Schuck v Stony Brook Surgical Assoc.
2014 NY Slip Op 30734(U)
March 20, 2014
Supreme Court, Suffolk County
Docket Number: 10-2294
Judge: Denise F. Molia
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SHORT FORM ORDER

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INDEX No. 10-2294
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SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 11-21-13
ADJ. DATE 2-21-14
Mot. Seq. # 001 - MD

JOSEPHINE SCHUCK, as Administratrix of the Estate of CARL SCHUCK, deceased and JOSEPHINE SCHUCK, individually,

Plaintiffs,

- against -

STONY BROOK SURGICAL ASSOCIATES, UNIVERSITY FACULTY PRACTICE CORPORATION and THOMAS V. BILFINGER, M.D.,

Defendants.

KELNER AND KELNER, ESQS.
Attorney for Plaintiffs
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New York, New York 10005

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Attorney for Defendants
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Upon the following papers numbered 1 to 53 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001) 1-17; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 18-48; Replying Affidavits and supporting papers 49-50;51; Other 52-53; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by the defendants Stony Brook Surgical Associates, University Faculty Practice Corporation, and Thomas V. Bilfinger, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied.

In this medical malpractice action, the plaintiff, Josephine Schuck, individually and on behalf of decedent Carl Schuck, seeks damages for personal injuries allegedly sustained by the decedent who was admitted to Stony Brook University Hospital on January 9, 2008, where he underwent cardiac catheterization. On January 10, 2008, the plaintiff's decedent underwent an aortic valve replacement with a porcine valve and closure of a patent foramen ovale. On January 16, 2008, the plaintiff's decedent complained of a popping sound in his chest. On January 18, 2008, when the decedent complained of dyspnea, a chest CT revealed dehiscence of the sternal (breast) bone, so he was scheduled for sternal reconstruction with titanium plates on January 21, 2008. However, during the night of January 18, 2008, the decedent experienced some medical issues, and about 6:00 a.m. on January 19,

EST

2008, he experienced a drop in blood pressure, coughing, and difficulty breathing deeply. His pain and anxiety increased throughout the day, and at 17:43 hours, advanced cardiac life support protocol (ACLS) was initiated as he became unresponsive, bradycardic and hypotensive. Dr. Bilfinger came in to see the decedent, opened his chest at the bedside, performed internal cardiac massage and inserted pacing wires. The decedent was then taken to the operating room for a sternal debridement and washing out of the pericardium. The decedent's chest was thereafter left open but covered with Gortex material. The decedent remained in critical condition throughout January 20, 2008, and on January 21, 2008, he died after he went into ventricular fibrillation and tachycardia, addressed with unsuccessful internal cardiac massage and ACLS protocol initiation.

Causes of action alleging medical malpractice, lack of informed consent, wrongful death of Carl Schuck, and a derivative claim by the decedent's spouse, Josephine Shuck, have been asserted. An action is also pending in the Court of Claims under claim number 117905, and is assigned to J. Lopez-Summa. Defendants in this action now seek summary judgment dismissing the complaint on the basis that they did not depart from the standards of care and treatment and did not proximately cause the decedent's injuries or death.

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, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [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, 427 NYS2d 595 [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, 435 NYS2d 340 [1981]).

In support of motion (001),the moving defendants submitted, inter alia, an attorney's affidavit; the affirmation of Eugene A Grossi, M.D.; copies of the summons and complaint, the moving defendants' answers and demands, and the plaintiffs' verified and supplemental verified bills of particulars; uncertified medical records from Stony Brook University Hospital which are not in admissible form pursuant to CPLR 3212 and 4518; and the unsigned but certified transcripts of the examinations before trial of Josephine Schuck dated December 20, 2010, and Ruth Saia, R.N. dated May 15, 2013 to which the plaintiff has not objected (***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); signed transcripts of the examinations before trial of Thomas Bilfinger, M.D. dated July 27, 2011, Denise Zivku dated December 11, 2012; and a copy of an autopsy report of Carl Schuck by deputy medical examiner Gwen I. Harleman, M.D. dated January 25, 2008, certified by Virginia Falcone, whose authority to certify the document has not been submitted.

