Greene v Pessah
2020 NY Slip Op 34972(U)
April 29, 2020
Supreme Court, Nassau County
Docket Number: Index No. 600884/2016
Judge: Steven M. Jaeger
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU - IAS/TRIAL PART 36

Present: **HON. STEVEN M. JAEGER**

_______________________________________X

ELLEN GREENE, AS EXECUTRIX OF THE ESTATE OF STEWART GREENE, DECEASED AND ELLEN GREENE, INDIVIDUALLY,

Plaintiff,

-against-

MARIUS PESSAH, MD, NEW HYDE PARK INTERNAL MEDICINE SPECIALISTS, RICHARD MARINO, MD, NEW YORK CARDIOVASCULAR, RATTAN PATEL, MD, NASSAU CHEST PHYSICIANS, PC, STEPHEN FRIEDMAN, PA, STEPHEN MEZZAFONTE, MD, ST. FRANCIS CARDIOVASCULAR PHYSICIANS, AND ST. FRANCIS HOSPITAL,

Defendants.

_______________________________________X

Index No.: 600884/2016
Motion Seq. Nos.: 06,07,08
Motion Submit Date: 02/05/20
Decision & Order

Papers submitted:

Notice of Motion (mot. seq. 06)	x
Notice of Motion (mot. seq. 07)	x
Notice of Motion (mot. seq. 08)	x
Affirmation in opposition (mot. seq. 06, 07, 08)	x
Reply Affirmation (mot seq. 06)	x
Reply Affirmation (mot. seq. 07)	x
Reply Affirmation (mot. seq. 08)	x

Motions by Defendants Rattan Patel, M.D. and Nassau Chest Physicians, P.C. ("NCP") (Mot. seq. #6), Marcus Pessah, M.D. and North Shore-LIJ Internal Medicine at New Hyde Park, P.C., s/h/a New Hyde Park Internal Medicine Specialists ("NS-LIJ") (Mot. seq. #7), and Stephen Mezzafonte, M.D. (Mot. seq. #8), for summary judgment dismissing the complaint, are **denied**.

Overview

This medical malpractice action arises out of the medical treatment provided by the Defendants to the decedent, Stewart Greene. On February 9, 2014, in the late evening, Mr. Greene went to shovel snow outside his residence. He re-entered his house shortly thereafter, with complaints of pressure in his chest and loss of vision (Ellen Greene tr., p. 124). Mrs. Greene called 911 and an ambulance arrived within minutes (Greene tr., p. 127). According to the ambulance report (Exhibit O to Dr. Pessah's moving papers), the ambulance arrived at the Greene residence at 11:35 p.m. Mr. Greene was transported to St. Francis Hospital, arriving in the Emergency Department at 12:04 a.m. on February 10, 2014 (hospital record annexed as Ex. H to Patel motion, p. 3). Mr. Greene was treated in the Emergency Department and then transported to the Catheterization Lab.

According to his death certificate, (Ex. Q to Dr. Pessah's moving papers), Mr. Greene expired at 2:48 a.m. on February 10, 2014. The immediate cause of death is listed as "acute aortic dissection." Aortic dissection is a "deadly condition" that occurs when the "inner layer of the aortic wall" tears, "causing blood to leak into and along the outer layers of the aortic wall. The leaking blood causes the outer layers of the aortic wall to expand." More specifically, Mr. Greene died from a Type A aortic dissection involving the ascending aorta. (Plaintiff's cardiologist's affirmation, par 55).

Background

Mr. Greene first sought treatment from Defendant Dr. Pessah, an internist, in 1996, when he was 38 years old. He was diagnosed with high blood pressure and was put on antihypertensive medication. Mr. Greene's family history included that his father died of "cardiac disease at a young age" (Pessah tr., p 57). According to Mrs. Greene, her husband was very concerned about his health. He ate healthy foods and worked out every day on the elliptical machine and treadmill in their house (Greene tr., pp. 74, 81, 91, 101-102). Over the years, Mr. Greene returned to Dr. Pessah for annual physical examinations and other tests, in addition to sick visits.

Echocardiograms, described as cardiac sonograms, were performed on Mr. Greene in 2005, 2007, 2009, and 2010. These echocardiograms were performed in Dr. Pessah's office, but the films were interpreted by Dr. Rutkowsky, a cardiologist.

The Echocardiogram Report from 6/6/09 states the following impressions by Dr. Rutkowsky:

1. Normal chamber sizes and systolic function
2. Mild mitral and tricuspid valve regurgitation
3. No significant change when compared with echo of 11/3/07.

