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SHORT FORM ORDER

INDEX No. 11-3159
CAL. No. 12-01716MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Justice of the Supreme Court

Mot. Seq. # 002 - MG; CASEDISP

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DIANE MILAZZO, Individually and as Executor of the Estate of ALBERT MILAZZO, deceased,

Plaintiff,

- against -

PAUL J. LEE, M.D. and SOUTH BAY CARDIOVASCULAR ASSOCIATES, P.C.,

Defendants.

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Upon the following papers numbered 1 to 23 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002) 1-18; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 19-21; Replying Affidavits and supporting papers 22-23; Other ____; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion (002) by defendants Paul J. Lee, M.D. and St. Francis Cardiovascular Physicians, P.C. s/h/a/ South Bay Cardiovascular Associates, P.C., for an order granting summary judgment dismissing plaintiff's complaint as asserted against them is granted and the complaint is dismissed.

This medical malpractice action, brought by Diane Milazzo, individually and as Executrix of the Estate of Albert Milazzo, deceased, is premised upon allegations of negligent departures from the good and accepted standards of care and treatment of Albert Milazzo. Plaintiff seeks damages for the decedent's conscious pain and suffering, wrongful death, and asserts a derivative claim. The plaintiff's decedent had been under the care and treatment of the defendants from on or about October 2008 for a cardiac condition. While under the care of the defendants, it is claimed that the decedent's condition worsened, and progressed to his death because the defendants failed to timely and properly diagnose his coronary condition, failed to obtain his admission records from St. Francis Hospital, and failed to timely and appropriately refer him for placement of an Implantable Cardioverter Defibrillator (ICD), depriving him of the opportunity to have his condition treated, and leaving him at risk for sudden cardiac death. He was hospitalized at St. Francis Hospital from October 6, 2008 through October 17, 2008, and at

Brookhaven Memorial Hospital from January 17, 2009 through February 4, 2009. He died on February 5, 2009 from cardiac arrest, acute renal failure, pulmonary edema, and acute myocardial injury.

The defendants, Paul J. Lee, M.D. and St. Francis Cardiovascular Physicians, P.C. seek summary judgment dismissing the complaint, claiming there were no departures from the requisite standards of care; and, the care and treatment provided by them was not the proximate cause of the decedent's injuries and damages claimed in this action.

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 eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (Friends of Animals v Associated Fur Mfrs., 46 NY2d 1065 [1979]; Sillman v Twentieth Century-Fox Film Corporation, 3 NY2d 395 [1957]). The movant has the initial burden of proving entitlement to summary judgment (Winegrad v N.Y.U. Medical Center, 64 NY2d 851 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (Winegrad v N.Y.U. Medical Center, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; Zuckerman v City of New York, 49 NY2d 557 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (Castro v Liberty Bus Co., 79 AD2d 1014 [2d Dept 1981]).

In support of this motion (002), the defendants have submitted, inter alia, an attorney's affidavit, copies of the summons and complaint, defendants' answers, and the plaintiff's verified and supplemental verified bills of particulars; a certified copy of the plaintiff's decedent's medical records; a copy of records of South Bay Cardiovascular Associates; a certified copy of the St. Francis Hospital record; computer printout of plaintiff's decedent's medications; transfer records; an uncertified copy of the Brookhaven Memorial Hospital record; and the affirmation of defendants' expert, Andrew Goldfarb, M.D.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept 1998], *app denied* 92 NY2d 818). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* Derdiarian v Felix Contracting Corp., 51 NY2d 308 [1980]; Prete v Rafla-Demetrious, 221 AD2d 674 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* Fiore v Galang, 64 NY2d 999 [1985]; Lyons v McCauley, 252 AD2d 516 [2d Dept 1998], *app denied* 92 NY2d 814; Bloom v City of New York, 202 AD2d 465 [2d Dept 1994]).

Diane Milazzo testified as to what she knew of her husband's care and treatment relating to his cardiac condition, including a blockage diagnosed by Dr. Aaron in 1998, followed by a visit to St.

