SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present:

HON. DANIEL PALMIERI
Acting Justice Supreme Court

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SCOTT MITTLEBERG, as Proposed Administrator of the Estate of BRUCE MITTLEBERG, Deceased,

Plaintiff,

-against-

NEWELL ROBINSON, GEORGE ABOU-EID, HAROLD A. FERNANDEZ, JAMES SULLIVAN, ANTHONY MOSCHETTO, VINCENT PACIENZA, JIM HILEPO and ST. FRANCIS HOSPITAL,

Defendants

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TRIAL PART: 48

INDEX NO.: 016975/05

MOTION DATE:6-30-08
SUBMIT DATE: 8-18-08
SEQ. NUMBER - 004 & 005

The following papers have been read on this motion:

Notice of Motion, dated 5-29-08.....1
Affirmation in Support, dated 5-29-08.....2
Notice of Motion, dated 5-28-08.....3
Affirmation in Support, dated 5-28-08.....4
Affirmation in Opposition, dated 7-23-08.....5
Supplemental Affirmation in Opposition, dated 8-11-08.....6
Reply Affirmation, dated 8-12-08.....7
Reply Affirmation, dated 8-15-08.....8

This motion by defendants James Sullivan, Anthony Moschetto, Vincent Pacienza, St. Francis Hospital, Newell Robinson, George Abou-eid and Harold A. Fernandez, and

cross-motion by defendant Jim Hilepo for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint against them are determined as provided herein.

In this action, the plaintiff Scott Mittleberg, as Administrator of the Estate of his father Bruce Mittleberg ("Mittleberg"), seeks to recover damages for medical malpractice, wrongful death and lack of informed consent based on the defendants' care of Mittleberg prior to, during and after surgery which was performed to treat him for ulcerative colitis. All of the defendants presently seek summary judgment dismissing the complaint against them.

The pertinent facts are as follows:

Mittleberg had a history of ulcerative colitis and cardiovascular disease. In 1992, he had a subtotal colectomy and colostomy. In 1993, he underwent six-way coronary artery bypass graft surgery and in 1996 he underwent mitral valve replacement. At all times pertinent to this case, defendant Jim Hilepo, (M.D.), was Mittleberg's primary care physician; defendant Anthony Moschetto, (M.D.), was his cardiologist; a Dr. Rizzo was his gastroenterologist; and, a Dr. Lummerman was his urologist.

On August 3, 2004, Dr. Rizzo, who had treated Mittleberg for episodes of ulcerative colitis, recommended a panprotocolectomy with possible ileostomy because a colonoscopy which Mittleberg had done in July, 2004 revealed dysplasia, an abnormal development, which, in Rizzo's opinion, coupled with Mittleberg's ulcerative colitis, put him at a significant risk for colon cancer. The recommended procedure involved the excision of the rectum and colon with the creation of ileal stoma for the elimination of feces and a surgical creation of an opening to the ileum which is part of the small intestine.

Dr. Rizzo referred Mittleberg to a surgeon, defendant James Sullivan, (M.D.), who recommended deferring the surgery because of Mittleberg's medical condition and the attendant risks. Dr. Rizzo nevertheless advised that surgery was necessary. The possibility of procuring a second opinion was discussed and in January 2005, Mittleberg informed Rizzo that he was in fact seeking such an opinion. Ultimately, on or about February 2, 2005, Mittleberg informed his doctors that he was electing to have the surgery, an elective pancolectomy, ileostomy and interosphincteric dissection with radical lymph node dissection. He scheduled the surgery with Dr. Sullivan.

At his examination-before-trial, Dr. Sullivan testified that he discussed the options, risks, benefits and cardiology issues with Mittleberg at length when he scheduled the surgery. Dr. Sullivan required Mittleberg to obtain surgical clearance from both his cardiologist Dr. Moschetto and his internist Dr. Hilepo. He also advised Mittleberg that he would have to discontinue Coumadin, which he took to mitigate the risk of thrombosis due to his artificial mitral valve, six days before the surgery. Mittleberg had in fact discontinued Coumadin and been placed on Lovenox twice before for surgical purposes without incident.