Thomas Bellinger, M.D. testified to the extent that in 2008, he was employed by New York State and Stony Book Surgical P.C., the practice corporation of surgery at Stony Brook. He is licensed to practice medicine in New York State and is board certified in surgery, thoracic surgery, and critical care. He also has a Swiss medical license. He first met the decedent, Carl Schuck, on January 9, 2008 for complaints of progressive shortness of breath with no triggering events. He had a history of coronary artery disease, sleep apnea, and known aortic stenosis. He described the decedent as a big man. After examination, he recommended admission for an aortic valve replacement due to progression of aortic stenosis. He performed surgery on the decedent on January 10, 2008. He noted that the pre-operative white blood count was elevated, which he testified indicated that the decedent was stressed, and not necessarily that he had an infection. The decedent had a hematoma in his groin after the cardiac catheterization, and the elevated white blood count could be consistent with that. A CT scan of the abdomen, chest-ray, and EKG were done pre-operatively. He also noted that the decedent had a patent foramen ovale, which is a small opening between the two receiving chambers of the heart, which normally closes at birth when breathing starts. In some people it does not close.

Dr. Bilfinger testified that during the surgery on January 10, 2008, he sawed the breast bone (sternum) in two, longitudinally, and used wires to close it back together after the surgery was finished. He continued that wire closure is overwhelmingly the most common way to close the sternum, and he was not aware of any method that is preferably used over standard wire closure. He had never used sternal plating to close the sternum in morbidly obese patients. In January 2008, sternal plating was not available at Stony Brook Hospital, if he chose to use it. He did not consider any method of sternal closure on the decedent other than sternal wires. He indicated that he used seven 6-gauge wires for the decedent, because the 6 wire is thicker. He described how he placed the wires. He stated that the decedent's bones were solid. On January 10, 2008, at 6:25, the CTICU (cardiothoracic intensive care unit) nurse's note indicated that the decedent was oozing blood from the MSI and MSCTs-the tube insertion sites, from which, he stated, 100% of patients ooze. The decedent was started on Aspirin and Plavix for blood thinning on January 12, 2008. He stated that the increase in the white blood count on January 11, 2008 from 16.5 to 23.6 was noticeable but not concerning. Additional albumins were administered to bring the blood pressure a little higher by expanding the volume. He also stated that pleural effusion, pulmonary vascular congestion, and abnormal heart beats are considered a common finding after this surgery. He was not surprised that the decedent had fatigue and slight shortness of breath on the 11th.

Dr. Bilfinger stated that the January 12, 2008 chest x-ray revealed the decedent's lungs were clear. The decedent experienced rapid atrial fibrillation of 130s to 140s, which he stated was very common after heart surgery, but he was not made aware of it that day. On January 13, 2008 at 10:38 p.m., the hemoglobin and hematocrit slowly dropped. He noted it on January 14, 2008, but was not concerned. Atrial fibrillation was also noted and Lasix was given to reduce fluid in his body. Coumadin was started. INR was obtained to measure blood clotting. He was aiming for a range of 2.5 to 3.5 as fewer blood clots develop without undue bleeding at that range. He stated the decedent was medically stable to go home either the next day or the following day. On January 15-16, 2008, the decedent complained of a popping sound in his sternum with breathing, but Dr. Bilfinger did not remember when he became aware of it. He testified that the popping usually indicates sternal dehiscence, so he obtained a chest x-ray which showed bilateral pulmonary edema, which was slightly worse, bilateral pleural

effusions which were unchanged, the heart was enlarged, and there was no pneumothorax. He stated that there was nothing which indicated that there had been any sternal dehiscence on January 15, 2008 at 6:32 p.m. He thought the plaintiff was retaining fluid and there was too much fluid within the lungs, both frequent findings after heart surgery. He was not sure he noticed a difference between that chest x-ray and the x-ray of January 16, 2008 at 3:02 a.m. He ordered another chest x-ray, but did not write down that it was to rule out sternal dehiscence, which he said he was looking for. He ordered an additional dose of Lasix due to the increase in moderate pleural effusion.

