mastrangelo also saw Antonio on February 24, 25, 27 and March 6, 2007, but Antonio was under Dr. Patetsios', cardiologist defendant Dr. Tsiamtsiouris' and, eventually, thoracic surgeons defendant Dr. Bercow's and Dr. Fernandez's care.

Defendant Dr. Tsiamtsiouris first saw Antonio during this hospitalization on February 26, 2007. Atrial fibrillation was revealed on the cardiac monitor, confirming paroxysmal atrial fibrillation since it was the second episode in seven days. For this reason, defendant Dr. Tsiamtsiouris prescribed Atenolol with instructions to discontinue it if Antonio's' heart rate or systolic blood pressure became too low. The next day, February 27, 2007, defendant Dr.

Tsiamtsiouris noted a normal sinus rhythm with these medications. However, Antonio was again noted to be in atrial fibrillation in the late afternoon the next day, February 28, 2007, and when defendant Dr. Tsiamtsiouris was so informed he moved up Antonio's next dose of Atenolol and asked to be contacted if Antonio's heart rate did not resolve. Later that night, when Antonio developed tachycardia with heart rates of 130-140, defendant Dr. Tsiamtsiouris added Amiodarone to his medications. On March 1, 2007, defendant Dr. Tsiamtsiouris noted that Antonio's heart rate was controlled. Cardizem, Atenolol and Amiodarone were continued by defendant Dr. Tsiamtsiouris. At 7:54 PM, the nurse noted that Antonio had an episode of ventricular tachycardia but it resolved by the following morning. Defendant Dr. Tsiamtsiouris recommended that Cardizem be decreased and that Amiodarone and Atenolol be continued. Defendant P.A. Siefring saw Antonio again on March 3, 2007. Antonio's wound was healing and Heparin was discontinued. On March 4, 2007, at 10:50 AM, Antonio's sinus rhythm and heart rate were normal. On March 5, 2007, Physician's Assistant Staphos noted Antonio's heart rate to be normal, however, later that day, his heart rate fell to the 30s. Atropine and Calcium were prescribed by defendant Dr. Tsiamtsiouris to increase Antonio's heart rate. Defendant Dr. Tsiamtsiouris discontinued the Amiodarone, Atenolol and Cardizem due to an electrocardiogram which showed an atrioventricular dissociation with conversion to sinus rhythm after the medications were given. Another electrocardiogram showed a sinus atrioventricular block and premature ventricular contractions.

Defendant Dr. Tsiamtsiouris brought Antonio to the catheterization laboratory for placement of a temporary pacemaker. He testified at his EBT that he discussed this with Antonio's family. Although it appeared to have been properly placed, the implantation of the temporary pacemaker by defendant Dr. Tsiamtsiouris, as a result of Antonio's drop in heart rate,

[* 7]

was "tenuous at best." Defendant Dr. Tsiamtsiouris was not happy with the thresholds obtained because it was not capturing the beat adequately. Defendant Dr. Tsiamtsiouris believed a permanent pacemaker was needed to protect against further episodes of irregular heart rates and rhythms and bradycardia. Defendant Dr. Tsiamtsiouris testified at his EBT that he discussed this with Antonio's family. Certified surgeon and thoracic surgeon defendant Dr. Bercow's first contact with Antonio occurred on March 5, 2007 when he was called to the catheterization lab for a consultation and to assist with the implantation of a permanent pacemaker.

Because Antonio's diagnosis was "systematic heart block, severe bradycardia, asystole," defendant Dr. Bercow implanted a pacemaker emergently. Antonio's chart reflects that the risks, benefits and alternatives of this procedure were also discussed with Antonio's family. The procedure began at 7:15 PM and ended at 7:33 PM. Defendant Dr. Bercow testified at his EBT that he used fluoroscopy to place the permanent pacemaker and access was via the left subclavian vein and the pacemaker was implanted on the left subclavian tossa. Defendant Dr. Bercow was not aware of any complications during the surgery. Following the surgery, defendant Dr. Bercow accompanied Antonio to the recovery room. A post-operative x-ray revealed a white spot on Antonio's chest in the left pleural space which indicated that fluid was accumulating in Antonio's lung. After evaluating the x-ray, defendant Dr. Bercow inserted a chest tube and Antonio's endotracheal tube was adjusted. 1300 ccs of "Kool-aid" appearing fluid was drained. A blood transfusion was given. Defendant Dr. Bercow eventually concluded that the source of the fluid draining which consisted of blood and pleural fluid was unclear. Defendant Dr. Bercow testified at his EBT that patients can have some bleeding during and after pacemaker surgery and that Antonio may have had fluid in his chest cavity before the surgery was performed. Defendant Dr. Bercow remained with Antonio in the recovery room for

