Melissinos v Moses
2018 NY Slip Op 30748(U)
April 24, 2018
Supreme Court, New York County
Docket Number: 805053/14
Judge: Martin Shulman

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

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ELAINE MELISSINOS and GREGORY MELISSINOS,
Plaintiffs,

Index No. 805053/14

-against-

JEFFREY MOSES, MD, MICHAEL ARGENZIANO, MD, TAKEYOSHI OTA, MD, THE NEW YORK AND PRESBYTERIAN HOSPITAL, INC.,
Defendants.

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Martin Shulman, J.:

In this medical malpractice action, defendants Jeffrey Moses, M.D. (Dr. Moses), Michael Argenziano, M.D. (Dr. Argenziano) and The New York and Presbyterian Hospital (NYPH) (collectively, defendants) move pursuant to CPLR 3212 for summary judgment dismissing this action against them[1] and related relief.[2] Plaintiffs Elaine Melissinos (Mrs. Melissinos or plaintiff) and Gregory Melissinos (Mr. Melissinos) oppose the motion.

Background

In 2011, Mrs. Melissinos, then 62 years of age, presented to Dr. Moses, an interventional cardiologist, at the recommendation of Dr. Bello, her treating cardiologist in Florida. The voluminous medical records indicate an extensive

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[1] The motion papers do not indicate the status of this action as to co-defendant Takeyoshi Ota, M.D. (Dr. Ota). No affidavits of service were filed for any of the defendants nor has Dr. Ota filed an answer. It is thus unclear whether Dr. Ota was ever served with the summons and complaint or whether he is in default in appearing.

[2] In the event this court grants summary judgment, the notice of motion also requests an order amending the caption to delete defendants, severing the claims against them and entering judgment in their favor with prejudice. Alternatively, defendants ask the court to dismiss any theory of liability as to which the court finds that plaintiffs failed to raise an issue of fact.

medical history of multiple cardiac procedures and hospitalizations dating as far back as 1999 due to her coronary artery disease. Since 2006, plaintiff had complained of recurring chest pain and shortness of breath, the cause of which eluded her various healthcare providers over the years. Prior cardiac procedures failed to alleviate these symptoms.

After speaking to Mrs. Melissinos and reviewing her medical records, including an August 29, 2011 angiogram, Dr. Moses performed a cardiac catheterization at NYPH on October 12, 2011. He determined that plaintiff's circumflex artery and the mid-section of her left anterior descending artery (LAD) were significantly blocked. He placed stents in the circumflex artery and LAD, however he soon discovered that the LAD's vessel wall had perforated. As his attempts to stop the resulting bleeding were unavailing, Dr. Moses called for surgical backup.

Dr. Argenziano responded and, assisted by Dr. Ota, performed a coronary artery bypass graft (CABG) utilizing Mrs. Melissinos' left internal mammary artery (LIMA) to bypass the perforated region, thereby creating a LIMA-LAD graft. Prior to plaintiff's discharge on October 18, 2011, blood flow through the graft was unobstructed.

On October 27, 2011 Mrs. Melissinos presented to Dr. Argenziano after two incidents of chest pressure. She was admitted to NYPH and an angiogram revealed that the LIMA-LAD graft was obstructed. An October 31, 2011 cardiac catheterization and balloon angioplasty restored blood flow through the graft and plaintiff was discharged on November 1, 2011.

Unfortunately, upon returning to Florida plaintiff continued to experience chest pain and shortness of breath. As of November 30, 2011, Dr. Bello diagnosed moderate coronary artery disease, SVT,[3] sarcoidosis, hypertension, carcinoid syndrome, anxiety/depression and bronchial asthma. Since Mrs. Melissinos' treatment with defendants, her symptoms have persisted and she has undergone multiple cardiac tests and procedures.[4]

Plaintiffs commenced this action on February 7, 2014. The complaint asserts causes of action for medical malpractice and a derivative claim on Mr. Melissinos' behalf. The bill of particulars, which does not differentiate each defendant's specific acts of alleged negligence, identifies *inter alia* the following alleged departures from accepted standards of care: failure to properly and adequately assess plaintiff's condition; failure to properly and adequately take, record and be aware of her medical history; failure to heed and respond to her complaints; failure to perform a stress test and an echocardiogram; failure to measure the degree of plaintiff's stenosis (FFR)[5]; performing an unindicated intervention on the LAD; attempting to place a stent where criteria for significance were not met; failure to be aware of and/or abate the myocardial bridge of tissue covering the LAD; failure to be aware of plaintiff's anatomy; failure to be aware of

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[3] Supraventricular tachycardia.