On January 17, 2008, the decedent was still receiving Aspirin and Plavix as well as Coumadin. The INR was 2.3. He continued to have atrial fibrillation but was actually trying to convert back to normal sinus rhythm, which he had at the time. Plavix was ordered to be discontinued as he was reaching a therapeutic range and the January 17, 2008 INR at 6:00 a.m. was 3.7, slightly above range. On January 18, 2008 at 6:00 a.m., the nurse practitioner ordered Cipro as a prophylactic antibiotic for decedent's elevated white blood cell count. However, Dr. Bilfinger stated he disagreed and stated that she ordered it for phlebitis in decedent's right upper extremity caused by an IV. He testified that Cipro can treat phlebitis if one presumes it was caused by a bacterial infection. Coumadin was held, and the January 18, 2008 INR was 3.1, so Coumadin was reordered. A CT scan was also ordered by nurse practitioner Canes on the 18th due to a rise in the decedent's white blood count, however, Dr. Bilfinger stated it was ordered by him because the patient had "coughing episodes the other day and experienced a popping sensation." The CT showed sternal dehiscence with multiple fragments. Coumadin was reversed and sternal reconstruction with titanium plates was planned for January 21, 2008.

When Dr. Bilfinger was asked why a CT scan was not obtained either late on January 15th or early on January 16th, he replied, "[u]nless there was some either physical sign or symptom or some abnormality pointing in the –abnormal laboratory data, there was no reason to obtain one." He continued that even when he suspected a sternal dehiscence, that in the absence of any other findings and extra chest x-rays, there was no reason to perform any additional specialized test. When asked if it wasn't important for him to definitively rule out whether the chest popping that his patient heard was, in fact, the sternal dehiscence actually occurring, Dr. Bilfinger replied that, "[e]ven if it had, with otherwise a normal-appearing x-ray and a patient doing otherwise well, the significance of that would have been very questionable." He continued that a simple, uncomplicated sternal dehiscence in an otherwise well patient can be managed in many ways, including doing nothing for the dehiscence. He described the sternal dehiscence as the separation of the bone but not the skin. Dr. Bilfinger testified that on January 15, 2008, sternal dehiscence had not been ruled out, and the standard of practice did not require that a suspicion of a sternal dehiscence be ruled out or ruled in as soon as possible. When asked if sternal dehiscence could lead to complications and threaten the decedent's life, he replied, "[i]n and of itself, they don't often do." He stated that the CT scan showed the decedent's sternum had dehisced into multiple pieces. The wire loops remained intact and it was the sternum itself which broke apart. Dr. Bilfinger testified that it was his opinion that the wire cut through the bone.

Dr. Bilfinger testified that he did not know if the titanium plates were ordered before the decedent died. Up to the date of his testimony, he stated, he had used the titanium plates about a dozen times for sternal dehiscence, but had never used them as a primary closure device after surgery. He

stated that he was not aware that the school of thought in 2008 that using the titanium plates as a primary closer device was the appropriate methodology in morbidly obese patients. He waited until January 21, 2008 to do the surgery so that the decedent's INR could come back to normal. He testified that the titanium plates could be obtained overnight now. He testified that the Coumadin was stopped on January 19, 2008. It was noted on that date that the decedent was experiencing shortness of breath and an expiratory wheeze, and a five-beat run wide-complex tachycardia for which Magnesium and Lasix were given.