approximately two hours. During that time, fluid consisting of blood and pleural fluid continued to drain from Antonio's chest. Despite the fact that damage to a blood vessel is a well known risk of the placement of a pacemaker, defendant Dr. Bercow did not form a differential diagnosis as to the cause of the draining fluid. When Dr. Bercow left at about 9:30 PM, Antonio's condition was stable. The chest tube was draining and his vital signs were okay. At his EBT, defendant Dr. Bercow testified (and none of the parties dispute) that both the risks of puncturing a vein and injuring the lung, as well as bleeding into the chest cavity and pneumothorax, are all clear well known risks of a pacemaker procedure.

Following defendant Dr. Bercow's departure, Antonio's chest continued to persistently drain 500 ccs of serosanguinous fluid. When Antonio's vital signs became unstable, i.e., his blood pressure dropped, his oxygenization became poor and he did not respond to medications, non-party Dr. Fernandez was called, at 2:30 AM on March 6, 2007, to perform a thoracotomy. Dr. Fernandez proceeded to the operating room to perform exploratory surgery to determine the source of the fluid. A large amount of blood was found in Antonio's thoracic cavity and an active bleeding site was found where the pacemaker lead was protruding through the subclavian vein and through the parietal pleura. Dr. Fernandez discovered that the pacing lead had taken a circuitous route outside the vein and back into the vein injuring the lung on the way. He was able to surgically repair the laceration to Antonio's vein and the puncture to Antonio's lung with Surgicel and Bioglue and sutures, thereby rendering the sites hemostatic. However, Antonio became unstable during the surgery and remained unresponsive afterwards. He remained in critical condition with severe hypoxia, hypocardia and on high doses of pressors and inotropes. When his condition did not improve, his family executed a Do Not Resuscitate. Antonio died on March 7, 2007.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent 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." *See Sheppard-Mobley v. King*, 10 A.D.3d 70, 778 N.Y.S.2d 98 (2d Dept. 2004), *aff'd as mod.* 4 N.Y.3d 627, 797 N.Y.S.2d 403 (2005) *citing Alvarez v. Prospect Hospital*, 68 N.Y.2d 320, 508 N.Y.S.2d 923 (1986); *Winegrad v. New York University Medical Center*, 64 N.Y.2d 851, 487 N.Y.S.2d 316 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v. King, supra* at 74; *Alvarez v. Prospect Hosp., supra*; *Winegrad v. New York University Medical Center, supra.* Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *See Alvarez v. Prospect Hosp., supra* at 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See Demishick v. Community Housing Management Corp.*, 34 A.D.3d 518, 824 N.Y.S.2d 166 (2d Dept. 2006), *citing Secof v. Greens Condominium*, 158 A.D.2d 591, 551 N.Y.S.2d 563 (2d Dept. 1990).

" 'The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (citations omitted).' " *Wexelbaum v. Jean*, 80 A.D.3d 756, 915 N.Y.S.2d 161 (2d Dept. 2011) *quoting DiMitri v. Monsouri*, 302 A.D.2d 420, 754 N.Y.S.2d 674 (2d Dept. 2003). "Thus on a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (citations omitted)." *Wexelbaum v. Jean, supra.*

Pursuant to New York Public Health Law § 2805-d, a cause of action for lack of informed consent is limited to cases involving non-emergency treatment, procedure or surgery or a diagnostic procedure involving an invasion or disruption of the patient's body. Thus, the "plaintiff must allege that the wrong complained of arose out of some affirmative violation of plaintiff's physical integrity." *Lazzetta v. Vicenzi*, 200 A.D.2d 209, 613 N.Y.S.2d 750 (3d Dept. 1994) *lv den.* 85 N.Y.2d 857, 624 N.Y.S.2d 375 (1995). *See also Flanagan v. Catskill Regional Medical Center*, 65 A.D.3d 563, 884 N.Y.S.2d 131 (2d Dept. 2009). Public Health Law § 2805-d(3) provides that "[f]or a cause of action it must . . . be established that a reasonably prudent person in the patient's position *would not have undergone* the treatment or diagnosis if he had been fully informed (emphasis added) (citations omitted)." *Ellis v. Eng*, 70 A.D.3d 887, 895 N.Y.S.2d 462 (2d Dept. 2010).

