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SHORT FORM ORDER

INDEX No. 10-20115
CAL No. 13-01711MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 21 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JEFFREY ARLEN SPINNER
Justice of the Supreme Court

MOTION DATE 2-26-14 (#001 & #003)
MOTION DATE 2-19-14 (#002)
MOTION DATE 3-5-14 (#004)
ADJ. DATE 5-7-14
Mot. Seq.# 001 - MD # 003 - MD
002 - MG # 004 - MD

BARBARA BURNS, Individually and as Executrix of the Estate of THOMAS J. BURNS, Deceased,

Plaintiffs,

- against -

SUDHIR GOYAL, M.D., SUFFOLK NEPHROLOGY ASSOCIATES, P.C., RAKESH B. PATEL, M.D., SUFFOLK HEART GROUP, LLP, MICHAEL TORELLI, M.D., SOUTH SHORE FAMILY PRACTICE ASSOC., P.C., and NORTH SHORE LIJ SOUTHSIDE HOSPITAL,

Defendants.

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Smithtown, New York 11787

CHARLES E. KUTNER, ESQ., LLP
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Attorney for Defendants Dr. Torelli & South Shore Family Practice
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Attorney for Defendant Southside Hospital
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Islip, New York 11751

Upon the following papers numbered 1 to 89 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001)1 -30; (002) 31-47; (003) 48-58; (004) 59-76; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 77-83; Replying Affidavits and supporting papers 84-85; 86-87; 88-89 ; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by the defendants, Michael Torelli, M.D. and South Shore Family Practice Associates, P.C., for summary judgment dismissing the complaint as asserted against them is denied; and it is further

ORDERED that motion (002) by the defendant, Southside Hospital s/h/a North Shore LIJ Southside Hospital, for summary judgment dismissing the complaint as asserted against it is granted; and it is further

ORDERED that motion (003) by the defendants, Sudhir Goyal, M.D. and Suffolk Nephrology Associates, P.C., for summary judgment dismissing the complaint as asserted against them is denied; and it is further

ORDERED that motion (004) by the defendants, Rakesh B. Patel, M.D. and Suffolk Heart Group, LLP, for summary judgment dismissing the complaint as asserted against them is denied.

In this medical malpractice action, the plaintiff, Barbara Burns, has asserted causes of action for the pain and suffering and wrongful death of her decedent spouse, Thomas J. Burns, as well as a derivative claim and a cause of action for pecuniary loss. It is asserted that the defendants negligently departed from good and accepted standards while rendering care and treatment to the decedent, who died on June 7, 2008 at age 58. The decedent had a history of hypertension, elevated cholesterol and myocardial infarction with resuscitation in October, 2003. He underwent emergency cardiac catheterization and angioplasty with placement of drug eluting stents, however, during the procedure he coded numerous times, but was successfully resuscitated. Thereafter, echocardiograms and nuclear cardiograms indicated a decreased ejection fraction of 49% and fixed defect in the inferior wall of the heart. In May 2005, the decedent underwent cardiac catheterization, angiogram and stenting for the right coronary artery, again coding during the procedure with successful resuscitation. Thereafter, the decedent was diagnosed with an inguinal hernia, and was scheduled to have the hernia surgery on about April 10, 2008, however, the surgery was canceled. The decedent was thereafter diagnosed with kidney failure, nephritic syndrome, and systemic lupus erythematous, and was to obtain medical clearance for a kidney biopsy in May 2008. As part of the medical clearance for the biopsy, Dr. David D'Agate recommended that the decedent's antiplatelet medication could be held for ten to twelve days and restarted two to three days after the biopsy. The biopsy was scheduled for June 6, 2008, but was cancelled. On the evening of June 7, 2008, the decedent was found unresponsive in his bed. CPR was unsuccessful. Autopsy revealed a 90% occlusion of the circumflex artery. The cause of death was coronary artery disease.

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 (***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 [2d Dept 1981]).

The general rule in New York is that an expert cannot base an opinion on facts he did not observe and which were not in evidence, and that expert testimony is limited to facts in evidence (*see* ***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]). Medical records which are not certified and are not in admissible form pursuant CPLR 3212 and CPLR 4518 may not be considered.

In support of motion (001), Michael Torelli, M.D. and South Shore Family Practice Associates, P.C. submitted, inter alia, an attorney's affirmation; affirmation of Vincent Garbitelli, M.D.; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars; copies of the transcripts of the examinations before trial of Barbara Burns, Sudhir Goyal, M.D., Rakesh B. Patel, M.D., Michael Torelli, M.D., Shen Chen, PhD; certified but unsigned transcript of the examination before trial of David D'Agate with proof of service pursuant to CPLR 3116; uncertified medical records from Suffolk Nephrology Associates, Suffolk Heart Group, Rheumatology Associates, Brookhaven Memorial Hospital record of May 2007, Island Surgical & Vascular; certified medical records from South Shore Family Practice, Southside Hospital for September 30, 2006; and an uncertified autopsy report.

In support of motion (002), North Shore LIJ Southside Hospital (Southside Hospital) submitted, inter alia, an attorney's affirmation; affirmation of James Thomas Bopp, M.D.; copies of the summons and complaint, defendants' answers, plaintiff's verified bill of particulars; transcript of the examination of before trial of Barbara Burns, Sudhir Goyal, Rakesh Patel, Michael Torelli, hen Cheng, David, D'Agate; and the certified copy of the Southside Hospital records of June 7, 2008 with autopsy report, and May 18, 2008 relating to decedent's complaint concerning his right foot.

In support of motion (003), Sudhir Goyal, M.D. and Suffolk Nephrology Associates, P.C. submitted, inter alia, an attorney's affirmation; affirmation of Gerard J. Tepedino, M.D.; certified medical records of Suffolk Nephrology, and of Southside Hospital for September 30, 2006, December 12, 2004, and October 11, 2003; and transcripts of the examinations before trial of Sudhir Goyal and Barbara Burns.

In support of motion (004), Rakesh B. Patel, M.D. and Suffolk Heart Group, LLP submitted, inter alia, an attorney's affirmation; affirmation of Jacob Shani, M.D.; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars; transcripts of the examiantions before trial of Barbara Burns, Sudhir Goyal, Rakesh Patel, Michael Torelli, and David D'Agate; and various uncertified medical records.

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 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420 [1999]). 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***,

224 AD2d 674, 638 NYS2d 700 [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, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 675 NYS2d 375 [2d Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 609 NYS2d 45 [2d Dept 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, 690 NYS2d 762 [3d Dept 1999]).

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]).

Michael Torelli, M.D. testified to the extent that he is board certified in family medicine and practices under the name of South Shore Family Practices Associates, P.C. He has two physician's assistants working for him. He had no independent recollection of the decedent. The decedent was first seen by his former associate, Dr. Walsh, on April 22, 1999 for hypertension, and subsequent treatment by Dr. Walsh for cholesterol. He was referred to Dr. LaRosa for peripheral vascular evaluation. There was a gap in decedent's treatment from 2002 to July 6, 2006. His record indicated treatment with Dr. Patel for cardiology issues, myocardial infarctions, angioplasty and stent placements, and there were reports for various tests, including thallium stress testing. The reports had been checked by his physician's assistant, Jennifer. The decedent was sent for a rheumatology consult with Dr. Rumore who performed various blood work.