On January 19, 2008, the decedent was seen by Dr. Rosengart, chief of the division of cardiothoracic surgery. Dr. Bilfinger stated that the white blood count was 30.7, and Dr. Rosengart wanted a re-culture of the blood. The decedent was medicated with Morphine for sternal pain. A code was called at 5:45 p.m. and Dr. Bilfinger stated he was called in. After he and Dr. Rosengart opened the decedent's chest at the bedside, internal defibrillation was performed at 6:15 p.m. Dr. Bilfinger testified that cardiac tamponade caused the decedent to code. He described cardiac tamponade as an accumulation of fluid around the heart in the pericardial space causing compression of the heart. He did not come to a conclusion concerning the cause of the tamponade. He stated that he reviewed the January 18, 2008 CT scan, but could not remember if there was evidence of pericardial infusion or fluid around the heart. He stated that pericardial infusion could progress and accumulate enough to compress the heart and cause a cardiac tamponade. Signs and symptoms of a cardiac tamponade are tachycardia, hypotension, shortness of breath, decreased urinary output, and possible anxiety. When he opened the decedent's chest at the bedside on January 19, 2008, prior to taking him to the operating room, he saw a large amount of dark old blood, and the heart was at a complete standstill. Dr. Bilfinger thereafter took the decedent to the operating room on January 19, 2008 for sternal debridement and pericardial irrigation. He noted that none of the wires on the sternum had fractured, but each loop or tie had failed. He did not know if the CPR performed aggravated an already existing condition, or how much. Dr. Bilfinger testified, however, that it was his opinion that it was likely that the tamponade pre-existed the code. He was not present for the second code on January 21, 2008. Dr. Bilfinger testified that he was the surgeon who was in charge of the case.

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, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). 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, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 221 AD2d 674, 638 NYS2d 700 [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, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in

simple conclusory form that the physician acted within the accepted standards of medical care" (***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

Expert testimony is limited to facts in evidence. (*see also* ***Allen v Uh***, 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom***, 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts, Inc.***, 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]).

The autopsy report of January 25, 2008 by Dr. Gwen I. Harleman established the cause of death of Carl Schuck, a 67 year old male, from complications of sternal dehiscence following cardiac valve replacement surgery due to aortic stenosis, contributed to by arteriosclerotic and hypertensive cardiovascular disease and morbid obesity. She stated that the manner of death was by "accident." She noted that shortly after dehiscence, the decedent was taken to the operating room where he was found to have a tamponade, possibly a result of an eroded vessel from wires around the sternum.

Defendants' expert, Eugene A. Grossi, M.D., affirms that he is licensed to practice medicine in New York and New Jersey and is board certified in thoracic surgery. He stated that defendant Dr. Bilfinger was an employee of Stony Brook Surgical Associates and University Faculty Practice Corporation at the time of the alleged malpractice. While Dr. Grossi identified the various medical records and reports he reviewed, the Eastern Suffolk Cardiology, Southside Hospital, and Hampton-Liggett Pharmacy records have not been provided. It is Dr. Grossi's opinion within a reasonable degree of medical certainty that the care rendered to the decedent by Dr. Bilfinger and the moving defendants was at all times in accord with good and accepted medical practice and that none of the care provided to him caused any of the decedent's injuries or death.

Dr. Grossi set forth that the decedent presented to Stony Brook University Hospital on January 9, 2008, for evaluation of progressive shortness of breath and chest pain. He had an abnormal stress test and a medium sized infarction of the inferior region of the heart and was admitted for cardiac catheterization. He had a history of coronary artery disease with stent placement, stenosis of the aortic valve, morbid obesity, chronic obstructive pulmonary disease, hypertension, sleep apnea, and a patent foramen ovale, described as a hole in the heart. He weighed 302.7 pounds on admission. Following the cardiac catheterization, the decedent developed a hematoma in his right groin with a drop in blood pressure, for which he was transfused with one unit of packed red blood cells due to the blood loss. On January 10, 2008, Dr. Bilfinger performed surgery wherein the aortic valve was replaced with a porcine valve and the patent foramen ovale was closed. Upon completion of the surgery, the pericardium was closed with Vicryl sutures and the sternum was closed with No. 6 gauge wire to close the sternal halves. He was thereafter monitored in CTICU, extubated, and transferred to the step-down unit on January 11, 2008. On January 13, 2008, the decedent experienced atrial fibrillation which stabilized with oral medication. Coumadin was started.