In anticipation of the surgery, Mittleberg saw Dr. Moschetto on March 7, 2005. Dr. Moschetto documented that Mittleberg denied chest pain, shortness of breath, edema, chest palpitations, lightheadedness, dizziness, syncope, weakness and fatigue. While his heart rate was irregular and he had atrial fibrillation, he had already been off Coumadin for two days. Dr. Moschetto gave him cardiac clearance based on a negative stress test which had been done a few months prior and acceptable blood pressure. While Dr. Moschetto advised

Mittleberg that he should be hospitalized and placed on the anticoagulant Heparin prior to surgery, Mittleberg refused but agreed to take the anticoagulant Lovenox up until the surgery. That same day, Mittleberg saw his internist, Dr. Hilepo, who also surgically cleared him and advised him that he switch to Lovenox until he entered the hospital, at which point Dr. Hilepo advised that Heparin be substituted. Mittleberg's medical records indicate that his prescription for Lovenox was filled that day.

Mittleberg was admitted to the St. Francis Hospital on the afternoon of March 10, 2005 by his surgeon, Dr. Sullivan, who obtained his consent. At their examinations-before-trial, Drs. Sullivan, Moschetto and Hilepo all testified that the management of anticoagulant and pain medication during Mittleberg's hospitalization would be up to Dr. Sullivan, since as his surgeon, he would have the best knowledge of the risks of bleeding. An Internationalized Normalized Ratio measured the level of Mittleberg's anticoagulation and Heparin was directed, but was to be discontinued a few hours prior to surgery when the epidural catheter was placed. Mittleberg's hospital record demonstrates that Dr. Sullivan personally directed that no anticoagulation medicine be given through at least March 14, 2005 at 5:00 and that it should not be resumed absent express orders by him. Pain medication was to be administered via a catheter in Mittleberg's spine, which also dictated that no anticoagulation medicine be given.

Mittleberg's hospital chart indicates that he was off anticoagulation "per surgery." In the afternoon of March 11, 2005, Dr. Sullivan performed the surgery assisted by Dr. Raynsood. It is not disputed that the procedure itself was well-tolerated by the patient. At

his examination -before-trial, Dr. Sullivan testified that post-operatively the resumption of anticoagulant depended upon a variety of things: An assessment of the magnitude of the surgery and the dissection, as well as the drainage from the Jackson Pratt drain. He explained that premature resumption of anticoagulant put Mittleberg at high risk for postoperative hemorrhage, so a day-to-day assessment was called for. From March 11, 2005 through March 14, 2005, Mittleberg's surgical site drained serosanguinous fluid. On March 14, 2005, Dr. Hilepo wrote that anticoagulation was to restart "on orders of surgical oncology" and the anesthesiologist also directed that anticoagulation be held until the epidural catheter was removed at 12:15 that day.

With the exception of a fever, Mittleberg recovered without notable incident until March 14, 2005, when his blood pressure increased. Surgical Physician's Assistant Varma prescribed Lopressor. When the results were negligible, Dr. Moschetto prescribed Lasix and Tridil. Mittleberg's mental status became disoriented. During the afternoon of March 14, 2005, Mittleberg became agitated and confused with yellowed sclera of the eyes. Varma evaluated him and Varma, Sullivan and Moschetto arranged for a neurological consult and CT scan of Mittleberg's head and directed the nurses to hold the Heparin and patient controlled pain medicine. The tests revealed pulmonary edema, fluid on Mittleberg's lungs, which is indicative of air-space disease and edema of his gallbladder, indicating possible cholecystitis. Mittleberg was transferred to the Coronary Care Unit. A HIDA scan and scans of his chest, abdomen and pelvis were done due to concerns about acute cholecystitis. The HIDA scan was unremarkable except for a thickening of the gallbladder and his bilirubin was

elevated. The HIDA was found to be consistent with parenchymal disease, not cholecystitis. A CT of the abdomen was negative except for free air consistent with recent abdominal surgery. The impression of the gastroenterologist was that the hyperbilirubinemia was secondary to cholecystitis. A neurologist, a pulmonologist and an infectious disease specialist consulted. In the CCU, a Swan-Ganz catheter was inserted with initial readings of 72/33, blood pressure 140/60, urine output approximately 20 cc per hour. An infusion of Dobutamine, continued Tridil and additional IV Lasix and Bumex were given. In the evening of March 14, 2005, Mittleberg was alert, oriented and felt better. Monitoring was continued. Dr. Sullivan ordered anticoagulant at 20:40 and 21:20 on March 10, 2005.

Dr. Pacienza, who was covering for Dr. Moschetto, was called in to evaluate Mittleberg at 6:30 PM on March 15, 2005 because he was having pulmonary artery pressure, decreased urine output and increased systematic vascular resistance and pulmonary vascular resistance. At the time, Mittleberg's temperature was elevated, his heart rate was 100 and his blood pressure was 140/70 with slightly diminished urine output. His bilirubin was elevated at 13.5 mg./dl. The impression was right lower and right middle lobe pneumonia for which antibiotic therapy was given in addition to the antibiotics being given for the surgical procedure. Dr. Pacienza ordered an echocardiogram which revealed acute thrombosis of Mittleberg's mechanical valve, that is, valve prosthesis: While the superior leaflet was functioning normally, the inferior leaflet was not mobile.