Francis Hospital where Dr. Taylor performed a cardiac catheterization and suggested surgery to the decedent, which the decedent opted not to have. He had no complaints of shortness of breath, dizziness, or sweating, and was thereafter under the care of Dr. Mohiuddin, who prescribed blood pressure medication, and possibly other medication. In the last ten years of his life, prior to October 6, 2008, she did not remember if her husband complained that his heart was beating rapidly or abnormally or whether he sought medical treatment for chest pain. When he went to Good Samaritan Hospital on October 6, 2008, because he could not breathe and was experiencing chest pain, he was seen and treated by defendant Dr. Lee who transferred him to St. Francis Hospital for bypass surgery, which was done the same day. She testified that Dr. Lee did not think her husband would survive bypass surgery.

At St. Francis, she was told that her husband was a very sick man. His heart stopped and he had a breathing tube. Her husband was discharged on October 17, 2008. Thereafter, she thought, he seemed tired a lot, and she thought his breathing was still labored. He followed up with Dr. Lee who recommended a stress test. She testified that her husband told her that he became short of breath during the stress test and asked them to stop the machine. After St. Francis Hospital, he had been walking and bicycling in the house, and if he overdid it, he became short of breath, which was more severe after, rather than prior to, his surgery. He also experienced chest pain. He was referred by Dr. Lee for an appointment on January 27, 2009 with a specialist concerning a defibrillator as her husband's heart was only working about 30%, however, his heart stopped on January 17, 2009 and he was resuscitated and admitted to Brookhaven Memorial Hospital.

Dr. Paul Lee testified to the extent that he is a cardiologist and an intervention cardiologist. Dr. Manaris was in his group, South Bay Cardiovascular Associates, and was an electrophysiologist who makes the final decision concerning whether an implant of an AICD should be done. He stated that Mr. Milazzo became a patient of Dr. Aaron in 1998. Although the decedent was recommended for evaluation for a coronary bypass procedure at that time, the decedent opted for medical treatment instead. On October 6, 2008, the decedent presented to Good Samaritan Hospital with a history of six or seven hours of chest discomfort along with EKG changes, including an incomplete left bundle branch block, consistent with an acute possible myocardial infarction, at which time Dr. Lee performed a cardiac catheterization and angiogram. He was transferred immediately thereafter to St. Francis Hospital as the tests revealed severe three-vessel disease with significant left main heart disease with an ejection fraction of 20-25%, a severe abnormality. He stated that the ejection fraction is the functioning of the heart, how much the heart can squeeze or contract to move blood forward. A rough normal range is 55-65%. A decreased ejection fraction can cause congestive heart failure, but does not always. Mr. Milazzo was not diagnosed with congestive heart failure as he did not have clinical symptoms for the same. He was recommended for bypass surgery. Because of the significant disease involving all branches, Dr. Lee stated that he did not consider a stent or angioplasty. Bypass surgery was the best treatment to save his life.

At St. Francis Hospital, Dr. Robinson, the cardiac surgeon, performed surgery on the plaintiff's decedent upon his transfer on October 6, 2008. He saw the decedent for post-operative treatment on November 4 and 18, 2008, and January 14, 2009. A stress test was done on January 12, 2009 to determine the functional status of the heart and blood flow to the heart, as determined by how much the person can exercise and to determine whether there are any arrhythmias. He usually obtains a stress test

about three months following the surgery to see if there was any improvement in the ejection fraction from prior to surgery. If the left ventricular function (the pump of the heart) does not improve three months after surgery, the decedent would be a candidate for a defibrillator for primary prevention of sudden cardiac death. He described sudden cardiac death as a cardiac arrest, and the treatment would be the prevention of a sudden cardiac death. Primary prevention of sudden cardiac death is for someone who never had any event or symptom suggestive of a problem. Mr. Milazzo had cardiomyopathy, but never had an event, thus he would be treated empirically to prevent something in the future, known as secondary prevention. The defibrillator could be used in either case. He had to wait for three months before performing the nuclear stress test as the CMS guidelines provide that an ICD (implantable cardiac defibrillator) cannot be inserted in a patient who had vascularization as this was a reversible cause for cardiomyopathy wherein the cause was fixed.