If the moving defendant only establishes that he did not commit medical malpractice, in opposing the motion, the plaintiff must establish the existence of a material issue of fact with respect to only that issue. *See Stukas v. Streiter*, ___A.D.2d _____, 2011 WL833959 (2d Dept. 2011). Similarly, if the moving defendant establishes a lack of proximate course, the plaintiff need establish only the existence of a material issue of fact with respect to that issue. *See Stukas v. Streiter, supra.* However, if the moving defendant establishes both a lack of negligence and proximate cause, in opposing the motion, the plaintiff must establish an issue of fact as to both of those issues. *See Stukas v. Streiter, supra.*

"[G]eneral allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" do not suffice (citations omitted). *Shectman v. Wilson*, 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept. 2009). *See also Diaz v. New York Downtown Hosp.*, 99 N.Y.2d 542, 754 N.Y.S.2d 195

(2002); *Romano v. Stanley*, 90 N.Y.2d 444, 661 N.Y.S.2d 589 (1997); *Amatulli by Amatulli v. Delhi Const. Corp.*, 77 N.Y.2d 525, 569 N.Y.S.2d 337 (1991). The plaintiff's expert must set forth the medically accepted standards of care and explain how they were departed from. *See Geffner v. North Shore University Hosp.*, 57 A.D.3d 839, 871 N.Y.S.2d 617 (2d Dept. 2008) (citations omitted). Additionally, the plaintiff's expert must address all of the key facts relied on by the defendant's expert. *See Kaplan v. Hamilton Medical Associates, P.C.*, 262 A.D.2d 609, 692 N.Y.S.2d 674 (2d Dept. 1999). *See also Geffner v. North Shore University Hosp., supra*; *Rebozo v. Wilen*, 41 A.D.3d 457, 838 N.Y.S.2d 121 (2d Dept. 2007).

An expert's affidavit which lacks evidentiary support in the record or is contradicted thereby is not sufficient to establish the existence of a triable issue of fact. *See Micciola v. Sacchi*, 36 A.D.3d 869, 828 N.Y.S.2d 572 (2d Dept. 2007) (citations omitted). Furthermore, "[a]n expert may not reach a conclusion by assuming material facts not supported by the evidence, and may not guess or speculate in drawing a conclusion (citations omitted)." *Rosato v. 2550 Corp.*, 70 A.D.3d 803, 894 N.Y.S.2d 513 (2d Dept. 2010). *See also Cassano v. Hagstrom*, 5 N.Y.2d 643, 187 N.Y.S.2d 1 (1959). "[H]indsight reasoning . . . is insufficient to defeat summary judgment (citations omitted)." *Micciola v. Sacchi, supra* at 871.

"To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury (citations omitted)." *Alicea v. Liguori*, 54 A.D.3d 784, 864 N.Y.S.2d 462 (2d Dept. 2008) *quoting Johnson v. Jamaica Hosp. Medical Center*, 21 A.D.3d 881, 800 N.Y.S.2d 609 (2d Dept. 2005). The plaintiff's expert need not "'quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of better outcome or increased [the] injury, as long as evidence is presented from which the jury

may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury (citations omitted).' " *Alicea v. Liguori*, *supra*, at 786 *quoting Flaherty v. Fromberg*, 46 A.D.3d 743, 849 N.Y.S.2d 278 (2d Dept. 2007).

"In general, a hospital may not be held vicariously liable for the malpractice of a private attending physician who is not an employee and may not be held concurrently liable unless its employees committed independent acts of negligence or the attending physician's orders were contraindicated by normal practice such that ordinary prudence required inquiry into the correctness of the same. (citations omitted)." *Toth v. Bloshinsky*, 39 A.D.3d 848, 835 N.Y.S.2d 301 (2d Dept. 2007). Where, however, there is evidence that allegedly negligent medical decisions were made by a hospital's employee, both may be liable. *See Cerny v. Williams*, 32 A.D.3d 881, 822 N.Y.S.2d 548 (2d Dept. 2006).