(Exhibit N). The aortic root was measured at 3.2 cm. The aortic root is the connection between the left ventricle and the aorta (Pessah tr., p. 71).

The Echocardiogram Report from 8/21/10 states the following impressions:

1. Normal chamber sizes and systolic function
2. Dilated aortic root
3. Calcified aortic valve with normal opening and mild to moderate aortic insufficiency
4. Mild mitral and tricuspid valve regurgitation
5. When compared with echo of 6/6/09, aortic insufficiency is now noted.

(Exhibit N). The aortic root was measured at 3.8 cm and described as "dilated."

Dr. Pessah testified that any measurement of the aortic root of "up to four sonometers[1] is considered normal," while "[f]our is the beginning of aortic dissection" and "4.5 is an indication to intervene radiologically (Id., pp. 80, 84). Dr. Pessah further testified, "we start with the echo first because it's the most non-evasive [sic], and we look at the numbers there." (Id., pp. 85-86). He also looked for aortic insufficiency or regurgitation (Id., pp. 87-88). He admitted that an echocardiogram has "probably a five to 10 percent variation statistically to the right or to the left. (Id., p. 91).

No further echocardiograms were performed at Dr. Pessah's office. Although Dr. Pessah asserted that Mr. Greene "refused to have an echo done" on 11/16/12 and 12/6/13 (Id., p. 96), Dr. Pessah questioned Mr. Greene in 2013 about his failure to have an echocardiogram since 2010, and Mr. Greene allegedly expressed that he had achieved his goals and was "at peace" in his life. (Id., pp. 98-99). Dr. Pessah later clarified his understanding that he simply advised Mr. Greene to have the echocardiogram done;

[1] Sonometers is another word for centimeters.

whether or not Mr. Greene was going to have it done, Dr. Pessah did not know. (Id., p 121). There are no Refusal of Treatment forms in the record, and Dr. Pessah admitted that Mr. Greene never verbally refused to schedule an echocardiogram (Id., p. 121).

Mrs. Greene testified that her husband followed Dr. Pessah's directions "to the letter" (Greene tr., pp. 90-91).

Treatment of the Decedent on February 9-10, 2014

Both the ambulance record (Exhibit O) and the hospital record (Exhibit P) recount that Mr. Greene reported chest pain or pressure while shoveling snow. Ambulance personnel gave Mr. Greene aspirin, and performed an EKG which revealed ST depressions. According to the ambulance record, Mr. Greene arrived at the hospital at 11:58 p.m. He was first seen by the triage nurse at 12:04 a.m., and then came under the care of Dr. Marino, the Emergency Department physician, at 12:11 a.m. Dr. Marino noted a history of hypertension and cholesterol, for which Mr. Greene was taking Benicar and Lipitor, respectively. Mr. Green's blood pressure on arrival was 92/54.

Dr. Marino ordered an immediate EKG, which revealed ST depressions. Mr. Greene's assessment of his pain was that it was a 3 or 4, on a scale of 1 to 10. At 12:12 a.m., Dr. Marino ordered lab work, including tests for cardiac enzymes, a chest x-ray, and another EKG. Dr. Marino testified that after the first EKG at the hospital, his concern was possible subendocardial injury or ischemia, meaning that the heart is not getting enough blood (Marino tr., p 43).

At 12:25 a.m., Dr. Marino called Dr. Mezzafonte, the on-call interventional cardiologist. The decision was made to give a trial on medication and if Mr. Greene did not do well, to call back. An angiogram, or catheterization, was scheduled to take place in the morning (hospital record, p. 21). The second EKG taken in the hospital was performed at 12:33 a.m., with the similar findings to the earlier EKG. At 12:39 a.m., Mr. Greene was started on heparin, an anti-coagulant. Dr. Marino testified that heparin is a standard treatment for a patient with cardiac ischemia and ST depressions.

Meanwhile, the bedside chest x-ray was performed at 12:28 a.m., and the x-ray image was available within 5 to 10 minutes. This x-ray was interpreted by Dr. Goodman, the radiologist, at approximated 9:30 a.m. that morning. Dr. Goodman advised Dr. Marino that the chest x-ray revealed fullness on the superior mediastinum and/or widening of the mediastinum (Marino tr., p. 110; see also p. 25).