Dr. Torelli indicated that various laboratory work was done on September 1, 2006, with findings including a slightly elevated glucose and slightly low hemoglobin and hematocrit, usually indicating anemia. The antinuclear antibody was positive, and could have meant anything from a false positive to a questionable autoimmune, to a viral reaction. The antinuclear B titre was done for lupus or autoimmune type reaction. Dr. Torelli stated that Dr. Rumore was following him on those studies. A detailed report from Dr. Rumore, dated October 23, 2006, was reviewed by Dr. Walsh. He knew of no referrals between August 31, 2006 and March 12, 2007. The decedent saw Dr. Walsh on March 12, 2007 for a refill of a prescription, but he did not know which medication. On February 28, 2008, the decedent returned for medication renewal and to be checked for a possible right-sided hernia in his groin, for which Dr. Torelli stated, he did a focused exam and not a physical. His impression was right inguinal hernia, hypertension, elevated cholesterol, coronary artery disease, and smoking. He planned an EKG, spiro, lung age, CBE, lipids, PSA and UA, a prescription for Chantix to stop smoking, and a referral to Dr. Wodicka, a laparoscopic hernia surgeon.

Dr. Torelli continued that when the blood work results were received, he noted an increase in the BUN and creatinine, and a decrease in albumin, hematuria, and anemia. Messages were left for the decedent to come in, which he did on March 7, 2008. Blood tests were re-ordered, as was an abdominal and pelvic sonogram. As a result of the ultrasound, he ordered a CTK Hida exam, for which the decedent never followed up. He again referred the decedent on March 18, 2008, to Dr. Wodicka, this time for follow-up for the gall bladder findings. Dr. Torelli testified that his physician's assistant reviewed the letter of March 25, 2008 from Dr. Patel, but he did not know if anyone from his office discussed it with the decedent. Dr. Patel had given clearance for the hernia surgery from a cardiac standpoint. The decedent presented on April 8, 2008 for medical clearance for hernia surgery. However, he noted an increase in the hospital lab work with a worsening of the kidney functioning, indicative of acute renal failure, so he sent the decedent to Dr. Goyal, stat. He then received a call from Dr. Goyal who advised that he discontinued the medication Alsace, changed it to Hydralazine, and changed the Crestor to Lipitor. Dr. Goyal was to continue the follow-up. Dr. Torelli testified that he believed that Dr. Goyal changed these medications because certain medications may have an effect on renal failure, and to see if the change has an effect on the BUN and creatinine. When Dr. Torelli saw the decedent on April 16, 2008, there was blood in the urine which indicated anything from kidney stones, leakage, dehydration, kidney disease, prostatitis, prostate cancer, renal cancer, or anything. Dr. Torelli put the hernia surgery on hold due to this.

Dr. Torelli also stated that his physician's assistant reviewed the letter of June 2, 2008 from Dr. D'Agate, but there was no indication anyone from his office discussed it with the decedent. Dr. Torelli stated that Dr. Patel's statement that it was safe to hold the antiplatelet therapy prior to undergoing renal biopsy, but there should be prompt re-initiation after should have been relayed to the decedent by one of the specialties, but he did not know which specialty. He guessed it would be the one taking care of the renal biopsy. He did not speak to Dr. D'Agate about it. He did not know if the renal biopsy was ever done. He stated that the decedent weighed 217 at his last visit with him and the autopsy reported his weight at 170. Dr. Torelli stated that his records reflected the decedent was 6' 2", but the autopsy report indicated 5'10".

Rakesh Patel, M.D. testified to the extent that he was board certified in internal medicine, cardiology, interventional cardiology, and cardiac nuclear medicine. In 2008, he was a partner in, and was employed by Suffolk Heart Group, LLP. Dr. D'Agate was one of his partners. He first met the decedent on October 21, 2003, at Southside Hospital after the decedent had gone into cardiac arrest on a ball field, and came back either on his own or after resuscitation. Dr. Patel stated that he was called in to the emergency room because the decedent went into cardiac arrest again and had to be defibrillated four times. The decedent was diagnosed with a big anterior wall infarction. Thereafter, he performed angioplasty and placed a stent into the decedent's left anterior descending artery as it was 100 % occluded, clogged or blocked. The angiogram revealed the decedent had developed his own bypasses from the left anterior descending to the right coronary artery. He then placed the decedent on Plavix and Aspirin to thin his blood, as well as Toprol (beta-blocker), Ramipril (ace inhibitor), Zetia and Zocor (for cholesterol), and Imdur (anti-angina). He stated the decedent was of average height, chunky in the middle with abdominal obesity, and weighed about 220.

Dr. Patel stated that he sent a letter to Dr. Torelli, the decedent's family practitioner, and advised various blood work, and a battery of tests, including a Holter monitor. On a subsequent visit on December 3, 2003, Dr. Patel noted that the decedent was compliant with his medication, and his cholesterol was controlled. He described the care and treatment, including a persantine myoview stress test which was done

because the decedent's right coronary artery appeared to be 100 % occluded and he wanted to determine the extent of the abnormality. An echocardiogram was also done. The nuclear cardiogram, he stated, indicated the presence of a heart attack in the right coronary artery, with no evidence of poor blood flow anywhere else. His impression was that of a fixed defect involving the inferior wall consistent with the prior infarct. On December 9, 2003, he noted the decedent stopped smoking and had lost 20 pounds. The plan was medical management, medication therapy, and no smoking. His impression was that the inferior wall of the heart was non-viable, that there was a heart attack, but the heart muscle was moving and not completely scarred, and was probably related to an occluded right coronary artery. Aspirin was decreased to 81 mg., but he wanted the decedent to remain on Aspirin and Plavix for at least one year.

On March 2, 2004, when Dr. Patel saw the decedent, he noted that he had two vessel coronary artery disease, in that there was severe disease of the left anterior descending artery relating to the heart attack, as a severely diseased right coronary artery. At this point, Dr. Patel stated, nothing was done to the right coronary artery which was 100% occluded, including stent placement or angioplasty to the artery as the decedent had already made his own bypass. Because his heart attack of October, 2003 involved the left anterior descending, the two arteries went down at the same time. On July 27, 2004, trace edema or water retention was noted in decedent's ankles, so he ordered the diuretic, HCTA 25 mg, and ordered blood tests to assess kidney function, and to assess the strength of the heart muscle. His impression was possible early congestive heart failure. An echocardiogram was done August 7, 2004 and a blood test was negative for congestive heart failure. The nuclear stress test indicated a mild abnormality-hypokinesis of the basal septum, correlating with the prior heart attack.