Dr. Lee described the defibrillator as a device that is inserted into the patient's body. A wire goes into the heart to monitor it, and if the heart goes into a brady arrhythmia, it will function as a pacemaker by pacing the heart faster. If the heart goes into tachycardia, it will recognize it and deliver a therapy with a shock to stop further tachycardia arrhythmia to prevent sudden cardiac death. He stated that ICDs are very effective, more effective than medication. Dr. Lee testified that he was not aware that the decedent had defibrillation and shocking immediately after surgery at St. Francis Hospital, and that neither he, nor anyone from his office, obtained the records from St. Francis; however, he received the discharge summary, operative report, and a letter from Dr. Robinson concerning the admission. Had he been aware that such an event of ventricular tachycardia requiring defibrillation postoperatively did occur at St. Francis, a defibrillator would have been considered right away, depending upon the number of days after the surgery the event occurred. He continued that if the decedent did have that episode, he would not have left St. Francis without a defibrillator, as that is the standard of practice. If ventricular tachycardia requiring defibrillation occurred within an hour or two of the bypass, he would have had the decedent seen by an electrophysiologist as soon as possible. However, in an event occurring within an hour or two following surgery, the heart is very irritable, the patient may go into ventricular arrhythmia, and may require defibrillation, but not necessarily require an ICD. He continued that the rules are not clear in those circumstances, and the patient may be referred for an electrophysiology study prior to discharge. If an inducible arrhythmia is found, then the patient will be provided with an ICD.

Dr. Lee testified that upon reading the St. Francis discharge summary, it would not have changed his treatment of the decedent, but perhaps management. If the decedent had not been seen by an electrophysiologist, he would have perhaps sent him for evaluation on a non urgent basis. He did refer the decedent for a V-ICD evaluation on January 14, 2009, after the three month waiting period, as the decedent's left ventricular function remained below 30%. This referral would not have been for a secondary prevention, but for primary prevention in that the arrhythmia at St. Francis occurred within three days of myocardial infarction.

Defendants' expert, Andrew Goldfarb, M.D. affirms that he is licensed to practice medicine in New York State and is board certified in internal medicine and cardiovascular disease. He is a diplomat of the certification board of nuclear cardiology. He set forth the materials and records which he reviewed. He opined within a reasonable degree of medical certainty that the care and treatment rendered by defendant Paul J. Lee, M.D. and the physicians, nurses, and staff at South Bay

Cardiovascular Associates, P.C., to Albert Milazzo, was not the proximate cause of his injuries and death, and that they did not deviate from good and accepted standards of care and treatment.

Dr. Goldfarb stated that the decedent first became a patient at South Bay Cardiovascular Associates in 1989 when nuclear stress testing was recommended for further evaluation concerning an abnormal exercise treadmill stress test, however, the decedent refused. In 1998, the decedent was seen again, at which time a Persantine nuclear stress test revealed a dilated left ventricle with transient dilation, moderate reversible inferior wall perfusion defect, and an ejection fraction noted to be approximately 36%. Severe proximal triple vessel disease was noted: two sequential greater than 90% stenosis in the right coronary artery with left to right collaterals. The circumflex had two greater than 90% stenosis proximal to the first marginal with narrowing extending into the osmium of the first marginal. The left anterior descending artery had a 90% stenosis proximal to the diagonal branch. The inferior wall was hypokinectic. He was started on aspirin and a beta blocker, and coronary artery bypass surgery was recommended, but refused by the decedent. Dr. Goldfarb described the decedent's continuing treatment and findings, including almost monthly refills of 100 nitroglycerin pills starting in 2005, and increased to 200 pills in July 2006 through September 30, 2008, to relieve chest pain caused by blockages in the coronary arteries. It was not until October 6, 2008, approximately ten years later, that the 66 year old decedent had any further involvement with a member of South Bay Cardiovascular Associates, when Dr. Paul Lee, an invasive cardiologist, was called into Good Samaritan Hospital to perform an emergency cardiac catheterization on him.