A widened mediastinum is a classic sign of aortic dissection (Plaintiff's cardiologist's affirmation, par 74; see also Marino tr., pp. 50-52). Fullness in the mediastinum is another way of saying widening of the mediastinum (Marino tr., p 110), and can be a sign of an enlarged aorta or aortic aneurysm (Mezzafonte tr., p.38),

Mr. Greene's blood pressure continued to drop and he was having difficulty breathing. Dr. Marino called a Rapid Response Code over the hospital's public announcement system, and an emergency Code Team headed by Dr. Patel arrived at 12:42

a.m. Dr. Patel is a critical care specialist, but not a cardiologist. Dr. Patel's objective was to stabilize the patient (Patel tr., pp. 67, 101-102).

Dr. Patel stayed for approximately 15 to 20 minutes at Mr. Greene's bedside. Staff called out to his attention any abnormalities, such as EKG changes. Dr. Patel testified that he had no time to review Mr. Greene's chart (Id., pp. 35, 42, 47, 65). Dr. Patel does not recall anyone mentioning the chest x-ray or the labs (Patel tr., pp. 42, 66-67).

Dr. Patel examined Mr. Greene and found that he was having rales or fluid in the lungs. Dr. Patel monitored Mr. Greene's blood pressure and discussed treatment options (Patel tr., pp. 35, 39-40). Mr. Greene consented to an internal jugular placement of a central line to get his blood pressure up and Dr. Patel ordered administration of phenylephrine. Dr. Patel testified that Dr. Marino advised him of Mr. Greene's difficulty breathing and chest pain and his opinion of cardiac ischemia (Id., pp. 41-42). At 12:55 a.m., Dr. Patel spoke with Dr. Mezzafonte, and advised him to come in and see if Mr. Greene required an emergency cardiac catheterization (Id., pp. 46-47, 64).

Another emergency required Dr. Patel's immediate attention, so he left Mr. Greene and requested Dr. Marino to place the central line (hospital record, p. 23; Patel tr. p. 32).

Mr. Greene's blood pressure improved, and a central line was not inserted. However, his respiratory distress worsened. He could not lie flat. Dr. Marino sedated and intubated Mr. Greene. Dr. Mezzafonte testified that he arrived at the hospital at approximately 1:30 a.m., and Mr. Greene was already intubated (Mezzafonte tr., p. 28).

Dr. Mezzafonte spoke to Mrs. Greene about the emergency procedure. He recalled reviewing the ECG[2] (Mezzafonte tr., p. 34), but does not recall if he was aware of the chest x-ray (Mezzafonte tr., p. 35), although he would customarily review EKG and chest x-rays (Id., pp. 41-42).

According to Dr. Mezzafonte, it took a while to move Mr. Greene from the Emergency Department to the Catheterization ("Cath") Lab, because a respiratory therapist and a ventilator were required (Id., p. 48). Mr. Greene arrived in the Cath Lab at 2:06 a.m., and Dr. Mezzafonte began the procedure at 2:18 a.m. (see hospital record, p. 72). Dr. Mezzafonte's report provides, inter alia:

> Aortography revealed a Type A aortic dissection. Stat CT surgical consult called. The patent had a PEA arrest ("pulseless electrical activity") and was unable to be resuscitated. He expired in the cath lab.

(Hospital record, p. 25) (parenthetical added). Mr. Greene was unsuccessfully defibrillated three times and pronounced dead at 2:48 a.m.

The death certificate provides that the cause of death was acute aortic dissection.

Procedural History

Plaintiff is Mrs. Greene, as executrix of the estate of Stewart Greene, and also in her individual capacity. She commenced this action on February 10, 2016. She alleges claims

[2] ECG is an alternative way of referring to an electrocardiogram or EKG.

for medical malpractice, loss of consortium, and wrongful death pursuant to New York Estate Powers and Trusts Law §§ 5-4.1 and 5-4.3 (Exhibit D to Dr. Pessah's moving papers).

The moving Defendants, Dr. Pessah and NS-LIJ, Dr. Patel and NCP, and Dr. Mezzafonte, served their answers with affirmative defenses (Exhibits E and F to Dr. Pessah's moving papers).

Plaintiff served her verified bill of particulars and amended verified bill of particulars (Exhibit G to Dr. Pessah's moving papers).

At this time the moving Defendants seek summary judgment dismissing all claims against them. Plaintiff opposes the motions.

Summary Judgment Standard

Summary judgment is the procedural equivalent of a trial (S.J. Capelin Assoc. v Globe Mfg. Corp., 34 NY2d 338, 341 [1974]). The function of the court in deciding a motion for summary judgment is to determine if triable issues of fact exist (Matter of Suffolk County Dept. of Social Servs. v James M., 83 NY2d 178, 182 [1994]). The proponent must make a prima facie showing of entitlement to judgment as a matter of law (Giuffrida v Citibank Corp., 100 NY2d 72, 82 [2003]); Alvarez v Prospect Hosp., 68 NY2d 320, 324 [1986]). Once a prima facie case has been made, the party opposing the motion must come forward with proof in evidentiary form establishing the existence of triable

issues of fact or an acceptable excuse for its failure to do so (Zuckerman v City of New York, 49 NY2d 557, 562 [1980]).