Dr. Grossi continued that on January 16, 2008, the decedent complained of a popping sound in his sternum upon expiration for which a chest x-ray was done. Dr. Grossi stated that the sternotomy wires looked unchanged. However, on January 18, 2008, the decedent became dyspneic and was started on oral antibiotics due to an increased white blood cell count. A CT scan revealed sternal dehiscence of the sternotomy wires, so he was scheduled for reconstruction of the sternum on Monday, January 21, 2008. Titanium plates were to be used, but had to be ordered. On the night of January 18, 2008, the decedent was administered magnesium, because, during the night, he suffered decreased oxygen saturation and a five-beat run of ventricular tachycardia. At 6:00 a.m. on January 19, 2008, his blood pressure dropped to 85/50, and he was seen by Dr. Rosengart, the on-call cardiothoracic surgeon who transferred him to CTICU for monitoring. However, the decedent continued to become more tachypneic and anxious. At 17:43 hours, during a chest x-ray, the decedent became unresponsive, bradycardic and hypotensive. ACLS was initiated and he was intubated. He exhibited pulseless electrical activity, then asystole. Dr. Bilfinger was called, and upon arrival, opened the decedent's chest at the bedside and performed internal cardiac massage and placed pacing wires which captured the heart rate at 18:35 hours. He noted old blood in the chest cavity. Thereafter, Dr. Bilfinger took the decedent to the operating room for sternal debridement and washing-out of the pericardium. The decedent's heart was noted to be swollen. Dr. Bilfinger left the decedent's chest open, and covered it with Gor-tex sewn into the skin, and covered it with a dressing. The decedent remained in critical condition. On January 21, 2008, the decedent went into ventricular fibrillation and tachycardia and died after unsuccessful ACLS protocol and internal cardiac massage.

Dr. Grossi opined that the valve replacement surgery was necessary and urgent as the decedent presented with critical aortic stenosis complicated by congestive heart failure. He stated that Dr. Bilfinger properly identified the critically stenotic valve and recommended an urgent aortic valve replacement and comported with the standard of care. He continued that the aortic valve replacement procedure was properly performed, including the closure of the decedent's sternum. He stated that the method of closure of a sternotomy is within the discretion and judgment of the surgeon, and that the method chosen does not change the risk of dehiscence, even with a large patient such as the decedent, as dehiscence is always a risk and does not mean that there was malpractice. He stated that the use of No. 6 wire was appropriate as the stainless steel wire is heavy and the decedent had an obese body habitat. He added that the looping procedure employed in wiring the sternum was an appropriate and accepted method of closing the sternum to increase stability and to decrease the likelihood of pulling through the bone. He continued that Dr. Bilfinger sawed through the sternum bone, observed the hemi-sternums, and found them to be suitable for the No. 6 wire. The wires did not break, he stated, but pulled through the entire hemi-sternum, which he stated can occur with any method of sternal closure, even with the titanium plates that the plaintiff alleges should have been used. He continued that regardless of the decedent's bone stock, Dr. Bilfinger's closure of the sternotomy adhered to all applicable standards of care.