Dr. Goldfarb stated that the decedent had a history of hypertension and hypercholesterolemia, and that a proper, adequate, and thorough history was obtained of the decedent, and appropriately appreciated and considered by Dr. Lee upon the decedent's arrival to Good Samaritan Hospital emergency room on October 6, 2008. The decedent had been having chest pain for about five hours, worse for the last three hours and associated with dyspnea, preceded with mild discomfort for several weeks prior. Dr. Goldfarb continued that the decedent had a left bundle branch block and findings consistent with an acute inferior wall injury. Dr. Lee performed a cardiac catheterization and angiogram, and transferred the decedent to St. Francis Hospital at 9:00 a.m. on October 6, 2008, following the procedure. Dr. Goldfarb opined that when the decedent presented to Good Samaritan Hospital, his underlying coronary artery disease was correctly diagnosed and treatment timely provided, including his transfer to St. Francis Hospital. At St. Francis Hospital, the decedent had a three vessel CABG (coronary artery bypass graft) procedure performed and was transferred to the ICU where he developed tachycardia and was shocked four times and intubated. He was followed by the cardiac surgeon, Dr. Robinson, and cardiologist, Dr. Pappas. An echocardiogram revealed an ejection fraction of 35-40%, and he was placed on various medications. Following the decedent's discharge to home on October 17, 2008, defendant Dr. Lee was provided with a copy of the surgery report and a letter from Dr. Pappas. He was then seen by Dr. Lee on November 4 and November 18, 2008, and January 12 and January 14, 2009.

When Dr. Lee saw the decedent on November 4, 2008, an echocardiogram revealed a dilated left ventricle with an ejection fraction of 30-35%, basal posterior wall and inferior wall akinesis, severe mitral regurgitation, and moderate to severe tricuspid regurgitation with an elevated right ventricular systolic pressure of 5-60 mm Hg. Dr. Goldfarb described Dr. Lee's treatment, including the

recommendation for cardiac rehabilitation, which the decedent refused as he did not want to travel, and was therefore told to exercise on a regular basis. On January 12, 2009, an adenosine nuclear stress test revealed a new infarction and an ejection fraction of 28%. Dr. Lee discussed possible biventricular ICD implantation based upon the nuclear stress test results and underlying conduction abnormality. The decedent was referred to Dr. Manaris, a member of South Bay Cardiovascular Group, by whom he was to be seen on January 24, 2009, however, on January 17, 2009, while at the dinner table, the decedent slumped over to the floor, unconscious. EMS, upon arrival, found no heart beat. He was provided advanced life support, shocked, and taken to Brookhaven Memorial Hospital, in ventricular fibrillation, still unconscious with fixed pupils. Due to continued deterioration and no return of mental functioning, withdrawal of care was commenced on February 4, 2009, and the plaintiff's decedent expired the following day.

Dr. Goldfarb opined that Dr. Lee, and the nurses and staff at South Bay Cardiovascular Associates, did not depart from the requisite standard of care provided to the decedent. He stated that prior to the decedent's stress test on January 12, 2009, he did not meet the indications for the implantation of an automatic implantable cardioverter defibrillator (AICD) according to the applicable guidelines established by the American College of Cardiology/American Heart Association/Heart Rhythm Society Guidelines for Device Based Therapy in May 2008, which currently remain in effect. Dr. Goldfarb continued that pursuant to those guidelines, the decedent would only have been considered for an AICD for primary prevention of sudden cardiac death due to being at risk for, but not yet having had an appropriate arrhythmia felt to be associated with an increased likelihood of sudden cardiac death. The decedent did not fall into that category of patients requiring prevention of sudden death via implantation of an AICD. Patients in that category are assessed to determine if an AICD is to be used for secondary prevention (rather than primary) via AICD implantation due to a prior history of sudden cardiac death or spontaneous sustained malignant ventricular rhythms occurring in appropriate circumstances.

Dr. Goldfarb opined that when the decedent was at St. Francis Hospital and had an episode of wide complex tachycardia post-operatively, that may have been ventricular tachycardia, but it was not a rhythm which would have required the implantation of an AICD for secondary prevention of sudden cardiac death as it occurred in the immediate 48 hour period following an acute myocardial infarction and/or during post reperfusion wherein such reperfusion injury related arrhythmias are common and are not prognostic for the occurrence of future spontaneous malignant arrhythmic events. At St. Francis, he continued, the decedent was treated without consideration of an immediate temporary external defibrillator device until the necessary and standard three month waiting period was over to assess the need for placement of a permanent device at that time for primary prevention. Dr. Goldfarb stated that Dr. Robinson and Dr. Pappas did not ask for an electrophysiology consult while the decedent was a patient at St. Francis. After that three month waiting period, the decedent is assessed to determine if the criteria is met with regard to improvement in the patient's myocardial contractility and ejection fraction which frequently occurs after revascularization. Decreased myocardial contractility leads to a low ejection fraction, and may be due to irreversibly damaged muscle (infarction), or the myocardium may merely be contracting poorly due to the muscle tissue being temporarily stunned or hibernating due to poor blood flow and diminished oxygen delivery in the absence of irreversible damage or infarction.