The evidence must be viewed in the light most favorable to the non-moving party (Vega v Restani Constr. Corp., 18 NY3d 499, 503 [2012]; Branham v Loews Orpheum Cinemas, Inc., 8 NY3d 931, 932 [2007]; Forrest v Jewish Guild for the Blind, 3 NY3d 295, 315 [2004]). And, it is not the court's function on a motion for summary judgment to assess credibility (Vega, supra at 505; Ferrante v American Lung Assn., 90 NY2d 623, 631 [1997]).

Medical Malpractice Principles

To establish liability in a medical malpractice action, a plaintiff must prove that the defendant deviated from accepted standards of medical practice and that such deviation proximately caused the plaintiff's injuries (Daniele v Pain Mgt. Ctr. of Long Is., 168 AD3d 672 [2d Dept 2019]; Gaspard v Aronoff, 153 AD3d 795 [2d Dept 2017]). Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause in a medical malpractice action (Daniele, supra at 675; Gaspard, supra at 796).

"In a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the defendant's deviation was a substantial factor in causing the injury" (Neyman v Doshi Diagnostic Imaging Servs.,

P.C., 153 AD3d 538, 545 [2d Dept 2017]; Semel v Guzman, 84 AD3d 1054, 1055 [2d Dept 2011]; Goldberg v Horowitz, 73 AD3d 691, 694 [2d Dept 2010]; Speciale v Achari, 29 AD3d 674 [2d Dept 2006]; Johnson v Jamaica Hosp. Med. Ctr., 21 AD2d 881, 883 [2d Dept 2005]).

When a failure to treat is alleged, the plaintiff must show that "it was probable some diminution in the chance of survival had occurred" (Goldberg, supra at 694; Fellin v Sahgal, 35 AD3d 800, 802 [2d Dept 2006]; Borawski v Huang, 34 AD3d 409, 410 [2d Dept 2006]; Wong v Tang, 2 AD3d 840 [2d Dept 2003]), or that defendant's act or omission "decreased the plaintiff's chance of a better outcome" (Daniele, supra at 675; Gaspard, supra at 797; Goldberg, supra at 694). It is not necessary to eliminate every other possible cause of decedent's death (Speciale, supra; Wong, supra).

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical opinions (Wexelbuam v Jean, 80 AD3d 756 [2d Dept 2011]; McKenzie v Clarke, 77 AD3d 637 [2d Dept 2010]; Goldberg, supra at 693; Roca v Perel, 51 AD3d 757, 759 [2d Dept 2008]; Graham v Mitchell, 37 AD3d 408, 409 [2d Dept 2007]; Feinberg v Feit, 23 AD3d 517, 519 [2d Dept 2005]).

The Motion by Dr. Pessah and NS-LIJ

In order to meet the burden of proof, Dr. Pessah and NS-LIJ submit affirmations from three experts. All three base their opinions on their education, training, and experience as well as their review of the pleadings, deposition

testimony herein, Mr. Greene's medical record and radiology studies and reports, and the hospital record.

Dr. Winters, an internist who has been board certified since 1977, avers that he has treated thousands of adult patients as an internist in an outpatient office. He characterizes Plaintiff's claims against Dr. Pessah, inter alia, as a negligent failure to timely diagnose and treat Mr. Greene's heart condition, namely, the increasing diameter of his aortic root, the failure to refer Mr. Greene to a cardiologist, and the failure to conduct and properly interpret diagnostic studies such as x-rays and echocardiograms.

Dr. Winters reviewed Mr. Greene's appointments with Dr. Pessah, and Dr. Pessah's treatment. Dr. Winters opines that Dr. Pessah properly conducted annual physical examinations of Mr. Greene in July of 2010, November of 2012, and December of 2013. According to Dr. Winters, Dr. Pessah appropriately referred Mr. Greene for echocardiograms in 2009[3] and 2010, and further advised him to have echocardiograms in 2012 and 2013.

Dr. Winters opines that a normal aortic root measures 4.0 cm or less, and no additional steps are warranted until the aortic root measure 4.5 cm or more. He asserts that Mr. Greene never met the criteria for a referral because his aortic root

[3] Dr. Winters describes the 3.2 cm measurement in 2009 of Mr. Greene's aortic root as "likely an anomaly" (Winters affirmation, par 42).

measured less than 4.0 cm. Ultimately, Dr. Winters concludes that Mr. Greene's aortic dissection was not preventable, and that it was not caused by any of Dr. Pessah's acts or omissions.