Where a general physician refers a patient to a specialist for treatment of a specific condition and is led to believe that expert has assumed such care, the general physician is absolved of liability. *See Wasserman v. Staten Island Radiological Associates*, 2 A.D.3d 713, 770 N.Y.S.2d 108 (2d Dept. 2003); *Bellino v. Spatz*, 233 A.D.2d 355, 650 N.Y.S.2d 751 (2d Dept. 1996).

"While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field . . . the witness nonetheless should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable (quotations omitted)." *Shectman v. Wilson*, *supra* at 849-850 *quoting Behar v. Cohen*, 21 A.D.3d 1045, 803 N.Y.S.2d 629 (2d Dept. 2005) *lv den.* 6 N.Y.3d 705, 812 N.Y.S.2d 34 (2006) *quoting Postlethwaite v. United Health Services Hospitals, Inc.*, 5 A.D.3d 892, 773 N.Y.S.2d 480 (3d Dept. 2004). "Thus, where a physician

opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered (citations omitted)." *Shectman v. Wilson*, *supra* at 850.

In support of his motion for summary judgment, defendant Dr. Mastrangelo has submitted his own affidavit. He opines that his care and treatment of Antonio was in accordance with good and accepted medical standards and that his care was not a proximate cause of Antonio's injuries and/or death. He notes that he never prescribed Heparin and he did not play any part in the insertion of the pacemaker or Antonio's ensuing medical condition. Defendant Dr. Mastrangelo has established his entitlement to summary judgment dismissing the complaint against him in its entirety thereby shifting the burden to the plaintiffs to establish the existence of a material issue of fact.

In support of their motion, Defendant P.A. Siefring and Hospital have submitted the affirmation of Dr. Ira C. Halperin, who is Board Certified in internal medicine, hematology and oncology. Having reviewed all of the pertinent medical records and legal documentation, he has concluded that the administration of Heparin did not cause HIT or any of the other injuries Antonio sustained and that even if HIT developed, Antonio did not suffer any affects of HIT thrombosis ("HITT"). He notes that defendant P.A. Siefring did not play any role in the prescription of any drugs other than Heparin nor did he play a role in Antonio's cardiocare which was tended to by defendant Dr. Tsiamtsiouris and eventually defendant Dr. Bercow and Dr. Fernandez. Dr. Halperin explains that HIT is the development of a low platelet count due to Heparin. He represents that while there is no allergy to Heparin, a well known adverse side effect, HIT, can develop which predisposes a patient to a formation of thrombosis, a clot. However, low platelet counts do not always cause problems and even when they do, they are often easily remedied. There are clinical signs of HIT such as petechia, i.e., painless pinpoint

skin discoloration and bruising, which he opines Antonio did not display, nor did he display any signs of bleeding as a result of HIT. Dr. Halperin further explains that a number of other things can cause decreased platelet counts. He explains that there are three characteristics of HIT: Timing, severity - - which is usually mild to moderate - -and thrombosis. Dr. Halperin explains that the Grenacher Scoring System aids in the diagnosis of HIT and applying that criteria, he opines that it is unlikely that Antonio developed HIT. He notes that his platelets remained normal from February 17-18, 2007, despite Heparin and that although Antonio began Heparin again on February 23, 2007, his platelets did not drop to below normal until February 28, 2007, which would have occurred sooner if Antonio was experiencing HIT because Antonio had been exposed to Heparin within ninety (90) days. Based on the timing, severity and the lack of new thrombosis and the presence of an alternative cause for Antonio's low platelet count, Dr. Halperin opines that Antonio's decreased platelet count was not due to HIT.

Dr. Halperin notes that even hematologist Dr. Ginsberg who did a hematology consult on March 5, 2007, did not definitively find that HIT had developed. Dr. Ginsberg noted that on a prior admission in November/December 2006, Antonio had thrombocytopenia secondary to infection and antibiotics but nevertheless, the likely diagnosis for Antonio's low platelet count then was not HIT. Hematologist Dr. Ginsberg found that although he had tested positive for the HIT antibody then, the ELISA test, which had been performed, falsely identifies antibodies that do not cause HIT. A serotonin release assay test which is the gold standard for diagnosing HIT was never done. Dr. Ginsberg had found that Antonio's low platelet count was of unclear etiology. He had considered an invasive bone marrow biopsy to ascertain the cause of Antonio's low platelet count and the inability to definitively diagnose HIT but it was not done. Dr. Halperin opines that while Dr. Ginsberg had been prudent in recommending the

discontinuation of Heparin in March 2007 to avoid HIT induced clotting, nothing ever materialized to enable a definitive diagnosis.