Dr. Grossi stated that it is not the standard of care to have titanium plates readily in stock or to have used them for the initial closure in this instance. He stated that titanium plates, theoretically, can be used initially to close sternums in obese patients, but would entail risks and are not the standard of care. Commonly, titanium plates are used only as a secondary closure method after a patient has already dehisced and the surgeon requires a secondary closure. Titanium plates are very expensive and

individually chosen, and each plate and screw is a different size and length for each patient, thus, it is not the standard of care to have such plates in stock as they are more of a method of last resort. Thus, he concludes, it was appropriate for Dr. Bilfinger not to use titanium plates for the initial sternotomy closure, and it was not the standard of care for titanium plates to be in stock at Stony Brook University Hospital. Dr. Grossi stated that on January 16, 2008, the decedent coughed and heard a pop. The chest x-ray taken thereafter "appeared to show the sternotomy still in place, being similar to his previous x-ray." Clinical exam, he stated, found the sternum to be stable.

Dr. Grossi opined that all the care provided by Dr. Bilfinger was appropriate as, in a patient as large as the decedent, it would have been extremely difficult to diagnose a dehiscence, especially where the sternum was found stable upon examination. The decedent was not in acute distress and there was "no immediate reason to obtain further diagnostic studies " to rule out dehiscence. Dr. Grossi continued that dehiscence is not a life-threatening event requiring immediate attention unless there is evidence of a flail chest. The CT scan, taken two days later on January 18, 2008, ordered due to the decedent's elevated white blood cell count and respiratory congestion, revealed that a dehiscence occurred. Therefore, Dr. Bilfinger decided to do a revisionary closure of the sternotomy with titanium plates on January 21, 2008. Because the decedent had stable respiratory mechanics, it was not indicated to either intubate the decedent or return him immediately to the operating room, and therefore, Dr. Bilfinger's plan was appropriate and adhered to all applicable standards of care. Dr. Grossi continued that because the decedent was placed on Coumadin therapy following atrial fibrillation, immediate intervention to re-close the sternotomy was relatively contraindicated because of the risk of severe bleeding during surgery, and elimination of the Coumadin effect may take greater than 48 hours. Thus, he stated, it was reasonable for Dr. Bellinger to schedule revisionary closure three days later.

Dr. Grossi further opined that the wound care provided to the decedent was appropriate, and he was appropriately evaluated for infection, fever, pain at the site, and pus. Elevated while blood cell counts is a common response following cardiac surgery, and the decedent had a history of respiratory problems and was not compliant with post-operative spirometry to help reduce congestion. Antibiotic therapy was appropriately ordered. He continued that Dr. Bilfinger appropriately supervised staff and there is no evidence in the record that the staff failed to comply with his orders. He added that all appropriate consults were ordered, including cardiology, cardiac surgery, nephrology, anesthesiology, and neurology, and no additional consults were needed. While Dr. Bilfinger was not scheduled to work and was not on call, he appropriately transferred care of the decedent to Dr. Rosengart, the head of Stony Brook University Hospital's Department of Cardiothoracic surgery.

Dr. Grossi also opined that no act or omission by Dr. Bilfinger or the defendants proximately caused the decedent's injuries or death, as Dr. Bilfinger appropriately performed every aspect of the valve replacement procedure, including the closure of the sternotomy; timely diagnosed the decedent with dehiscence on January 18, 2008; and timely decided to schedule reclosure of the wound on January 21, 2008. He continued that the CT scan of January 18, 2008, showed no evidence of cardiac tamponade; and after Dr. Rosengart transferred the decedent back to CTICU, the decedent began showing signs and symptoms of respiratory distress. Dr. Bilfinger was not on call when the decedent became unresponsive on January 19, 2008, however, upon being called, he came in and re-opened the decedent's chest at the bedside, removed blood, and placed a pacemaker. Due to the decedent's size,