Dr. Pacienza recommended a cardiothoracic consult which was done by defendant Newell Robinson, (M.D.), at 12:15 AM on March 16, 2005. After evaluating Mittleberg, Dr.

Robinson recommended thrombolytic therapy to try and treat the clot at the mitral valve. He thought that surgery was too risky and that Mittleberg would not survive cardiac bypass surgery. All of these things were discussed with Mittleberg's family. An echocardiogram done six hours after the anti-thrombolytic therapy began revealed some improvement with reduction of the transvalvular gradient but impingement on the inferior valve continued. Urine output had increased during thrombolysis with no evidence of complicating bleeding.

At this point, Dr. Robinson recommended surgical intervention which was accepted by Mittleberg's family. Dr. Robinson obtained consent to proceed with surgery to replace the mitral valve and, if needed, to implant a temporary bi-ventricular support device based upon the echocardiographic findings. At this point, Dr. Robinson testified at his examination-before-trial that he discussed with Mittleberg's family that Mittleberg was not likely to survive but since he was a potential candidate for ventricular and circulatory support, an attempt to replace the valve so he could be transferred to another hospital for a heart transplant was in order. Mittleberg was accordingly taken to surgery which was done by Dr. Robinson assisted by defendant George Abou-eid, (M.D.), also present was defendant Harold A. Fernandez, (M.D.). On entry to the chest, stenosis of the right coronary artery bypass graft was noted, the St. Judge mechanical valve was removed and a Mosaic porcine mitral valve was implanted. The patient's condition deteriorated secondary to bi-ventricular failure. A temporary bi-ventricular support device was implanted by Dr. Fernandez and the right coronary artery bypass graft stenosis bypassed using a segment of vein from the leg. Circulation could not be re-established despite the bi-ventricular assistance device. All treatment alternatives were exhausted without success and the patient was declared dead in

the operating room.

Plaintiff alleges that defendants failed to properly manage Mittleberg preoperatively; negligently recommended and performed surgery which was not indicated; failed to properly manage Mittleberg in the postoperative period; failed to determine the etiology of Mittleberg's medical condition postoperatively; failed to timely admit Mittleberg to the cardiac care unit postoperatively; failed to diagnose a ruptured pannus; failed to diagnose an obstruction of the outflow of the mechanical prosthesis; failed to timely initiate thrombolytic therapy and surgery; and, failed to restart anticoagulation postoperatively.

Applicable Law

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept. 2004), *aff'd. as mod.*, 4 NY3d 627 (2005), *citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v King, supra*, at p. 74; *Alvarez v Prospect Hosp., supra; Winegrad v New York Univ. Med. Ctr., supra*. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *Alvarez v Prospect Hosp., supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they

must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 AD3d 518, 521 (2d Dept. 2006), *citing Secof v Greens Condominium*, 158 AD2d 591 (2d Dept. 1990).

The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damages. *Ramsay v Good Samaritan Hosp.*, 24 AD3d 645 (2d Dept. 2005); *see also, Thomason v Orner*, 36 AD3d 791 (2nd Dept. 2007); *DiMitri v Monsouri*, 302 AD2d 420, 421 (2d Dept. 2003); *Holbrook v United Hosp. Medical Center*, 248 AD2d 358 (2d Dept. 1998). "In a medical malpractice action, the party moving for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant physician [and/or hospital] were negligent." *Taylor v Nyack Hospital*, 18 AD3d 537 (2d Dept. 2005) *citing Alvarez v Prospect Hosp., supra.* Thus, a moving defendant doctor or hospital has "the initial burden of establishing the absence of any departure from good and accepted medical malpractice or that the plaintiff was injured thereby." *Chance v Felder*, 33 AD3d 645 (2nd Dept. 2006) quoting *Williams v Sahay*, 12 AD3d 366, 368 (2d Dept. 2004), *citing Alvarez v Prospect Hosp., supra; Johnson v Queens-Long Island Medical Group, P.C.*, 23 AD3d 525, 526 (2nd Dept. 2005); *Taylor v Nyack Hospital, supra; see also, Thompson v Orner, supra.*