Dr. Halperin in addition opines that there is nothing to suggest that Antonio's low platelet count was significant enough to contribute to his hemorrhage. He notes that there is no evidence in the record to demonstrate that Antonio's bleeding was caused or exacerbated by his platelet count. The bleeding was caused by the lacerations which when repaired stemmed the bleeding. He similarly opines that Antonio's low platelet count did not cause or contribute to his deteriorating cardiac condition which necessitated the implantation of a pacemaker.

Dr. Halperin further opines that another cause of Antonio's low platelet count evolved- A coagulation study done on March 6, 2007 was consistent with disseminated intravascular coagulation ("DIC") attributable to sepsis. Thus, Antonio's low platelet count could have been attributable to an infective process.

Defendant P.A. Siefring and concomitantly defendant Hospital have established their entitlement to summary judgment dismissing the complaint against them in its entirety thereby shifting the burden to the plaintiffs to establish the existence of a material issue of fact.

In support of their motions, defendants Drs. Tsiamtsiouris and Bercow have submitted the affirmation of Dr. Alfred T. Culliford, a Board Certified Thoracic and General Surgeon. He explains the risks of atrial fibrillation and the need to control the irregular heart rates associated with it, using betablockers (Atenolol), calcium channel blockers (Cardizem), Digoxin and Amidarone. He notes and it is not disputed that neither defendant Dr. Tsiamtsiouris nor defendant Dr. Bercow played any role in the prescription of Heparin. Detailing each and every act taken by defendant Dr. Tsiamtsiouris, he opines to a reasonable degree of medical certainty that he appropriately prescribed, adjusted, and/or discontinued Antonio's medications in an

attempt to obtain control of atrial fibrillation at the lowest possible dose. He also opines that defendant Dr. Tsiamtsiouris properly recommended that a permanent pacemaker be inserted since the temporary one inserted by him was not properly pacing Antonio's heart.

As for defendant Dr. Bercow, Dr. Culliford explains that the insertion of a pacemaker even when done with fluoroscopic guidance (as was done here) is a blind procedure which has a known risk of perforating a blood vessel and damaging surrounding organs such as the lungs and that this does not constitute negligence. He opines that the fact that defendant Dr. Bercow "guided the pacing wire into the appropriate location and that the pacemaker was functioning properly at the end of the surgical procedure **suggests** that he utilized appropriate techniques in performing the procedure (emphasis added)." He further opines that defendant Dr. Bercow appropriately managed the fluid in Antonio's lungs via a chest tube and that he appropriately remained with Antonio until his vital signs were stabilized and there was an acceptable amount of drainage from the chest tube.

Finally, Dr. Culliford opines that the defendants Dr. Tsiamtsiouris and Dr. Bercow appropriately discussed the two procedures with Antonio's family before performing them.

In sum, it is Dr. Culliford's opinion that neither defendant Dr. Tsiamtsiouris nor defendant Dr. Bercow departed from the applicable standards of care nor caused Antonio's injuries and death.

Both defendants Drs. Tsiamtsiouris and Bercow have established their entitlement to summary judgment dismissing the lack of informed consent claims against them.

However, neither defendant Dr. Tsiamtsiouris nor defendant Dr. Bercow have established their entitlement to summary judgment dismissing the medical malpractice claims against them.