At the February 1, 2005 visit, he noted that the Zocor was changed to Crestor, but he had not changed it. A random albumin level of 3.1 was noted, but Dr. Patel stated that he is not an expert on that, however, the liver function electrolytes and creatinine and BNP levels were fine. Dr. Patel stated that the confirmed edema had nothing to do with the decedent's heart, and no edema was noted at this visit. On May 23, 2005, as noted by his partner, Dr. Lee, it was indicated the decedent was going to have another cardiac catheterization, at North Shore Hospital due to complaints of chest pain. The coronary angiogram was done, and then a stenting procedure was performed to the right coronary artery on May 26, 2005. He noted that there was branch of the LAD that had some blockage, which he did not touch and which he planned to treat medically. On June 3, 2005, Dr. Lee's impression was severe ASHD (atherosclerotic heart disease). HCTA was reduced to a half dose to avoid electrolyte imbalance. Dr. Patel testified that Dr. Torelli was issued a report concerning the visits. A laboratory hemoglobin A1C was borderline abnormal at 6.3 and was sent to Dr. Torelli. Nothing changed on a stress test which was repeated at that visit, or the echocardiogram on March 29, 2006.

Dr. Patel stated that the decedent was seen on March 25, 2008 for pre-operative clearance for hernia surgery. Dr. Patel testified that he found no cardiac contraindications for performing the hernia surgery. He stated that it was safe for the Plavix to be withheld for a few days before surgery, and although he did not mention the Aspirin, it could be continued through the surgery. He then testified that the Plavix should be stopped for five days prior to the surgery, if the surgeon wishes, and to be resumed post-surgery whenever the surgeon feels it is safe.

Dr. Patel continued that a letter dated June 2, 2008 by Dr. D'Agate, indicated he had received a call advising the decedent needed medical clearance for a renal biopsy. Dr. D'Agate did not see the decedent,

but based clearance upon Dr. Patel's letter clearing the decedent for the hernia surgery. He indicated Plavix was to be stopped five days prior to the procedure and that Dr. D'Agate advised prompt re-initiation of the antiplatelet medications. Whichever surgeon is doing the surgery is the physician who must order re-initiation of the antiplatelet medications, Dr. Patel testified. The procedure is that when the patient has the surgery, he is called to see the patient post-operatively to evaluate the patient for cardiac reasons, to see what is missing, what needs to be done, and to start medicines. There was no indication in his record that his office was called to see the decedent after the biopsy. It was Dr. Patel's opinion that when he saw the decedent on March 25, 2008, that the decedent was stable, he could climb two flights of stairs, and he had no angina and no heart failure. But based upon his history, Dr. Patel stated, the decedent had previous heart attacks and can have sudden death or even another heart attack, and was at a higher risk than a patient who never had a heart attack.

Sudhir Goyal, M.D. testified to the extent that he is board certified in nephrology/internal medicine. He has a 25% ownership interest in Suffolk Nephrology Associates, P.C. On April 9, 2008, Dr. Torelli referred the decedent to him for an increased blood serum creatinine and BUN, an indication that the kidneys are not functioning properly. The decedent was also passing a small amount of blood and too much protein in his urine. He stated the decedent had a history of coronary artery disease and a myocardial infarction two years prior, with emergent stents placed. His notes indicated the decedent had been "revived." Upon examination, the decedent was found to weigh 218 pounds. Dr. Goyal spoke with Dr. Torelli while the decedent was at his office, and was advised by Dr. Torelli that the creatinine level was normal the year before. At the time, the decedent was on Toprol, Crestor, Plavix, and Aspirin 325 mg daily. Zetia had been stopped the day before, but he did not know why. His impression was acute renal failure over the past year, possibly secondary to medications, including Altace, HCTZ and Crestor, as such drugs could be contributing to renal failure. Thus, he changed the Crestor to Lipitor, substituted Hydralazine for Altace, and stopped the HCTZ. He told the decedent to check with his cardiologist, and he ordered an abdominal sonogram and 24 hour urine exam.

Dr. Goyal stated that laboratory studies reviewed on April 25, 2008, revealed systemic lupus erythemastosus (SLE), and that there was something very wrong with his kidney function. The decedent was examined by Dr. Goyal on that date. The decedent was found to have gained 18 pounds since the last visit, and had swelling of his feet from water retention. His impression was acute renal failure, nephrotic syndrome, and systemic lupus erythematosus. Dr. Goyal described SLE as a condition in which the body forms antibodies against its own tissues and tends to destroy the tissue. His plan was to stop the Hydralazine, substituting Cardizem, give Lasix for the edema, and he ordered additional tests. Dr. Goyal testified that his plan was to obtain a renal biopsy to diagnose for any other renal pathology. He continued that the Plavix and Aspirin needed to be discontinued prior to the biopsy as the two medications are antiplatelet agents which can cause bleeding. He did not tell the plaintiff to stop Aspirin and Plavix. He discussed the need for cardiac clearance prior to the biopsy.

Dr. Goyal stated that he next saw the decedent on May 5, 2008 and noted that he still had edema, complained of swelling of his feet, felt slightly fatigued, and had lost four pounds. His impression was significant proteinuria with nephrotic syndrome and renal insufficiency most likely secondary to SLE. The risks and benefits of the biopsy were discussed. He advised that a biopsy was needed because the drugs which are required to treat his condition can be toxic, there were no other procedures available, and no alternative way to do the testing. On May 29, 2008, the plaintiff had no significant change, Lasix was

increased, and his weight changed by only one pound. The Lasix was not working, as he demonstrated the same degree of edema. His impression was nephrotic syndrome, renal insufficiency, SLE, hypertension, severe edema, and CAD. He spoke with Dr. D'Agate by telephone while the plaintiff was in the office at that visit. He had an addendum to his note of May 29, 2008, indicating that when he tried to speak with Dr. Patel, Dr. D'Agate was there instead, so he discussed the antiplatelet therapy with Dr. D'Agate. Dr. Goyal testified that Dr. D'Agate read from Dr. Patel's note which indicated Dr. Patel advised that the plaintiff could be off the Plavix and Aspirin for ten to twelve days prior to the biopsy, and to restart the medications the second or third day after the biopsy. He stated that he asked Dr. D'Agate to confirm their conversation in a letter. The biopsy was scheduled for June 6, 2008 in the department of interventional radiology.

When questioned about a letter dated June 2, 2008, sent by Dr. D'Agate to Dr. Torelli, Dr. Goyal testified that he did not receive that letter although it was copied to him. The letter provided that it was safe to hold antiplatelet therapy prior to undergoing renal biopsy as he was three years out from the stent placement. He also stated that the decedent should have prompt reinitiation of antiplatelet agents. Dr. Goyal felt that two days after the biopsy would be okay to reinitiate antiplatelet therapy unless there was bleeding. Dr. Goyal testified that he never received written confirmation from Dr. Patel or Dr. D'Agate, although that was the procedure, and he requested confirmation. Dr. Goyal testified that the biopsy was never done, but he did not know why.