If the moving party meets his burden, "in opposition, 'a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent

producing cause of the injury.' " *Domaradzki v Glen Cove Ob/Gyn Assocs.*, 242 AD2d 282 (2d Dept. 1997); *see also, Mosezhnik v Berenstein*, 33 AD3d 895 (2d Dept. 2006). An expert may not render conclusions based on facts not in evidence or which are directly contradicted by the evidence. *See, Holbrook v United Hospital Medical Center, supra; see also, Kaplan v Hamilton Medical Associates, P.C.*, 262 AD2d 609, 610 (2nd Dept. 1999). A qualified expert's opinion that "a plaintiff's injuries were caused by a deviation from relevant industry standards has no probative force when the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation." *See, Wong v Goldbaum*, 23 AD3d 277, 279 (1st Dept. 2005) *citing Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 (2002). Further, the plaintiff's expert must not only differentiate between the specific acts of each defendant but must also address the operative facts relied on by the defendants' experts. *See, Kaplan v Hamilton Medical Associates, P.C., supra*, at p. 610; *see also, Rebozo v Williams*, 41 AD3d 457, 459 (2nd Dept. 2007); *Slone v Salzer*, 7 AD3d 609 (2d Dept. 2004); *Ventura v Beth Israel Medical Center*, 297 AD2d 801, 803 (2d Dept. 2002), *lv den.*, 99 NY2d 510 (2003); *Fhima v Maimonides Medical Center*, 269 AD2d 559, 560 (2d Dept. 2000).

As for the defendant hospital, "[a]s a rule, a hospital is normally protected from tort liability if its staff follows the orders of the patient's private physician. An exception exists where the hospital staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders." *Cook v Reisner*, 295 AD2d 466 at p. 467 (2nd Dept. 2002), quoting *Warney v Haddad*, 237 AD2d 123 (1st Dept. 1997); *see also, Quezada v O'Reilly-Green*, 24 AD3d 744 (2d Dept

.2005), *lv to app den.* 7 AD3d 703 (2006), *citing Orgovan v Bloom*, 7 AD3d 770 (2d Dept. 2001); *Evans v Abitbol*, 1 AD3d 313, 314 (2d Dept. 2003); *O'Regan v Lundie*, 299 AD2d 531 (2d Dept. 2002).

Furthermore, it is the duty of a patient's private physician, not the hospital, to obtain the patient's informed consent. Public Health Law § 2805-d; *Sita v Long Island Jewish-Hillside Medical Center*, 22 AD3d 743 (2d Dept. 2005) *citing Fiorentino v Wenger*, 19 NY2d 407, 417 (1967). The physician who prescribes or performs the procedure is obligated to obtain the patient's informed consent; however, the obligation to procure informed consent continues only if a degree of participation is retained by way of control, consultation or otherwise. *Spinosa v Weinstein*, 168 AD2d 32, 39-40 (2d Dept. 1991), *citing Blank v Rosenthal*, 84 AD2d 688 (1st Dept. 1981), *app den.*, 55 NY2d 974 (1982); *Nisenholtz v Mount Sinai Hosp.*, 126 Misc.2d 658 (Supreme Court N.Y. County 1984); *Prooth v Wallsh*, 105 Misc.2d 603, 605-606 (Supreme Court N.Y. County 1980); *see also, Domaradzki v Glen Cove Ob/Gyn Associates*, 242 AD2d 282 (2d Dept. 1997).

To extend that obligation to other medical personnel simply because they have contact with the patient in connection with her treatment could deter a patient from procuring needed care as a result of repeated warnings and cautions and intrude on the patient-doctor relationship. *Fiorentino v Wenger, supra*, at p. 415-416; *Spinosa v Weinstein, supra*, at p. 39-40. Moreover, to establish a claim for lack of informed consent, plaintiff must establish that "a reasonably prudent person in the patient's position would not have undergone the treatment . . . if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought." *Manning v Brookhaven Memorial Hosp. Medical Center*, 11 AD3d 518 (2d Dept. 2004).

Defendant's Proof (Except Defendant Hilepo)

In support of their motion, defendants James Sullivan, Anthony Moschetto, Vincent Pacienza, St. Francis Hospital, Newell Robinson, George Abou-eid and Harold A. Fernandez have submitted the Affirmation of Dr. Henry Partridge, a Board Certified Surgeon. He has reviewed Mittleberg's medical records and the transcripts from the parties' examinations-before-trial as well as the legal documents of this case. He opines to a reasonable degree of medical certainty that all of those defendants' conduct was consistent with good and accepted standards of medical practice, and that none of their acts or omissions proximately caused Mittleberg's death. More specifically, Dr. Partridge opines as follows:

St. Francis' personnel followed Dr. Sullivan's directives which were never contraindicated, thereby absolving them of responsibility as under those circumstances. St. Francis Hospital cannot be held liable for plaintiff's private attending physicians' negligence, if any.