Again, while an expert needn't be certified in the specific medical field at issue, he nevertheless must establish his qualifications to judge the care and treatment provided by a doctor. Dr. Culliford, as a surgeon and thoracic surgeon, has failed to set forth any grounds for his opinions regarding defendant Dr. Tsiamtsiouris' management of Antonio's cardiac medications regime. *See Behar v. Cohen*, *supra* at 1046-1047. *See also Applewhite v. Accuhealth, Inc.*, 81 A.D.3d 94, 915 N.Y.S.2d 223 (1st Dept. 2010); *Townes v. Fischer*, 68 A.D.3d 1294, 890 N.Y.S.2d 708 (3d Dept. 2009); *Schectman v. Wilson, supra*; *Geffner v. North Shore University Hosp., supra.*

Defendant Dr. Bercow has also not established his entitlement to summary judgment. While plaintiffs have not maintained that his laceration of Antonio's vein and puncture of Antonio's lung were negligent, Dr. Culliford has not addressed (let alone in a meaningful fashion) defendant Dr. Bercow's failure to investigate the source of Antonio's post-operative bleed despite its consistency, i.e., "Kool-aid" like, containing blood, its intensity which necessitated a transfusion and its continued flow.

In opposition to the defendants' motions, plaintiffs have submitted the affidavit of a doctor Board Certified in internal medicine and cardiovascular disease. They have not opposed dismissal of the lack of informed consent claim. Plaintiffs' expert states that s/he is "familiar with and experienced in the evaluation, diagnosis and treatment of patients who present with atrial fibrillation, ventricular tachycardia, bradycardia and atrioventricular heart block" and that s/he is "familiar with the standard of care related to the assessment, diagnosis and treatment of a patient suffering from atrial fibrillation and the standard of care regarding the use and placement of a pacemaker (either temporary or permanent) to control a patient's heart rate and the post-operative care required following the use of same." Having reviewed all of the pertinent

medical records and legal documents, plaintiffs' expert opines to a reasonable degree of medical certainty that defendant Dr. Tsiamtsiouris' efforts to control Antonio's atrial fibrillation through the three medicines-Atenolol, Amiodarone and Diltiazem (a/k/a/ Cardizem)- was improperly managed and led to Antonio's development of bradycardia which necessitated the placement of a pacemaker. More specifically, s/he opines that while the three medications prescribed are used to treat atrial fibrillation, the administration of them in conjunction with each other at the dosages prescribed was inappropriate. S/he explains:

> "[a]ll three classes of medications, namely anti-arrhythmics (Amiodarone), beta-blockers (Atenolol) and calcium-channel blockers (Biltiazem), work to lower the heart rate and thus are all, singularly, capable of leading to the development of sinus bradycardia and/or heart block. The combination of these medications, however, yields powerful electrophysiologic effects including possible development of severe bradycardia and heart block and significantly increases the risk of said condition."

S/he explains that the administration of Amiodarone on March 1, 2007, coupled with IV Diltiazem (a/k/a/ Cardizem) and Atenolol, posed a risk of sinus bradycardia and/or complete heart block occurring - which happened. S/he opines that when Amiodarone was begun, IV Diltiazem (a/k/a/ Cardizem) should have been stopped or its dosage along with Atenolol should have been significantly decreased. S/he notes that when the dose of IV Diltiazem (a/k/a Cardizem) was lowered on March 2, 2007, Antonio's heart rate remained regular and the ventricular tachycardia resolved itself. S/he further notes that while Antonio converted to sinus rhythm for the next twenty-four hours, he was nevertheless controlled on all three medications which s/he opines contributed to Antonio's bradycardic episode. S/he further opines that had the IV Diltiazem (a/k/a Cardizem) been discontinued or lowered along with Atenolol, significant bradycardia would not have occurred, negating the need for a pacemaker.

While plaintiffs' expert opines that defendant Dr. Tsiamtsiouris' attempt at placing a

temporary pacemaker was correct, s/he states that the femoral vein route taken was the most difficult one and the least likely to be successful. Because the subclavian vein or internal jugular vein are easier and create a more stable position, plaintiffs' expert opines that defendant Dr. Tsiamtsiouris should have attempted to place a temporary pacemaker via one of those routes which would have allowed time for the medications to wear off before the implementation of a permanent pacemaker. S/he opines that "permanent pacing should only have been considered once support of the temporary pacer was established, the effects of the medications were ceased and, despite this, the problems with the conduction system persisted."