[4] The supporting medical records detail Mrs. Melissinos' treatment through 2015.

[5] Dr. Moses performed a fractional flow reserve test (FFR) during the catheterization procedure which revealed a hemodynamically significant stenosis causing reduced blood flow to the distal LAD.

and account for the compression within the intramyocardial portion of the LAD; causing a perforation to plaintiff's LAD; and failure to properly perform a bypass graft.

DEFENDANTS' EXPERTS

In support of their motion for summary judgment dismissing the complaint, defendants submit expert affirmations from Michael J. Attubato, M.D. (Dr. Attubato) and Alfred T. Culliford, M.D. (Dr. Culliford). Dr. Attubato is board certified in internal medicine, cardiovascular diseases and interventional cardiology and has over 30 years of training and experience (Motion at Exh. A). Dr. Attubato offers the following opinions within a reasonable degree of medical certainty as to the treatment Dr. Moses rendered to plaintiff:

- certain of plaintiff's injuries alleged in the bill of particulars predate defendants' treatment (to wit, paroxysmal supraventricular tachycardia [PSVT], chest pain and shortness of breath);
- the standard of care did not require Dr. Moses to have plaintiff undergo a stress test and echocardiogram prior to performing the catheterization as the August 29, 2011 angiogram demonstrated a branch of the circumflex was severely narrowed by a previously placed stent, thus no further information was needed prior to determining that catheterization was indicated, and in fact a stress test would be contraindicated since plaintiff's symptoms were increasing in severity;
- catheterization was within the standard of care given plaintiff's unstable angina (chest pain);
- it was within the standard of care for Dr. Moses to insert stents to relieve blockages in plaintiff's circumflex and LAD based upon his having measured her blood flow and found severely abnormal flow;
- perforation of a vessel is a known risk of catheterization;
- with respect to the allegation in the bill of particulars that Dr. Moses failed to detect a myocardial bridge of tissue covering the LAD, same could not

be detected in the angiogram, and in any event it is generally a benign condition which would not increase the risk of perforation;

- the standard of care only required Dr. Moses to review the angiogram in order to determine the size of stent to insert, and any resulting complications are known risks;

- Dr. Moses promptly recognized and responded when the perforation occurred by attempting to stop the bleeding and, when it did not stop, he appropriately called for backup;

- approximately two months after defendants treated plaintiff an echocardiogram revealed normal left ventricular function, thus indicating (1) that plaintiff's chest pain was not cardiac related or was multifactorial and (2) that the procedures defendants performed preserved the viability and functionality of the myocardium;

- as of May 21, 2014 plaintiff continued to have good left ventricular function, thus confirming that her complaints were not causally related to defendants' treatment; and

- subsequently reduced blood flow in plaintiff's distal LAD was not due to the procedures defendants performed but rather due to the progressive nature of her cardiac disease, which cannot be prevented by any procedure other than a heart transplant.

Dr. Culliford states that he is board certified in surgery and thoracic surgery and has over 40 years of training and experience. He offers the following opinions within a reasonable degree of medical certainty as to the treatment Dr. Argenziano rendered to plaintiff:

- Dr. Argenziano not only acted in accordance with the standard of care, but saved plaintiff's life;

- any subsequent symptomology such as chest pain or shortness of breath, which were ongoing complaints years prior to the October 12, 2011 catheterization and CABG, and any subsequent cardiovascular issues were unrelated to the CABG and instead caused by plaintiff's progressive cardiovascular disease and other comorbidities;

- CABG was the only option available to Dr. Argenziano as repair of plaintiff's LAD was not an option in the setting of a life threatening hemorrhage;

- the fact that plaintiff's distal target LAD was small and intramyocardial would not affect Dr. Argenziano's approach or technique in plaintiff's situation, the goal being to stop bleeding and restore blood flow to the distal LAD, which goals were successfully achieved;

- graft blockage is not uncommon and is a known complication of CABG;

- there is no causal relationship between the CABG procedure and plaintiff's continued complaints and in fact, the LIMA-LAD bypass graft was patent as of June 4, 2012 (meaning blood flowed unobstructed through it);

- there is further no causal relationship between the CABG procedure and plaintiff's continued complaints in light of her other comorbidities and subsequent stent deployment in the first diagonal artery on January 29, 2015; and

- a May 21, 2014 cardiac catheterization revealed narrowing of the bypass graft but left ventricular function continued to be preserved and thus the narrowing was clinically insignificant.