The standard of care requires that the ejection fraction be evaluated after a period of at least three months before considering implantation of an AICD.

Dr. Goldfarb continued that during this three month period, the decedent's ejection fraction increased from 20-25% on October 6, 2008 at Good Samaritan, to 35-40% on October 7, 2008 at St. Francis Hospital, just one day after bypass surgery had been performed. Thus, stated Dr. Goldfarb, due to the improvement in the ejection fraction, that implanting an AICD should not be undertaken until at least three months post coronary bypass surgery. He opined that pursuant to the New York Heart Association (NYHA) Functional Classification, at the time of the decedent's visit to Dr. Lee on January 14, 2009, that the decedent was Class I, defined as a patient with cardiac disease without resulting limitation of physical activity and where physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain. On January 14, 2009, the decedent was slightly more than three months post surgery and did not have any complaints of shortness of breath or chest discomfort. He was in the exercise program in which he walked thirty minutes a day and bicycled thirty minutes. For the decedent at that point to qualify for an AICD implantation, an ejection fraction must be less than or equal to 30%. On January 14, 2009, the decedent's ejection fraction was 36%, as determined by stress test. An angiogram performed by the decedent's prior treating physician, Dr. Aaron, was 40% on April 16, 1998, as interpreted by Dr. Taylor. Thus, opined Dr. Goldfarb, the decedent did not meet the criteria for AICD implantation in 1998 as the guidelines restricted implantation to those patients with a documented cardiac arrest due to ventricular fibrillation, or pursuant to the evolving criteria over the ensuing years until his myocardial infarction and emergent bypass surgery as his ejection fraction was not sufficiently decreased nor did he have a documented ventricular tachyarrhythmia. The decedent did not exhibit any clinical signs during that three month period. The Holter monitor placed on November 4, 2008 at Dr. Lee's request showed no evidence of ventricular tachycardia, sustained or nonsustained, and the echocardiogram revealed an ejection fraction between 30-35% within that three month period. Thus, at that time, the decedent did not qualify for the implantation of the AICD.

Dr. Goldfarb continued that on January 12, 2009, when Dr. Lee obtained an ejection fraction of 28% on nuclear stress testing, he appropriately and timely referred the decedent to an electrophysiologist for evaluation for AICD implantation. However, he continued, an ejection fraction of 28% in isolation does not mandate that an AICD be implanted. Dr. Goldfarb stated that significantly, the ejection fraction obtained by echocardiography at Brookhaven Memorial Hospital was 35-40%, which did not meet the ejection fraction criteria for AICD implantation for primary prevention of sudden cardiac death in a NYHA Class I individual. Dr. Goldfarb further opined that Dr. Lee and the staff at South Bay Cardiology acted in accordance with the accepted standard of medical care and treatment and did not proximately cause the injuries or damages claimed by the plaintiff's decedent.

Based upon the foregoing, the defendants have demonstrated prima facie entitlement to summary judgment dismissing the complaint.

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff

(*see* Lifshitz v Beth Israel Med. Ctr-Kings Highway Div., 7 AD3d 759 [2d Dept 2004]; Domaradzki v Glen Cove OB/GYN Assocs., 242 AD2d 282 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (Bengston v Wang, 41 AD3d 625 [2d Dept 2007]).

In opposition, the plaintiff has submitted an attorney's affirmation and the redacted expert affirmation from a physician who is licensed to practice medicine in New Jersey. Such affirmation is not sworn to under the penalties of perjury. In that the plaintiff's expert is not licensed in New York, a duly notarized affidavit is required pursuant to CPLR 2106. As such, the affirmation is not in admissible form and may be disregarded by this court (see Palo v Latt, 270 AD2d 323 [2d Dept 2000]). However, the defendant has not objected to such affirmation, and the court will consider the same to avoid unnecessary delay as the affirmation could be given nunc pro tunc effect once duly acknowledged to correct the defect (Fredette v Town of Southampton, 95 AD3d 940 [2d Dept 2012]; Fatah v Stop & Shop Companies, Inc., 41 AD3d 638 [2d dept 2007]; Nandy v Albany Medical Center, 155 AD3d 833 [3d Dept 1989]; Raynor v Raynor, 279 AD 671 [2d Dept 1951]; but see Niazov v Corlean Cab Corp., 71 AD3d 749 [2d Dept 2010]; Macro v Huang, 8 AD3d 245 [2d Dept 2004]; Cwiekala v Siddon, 267 AD2d 193 [2d Dept 1999]).