David D'Agate, D.O. testified to the extent that he is board certified in internal medicine, cardiology, nuclear cardiology, and has advanced training in vascular technology imaging blood vessels. He testified that he never met Thomas Burns, the decedent and never saw him in the office on a professional basis. He was contacted by telephone by Dr. Goyal who felt the decedent needed a renal biopsy. They discussed his condition, noting he was stable, without new cardiovascular complaints. He continued that Dr. Goyal wanted to review Dr. Patel's March letter in regard to Plavix, when the decedent was scheduled for hernia surgery. Dr. D'Agate stated that Dr. Patel wrote in his letter that it would be safe to hold the Plavix for a few days prior to surgery, and that it should be resumed post-surgery. After speaking with Dr. Goyal, Dr. D'Agate stated that he dictated a letter dated June 2, 2008, and sent it to Dr. Torelli, as it is customary to advise the patient's primary care physician and specialties. The letter advised about the use of Plavix, that it was safe to hold it prior to undergoing renal biopsy, but it should be promptly reinitiated following surgery, to be determined by the proceduralist performing the biopsy. He based his recommendation upon Dr. Patel's letter and his discussion about the decedent with Dr. Goyal. Dr. D'Agate testified that he did not discuss stopping the decedent's Aspirin prior to surgery. Dr. D'Agate testified that the American College of Chest Physicians' Guidelines for 2011 for patients with drug-eluting stents can have the Plavix discontinued after one year. In 2008, many times Plavix would be stopped after one year with drug-eluting stents.

Barbara Burns testified that her husband received a telephone call on June 5, 2008, advising him that the biopsy was cancelled as there was no pre-authorization obtained from the insurance company. However, a couple weeks after her husband's death, she found an opened envelope at home containing a document from HIP giving approval for the biopsy. She did not know if her husband ever saw the letter. She testified that Dr. Goyal advised her husband he could stop his medications three days prior to the biopsy. She was not aware that her husband resumed his mediation prior to his death.

Shen Chen testified to the extent that he is employed by North Shore LIJ Health Care as a pathologist. He has a PhD in neuroscience, and went to medical school in China. He is board certified in pathology. Referencing the autopsy report, his name did not appear on it because he was the pathologist involved in the report and not in patient care. He indicated the report he was being shown was from Southside Hospital, and that his report was copied into their report. He testified that the autopsy findings and cause of death were made by him, based upon the autopsy which he performed. He then stated that a resident, Jennifer Romans, performed the autopsy dissection and review of the body organs, and that he supervised. The decedent's body was brought from home to Southside Hospital emergency department, and then transferred to LIJ Medical Center for the autopsy. He did not recall if he spoke to any of decedent's physicians at any time, and indicated that he does not usually, unless there is a question that needs to be addressed.

Dr. Chen stated that the preliminary autopsy finding and cause of death were set forth in a preliminary report dated June 11, 2008, which was sent to Dr. Schapfel, a pathologist at LIJ Medical Center and to Southside Hospital. After the preliminary report, they waited for the microscopic slides from tissues samples which are processed in the laboratory at LIJ Medical Center. The slides were reviewed by the resident and by him. The autopsy does not become final until the slides are reviewed. In this case, he issued addendum number one to the report on August 9, 2008, because, when he issued the preliminary report, he pressed the button for final report instead of preliminary report, thus necessitating an addendum. He did not enter the external examination findings of the decedent into the preliminary report. He stated that the resident enters the external examination findings after the preliminary stage. With reference to the decedent's age, height and weight, he stated that the resident estimated it, and no weight and no measurements were taken. The decedent was identified by a name tag. Chen continued that upon examination of the decedent's coronary artery, there were stents noted and the coronary artery show atherosclerosis with significant narrowing of the lumen, occlusion of the lumen. There was fibrosis indicating a prior heart attack. There were stents in the circumflex and in the left anterior descending artery. He also noted mild to moderate arterionephrosclerosis of the kidney due to hypertension, diabetes or other kidney disease. It was his opinion that the decedent's cardiac arrest was secondary to coronary artery disease with 90% occlusion in the circumflex.

MOTION (001)

In motion (001), Michael Torelli, M.D. and South Shore Family Practice Associates, P.C. have submitted the affirmation of Vincent Garbitelli, M.D. who affirmed that he is licensed to practice medicine in New York State and is a board certified internist. Dr. Garbitelli has submitted a copy of his curriculum vitae to qualify as an expert. 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 to decedent Thomas Burns by the South Shore defendants was rendered within the applicable standards of care, they did not depart from good and accepted medical practice, and did not proximately cause any of the injuries or death of the plaintiff's decedent.

Dr. Garbitelli stated that care and treatment was appropriately provided to the decedent who was initially seen as a South Shore patient in 1999 through July 2002 for routine care, including lab work, EKGs, urinalysis, physical examination, blood pressure check-up, medication, and cholesterol monitoring. The decedent was advised to stop smoking, diet, and exercise, and appropriate adjustments were made to

his medication. Dr. Garbitelli stated in a conclusory opinion that the decedent was often noncompliant with medications and follow-up. He continued that the decedent never had cardiac complaints or any indications warranting a referral to a cardiologist before suffering a myocardial infarction in October, 2003, more that a year after having been last seen at South Shore Family Practice. In October, 2003, the decedent was emergently treated by cardiologist, Dr. Patel, at Southside Hospital, for angioplasty with stent placement, and he continued care and treatment with Dr. Patel throughout 2003 through 2006.

On July 6, 2006, the plaintiff's decedent returned to South Shore Family Practice. Dr. Garbitelli stated that a history of the current medications, specialists, and recent cardiac testing was obtained, however, he does not indicate which physician saw the decedent. He added that blood work, labs, and testing were appropriately reviewed and discussed with the decedent. Dr. Garbitelli stated that Dr. Torelli referred the decedent to a vascular surgeon and that the decedent returned on March 7, 2008. Although he stated that appropriate blood work and abdominal/pelvic sonogram was ordered, and testing reviewed, he does not specify any tests, blood work, or studies, or the findings. Dr. Garbitelli stated that on March 18, 2008, Dr. Torelli reviewed the abdominal/pelvic sonogram, advised a Hida scan, and referred the decedent back to the vascular surgeon to be evaluated for a possible surgical gallbladder procedure. He continued that on March 25, 2008, the decedent received pre-operative clearance from Dr. Patel, for hernia repair to be performed by Dr. Wodicka. Dr. Garbitelli stated that the decedent presented to South Shore Family Practice for pre-operative testing which was problematic, indicating possible worsening kidney function and acute renal failure, but Dr. Torelli's expert does not indicate when previous kidney problems and renal failure were first diagnosed and by whom. He continued that Dr. Wodicka postponed the hernia surgery and that Dr. Torelli referred the decedent to a nephrologist, Dr. Goyal.

Dr. Garbitelli indicated that the decedent was seen by Dr. Goyal on April 9, 2008, and that Dr. Goyal contacted Dr. Torelli to obtain background medical history. Dr. Goyal adjusted the decedent's medications, although Dr. Garbitelli does not indicate which medications were adjusted, and why. Dr. Goyal also advised the decedent to follow-up with his cardiologist, ordered an abdominal sonogram and further lab work, and advised the decedent to follow-up with him. Dr. Garbitelli stated that the decedent returned to Dr. Torelli on April 16, 2008, and up to this time, the South Shore defendants had appropriately rendered care in accordance with the standard of care, made appropriate referrals, and deferred to the decedent's specialists. He continued that on April 25, 2008, Dr. Goyal discussed a kidney biopsy with the decedent, the possibility of having to discontinue the antiplatelet medication, and the need to obtain cardiac clearance for the procedure. Dr. Goyal, he stated, also contacted Dr. D'Agate, decedent's cardiologist to ascertain resumption of the antiplatelet medication after the procedure. Dr. D'Agate memorialized his conversation with Dr. Goyal to Dr. Torelli.