As for Dr. Sullivan, Dr. Partridge opines that performing the surgery was proper in light of Mittleberg's history of dysplasia coupled with ulcerative colitis, which, under the circumstances, is considered a transition to a malignancy. He further opines that Drs. Sullivan and Moschetto properly managed Mittleberg's anticoagulant both prior to and following his surgery. He explains that Mittleberg was taking Coumadin on account of his prosthetic mitral valve. He explains that it was properly discontinued prior to surgery because Coumadin increases the risk of hemorrhage.

He further opines that it had to be stopped six days before surgery to allow the body

to eliminate it. He further opines that because of Mittleberg's prosthetic mitral valve, a substitute anticoagulant whose half-life was shorter had to be used. He explains that Lovenox or Heparin could be used because the body eliminates them within hours of their administration.

It is also Dr. Partridge's opinion that Dr. Moschetto appropriately suggested in-hospital IV Heparin when he saw Mittleberg on March 7, 2005 and that in light of Mittleberg's refusal to be treated in the hospital, he properly prescribed Lovenox. Dr. Partridge also opines that Dr. Moschetto properly referred Mittleberg to Hilepo so that Lovenox could be prescribed. Dr. Partridge also opines that Dr. Moschetto properly gave Mittleberg cardiac clearance for his surgery. Again, Mittleberg denied chest pain, shortness of breath, edema, palpitations, lightheadedness, weakness and fatigue and his blood pressure was 140/86. His irregular pulse and atrial fibrillation was consistent with his medical history. He also had an acceptable recent stress test, and his blood pressure and cardiac status were acceptable.

It is also Dr. Partridge's opinion that in light of the INR test results, Heparin was properly administered in the hospital and stopped pre-surgery to allow the body time to eliminate it and to mitigate the risk of hemorrhaging from the epidural catheter, which was used for pain. As for the post-operative management of Mittleberg's anticoagulant, Dr. Partridge opines that as the surgeon, Dr. Sullivan, who ultimately managed Mittleberg's anticoagulant post-operatively, was in the best position to make those decisions. He was able to make an intraoperative assessment of Mittleberg's tissue, the operative site and the surgical incision, which plays a vital determining factor regarding postoperative bleeding or

hemorrhaging. Dr. Partridge explains that the decision on when to resume anticoagulant had to be based on the magnitude of the surgery and the dissection as well as the assessment of the Jackson Pratt drain. Dr. Partridge further opines that Dr. Sullivan properly based his decision on when to resume anticoagulant on the very large dissection and the very raw surgical site that was necessary and daily assessment of the drainage of fluid from the Jackson Pratt drain.

As for Mittleberg's general postoperative monitoring, Dr. Partridge opines to a reasonable degree of medical certainty that all of the defendants appropriately monitored, assessed and treated him postoperatively and that their care did not proximately cause his death. He explains that all of Mittleberg's issues were recognized and treated in a timely manner, namely, his elevated blood pressure and the change in his mental status. Dr. Partridge opines that appropriate medication was provided, tests were run and the test results were all responded to appropriately.

As for Dr. Pacienza, Dr. Partridge opines that the echocardiogram which revealed a thrombus on Mittleberg's mechanical valve was properly and timely obtained and that the cardiothoracic surgery consult was properly and timely ordered as well. Dr. Partridge further opines that not only did Dr. Pacienza's actions comport with good and accepted medical standards, they did not cause Mittleberg's death.

As for Dr. Robinson, Dr. Partridge opines that in light of Mittleberg's condition and the risks presented when Robinson became involved in his care at 12:15 AM on March 16, 2005, he exercised good judgment in recommending thrombolytic therapy to attempt to treat the clot in his mitral valve, and acted appropriately in having it done timely. Furthermore, Dr.

Partridge opines that in light of the echocardiogram results obtained subsequently, which revealed that the inferior leaflet of the mitral valve was still thrombosed, Dr. Robinson properly recommended surgical intervention in an attempt to save Mittleberg's life. Dr. Partridge further opines that none of Dr. Robinson's acts or omissions proximately caused Mittleberg's death.

As for Dr. Abou-Eid, Dr. Partridge opines to a reasonable degree of medical certainty that he rendered no medical judgment personally as he acted entirely under Dr. Robinson's direction. In addition, Dr. Partridge opines that Dr. Abou-eid did nothing that caused Mittleberg's death.