Dr. Sahar is Dr. Pessah's expert cardiologist. He avers that he has treated thousands of patients with cardiac conditions, including patients with a dilated aortic root, and aortic dissections. He is familiar with when a patient should be referred to a cardiologist, and the indications for echocardiograms. Dr. Sahar describes Plaintiff's claims against Dr. Pessah, inter alia, as the purported failure to have Mr. Greene timely evaluated by a cardiologist and the failure to timely conduct and properly interpret serial diagnostic studies such as echocardiograms.

Dr. Sahar states that Mr. Greene did not exhibit any signs or symptoms of aortic dissection prior to February 9, 2014. Not only was Mr. Greene asymptomatic in 2010, 2011, 2012, and 2013, he exercised regularly without complaints.

Dr. Sahar opines that no surveillance or imaging is required for an aortic root that measures 4 cm or less. He asserts that Mr. Greene's aortic root size was at all times normal and never enlarged on his echocardiograms, and that there is no range of error reported on these studies. He concludes that Dr. Pessah's acts were at all times appropriate and nothing Dr. Pessah did or did not do caused the dissection or could have prevented the outcome.

Dr. Mennitt is Dr. Pessah's expert radiologist. He opines that the chest x-rays of Mr. Greene obtained and interpreted by Dr. Pessah in 2010, 2011, and 2012 were correctly interpreted as normal, and none of them revealed mediastinal widening or enlargement of the aorta. Dr. Mennitt asserts:

> Finally, an ascending aortic dissection is often a fatal surgical emergency defined by a tear in the wall of the major artery carrying blood out of the heart (aorta). Based on my review of the available videography of the angiogram, I can visualize the dissection but there is no evidence of a contributing aneurysm or any evidence of a blown heart valve or leak that could have been picked [sic] or diagnosed earlier.

(Mennitt affirmation, par 24). He concludes that Dr. Pessah provided proper medical care to Mr. Greene, and none of his acts or omissions was a substantial factor in Mr. Greene's death.

On this record Defendants Dr. Pessah and NCP have made out a prima facie case for summary judgment dismissing the Plaintiff's claims against them. The burden then shifts to Plaintiff to raise a triable issue of fact.

In opposition Plaintiff submits redacted affirmations from a board-certified cardiologist and a board-certified internist, as well as deposition transcripts of Mrs. Greene, Dr. Marino, Dr. Mezzafonte, and Dr. Patel.

Plaintiff's cardiologist avers that he/she has evaluated patients in both the Emergency Department and private office settings, who present with signs of aortic dissection, and related cardiac issues. The cardiologist asserts that

> an aortic aneurysm, also referred to as an enlarged aorta, is an abnormal enlargement of the aorta… most patients with an aortic aneurysm … are asymptomatic. Because of this, the diagnosis is usually discovered through a diagnostic study.

(Cardiologist affirmation, par 75).

The cardiologist opines that Dr. Pessah deviated from the appropriate standard of care by, inter alia, failing to diagnose an aortic aneurysm after the 2010 echocardiogram, failing to refer Mr. Greene to a cardiologist from August 2010 to February 2014, and failing to have performed an echocardiogram in 2011, 2012, and 2013 (Id., par 76).

Plaintiff's cardiologist opines that the 2010 echocardiogram evidenced the presence of a dilated aorta (or aortic aneurysm) and aortic regurgitation. When compared to the 2009 echocardiogram, the 2010 study shows a growth rate of 0.6 cm, for which "referral to a cardiologist was mandated" (Id., par 80). The cardiologist cites The Guidelines for the Diagnosis and Management of Patients ("Guidelines") (Exhibit I to Bloom Reply Affirmation) by the American College of Cardiology Foundation and the American Heart Association, which provide:

> Patients with a growth rate of more than 0.5 cm/y in an aorta that is less than 5.5 cm in diameter should be considered for operation.

Guidelines, p. 47). [Defendant objects that this provision of the Guidelines is for patients who have aortic aneurysms and that the Guidelines state that the normal male thoracic aortic diameter is 3.63 to 3.91 cm (Guidelines at p. 17)].