PLAINTIFFS' EXPERT

In opposition to defendants' motion plaintiffs submit an affidavit from Erik Altman, M.D. (Dr. Altman), a cardiologist who is board certified in cardiovascular disease and clinical cardiac electrophysiology (Bacotti Aff. in Opp., Exh. A). Dr. Altman avers within a reasonable degree of medical certainty that:

- the care defendants rendered to Mrs. Melissinos "**can be considered** inconsistent with, and contrary to, accepted medical practice" (emphasis added);

- Dr. Moses "**can be considered** to have departed from accepted standards of care . . . "[i]n his approach to Ms. Melissinos' care" and "[i]n his employment of a stent based approach" (emphasis added);

- Dr. Moses "departed by employing a stent based approach . . . when a bypass-graft approach **can be warranted**" and "would have been within the standard of care" (emphasis added);

- perforation after stenting is mainly caused by excessive overdilatation or an oversized stent implantation;

- defendants failed to account for plaintiff's anatomical complexities;

- plaintiff had already undergone stent insertion procedures which did not alleviate her symptoms, thus Dr. Moses departed from accepted standards of care since "**a better first approach** . . . would have been CABG" (emphasis added);

- bypass grafting is preferable to stenting particularly in patients, like plaintiff, with narrow arteries,[6] and "**was potentially preferable** to the balloons and stents" Dr. Moses employed (emphasis added);

- Dr. Argenziano erred by not locating the graft correctly, attaching it to an area surrounded by squeezing heart tissue, thus leading to blockage and requiring re-intervention approximately two weeks after the CABG;

- defendants failed to recognize plaintiff's atypical anatomy, particularly the presence of a myocardial bridge of tissue covering the LAD, meaning that the blood vessel "dives under the heart tissue" and is "constrained by the surrounding tissue and the commensurate pressure exerted upon the vessel"; here, "[t]he perforation occurred in a region of the blood vessel that was under heart tissue" and "the LIMA (bypass graft vessel) was attached to the area of the LAD after the perforation that was also intramyocardial"; and

- a cardiac catheterization performed on June 4, 2012 revealed the stent in the artery Dr. Moses perforated had a 100% occlusion, thus defendants rendered plaintiff in worse condition than when she presented.

SUMMARY JUDGMENT

An award of summary judgment is appropriate when no issues of fact exist. *See* CPLR 3212(b); *Sun Yau Ko v Lincoln Sav. Bank*, 99 AD2d 943 (1st Dept), *aff'd* 62 NY2d 938 (1984); *Andrea v Pomeroy*, 35 NY2d 361 (1974). In order to prevail on a motion for summary judgment, the proponent must make a

[6] The records describe plaintiff's distal LAD as being "almost threadlike in size".

prima facie showing of entitlement to judgment as a matter of law by providing sufficient evidence to eliminate any material issues of fact. *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). Indeed, the moving party has the burden to present evidentiary facts to establish his cause sufficiently to entitle him to judgment as a matter of law. *Friends of Animals, Inc. v Associated Fur Mfrs., Inc.*, 46 NY2d 1065 (1979).

In deciding the motion, the court views the evidence in the light most favorable to the nonmoving party and gives him the benefit of all reasonable inferences that can be drawn from the evidence. *See Negri v Stop & Shop, Inc.*, 65 NY2d 625, 626 (1985). Moreover, the court should not pass on issues of credibility. *Assaf v Ropog Cab Corp.*, 153 AD2d 520, 521 (1st Dept 1989). While the moving party has the initial burden of proving entitlement to summary judgment (*Winegrad*, *supra*), once such proof has been offered, in order to defend the summary judgment motion, the opposing party 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, 562 (1980); *Freedman v Chemical Constr. Corp.*, 43 NY2d 260 (1977); see also, *Friends of Animals, Inc.*, *supra*.