stated Dr. Grossi, Dr, Bilfinger was unable to efficiently pump blood to his body and the decedent died. He continued that while Dr. Bilfinger found evidence of a tamponade, which may have been a contributing factor in the decedent's code, it is his opinion that the most significant factor was the decedent's respiratory decompensation and refusal for appropriate therapy by refusing to have a foley catheter placed, refusing breathing treatment, and intubation. This, however conflicts with Dr. Grossi's earlier opinion wherein he stated that on January 18, 2008, the decedent had stable respiratory mechanics, and it was not indicated to either intubate the decedent or return him immediately to the operating room. He now states that fluid was observed in the decedent's lungs on the January 16, 2008 chest x-ray, and his non-compliance, coupled with his obesity and COPD, created a higher risk for respiratory distress. Dr. Grossi opined that the decedent died from respiratory distress and an acute cardiac tamponade event, and therefore, no act or omission by Dr. Bilfinger could have proximately caused the decedent's death. He added that Dr. Bilfinger obtained informed consent from the plaintiff; that he explained the risks, benefits, and alternatives to the aortic valve replacement surgery; that no reasonable patient could have refused the aortic valve replacement surgery; and the decedent would have died if he didn't have the surgery.

It is determined that defendants' expert, Dr. Grossi, has raised some factual issues in the moving papers. While he stated that the decedent's death was caused in part from a tamponade, he does not indicate when the tamponade occurred, what caused it, or the amount of blood involved. He noted that Dr. Bilfinger found old blood when he entered the decedent's chest to perform internal cardiac massage on January 19, 2008. Dr. Grossi does not address the significance of the tamponade, the standard of care for diagnosing such condition, or ruling it in or out, treatment of the tamponade, the significance or lack of significance of the tamponade in contributing to the decedent's symptoms and eventual demise, as noted in the autopsy report. It is noted in Dr. Bilfinger's operative report of January 19, 2008, that the decedent had been complaining throughout the day of progressive shortness of breath. Dr. Grossi does not address this. Dr. Bilfinger also indicated in his note that when the sternotomy was opened at the bedside, there was a large amount of dark old blood present and the heart was at a complete standstill. The nephrology consult note of January 20, 2008, indicates that the decedent was given six units of packed red blood cells, six units of fresh frozen plasma, and three units of platelets when he was taken to the operating room by Dr. Bilfinger on January 19, 2008. Dr. Grossi does not address this event in his expert affirmation, raising factual issues concerning the totality of the events experience by the decedent, their significance and the proximate cause of the injuries and death of the decedent. He does not set forth the appropriate standard of care for diagnosing, ruling in or ruling out, a dehiscence of the sternum. Dr. Grossi's expert opinions are found to be conclusory and unsupported. Even assuming that the defendants established prima facie entitlement to summary judgment dismissing the complaint as asserted against them, it is determined that the plaintiff's expert has raised factual issues which preclude summary judgment from being granted.

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, 776 NYS2d 907 [2d Dept

2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997])

The plaintiff has submitted a redacted expert affirmation with the opposing papers, and has also provided an unredacted copy of said affirmation to this court for review (*see* ***Marano v Mercy Hospital***, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). This procedure preserves the confidentiality of the name of plaintiff's medical expert while also preserving plaintiffs' 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 [NY County 1988]). The unredacted expert affirmation has been reviewed and returned to counsel for the plaintiff.

Plaintiff's expert is a physician licensed to practice medicine in New York State and is board certified in thoracic surgery and surgery. He/she set forth the materials and records reviewed and opined that there were deviations from good and accepted medical practice on the part of the moving defendants. He does not offer an opinion with regard to the matter pending in the Court of Claims. The plaintiff's expert set forth the decedent's history and presentation to Stony Brook University Hospital, indicating that a cardiac catheterization was performed on this 67 year-old man on January 9, 2008. After the cardiac catheterization, the plaintiff developed a large hematoma of the right thigh, an episode of bardycardia with a heart rate of 38, and hypotension. Immediate surgery was recommended by his cardiologist for aortic valve replacement which was performed on January 10, 2008 by Dr. Bilfinger. He stated that post-operatively, the decedent developed bleeding from the mid-sternal incision and chest tube insertion sites, and that two units of platelet were infused. He continued that the decedent did well post-operatively and was transferred to the intensive cardiac rehabilitation unit. On January 13, 2008, he developed atrial fibrillation with a ventricular rate of 130's to 140's. Coumadin therapy was commenced on January 14, 2008, and discharge planning was instituted.