Plaintiff's cardiologist opines that the 2010 echocardiogram showed an aortic aneurysm, and argues that in any event, the numbers alone do not tell the whole story. It is the growth rate of the dilated aortic root in a patient with chronic hypertension, together with evidence of aortic regurgitation and aortic valve calcification that "mandated the diagnosis of aortic aneurysm," . . . and "mandated echocardiograms be performed in 2010, 2011, 2012, and 2013" (Cardiologist affirmation, par 81).

Plaintiff's cardiologist goes on to question whether Dr. Pessah actually recommended echocardiograms to Mr. Greene in 2012 and 2013. This is not an accusation of intentional misconduct or falsification of records. It is merely questioning whether Dr. Pessah communicated to Mr. Greene what he wrote in his notes, given the absence of a refusal of treatment form for a patient who cooperated with all other recommendations except a colonoscopy, that echocardiograms could have been performed right in Dr. Pessah's office, Mrs. Greene's testimony that her husband followed Dr. Pessah's recommendations "to the letter," and Dr. Pessah's inability to remember whether he spoke to Mr. Greene in 2010 about the 2010 echocardiogram (Pessah tr., p 111).

The cardiologist further opines that if an aortic aneurysm had been diagnosed at any time prior to February 2014, such a diagnosis would have likely saved Mr. Greene's life, because the clinicians at the hospital would have immediately ruled aortic dissection into their differential diagnosis, and immediately commenced a workup to urgently evaluate

aortic dissection, including a decision NOT to administer heparin until an aortic dissection was ruled out (Cardiologist affirmation, par 89).

Plaintiff's cardiologist disagrees with Dr. Sahar about various parts of his opinion, including for example, the alleged lack of risk factors for the development of aortic dissection. He/she points to Mr. Greene's aortic aneurysm and valve calcification as of 2010, his chronic hypertension, and in 2012 his elevated cholesterol and heart murmur, as examples of risk factors.

Plaintiff's cardiologist further disagrees with Dr. Mennitt's conclusion that "there was no evidence of a contributing aneurysm that could have been picked [sic] or diagnosed earlier," based on his/her review of Dr. Mezzafonte's angiogram.

Moving on, Plaintiff's internist states that he has treated patients for approximately 22 years in his private practice and in his hospital-based employment. The internist opines that Dr. Pessah deviated from the appropriate standard of care by, inter alia, failing to refer Mr. Greene to a cardiologist after the 2010 echocardiogram, failing to have performed echocardiograms in 2011, 2012, and 2013, and in misleading Mr. Greene about his condition (Internist affirmation, par 33). This opinion is not only based on the size of Mr. Greene's aorta and the 2010 echocardiogram, but also on the fact that the study showed regurgitation and aortic insufficiency in a patient with chronic hypertension (Id., par 39).

Plaintiff's internist opines that a patient's refusal to undergo medically necessary testing should be documented, especially here where Dr. Pessah alleged that Mr. Greene

expressed apathy to continuing to live (Id., par 42 – 43). He/she finds it a "likely and reasonable inference that Dr. Pessah never advised Mr. Greene of the abnormalities of the 2010 echocardiogram results" (Id., par 15).

Overall, this Court finds that plaintiff has raised triable issues of fact, inter alia, as to whether Dr. Pessah appreciated and communicated to Mr. Greene concerning information in the 2010 echocardiogram, and whether Dr. Pessah explained to Mr. Greene the need for echocardiograms in 2012 and 2013. This is the linchpin of Plaintiff's claims that Dr. Pessah deviated from accepted standards of medical practice. Plaintiff has further raised triable issues of fact as to whether it is probable that Dr. Pessah's conduct caused some diminution in Mr. Greene's chance of survival, or that Dr. Pessah's alleged omissions decreased Mr. Greene's chance of a better outcome. Where, as here, conflicting expert testimony is presented, it is the province of the jury to determine the experts' credibility.

Business corporations are liable under the doctrine of respondeat superior for the torts of their employees committed within the scope of the business, and as with any other corporation, professional service corporations are similarly vicariously liable for the torts of their members (see Poplawski v Gross, 81 AD3d 801, 802-803 [2d Dept 2011]). To the extent that Dr. Pessah may be found liable for Plaintiff's claims, NS-LIJ may be vicariously liable for Dr. Pessah's conduct.

Based on the foregoing the motion by Dr. Pessah and NS-LIJ for summary judgment dismissing Plaintiff's claims against them must be **denied**.

The Motion by Dr. Mezzafonte

Defendant Dr. Mezzafonte moves for summary judgment dismissing the complaint. In support of his motion he submits an expert affirmation by Dr. Fox, who is board-certified in interventional cardiology. Dr. Fox bases his opinions upon review of the pleadings, deposition transcripts, and Mr. Greene's medical records, as well as his knowledge, training, and experience.