Plaintiffs' expert further opines that defendant Dr. Bercow deviated from the accepted standards of care by failing to properly monitor Antonio after he placed the permanent pacemaker in light of the well known risks of laceration and injury to vessels and lungs. S/he observes that "despite clear signs of post-operative hemorrhage including an opacification seen on a post-operative chest x-ray, bloody return from the chest tube and Antonio's need for a blood transfusion, Dr. Bercow never had Antonio returned to the operating room to determine the source of the post-operative bleeding." S/he notes that as a result, Antonio bled internally for seven hours before efforts to stop it were made. S/he declares that

> "once a hemothorax was identified post-operatively, in a patient taking Plavix and Aspirin and who was suffering from thrombocytopenia, the patient should have urgently been brought to the operating room to control the bleeding and correct the issue. Furthermore, the amount of initial bleeding was an indicator that the bleeding needed to be controlled. The standard of care mandated that Antonio be brought back into the operating room for an exploration, or, ordered that such an exploration be performed."

S/he opines that "the count of blood return from [Antonio's] chest tube would never be considered normal post-operative bleeding."

Plaintiffs' expert also opines that the "administration of Heparin in a patient with a potential prior HIT was below the standard of care" and that "[h]eparin contributed to the bleed suffered by [Antonio]" following the surgery. S/he notes that Antonio's chart noted a potential allergy to Heparin, that defendant P.A. Siefring ordered it and that Antonio developed thrombocytopenia, which s/he opines to a reasonable degree of medical certainty was a result of the Heparin because "no other causative factors existed." S/he explains that there was no evidence of diseases which could also have caused thrombocytopenia and accordingly concludes that thrombocytopenia was caused by Heparin. S/he further opines that HIT contributed to Antonio's hemorrhage which caused his death.

Assuming, *arguendo*, that the defendants Dr. Tsiamtsiouris and Dr. Bercow established their entitlement to summary judgment dismissing the complaint against them thereby shifting the burden to the plaintiffs to establish the existence of a material issue of fact, plaintiffs have met that burden. Plaintiffs' expert calls into questions whether defendant Dr. Tsiamtsiouris' management of Antonio's medication was proper and whether it caused his bradycardia and the need for a pacemaker. S/he has also established an issue of fact as to whether defendant Dr. Tsiamtsiouris' decision to have a permanent pacemaker inserted was premature and unnecessary as alternative safer routes for a temporary pacemaker existed.

S/he has also established the existence of an issue of fact regarding defendant Dr. Bercow's post-operative care of Antonio. There is an issue of fact as to whether his leaving the hospital and leaving Antonio in the condition in which he did was medically sound and caused or at least contributed to Antonio's demise.

However, plaintiffs have failed to establish the existence of a material issue of fact regarding the care rendered by the defendant Dr. Mastrangelo. While they now seek to attribute

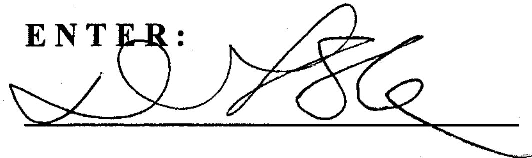
responsibility to him for the defendant P.A. Siefring's prescription of Heparin, that was not alleged in the plaintiffs' Bill of Particulars and may not be relied on now. *See Harty v. Lenci*, 294 A.D.2d 296, 743 N.Y.S.2d 97 (1st Dept. 2002); *Golubo v. Wolfson*, 22 A.D.3d 635, 801 N.Y.S.2d 914 (2d Dept. 2005); *Winters v. St. Vincent's Medical Center of Richmond, H.B.B.A., Inc.*, 273 A.D.2d 465, 711 N.Y.S.2d 892 (2d Dept. 2000). In any event, it is clear that defendant P.A. Siefring was not being supervised by defendant Dr. Mastrangelo, but was being supervised by Dr. Patetsios.

Plaintiffs have also failed to establish an issue of fact with respect to defendant P.A. Siefring and defendant Hospital. They have failed to establish the existence of an issue of fact as to whether Antonio developed HIT because any such conclusion would clearly be speculative. In any event, assuming, *arguendo*, that they did, they have not established that HIT was actually a proximate cause of Antonio's hemorrhage and death.

Defendants Dr. Mastrangelo, P.A. Siefring and Hospital's motions are granted and the complaint against them is dismissed.

This constitutes the Decision and Order of this Court.

ENTER:



DENISE L. SHER, A.J.S.C.

ENTERED
APR 08 2011
NASSAU COUNTY
COUNTY CLERK'S OFFICE

Dated: Mineola, New York
April 5, 2010