Dr. Partridge similarly opines that given Mittleberg's condition when Dr. Hernandez was called upon to render care, he properly placed the bi-ventricular assist device and bypass. As for Dr. Hernandez, Dr. Partridge also opines that given the timing and extent of his limited involvement with Mittleberg, he could not possibly have caused his demise.

Lastly, Dr. Partridge opines that Dr. Sullivan's procurement of Mittleberg's consent was informed.

In view of the foregoing, the Court finds that defendants James Sullivan, Anthony Moschetto, Vincent Pacienza, St. Francis Hospital, Newell Robinson, George Abou-eid and Harold A. Fernandez have established their entitlement to summary judgment, thereby shifting the burden to plaintiff to establish the existence of a material issue of fact.

Plaintiff's Opposing Proof

Plaintiff has not opposed the motion insofar as it is made on behalf of defendants

Robinson, Abou-Eid, Fernandez, Pacienza or St. Francis Hospital. Accordingly, those defendants are granted summary judgment and the action as against them is dismissed.

In opposition to the motion as it is made on behalf of defendants Drs. Sullivan and Moschetto, the plaintiff has submitted the affirmation of Board Certified Surgeon Dr. Jeffrey S. Freed. Dr. Freed has reviewed Mittleberg's medical records, Drs. Moschetto, Sullivan's and Hilepo's examination-before-trial testimony and Dr. Partridge's affirmation in support of their application. He opines to a reasonable degree of medical certainty that both Dr. Moschetto and Dr. Sullivan deviated from accepted medical practice in their care and treatment of Mittleberg and that such deviations were competent producing causes of Mittleberg's death.

It is his opinion to a reasonable degree of medical certainty that Mittleberg was not a candidate for surgery and that his anticoagulation therapy was "abominably managed both preoperatively and postoperatively." As for the surgery, he notes that only one of Mittleberg's colonoscopies was positive for dysplasia and it was "low grade." He states that "there was no statistically significant difference in survival rates between patients with low grade dysplasia whose colons were removed and those whose colons were not removed." He further opines that "there was a tremendous interobserver difference in dysplasia," thus, Mittleberg's "slides should have been reviewed by another pathologist who specialized in gastroenterology/pathology before surgery was recommended." Thus, Dr. Freed concludes that Dr. Sullivan's recommendation for surgery was a deviation from accepted practice.

Dr. Freed also opines that "given the insignificant difference in survival rates as noted

above and the compounding problem of stopping and resuming anticoagulation because of Mittleberg's artifical mitral valve, Dr. Moschetto [also] deviated from good and accepted medical practice in clearing Mittleberg for this unnecessary surgery." Dr. Freed further opines that Mittleberg's anticoagulation was stopped too soon. He opines that "[s]ix days before surgery is not the standard protocol for discontinuing Coumadin."

Moreover, Dr. Freed further opines that Dr. Moschetto's and Dr. Sullivan's failure to communicate with each other regarding a plan for Mittleberg's preoperative anticoagulation was a further departure from accepted medical practice. He notes that Mittleberg discontinued Coumadin after seeing Dr. Sullivan on March 5, 2005, but the substitute Lovenox was not begun until two days later when he saw Dr. Moschetto on March 7, 2005. Dr. Freed further opines that to his detriment Mittleberg refused hospitalization for Heparin administration because of this gap.

Dr. Freed opines that Mittleberg's postoperative anticoagulant was also mismanaged. He opines that "[t]here was absolutely no reason to delay resumption of heparin for three days." He explains that "[s]erosanguinous drainage, even 150 ccs., is to be expected and is the most reactive fluid from removing a colitis bowel but not related to an increased risk of postoperative bleeding. The mere presence of serosanguinous drainage–an expected occurrence following this type of surgery–is not a reason to delay resumption of anticoagulation, and accepted medical practice mandated that heparin should have been resumed immediately." He opines that Dr. Sullivan's failure to resume Mr. Mittleberg's anticoagulation for three days postoperatively was therefore a deviation from accepted practice. Dr. Freed further notes that after Dr. Hilepo ordered the resumption of heparin there

was an unexplained 12-hour delay in its administration.