Dr. Garbitelli stated that Dr. Goyal scheduled the kidney biopsy for June 6, 2008, and that the decedent stopped taking medication(s) in advance of the procedure, which was cancelled for some "unknown reason." Dr. Garbitelli opined that there is no evidence that the South Shore defendants had any involvement in preparing the decedent for the intended kidney biopsy, scheduling of the biopsy, suspension of medications in advance of the procedure, or the cancelling of the biopsy, and that there is nothing that the South Shore defendants did or did not do during their care and treatment of the decedent which proximately caused the ultimate demise of the decedent on June 7, 2008.

Based upon the foregoing, it is determined that Dr. Garbitelli's affirmation is conclusory and

unsupported with the standard of care and treatment for the medical care provided to the defendant by Dr. Torelli and the South Shore defendants. Dr. Garbitelli does not indicate what medications, if any, were prescribed by Dr. Torelli, for what conditions he was treating the decedent, whether or not any of the medications prescribed by Dr. Torelli caused or contributed to the decedent's acute renal failure, his findings upon examination, and whether proper diagnostic testing was being provided to the decedent, and the results of such testing. Dr. Garbitelli does not indicate whether or not Dr. Torelli provided medical clearance for the renal biopsy or whether he was involved in coordinating care and ordering medications. Dr. Garbitelli does not discuss the letter of June 2, 2008 sent by Dr. D'Agate to Dr. Torelli, and what, if anything, Dr. Torelli did in response to said letter. Dr. Garbitelli does not indicate the cause of the decedent's death to support his opinion that there is nothing that the South Shore defendants did or did not do during their care and treatment of the decedent which proximately caused decedent's death. Dr. Garbitelli does not discuss the cause of death set forth in the autopsy report, namely, coronary artery disease, and does not discuss or opine with regard to this disease and any care and treatment provided by Dr. Torelli and South Shore Family Associates relative thereto, raising factual issues which preclude summary judgment.

The plaintiff's expert set forth that, as decedent's primary care physician, Dr. Torelli's function was to coordinate the decedent's care and treatment, especially as it relates to a patient with various specialists treating at one time. It is imperative that prescriptions be reviewed, and that the drugs prescribed by the various specialists do not conflict. Here, defendant Torelli was made aware of the elevated kidney function and canceled the hernia procedure. The plaintiff's expert stated that it was the policy of South Shore Cardiology Group to direct their clearance to the primary care physician and to carbon copy to the known specialists, which was done for both the hernia surgery clearance and the renal biopsy clearance, with no objection from Dr. Torelli. The plaintiff's expert opined that it was a departure from good and accepted practice when defendant Torelli ignored or failed to act when he received the June 2, 2008 letter addressed to him as the letter warned of the importance of prompt reinitiation of the antiplatelet agent. In view of the fact that Dr. D'Agate did not give cardiac clearance, but instead insisted that he only discussed the antiplatelet agent, it calls into question whether the decedent was medically sound to have the biopsy performed. The plaintiff's expert stated that Dr. Torelli referred the decedent to Dr. Goyal to treat his kidney issues and medical clearance was a pre-requisite to allowing the biopsy to take place. Plaintiff's expert opined that it was a departure from good and a accepted practice to allow the biopsy to proceed unless the decedent was physically able to withstand the procedure, and that determination was never made.

Based upon the foregoing, there are factual issues concerning whether or not Dr. Torelli departed from the standard of care by failing to coordinate the decedent's care and treatment with the specialists, properly clearing the decedent for biopsy, and failing to advise the surgeon of the need for prompt reinitiation of the antiplatelet therapy.

Accordingly, motion (001) by Michael Torelli, M.D. and South Shore Family Practice Associates, P.C. for summary judgment dismissing the complaint asserted against them is denied.

MOTION (002)

In motion (002), Southside Hospital submitted the affidavit of James Thomas Bopp, M.D. who averred that he is licensed to practice medicine in New York State and is board certified in emergency

medicine and internal medicine. He maintains a private medical practice. He set forth the materials and records he reviewed. He opined to a reasonable degree of medical certainty that the doctors, nurses and staff of Southside Hospital did not deviate from the accepted standard of care in medicine in rendering care and treatment to the decedent, and that there was nothing which they did or failed to do which proximately caused the decedent's injuries, including myocardial infarction, cardiac arrest, and death. Dr. Bopp stated that the decedent was not treated at Southside Hospital on June, 4th, 5th, or 6th, 2008, and that the only claims against Southside Hospital concern the visit of June 7, 2008.

Dr. Bopp set forth the decedent's history and various visits with Dr. Patel, including cardiac catheterizations, stent placements, and medication regimens. He continued to address the decedent's visits to Dr. Torelli and Dr. Walsh, the decedent's primary care physicians, and noted that the decedent was referred to Dr. Rumore for a rheumatology consult, and to Dr. Wodicka for surgical consult regarding an inguinal hernia in February 2008, and thereafter in March 2008, for a consultation regarding decedent's gall bladder. However, increased BUN and creatinine levels, and low hemoglobin and hematocrit levels were revealed in the decedent's blood work, and blood was noted in his urine. The decedent was seen by Dr. Patel for cardiac clearance for the hernia surgery, which was never performed despite Dr. Patel finding no cardiac contraindications to the surgery. Dr. Bopp continued that Dr. Torelli provided medical clearance on April 8, 2008 for the hernia surgery, but Dr. Torielli placed the surgery on hold due to the decedent's worsening kidney function, and sent him to Dr. Goyal for a nephrology evaluation.

Dr. Bopp discussed Dr. Goyal's care and treatment of the decedent, including his determination that the decedent needed a kidney biopsy. He stated that Dr. Goyal also ordered an abdominal ultrasound and carotid ultrasound with no significant plaque in the bilateral carotids, and no hemodynamically significant stenosis bilaterally. He addressed the continuing care by Dr. Goyal, and on May 5, 2008, Dr. Goyal advised the decedent that he would have to discuss the procedure with his cardiologist with regard to stopping the Plavix and Aspirin. Dr. Goyal's impression was that the kidney failure was caused mostly by lupus, and that he could not treat him without getting a biopsy as the required drugs were toxic. As of May 29, 2008, the decedent had not yet received cardiac clearance, so Dr. Goyal spoke with Dr. D'Agate about the antiplatelet therapy as Dr. Patel was not available. Because the decedent was three years out from stent placement, it was determined safe to hold antiplatelet therapy prior to undergoing the biopsy, with prompt reinitiation thereafter. Dr. Goyal discussed the biopsy with the decedent on that date, advising it was scheduled for June 6, 2008 at Good Samaritan Hospital

The decedent was seen at Southside Hospital emergency room on June 7, 2008 at 5:13 p.m., presenting without pulses, blood pressure, or respirations. He was in cardiac arrest, as demonstrated by asystole on the monitor. An intubation tube was in place. CPR was in progress. The arrest was not witnessed, and more than ten minutes passed from when the decedent was found in bed by his wife at 4:40 p.m., until ALS arrived. He was comatose upon arrival, with pupils at 6mm and fixed. He had no bowel sounds, and his Glasgow coma scale was 3, the lowest possible value which reflects deep coma or death. He was defibrillated three times, intravenous lines were placed, medications were given. Dr. Bopp stated that the autopsy revealed that the decedent died of cardiac arrest due to coronary artery disease wherein the coronary artery was significantly narrowed from atherosclerosis. Mr. Burns was pronounced dead at 5:18 p.m.