Dr. Fox states that aortic dissection is an uncommon condition that "typically presents with excruciating chest pain or upper back pain often described as tearing or ripping (Fox affirmation, par 37). He states that 20% of people die from aortic dissection prior to arriving to the hospital, and hospital mortality rates are about 30% for treated patients (Id.)

According to Dr. Fox, the "blockage of blood flow from the aortic dissection mimics the vastly more common blockage of blood flow from coronary artery disease," making it "very difficult to distinguish between the two" (Id., par 39). Because Mr. Greene's EKGs showed ST depressions, and because he complained of anterior chest pain, Mr. Greene's presentation was consistent with an ischemic event (Id., pars 18 and 31).

Dr. Fox opines that heparin is the standard of care in a patient presenting with an acute coronary syndrome due to coronary artery disease, and in a Type A aortic dissection causing EKG changes, the mortality rate would not be significantly impacted by the dose and duration of heparin that was used in this case (Id., par 40). The Court notes that Dr.

Fox appears to contradict Dr. Mezzafonte, who plainly testified that "heparin is contraindicated in acute aortic dissection" (Mezzafonte tr., p. 37).

Mr. Greene's transient vision loss before arriving at the hospital is not noted by Dr. Marino or Dr. Patel. Dr. Fox concludes that Dr. Mezzafonte must have learned of this symptom when he spoke to Mrs. Greene at 1:30 a.m. Dr. Fox opines that the logical path in this situation is the performance of a catheterization, with the potential to provide life-saving treatment if the condition is based on coronary artery disease, and still have the ability to diagnose aortic dissection (Fox Affirmation, par 43).

Dr. Fox opines that the standard of care for an interventional cardiologist in this setting did not require Dr. Mezzafonte to review Mr. Greene's chest x-ray taken earlier that morning (Id., par 44). He insists that even if Dr. Mezzafonte had ordered a CT scan after he arrived to diagnose an aortic dissection, the patient's outcome would not have changed (Id.)

Dr. Fox concludes that Dr. Mezzafonte acted within the accepted standard of care in his treatment of Mr. Greene, and there is nothing Dr. Mezzafonte did or did not do that caused Mr. Greene's injuries (Id., par 46). In essence, Dr. Fox appears to argue that Mr. Greene's EKG changes and symptoms supported the choice of medical management followed by catheterization, and further that Mr. Greene would have died regardless of treatment because of his "deadly condition," namely his aortic dissection rupture.

On this record Defendant Dr. Mezzafonte has presented a prima facie case for summary judgment and the burden shifts to plaintiff.

In opposition, Plaintiff's cardiologist opines that Dr. Mezzafonte deviated from the standard of care by failing to learn the results of Mr. Greene's chest x-ray, failing to formulate a differential diagnosis, and failing to discontinue the use of heparin and start a medication to counteract the effects of heparin. These failures led to the wrong procedure being performed, which ended with Mr. Greene's death.

It is undisputed that hospital protocol required a chest x-ray for patients presenting to the Emergency Department with chest pain. According to Plaintiff's cardiologist, had Dr. Mezzafonte inquired as to the chest x-ray, he would have learned of the fullness of the mediastinum, after which he would have included aortic dissection in his differential diagnosis and discontinued heparin. He/she notes that when Mr. Greene arrived at the hospital, his pain level was a 3-4 out of 10, and it was only after the administration of heparin that Mr. Greene's condition experienced a sharp decline and became so unstable as to warrant a Rapid Response Code (Cardiologist affirmation, par 66). He/she further opines that "the window of time to provide life-saving treatment and/or surgery would have been much wider if heparin was not administered and/or timely discontinued" (Id., par 67).

Plaintiff's cardiologist asserts that because the ECG findings were consistent with both ischemia and aortic dissection, a differential diagnosis should have been formulated to include aortic dissection. At that point, the physicians should have learned the results

of the chest x-ray and required further diagnostic testing on a STAT basis to evaluate possible aortic dissection (Id., pars 71-74).

On this record Plaintiff has raised triable issues of fact as to whether Dr. Mezzafonte deviated from accepted standards of care by failing to affirmatively learn the results of Mr. Greene's chest x-ray, failing to formulate a differential diagnosis including aortic dissection, and failing to discontinue heparin and administer an antidote to heparin. Plaintiff has submitted sufficient evidence from which a reasonable person might conclude that it was more probable than not that Dr. Mezzafonte's alleged deviations were a substantial factor in causing Mr. Greene's death. Again, conflicting expert testimony presents a question of credibility for the jury.