As for causation, Dr. Freed opines that "[t]he combined effect of inappropriately recommending the surgery, together with the pre and postoperative mismanagement of Mr. Mittleberg's anticoagulation, were proximate causes of the acute thrombus of Mr. Mittleberg's mitral valve prosthesis and his ensuing death during surgery on March 16, 2005 to correct that condition." He opines that "[h]ad Drs. Sullivan and Moschetto refrained from recommending an unnecessary surgery, and had they appropriately managed Mr. Mittleberg's anticoagulation therapy, it is [his] opinion to a reasonable degree of medical certainty that a thrombus would not have occurred and Mr. Mittleberg's death would have been avoided."

The Court finds the foregoing does not overcome the defendants' proof with regard to Dr. Moschetto. Although Dr. Moschetto did not recommend the initial surgery, plaintiff's expert faults his clearance of Mittleberg for surgery based on an alleged failure to question the need for the surgery itself. However, Dr. Moschetto was asked to do no more than determine whether Mittleberg could tolerate a procedure recommended by another physician – a procedure which undisputedly was tolerated by the patient – and Dr. Freed does not state that good and accepted medical practice dictated that Dr. Moschetto, a cardiologist, separately determine the need for the gastro-intestinal surgery proposed. Thus, the underlying decision to recommend the surgery to the patient, even if erroneous, cannot be viewed as departures from accepted practice by Dr. Moschetto.

Furthermore, there is no evidence advanced that in following (or at least failing to

question) Dr. Sullivan's recommendation that Coumadin be discontinued six days before surgery he acted contrary to accepted practice. Dr. Freed states that this was too soon but never provides a statement of what the correct standard should have been in this case, and why. Further, Dr. Freed claims that "confusion" regarding the Coumadin led to Mittleberg's refusal to be hospitalized so that Heparin could be administered, but this is little more than speculation as to Mittleberg's motives, and Dr. Moschetto's role in that decision. Accordingly, the plaintiff has been unable to place in issue Dr. Moschetto's showing that the care he rendered did not deviate from acceptable medical practice, and/or that decisions he made were a cause of death. Summary judgment is thus granted to this defendant and the action as against him is dismissed.

The Court reaches a different conclusion with regard to Dr. Sullivan. In reply, Dr. Sullivan's attorney stresses the alleged failure of Dr. Freed to address Mittleberg's history of ulcerative colitis as a separate and valid basis for recommending the surgery. However, reading the record and evidence presented, as it must, in a manner most favorable to the plaintiff as the motion opponent, the Court cannot agree that Dr. Partridge asserted that the presence of ulcerative colitis, on its own, was a reason surgery was recommended, and that Dr. Freed's statement did not place Dr. Partidge's analysis in issue.

Specifically, Dr. Partridge stated that

> "The purpose of performing surveillance colonoscopies in a patient with ulcerative colitis is to look for dysplastic changes in the colon. One of the tissue specimens collected during the July 20, 2004 colonoscopy revealed displasia. Dysplasia is an abnormality in the mucosa of the bowel which is considered a transition from normal tissue to malignancy in a patient with ulcerative colitis. In addition to dsyplasia, Mr.

> Mittleberg had a longstanding history of ulcerative colitis. On August 3, 2004 Dr. Rizzo spoke to decedent by telephone and recommended that he undergo a panproctocolectomy. Dr. Rizzo documented in his records that the patient was aware of the risk of developing colon cancer, that the patient would likely pursue the proposed procedure... and would see Dr. Sullivan regarding the procedure."

The Court does not read the foregoing to mean that the presence of ulcerative colitis, by itself, was enough to justify the significant surgery the decedent underwent. Notwithstanding the separate sentence regarding the colitis, Dr. Partridge never states there or anywhere else that this condition, standing alone, can indicate that cancer might develop. Rather, he refers to it expressly as a basis for looking for dysplasia, and that it is the dysplasia that can signal the risk of colon cancer, forming the reason for the surgery. Therefore, if an issue of fact exists regarding a departure tied to the analysis of the dysplasia, the fact that Dr. Freed did not also separately address the ulcerative colitis does not fatally undermine his contrary analysis.

The Court finds that such an issue has been raised. Dr. Freed did note the history of ulcerative colitis (¶ 4). However, he opines, as noted above, that the sample reviewed indicated "low grade" dysplasia, and that because survival rates of patients with such dysplasia were statistically no better in patients who underwent the surgery than those who did not surgery was not indicated. He also claims that because "there was a tremendous interobserver difference in readings of dysplasia" the sample slides should have been reviewed by another pathologist who specialized in gastroenterology before surgery was

recommended. An issue of fact is therefore presented as to whether the surgery was unnecessary, which led to the hospitalization and the complications that ultimately caused Mittleberg's death. *See, Taylor v Nyack Hospital., supra; Dunlop v Sivaraman,* 272 AD2d 570 (2d Dept. 2000); *Lipsius v White,* 91 AD2d 271 (2d Dept. 1983). Further, reading the record in plaintiff's favor, the initial hesitancy Dr. Sullivan expressed to Dr. Rizzo because of Mittleberg's overall condition serves to support Dr. Freed's position that the surgery should not have been performed. Accordingly, summary judgment is denied to Dr. Sulllivan.