Dr. Bopp opined that the decedent died at home prior to his transfer to Southside Hospital. He set forth the bases for this opinion, stating therefore, that there was no proximate cause between the care and treatment provided at Southside Hospital and the decedent's myocardial infarction, cardiac arrest, and death. Appropriate, timely, and proper efforts to restore life to the decedent was not possible. No specialists could have been called in which would have changed the outcome. Because the kidney biopsy was to be performed at Good Samaritan Hospital, Southside Hospital therefore had no involvement regarding scheduling, clearance, or cancellation of the biopsy. There was no involvement by Southside Hospital staff or employees to stop the Plavix or alter any of the decedent's medications at any time.

Based upon the foregoing, it is determined that Southside Hospital has established prima facie entitlement to summary judgment dismissing the complaint. Here, the plaintiff has submitted the unredacted affirmation of her expert physician who affirms that he is duly licensed to practice medicine in New York and is board certified in internal medicine, and cardiovascular disease. Upon review and careful consideration of plaintiff's expert's affirmation, it is determined that the plaintiff has failed to raise a factual issue to preclude summary judgment from being granted to defendant Southside Hospital.

Accordingly, motion (002) by defendant Southside Hospital is granted and the complaint and any cross claims which are or could be asserted against it are dismissed.

MOTION (003)

Sudhir Goyal, M.D. and Suffolk Nephrology Associates, P.C. submitted the affirmation of Gerard J. Tepedino, M.D., a physician licensed to practice medicine in New York State and board certified in internal medicine with a subspecialty in nephrology, who maintains a practice in medicine. He set forth that he reviewed Dr. Goyal's records and the examinations before trial of Dr. Goyal and Barbara Burns, as well as additional records. It is Dr. Tepedino's opinion within a reasonable degree of medical certainty that at all times, Dr. Goyal conformed to accepted standards of good medical practice, and that there is no evidence that he deviated therefrom.

Dr. Tepedino set forth that the decedent was seen by Dr. Goyal on April 9, 2008 for an elevated creatinine level, and formed the impression of acute renal disease, initially thought to be related to medication the decedent was taking, namely, Altace, HCTZ and Crestor. Dr. Goyal obtained the decedent's history, performed a physical, noted the medications being taken by the decedent, and changed the Crestor to Lipitor 80 mg daily, and HCTZ to Hydralazine 25 mg three times a day. When the decedent returned to Dr. Goyal on April 25, 2008, he had gained 18 pounds and now weighed 236 pounds. Due to the creatinine and BUN levels, Dr. Goyal formed the impression that the decedent may have acute renal failure, nephritic syndrome, lupus, and edema. He discontinued the Hydralazine and prescribed Cardizem CD and Larix. He indicated to the decedent that a kidney biopsy would be needed. On May 5, 2009, the decedent weighed 232 pounds, complained of swollen feet, and stated that there was no significant change from the Lasix. Again, Dr. Goyal advised the decedent of the need for a renal biopsy, that the decedent would need to stop ASA (Aspirin) and Plavix, and referred the decedent back to his cardiologist to evaluate the issue of stopping those medications.

Dr. Tepedino continued that on May 29, 2008, when the decedent returned to Dr. Goyal, he had not yet seen his cardiologist. Dr. Goyal then spoke with Dr. D'Agate, a cardiologist practicing at Suffolk Heart

Group with Dr. Patel, decedent's cardiologist. Dr. Tepedino stated that Dr. Goyal was advised by Dr. D'Agate that the Plavix/ASA can be held for ten to twelve days, and should be restarted two to three days after the biopsy. A CT guided renal biopsy was scheduled for June 6, 2008, however, it was not done due to the lack of preauthorization by decedent's insurance company. The decedent died on June 7, 2008.

Dr. Tepedino opined that the renal biopsy was medically necessary, and absolutely indicated as the decedent presented to Dr. Goyal with advanced kidney dysfunction and nephrotic range proteinuria with blood tests suggesting an immune-mediated glomerular process. No further diagnostic information would have been attained without a kidney biopsy, and the decedent would have likely needed renal replacement therapy in the not so distant future without addressing the change in his kidney dysfunction. Dr. Tepedino opined that the decedent's antiplatelet therapy needed to be stopped prior to the renal biopsy because bleeding is the major complication of a renal biopsy, and stopping the medication ensures normal coagulation. Dr. Goyal deferred to the expertise of the cardiologist, thus, he did not deviate from the standard of care. Dr. Tepedino stated that the cardiologists did not consider the decedent a high risk for ceasing the antiplatelet drug regimen, and had the cardiologist thought that the decedent was high risk, Dr. Goyal would have done an open renal biopsy instead. Dr. Tepedino opined that while there is risk to withholding anti-coagulation agents, the risk of doing so temporarily, three years after the decedent had stent placement, is relatively small and needs to be weighed against the risk of not withholding the agents. In this case, not withholding the anti-coagulants and performing open renal biopsy carried more risks and morbidity than performing a percutaneous biopsy. Not performing the biopsy was not a trivial matter and would have required dialysis or kidney transplant without intervention.

Dr. Tepedino stated that Dr. Goyal properly managed the medications which he prescribed and it was not his obligation to monitor the cardiac medications the decedent was taking. Dr. Goyal properly monitored the medications that affected the decedents creatinine level. When Dr. Goyal felt the elevated creatinine level was due to his medication, Dr. Goyal changed the medication. He continued that Dr. Goyal appropriately contacted Dr. Torelli, who referred the decedent to him, to determine the decedent's baseline creatinine level to determine how long it had taken for the creatinine level to increase to the present level. Dr. Tepedino also opined that Dr. Goyal appropriately contacted Dr. Patel's office and spoke with Dr. D'Agate about the antiplatelet therapy, and coordinated care. If the cardiologists did not clear the decedent for the biopsy and withhold the medications, the procedure would have been cancelled. Dr. Goyal, stated Dr. Tepedino, created records that appear thorough, that he recorded exams, assessments, and orders.