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury." *Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 (1st Dept 2009) (citation omitted). A defendant physician seeking summary judgment must make

a prima facie showing establishing the absence of a triable issue of fact as to the alleged departure from accepted standards of medical practice (*id*).

In opposition, "a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice'." *Id.*, citing *Alvarez v Prospect Hosp.*, 68 NY2d at 325. "In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude a grant of summary judgment in a defendant's favor (citation omitted)." *Id.* However, where an expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, the opinion should be given no probative force and is insufficient to withstand summary judgment. *Id.*, citing *Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 (2002).

"To establish the reliability of an expert's opinion, the party offering that opinion must demonstrate that the expert possesses the requisite skill, training, education, knowledge, or experience to render the opinion [citations omitted]" (*Hofmann v Toys "R" Us-NY Ltd. Partnership,* 272 AD2d 296, 296 [2d Dept 2000]). An expert "need not be a specialist in a particular field" in order to render an expert opinion "if he [or she] nevertheless possesses the requisite knowledge necessary to make a determination on the issues presented" (*see Joswick v Lenox Hill Hosp.,* 161 AD2d 352, 355 [1st Dept 1990]).

In this case, both parties' experts have cardiology backgrounds and based their opinions on their review of plaintiff's medical records, as well as the pleadings and deposition transcripts herein. However, defendants question plaintiffs' expert's qualifications as to his opinions regarding treatment Dr. Argenziano rendered to plaintiff because he is not a surgeon and does not perform cardiothoracic surgery. Defendants argue that Dr. Altman fails to demonstrate that he possesses the "requisite skill, training, education, knowledge, or experience" to opine regarding CABG.

Having reviewed Dr. Altman's affidavit, this court finds that he has sufficient professional experience to provide an expert opinion on the facts underlying this action. While he only generally states that he has "extensive experience in the surgical and medical management of Cardiology", he also avers that his "practice predominantly involves care, treatment and management of cardiac patients with ischemias, malignancies and abnormal conditions", such as those of Mrs. Melissinos. It is readily apparent that he has extensive knowledge of the heart and its functioning. Accordingly, this court finds that Dr. Altman is qualified to proffer his opinions. *See Frye v Montefiore Med. Ctr.,* 70 AD3d at 24-25; *Guzman v 4030 Bronx Blvd. Assoc. L.L.C.*, 54 AD3d 42, 49 (1st Dept 2008) ("whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court").

Dr. Moses

With respect to Dr. Moses, plaintiffs' opposition primarily focuses on the argument that a CABG "was a better first approach" than the catheterization Dr.

Moses opted to perform.[7] Dr. Altman's affidavit fails to establish that Dr. Moses departed from the standard of care described in Dr. Attubato's affirmation.

At the outset, it must be noted that several of Dr. Altman's opinions are equivocal, as the court has emphasized above in bold face type, and as such are insufficient to establish that Dr. Moses deviated from the standard of care in deciding to implant a stent in plaintiff's LAD. In any event, under the professional medical judgment doctrine, although a plaintiff's expert may have chosen a different course of treatment, this merely represents a difference of opinion which is insufficient to establish a prima facie case of medical malpractice. *Park v Kovachevich*, 116 AD3d 182, 190 (1st Dept 2014), *lv denied* 23 NY3d 956 (2014). Dr. Altman also does not address Dr. Attubato's claim that the procedure Dr. Moses performed is less invasive than open heart surgery through CABG, entails fewer risks and has a shorter recovery time.

Further, Dr. Altman does not dispute that perforation is a known complication of catheterization and stent placement and can occur without negligence. Ultimately, the CABG procedure Dr. Altman deems preferable was promptly performed on an emergent basis by Dr. Argenziano when Dr. Moses became aware of the perforation and was unable to stop the resulting bleeding. Put simply, Dr. Moses resolved the intraoperative complication that arose and there can be no damage to plaintiff if the intervention Dr. Altman recommends

[7] The court notes that this allegation is not specifically articulated in plaintiffs' bill of particulars, which merely states that a cardiac catheterization was not indicated and was "too risky" given plaintiff's small LAD. However, defendants have raised no objection to the foregoing in their reply.

was ultimately performed. Nor does plaintiffs' expert establish any causal connection between Mrs. Melissinos' alleged injuries and the procedure Dr. Moses performed.