The plaintiff's expert continued that on January 15, 2008, during an episode of coughing, the decedent experienced a popping sound in his sternum, which complaint was confirmed on physical examination on January 16, 2008, wherein a popping sound could be heard on expiration. On January 16, 2008, the decedent became, and remained, hypotensive and in atrial fibrillation. An x-ray revealed increased pleural effusion and Lasix was administered. He was to be discharged home after physical therapy stair assessment on January 17, 2008, however, his INR was noted to be elevated to 3.7. On January 18, 2008, the decedent's white blood count was noted to be rising. A CT scan of his chest demonstrated sternal dehiscence with multiple fragments, with a hematoma between the sternal fragments and effusion. The plan was to reverse Coumadin and perform sternal reconstruction with titanium plates on January 21, 2008. There were no plates available at SUNY Stony Brook.

The plaintiff's expert stated that during the night of January 18, 2008, the decedent experienced tachypnea with wheezing on inspiration and expiration, and sternal pain for which he received 2 doses of Morphine. Lasix was administered on the morning of January 19, 2008. The nursing staff noted hypotension and tachycardia, with EKG changes consistent with tachy-arrhythmia and PVCs. His white blood cell count was elevated to 30,7000. A chest x-ray again revealed effusion. He was transferred to CTICU for monitoring at 10:55 a.m. He was noted to have generalized edema, scattered rhonchi, crackles, and expiratory wheeze, 3+ peripheral edema, and anxiety. His blood pressure was 80/40, heart

rate 100-120, and respiratory rate was increased 20-36. He was noted to have severe anxiety with labored breathing for which Xanax and Fentanyl were administered. Arterial blood gas revealed base excess of 4.3, and a Potassium level of 5.5. That evening, he was noted to be unresponsive with a heart rate of 60s, ashen in color, and an oxygen saturation in the 80s. Resuscitation was commenced and he was intubated . At 6:10 p.m., the decedent's chest was opened, resuscitation started, and internal pacing wires placed. At 7:15 p.m., he was transferred to the operating room, and cardiac tamponade was diagnosed. He continued to be unstable, acidotic, and required ventilatory support with hemodynamic instability. He was pronounced dead at 1:57 a.m. on January 21, 2008.

The plaintiff's expert opined within a reasonable degree of medical certainty that there were departures from the standard of care by Dr. Bilfinger, Stony Brook Surgical Associates, and the cardio-thoracic staff at SUNY Stony Brook in connection with the care and treatment rendered to the plaintiff's decedent Carl Schuck. He opined, that, post-operatively, when the decedent exhibited signs and symptoms of labored breathing, shortness of breath, tachycardia, tachypnea, decreased urinary output, laboratory findings of increasing INR, decreased hemoglobin and hematocrit, and elevated serum potassium levels, the failure to investigate the possibility of impending cardiac tamponade constituted a departure from accepted standards of surgical care and management. He continued that these signs and symptoms required investigation and a diagnostic work-up with imaging which would have revealed impending tamponade requiring surgical intervention. The failure to perform the work-up and the erroneous diagnosis of the patient's complaints as anxiety, delayed appropriate treatment causing hemodynamic collapse, asystole, and decedent's death on January 21, 2008. The hemodynamic collapse and asystole from cardiac tamponade was the proximate cause of the decedent's death, and timely and proper treatment, more likely than not, would have prevented the cardiac tamponade that lead to the decedent's demise. Plaintiff's expert opined that the failure of Dr. Bilfinger and Stony Brook Surgical Associates to follow the standards of care was a substantial cause of the decedent's untimely death.

Based upon the foregoing, it is determined that the plaintiff has raised factual issues which preclude summary judgment from being granted.

Accordingly, motion (001) is denied.

Dated: March 20, 2014

Hon. Denise F. Molia
A.J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**