However, the redacted version of the expert affidavit submitted by the plaintiff lacks evidentiary value (Marano v Mercy Hospital, 241 AD2d 48 [2d Dept 1998]). "A party may successfully oppose a summary judgment motion without disclosing the names of the party's expert witnesses. In opposition to such a motion the party defending against a summary judgment motion may serve the movant with a redacted copy of its expert's affirmation as long as an unredacted original is provided to the court for its in camera inspection (Marano v Mercy Hospital, supra). This procedure preserves the confidentiality of the name of plaintiff's medical expert while also preserving plaintiff's obligation in opposing defendant's motion, in that by submitting a redacted affirmation and by offering the original to the court for in camera inspection, plaintiff has opposed the motion by evidence in admissible form (Rubenstein v Columbia Presbyterian Medical Center, 139 Misc.2d 349, 527 NYS2d 680 [N. Y. County 1988]). A copy of the affirmation with the expert's name and signature have not been provided to this court under separate cover. Accordingly, plaintiff's expert affirmation is not in admissible form and is insufficient to raise a triable issue of fact as to the defendant's alleged malpractice (Rose v Horton Medical Center, 29 AD3d 977 [2d Dept 2006]).

It is further determined that even if the plaintiff's expert affirmation or affidavit were in admissible form, that the expert's opinion is conclusory and unsupported and fails to raise factual issues sufficient to defeat summary judgment. The plaintiff's expert acknowledges that the standard of care was to wait ninety days following bypass surgery for ICD implantation. However, he continued that the evaluation for the same should have been done prior to this three month period. However, he does not set forth a time frame indicating at what point prior to the three month period the evaluation should have been done in his opinion, and whether the guidelines recommend evaluation prior to the three months following the surgery. He does not address the issue of revascularization and if the same would have been completed prior to the three month period to obtain a more accurate determination of the ejection fraction. The plaintiff's expert fails to state what the guidelines are for the percentage of ejection fraction which dictates when and if an ICD implantation is warranted, and instead bases his opinion on

the percentage of the ejection fraction without consideration of the decedent's clinical presentations and cardiac status, such as arrythmia. While the plaintiff's expert opined that the decedent's ejection fraction was not likely to improve since it was decreasing following surgery, it is noted that the decedent's ejection fraction increased from 20-25% on October 6, 2008 at Good Samaritan, to 35-40% on October 7, 2008 at St. Francis Hospital, just one day after bypass surgery had been performed. He does not set forth how he determined that there was a decrease in the ejection faction from 35-40% thereafter prior to the three month period, or set forth what, if any, testing was performed and upon which he based his opinion. While he opined that the ICD should have been implanted earlier, based upon a prior history of a myocardial infarction, he does not reconcile this opinion with the fact that the myocardial infarction occurred on or about October 6, 2008, and no ICD was placed, or electrophysiology evaluation performed at St. Francis Hospital after surgery and prior to his discharge. He does not indicate whether or not the plaintiff had any cardiac arrhythmias prior to January 12, 2009. It was not until January 12, 2009 that the nuclear stress test demonstrated an ejection fraction of 28%, but plaintiff's expert does not indicate whether or not any arrhythmias were present. The plaintiff's expert does not address the finding that the plaintiff's ejection fraction obtained by echocardiography at Brookhaven Memorial Hospital after January 17, 2009 was 35-40%, contradicting the basis for his prior statement that the ejection fraction of 28% on January 12, 2009 represented a decrease and a basis for ICD implantation. Although the plaintiff's expert disagrees with the defendants' expert with regard to the decedent's classification pursuant to the New York Heart Association Functional Classification System, he continues that the classification of patients is not at all objective, but rather subjective, with wide variation in patient assessments made by clinicians. Plaintiff's expert's opinions do not raise a triable factual issue.

Accordingly, motion (002) is granted and the complaint is dismissed.

Dated: July 11, 2013

HON. JOSEPH C. PASTORESSA, J.S.C.

__X__ FINAL DISPOSITION ___ NON-FINAL DISPOSITION