For the foregoing reasons, the first cause of action alleging medical malpractice must be dismissed as to Dr. Moses and, upon dismissal, Mr. Melissinos' derivative claim (second cause of action) must also be dismissed. See *Holmes v City of New Rochelle*, 190 AD2d 713, 714 (2d Dept 1993), citing *Maddox v City of New York*, 108 AD2d 42 (2d Dept 1985), *affd* 66 NY2d 270 (1985).

Dr. Argenziano

Similarly, Dr. Altman fails to clearly state the applicable standard of care for CABG and how Dr. Argenziano allegedly deviated therefrom. Plaintiffs' expert maintains that Dr. Argenziano erred by not locating the graft correctly, attaching it to an area surrounded by squeezing heart tissue, thus leading to blockage and requiring re-intervention on October 31, 2011. Notably, Dr. Altman does not indicate where the graft could or should have been placed.

Dr. Altman does not dispute that graft blockage is a common and known complication of CABG. Although the graft became blocked within approximately two weeks of Dr. Argenziano performing the CABG it was unblocked via a balloon angioplasty, blood flow was restored and the graft remained patent for several years, thus indicating that the CABG was successful.

Dr. Altman similarly does not dispute that the graft's gradual narrowing, discovered during a May 21, 2014[8] catheterization, was due to the progressive nature of Mrs. Melissinos' coronary artery disease, and does not address Dr. Culliford's statement that restenosis is common due to atherosclerotic deposits rather than negligently performed CABG surgery. As held in *Park v Kovachevich*, *supra*, "a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective." These deficiencies in Dr. Altman's affidavit fail to establish that the CABG procedure Dr. Argenziano performed proximately caused Mrs. Melissinos' claimed injuries.

For the foregoing reasons, the first cause of action alleging medical malpractice must be dismissed as to Dr. Argenziano and, upon dismissal, Mr. Melissinos' derivative claim (second cause of action) must also be dismissed.

NYPH

As previously stated, the allegations in plaintiffs' bill of particulars are undifferentiated in that every claim asserted against NYPH is identical to those made against the individual defendants. Plaintiffs have failed to identify any individuals for whom NYPH is vicariously liable or to assert any independent acts of negligence against it. Indeed, plaintiffs' opposition does not even address NYPH. Accordingly, the complaint is dismissed as to NYPH.

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[8] At that time left ventricular function continued to be preserved notwithstanding the graft's narrowing.

Dr. Ota

This action is dismissed *sua sponte* as to Dr. Ota. This defendant was either never served, or if he is in default in failing to answer or otherwise appear, plaintiffs have failed to move for a default judgment within one year of the default. See CPLR §3215(a).

For all of the foregoing reasons it is hereby

ORDERED that defendants' motion for summary judgment dismissing the complaint is granted and the Clerk is directed to enter judgment in favor of defendants dismissing this action with prejudice, together with costs and disbursements as taxed by the Clerk upon the submission of an appropriate bill of costs; and it is further

ORDERED that the caption in the above action is hereby amended to reflect the dismissal of this action as to defendants Jeffrey Moses, M.D., Michael Argenziano, M.D. and The New York and Presbyterian Hospital; and it is further

ORDERED that all papers, pleadings and proceedings in the above entitled action be deemed amended accordingly, without prejudice to the proceedings heretofore had herein; and it is further

ORDERED that counsel for the said defendants is directed to serve a copy of this decision and order by e-mail upon the Clerk of the Court (cc-nyef@nycourts.gov), and upon the Trial Support Office (trialsupport-nyef@nycourts.gov), who are directed to amend their records to reflect such change in the caption herein; and it is further

ORDERED that the action is dismissed *sua sponte* as to defendant Takeyoshi Ota, M.D., and the Clerk is directed to enter judgment in favor of said defendant dismissing this action with prejudice as against him.

The foregoing constitutes this court's decision and order.

Dated: New York, New York
April 24, 2018

HON. MARTIN SHULMAN, J.S.C

SO ORDERED.

HON. MARTIN SHULMAN