Defendant Hilepo's Proof

In support of his motion, Dr. Hilepo has submitted the Affirmation of Dr. Sheldon Alter, a Board Certified Internist and Nephrologist and a Diplomat of the American Board of Internal Medicine. He has reviewed Mittleberg's pertinent medical records as well as the transcripts of the parties' examinations-before-trial and the legal documents of this case. Dr. Alter notes that it was Dr. Sullivan who managed Mittleberg's anticoagulant medication in the hospital and that it was in fact his role to do so given the risks of operative and postoperative bleeding from the extensive surgery performed. He also notes that the anesthesiologist concurred that anticoagulant medication be withheld until the epidural catheter was removed because of the risk of hemorrhage into the spine. Dr. Alter opines that under the circumstances, Dr. Hilepo acted in accordance with applicable medical standards and that none of his acts or omissions were the proximate cause of Mittleberg's death. Dr. Hilepo has also established his entitlement to summary judgment shifting the burden to plaintiff to establish the existence of a material issue of fact.

In opposition to defendant Dr. Hilepo's application, plaintiff has submitted the Affirmation of Dr. Bruce D. Charash, who is Board Certified in Internal Medicine and Cardiovascular Disease. Dr. Charash has also reviewed Mittleberg's medical records, the transcript of Dr. Hilepo's examination-before-trial and Dr. Alter's Affirmation in support of Dr. Hilepo's application. Dr. Charash is of the opinion to a reasonable degree of medical certainty that Dr. Hilepo deviated from the standards of acceptable medical practice in his care of Mittleberg and that that deviation was a competent cause of Mittleberg's death.

He states that "accepted medical practice dictates that anticoagulation therapy in a patient such as Mittleberg is a **shared, joint responsibility** of both his Internist and Surgeon;" that as his internist, it was Dr. Hilepo's responsibility to monitor his anticoagulation therapy on a regular basis; and that it was "Dr. Hilepo's responsibility to consult with Dr. Sullivan **each and every day postoperatively** in order to determine whether anticoagulation should resume." He also states that Dr. Hilepo as Mittleberg's Internist "had a responsibility to participate in the medical decisions and care postoperatively, especially as it impact[ed] upon a chronic medical condition for which he ha[d] been involved in caring for and treating [Mittleberg] for in the past."

Dr. Charash notes that Dr. Hilepo failed to communicate with Dr. Sullivan every day regarding Mittleberg's anticoagulation and in fact at all regarding his treatment, which, Dr. Charash opines, was a departure from accepted medical practice. As for causation, Dr. Charash opines that Dr. Hilepo's failure to communicate with Dr. Sullivan and to urge him

to resume anticoagulation therapy sooner proximately caused the acute thrombus of Mittleberg's mitral valve prosthesis and his death: had Dr. Hilepo seen to it that Mittleberg's anticoagulation medicine resumed earlier, the thrombus would not have occurred and Mittleberg's death would have been avoided.

The foregoing is inadequate to overcome defendant's proof. Even assuming that Dr. Hilepo should have been in communication with Dr. Sullivan, and that this was a departure from good and accepted medical practice, there is no proof that the decision Dr. Charash states was the cause of death constituted malpractice. Specifically, he alleges that the failure to urge Dr. Sullivan to resume anticoagulation therapy before the third day postoperatively caused death. However, this conclusion is unsupported by any reference to the medical record placing in issue the correctness of the professional decision-making process involved in delaying the anticoagulant therapy, which Dr. Alter notes was based on the fear of hemorrhage into the spine. If there was no departure from accepted medical practice on Dr. Sullivan's part, then a failure by Dr. Hilepo's to communicate with him and urge a different course cannot be viewed as contributing to the malpractice, and thus constitute a cause of injury to the patient.

Accordingly, the Court finds that the plaintiff has failed to establish the existence of a material issue of fact with respect to Dr. Hilepo. This defendant is therefore granted summary judgment, and the complaint is dismissed insofar as it is asserted against him.

This shall constitute the Decision and Order of this Court.

ENTER

DATED: September 12, 2008

HON. DANIEL PALMIERI
Acting Supreme Court Justice

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