Based on the foregoing, Dr. Mezzafonte's motion for summary judgment must be **denied**.

The Motion by Dr. Patel and NCP

Defendants Dr. Patel and NCP move for summary judgment dismissing the complaint. In support of their motion, they submit an expert affidavit by Dr. Kaufman, a board-certified internist with a sub-certification in critical care medicine. Dr. Kaufman bases his opinions on Plaintiff's verified bill of particulars, the amended bill of particulars, the hospital record, the ambulance record, and the deposition transcripts.

Dr. Kaufman emphasizes Dr. Patel's limited role in connection with the treatment of Mr. Greene. Dr. Patel responded to the Rapid Response Code, and his role was to stabilize the patient whose blood pressure was crashing. According to Dr. Kaufman, Dr. Patel had a right to rely on the ED staff and Dr. Marino to tell him of any abnormal lab or test results. (Kaufman affirmation, pars 20-21). Dr. Patel was at Mr. Greene's bedside for approximately 15-20 minutes, at which time he was called away to another emergency. When he returned, Mr. Greene had already been taken to the Cath Lab.

Dr. Kaufman asserts that Dr. Patel had no opportunity to read the chest x-ray even if he was made aware of it (Id., par 22), and played no part in the decision to administer heparin to Mr. Greene (Id., par 29). There is no evidence that Dr. Patel was made aware of Mr. Greene's transient blindness (Id., par 30), and Mr. Greene made no complaints of any tearing chest pain or upper back pain (Id., par 24). Dr. Kaufman further opines, "even if the dissecting aortic aneurysm had been diagnosed sooner, the patient likely still would not have been able to be saved" (Id., par 31).

Dr. Kaufman concludes that the care provided by Dr. Patel to Mr. Greene was within community standards and that no act or omission on his part was in any way a proximate cause of Mr. Greene's injuries (Id., 34). On this record, Dr. Patel and NCP have made out a prima facie case for summary judgment dismissing the claims against them. The burden shifts, once again, to the Plaintiff to raise a triable issue of fact.

In opposition Plaintiff relies on the affirmation of her cardiologist, who opines that Dr. Patel deviated from the standard of care in a number of ways, most importantly, in failing to learn the results of the chest x-ray when he participated in Mr. Greene's care, in failing to discontinue heparin and administer an antidote in preparation for the plan at that time to place a central line, and in failing to formulate a differential diagnosis that included aortic dissection (Cardiologist's affirmation, pars 57-62, 71).

He/she insists that the standard of care mandates that a physician make an affirmative inquiry to learn about the occurrence and results of all diagnostic tests and medications provided for a patient with a presumed cardiac condition (Id., pars 58 and 60). Further, he/she opines that the administration of heparin was a substantial factor in significantly worsening Mr. Greene's condition, and a substantial factor in causing his death (Id., pars 56, 62, 65, and 66).

This motion is the most difficult to determine because Dr. Patel's role in Mr. Greene's treatment was so limited. While Dr. Patel is not a cardiologist, he is a critical care specialist, and the Court is persuaded that a physician treating a patient should inquire as to the results of all diagnostic tests performed and medications given. However, the Court is not persuaded that it is the responsibility of a critical care specialist, whose job it is to stabilize a crashing patient, to formulate a differential diagnosis.

Viewing the evidence in the light most favorable to Plaintiff, the Court concludes that Plaintiff has raised triable issues of fact as to Dr. Patel's treatment of Mr. Greene. Dr.

Patel's alleged deviations from accepted standards of care include his failure to affirmatively learn the results of Mr. Greene's chest x-ray and the failure to discontinue heparin and administer an antidote. Plaintiff has further raised triable issues of fact as to whether a reasonable person might conclude that it was more probable than not that Dr. Patel's alleged deviations were a substantial factor in causing Mr. Greene's death. Conflicting expert testimony presents questions for the jury.

Based on the foregoing, the motion by Dr. Patel and NCP for summary judgment dismissing the complaint against them must be **denied**.

As the issue of negligence on the part of the moving Defendants presents questions of fact for the jury, summary judgment on the loss of consortium and wrongful death claims must be **denied** as premature.

The parties remaining contentions have been considered and do not warrant discussion. Any applications not specifically addressed herein are denied.

This shall constitute the decision and Order of this Court.

Dated: April 29, 2020
Mineola, NY

Steven M. Jaeger

Hon. Steven M. Jaeger
Acting Justice of the Supreme Court

ENTERED
May 01 2020
NASSAU COUNTY
COUNTY CLERK'S OFFICE