Dr. Tepedino opined that Dr. Goyal obtained the decedent's health history, and recognized the risk of performing the biopsy in the presence of the antiplatelet agents. He continued that despite the cancellation of the surgery, the decedent was off the antiplatelet agents within the window of time for the planned withholding, which would have ended approximately on June 8, 2008. Despite the cancellation of the procedure, the decedent was still cleared to be off the medication by his cardiologist for at least another three days. Whether or not the biopsy occurred on June 6, 2008, the decedent's risk for a cardiac event would have been the same on the day he died. Thus, the decedent's death fell within the window of time he had been cleared to be off the antiplatelet agents. The decedent did not apprise Dr. Goyal or any other health care provider that his biopsy would not be going forward. There was no inaction by Dr. Goyal that exacerbated the decedent's condition. That the biopsy was cancelled is a fact of independent significance that had no effect on the decedent having a heart attack. Dr. Tepedino concluded that there was no

departure from the community medical standards by Dr. Goyal and no evidence Dr. Goyal abandoned the decedent's treatment, or that there was medical malpractice.

Based upon the foregoing, it is determined that Dr. Goyal and Suffolk Nephrology Associates, P.C. have established prima facie entitlement to summary judgment dismissing the complaint as asserted against them.

In opposition, the plaintiff's expert stated that it is common practice to hold Aspirin for up to 14 days prior to any specific invasive procedure as it takes approximately 14 days for the body to produce new platelets to replace those that had been permanently blocked by the last given dose of Aspirin. Likewise, for patients who have drug eluding stents in their coronary arteries, like the decedent, holding the Aspirin for this long is considered medically safe and to be of low risk. On the other hand, he continued, it is not acceptable medical practice to hold Plavix in patients with drug eluding stents in their coronary arteries for this period of time. Plavix, he stated, is the more important of the two antiplatelet agents in protecting patients against forming a clot within the drug eluding stents. Consequently, the standard of care requires that Plavix either not be held at all or to hold the Plavix for a maximum of two to three days prior to the performance of any invasive procedure.

The plaintiff's expert opined that Dr. Goyal instructed the decedent to stop taking Plavix, however, when the procedure was cancelled, Dr. Goyal did not contact the decedent to advise him to immediately restart Aspirin and Plavix. He stated that the failure of Dr. Goyal to direct the decedent to immediately resume the Aspirin and Plavix was a departure from the standard of care. He continued that it was unacceptable for the decedent to remain off the Aspirin and Plavix while awaiting a new date for his biopsy to be assigned. The plaintiff's expert stated that Dr. Goyal's addendum indicated that both Aspirin and Plavix be resumed two to three days after the kidney biopsy, but that this is not consistent with good and accepted standards of medical practice as Aspirin and Plavix shall be resumed as quickly as possible after a kidney biopsy. This, stated plaintiff's expert, is consistent with Dr. D'Agate's confirmation letter which clearly stated that antiplatelet therapy should be promptly initialized (immediately after the procedure if there is no bleeding noted). The plaintiff's expert stated that the failure to reinitiate and continue the Aspirin and Plavix as quickly as possible is a departure from the standard of care.

The plaintiff's expert also stated that Dr. Goyal's expert, Dr. Tepedino, assumed that Dr. D'Agate told Dr. Goyal that the antiplatelet therapy could be withheld for ten to twelve days and it could be resumed two to three days after the procedure, and that the decedent was not a high risk patient, however, Dr. D'Agate denied he made that recommendation and stated that he would never say that Aspirin and Plavix can be held ten to twelve days. The plaintiff's expert added that Dr. D'Agate's letter to Dr. Goyal supports this, as well as Dr. Patel, who disagreed with the addendum and stated that antiplatelet therapy should be re-initialized immediately.

Based upon the foregoing, the plaintiff's expert has raised factual issues which preclude summary judgment from being granted to Sudhir Goyal, M.D. and Suffolk Nephrology Associates, P.C.

Accordingly, motion (003), by Sudhir Goyal, M.D. and Suffolk Nephrology Associates, P.C. is denied.

MOTION (004)

Rakesh B. Patel, M.D. and Suffolk Heart Group, LLP have submitted the affirmation of Jacob Shani, M.D. in support of their application. Dr. Shani affirmed that he is a physician licensed to practice medicine in New York State and is board certified in cardiovascular disease, interventional radiology, and internal medicine. He set forth the materials and records which he reviewed. Dr. Shani opined within a reasonable degree of medical certainty that the care and treatment rendered to the decedent by Dr. Rakesh Patel and the Suffolk Heart Group was within the standard of care and did not proximately cause any of the injuries as alleged in the bill of particulars.

Dr. Shani set forth that the decedent was born in 1954, was a patient of the South Shore Family Practice Associates from April 22, 2002, and was treated for high blood pressure and high cholesterol. On July 6, 2006, the decedent presented with a history of a myocardial infarction in 2003 and cardiac stenting in 2003 and 2006. The decedent was first treated by Dr. Rakesh Patel at Southside Hospital on October 21, 2003, for an anterior wall myocardial infarction for which Dr. Patel performed angioplasty and placement of multiple stents in the left anterior descending artery. He set forth the decedent's medications and that Dr. Patel, in a letter to Dr. Torelli, dated May 23, 2005, advised that the decedent was complaining of recurrent chest burning and pinching pains in the left side of his chest since the day before, and that a repeat cardiac angiogram was planned at North Shore University Hospital on May 26, 2005. This angiogram was done as planned, at which time stenosis of the right coronary artery was noted. The impression was three vessel coronary artery disease (LAD, LCX, and RCA), a mildly decreased left ventricular ejection fraction of 50%, and elevated left ventricular end diastolic pressure. Three stents were placed into the osteal, mid, and proximal right coronary artery.

Dr. Shani continued that the decedent presented to Dr. Torelli on February 28, 2008 with right-sided groin pain after lifting, and was diagnosed with a right inguinal hernia, hypertension, elevated cholesterol, coronary artery disease, and smoking 1 ½ packs of cigarettes a day. A referral was made to Dr. Wodicka for surgical evaluation. On March 7, 2008, however, the decedent was found by Dr. Torelli to have hematuria, elevated BUN and creatinine, hypertension, and anemia. An echodensity was noted in the gallbladder on March 13, 2008 upon radiological examination. Sonograms were ordered as well a HIDA scan with CCK, and another referral was made to Dr. Wodicka. On March 25, 2008, Dr. Patel advised Dr. Torelli by letter that the decedent presented to obtain cardiac clearance for the bilateral inguinal hernia surgery, and that the decedent was doing very well, performing all activities of daily living, he quit smoking, he was compliant with his medical regimen, and was three years out since his last coronary stenting procedure. Dr. Patel noted no cardiac contraindication to the hernia surgery, and wrote that if Plavix needs to be held for a few days prior to surgery, this will be safe, however, it should be resumed post surgery. Although Dr. Patel did not mention that the decedent was also on Aspirin, he testified that it could be continued for the procedure. Dr. Patel also testified that if the surgeon wishes, Plavix could be stopped for five days prior to the procedure and should be resumed based upon the discretion of the surgeon, whenever the surgeon feels it would be safe.

Dr. Shani continued that the hernia surgery was delayed by Dr. Torelli upon receipt of blood testing of April 4, 2008, which showed possible kidney problems, acute renal failure, and elevated creatinine and BUN, for which Dr. Torelli referred the decedent to Dr. Goyal for nephrology consultation. The decedent was seen by Dr. Goyal on April 9, 2008, whose impression was questionable acute renal failure, possibly

secondary to medications, including Altace, hydrochlorothiazide, and Crestor, which medications Dr. Goyal stopped and replaced with different medications. He also ordered various laboratory studies. When Dr. Goyal saw the decedent on April 25, 2008, he had gained 18 pounds, had swollen feet, and was diagnosed with acute renal failure, nephrotic syndrome, systemic lupus erythematosus (SLE), and edema. Dr. Shani discussed the visits of May 5 and May 29, 2008, and Dr. Goyal's need to obtain a renal biopsy which was scheduled for June 6, 2008. Dr. Goyal contacted Dr. Patel's office for medication consultation regarding the antiplatelet agents the decedent was taking, and spoke to cardiologist Dr. D'Agate, who referenced the decedent's cardiac records indicating that the decedent could be off the antiplatelet agents for ten to twelve days with restart two to three days after the biopsy. Dr. D'Agate informed Dr. Goyal that the decedent was stable from a cardiology standpoint with no new symptoms, and dictated a letter to Dr. Torelli with a copy to Dr. Goyal. Dr. D'Agate testified that his reference to the antiplatelet therapy referred only to the Plavix. The biopsy was not done.

Dr. Shani opined that since platelets have a tendency to aggregate at stented segments of coronary arteries, the standard of care in 2008, and currently, is to prescribe antiplatelets, Plavix and Aspirin, for one year following coronary stenting to help prevent stent thrombosis. The decedent had been taking Plavix and Aspirin for three years following his last stenting procedure on March 26, 2005. The standard of care did not require continuation of the antiplatelet medication. Dr. Shani opined that since the decedent did not require the use of antiplatelets in 2008, it was not a departure to withhold antiplatelets prior to a scheduled surgery for any length of time. He continued that, additionally, even if the standard of care required continued treatment with antiplatelets for decedent in 2008, it would still be within the discretion of a physician to discontinue antiplatelet medications prior to renal biopsy since a renal biopsy involves a significant bleeding risk. Plavix and Aspirin retain 70 % of their effects three days after discontinuance. Accordingly, he stated, even if the standard of care had required continued antiplatelet therapy, it would have still been appropriate for Dr. Patel to have permitted the holding of Plavix for a few days. Thus, opined Dr. Shani, the care and treatment rendered by Dr. Patel to the decedent in 2008 was within the standard of care that existed at that time and did not proximately cause any of the decedent's injuries. Dr. Shani added that because Dr. Patel did not order the decedent to discontinue the antiplatelet therapy, it was not his role to then instruct the plaintiff to resume the antiplatelet medication after the scheduled renal biopsy. With reference to the advice given by Dr. D'Agate to Dr. Goyal, Dr. Shani opined that the same standard of care applied to Dr. D'Agate as to Dr. Patel, and that the same reasons that Dr. Patel comported with the standard of care for antiplatelet therapy applied to Dr. D'Agate as well. In that Dr. D'Agate did not instruct the decedent to stop the antiplatelet medication, he too had no responsibility to direct the decedent to resume it.

Moreover, opined Dr. Shani, the autopsy showed no embolus, and is inconsistent with a cardiac arrest caused by a heart attack (occluded coronary arteries). Here, the plaintiff testified that at 4:45 p.m., approximately 11 minutes after decedent went upstairs, she found the decedent dead and unresponsive. Dr. Shani opined that both the autopsy and clinical picture are consistent with sudden death caused by the heart's electrical system, i.e.: ventricular fibrillation or atrioventricular block, and not an occluded artery. Dr. Shani opined that the discontinuance of antiplatelets was unrelated to the cardiac arrest.

Based upon the foregoing, it is determined that Dr. Patel and the Suffolk Heart Group have demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against them.

The plaintiff's expert set forth that Dr. Shani, the expert for defendants Rakesh B. Patel, M.D. and Suffolk Heart Group, LLP, stated his opinion regarding the standard of care in 2008 for antiplatelet therapy following coronary stenting and its role in helping to prevent the complication of thrombosis within the stent. He stated that Dr. Shani alluded to the guidelines which state that Plavix and Aspirin need only be continued for one year, that there was no contraindication for holding the decedent's Plavix for any period of time, and that the defendants did not deviate from the standard of care. The plaintiff's expert stated that it is clear that Dr. Patel, the decedent's regular cardiologist, had made the medical decision to indefinitely continue treatment with Plavix and Aspirin for more than the one year period of time raised by Dr. Shani. The plaintiff's expert continued that the guidelines are just that, meant to guide medical therapy, but are not rules. The guidelines are general principles which must be applied to individual cases, based on that patient's individual outcome and residual anatomy after angioplasty and stent placement. The one-size approach suggested by Dr. Shani does not apply as it is clear from both Dr. Patel and Dr. D'Agate that they would have wanted the decedent placed back on Plavix as soon as possible after the renal biopsy. It is clear from their testimony, stated plaintiff's expert, that Dr. Patel and Dr. D'Agate recognized the decedent was at an unreasonably increased risk of harm should he remain off Plavix for too long a period of time, that they wanted him placed back on Plavix as soon as possible, and starkly contradicts Dr. Shani's opinion that the decedent no longer needed to be taking Plavix according to the 2008 guidelines.

The plaintiff's expert further disagrees with Dr. Shani's opinion that the autopsy, which showed no acute clot inside of the decedent's coronary arteries is inconsistent with the decedent's death being caused by withdrawal of Plavix. He stated that approximately 50 % of those who have heart attacks caused by the acute formation of a clot will not show a clot on autopsy, as the clot dissipates or dissolves prior to the autopsy, and the decedent falls into this group as a consequence of being off Plavix. It is plaintiff's expert's opinion that the decedent died because he was not taking Plavix for several days, including at the very time of his death, because he was vulnerable to the very thing from which Plavix had been protecting him, the formation of an acute thrombus within one of his coronary arteries, at the site of one of his drug eluding stents. The plaintiff's expert continued that it is certainly not a coincidence that the decedent died during the period of time that he was not taking Plavix, and that the decedent's cardiologist expressed concern about the decedent being off Plavix beyond that time which was absolutely necessary. He also stated that upon viewing the anatomic findings on autopsy, in combination with the clinical circumstances leading up to the decedent's death, it is clear that the decedent died from an arrhythmia caused by an acute clot formation at the site of one of his imbedded drug eluding stents.

The plaintiff's expert continued that if the addendum written by defendant Goyal is accurate and Dr. D'Agate told defendant Goyal that he could withhold the antiplatelet therapy for ten to twelve days prior to the procedure, and two to three days after the procedure, that advice would have been a departure from good and accepted practice. He also stated that Dr. Patel's direction of holding the Plavix for a few days is vague at best and does not give sufficient direction to whomever was scheduled to do the procedure.

Accordingly, motion (004) by the defendants, Rakesh B. Patel, M.D. and Suffolk Heart Group, LLP, for summary judgment dismissing the complaint as asserted against them is denied.

Dated: JUL 23 2014

J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION

HON. JEFFREY ARLEN SPINNER