SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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CHRISTOPHER BARTNICK, Individually and as Administrator of the Estate of VIVIAN BARTNICK, Deceased

Plaintiff,

-against-

MICHAEL M. MANNINO, M.D., MANHASSET MEDICAL ASSOCIATES, P.C., PETER D. BUFFA, M.D., and ISLAND MEDICAL GROUP, P.C.

Defendants.

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MICHELE M. WOODARD, J.S.C.
TRIAL/IAS Part 16
Index No.: 8530/04
Motion Seq. Nos.: 02 & 03

DECISION AND ORDER

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Defendant Michael M. Mannino, M.D. and Manhasset Medical Associates, P.C. move and Defendant Peter D. Buffa, M.D. and Island Medical Group, P.C., cross-move for an order pursuant to CPLR §3212 granting them Summary Judgment dismissing the Plaintiff's complaint against them.

The Plaintiff in this action seeks to recover for the wrongful death of his wife, the decedent Vivian Bartnick. Her death was allegedly caused by the Defendants' medical malpractice. The cause of death listed on the decedent's death certificate is "acute cardiac failure" and "myocarditis." "Mitral Valve Prolapse," for which Defendant Mannino was treating the decedent, is listed on the death certificate as "other significant condition contributing to death but not related to other causes."

The Defendants both seek summary judgment dismissing the complaint. "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. 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 (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." Perro v Schappert, ___ AD2d___, 848 NYS2d 882 (2nd Dept. 2008), citing Anderson v Lamaute, 306 AD2d 232 (2nd Dept. 2003); DiMitri v Monsouri, 302 AD2d 420, 421 (2d Dept. 2003). "On a motion for summary judgment in a medical malpractice action, a Defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice or that the Plaintiff was not injured thereby." Shahid v New York City Health & Hospitals Corp., ___ AD2d ___, 2008 WL 191796 (2nd Dept. 2008), citing Rebozzo v

Wilen, 41 AD3d 457, 458 (2nd Dept. 2007); Thompson v Orner, 36 AD3d 791, 791-792 (2nd Dept. 2007); Williams v Sahay, 12 AD3d 366, 368 (2nd Dept. 2006). Once the Defendant doctor establishes his entitlement to summary judgment, the burden shifts to the Plaintiff to establish the existence of a triable issue of fact. Shahid v New York City Health & Hospitals Corp., supra, citing Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986).

"To establish a *prima facie* case of medical malpractice, a Plaintiff must establish that the physician's actions deviated from accepted medical practice and that such deviation proximately caused his or her injuries." Flaherty v Fromberg, 46 AD3d 743, 745 (2nd Dept. 2007), citing Thompson v Orner, supra; Texter v Middletown Dialysis Ctr., Inc., 22 AD3d 831 (2nd Dept. 2005); Prete v Rafla-Demetrious, 224 AD2d 674, 675 (2nd Dept. 1996). "To meet this burden, a Plaintiff ordinarily presents expert testimony on the Defendant's deviation from the requisite standard of care." Flaherty v Fromberg, supra, at p. 745, citing Texter v Middletown Dialysis Ctr., Inc., 22 AD3d 831 (2nd Dept. 2005). "To establish proximate cause, the Plaintiff must demonstrate '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." Flaherty v Fromberg, supra, at 745, citing Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881 (2nd Dept. 2005); Holton v Sprain Brook Manor Nursing Home, 253 AD3d 852 (2nd Dept. 1998). "[T]he Plaintiff's evidence may be deemed legally sufficient even if its expert cannot quantify the extent to which the Defendant's act or omission decreased the Plaintiff's chance of a better outcome or increased his injury as long as evidence is presented from which the jury may infer that the Defendant's conduct diminished the Plaintiff's chance of a better outcome or increased his injury." Flaherty v Fromberg, supra, at 745, citing Barbuto v Winthrop Univ. Hosp., 305 AD2d

623, 624 (2nd Dept. 2003); Wong v Tong, 2 AD3d 840, 840-841 (2nd Dept. 2003); Jump v Facelle, 275 AD2d 345, 346 (2nd Dept. 2000). Accordingly, to establish the existence of a factual issue regarding proximate cause, only evidence from which "a jury can infer that it was probable that some diminution in the chance of survival . . . occurred" is required. Jump v Facelle, supra, at p. 346, citing Mortensen v Memorial Hosp., 105 AD2d 151 (1st Dept. 1984); Provost v Hassam, 256 AD2d 875 (3rd Dept. 1988); Fridovich v David, 188 AD2d 984 (3rd Dept. 1992). When grounded on facts in the record, conflicting experts' opinions establish the existence of an issue of fact. Feinberg v Feit, 23 AD3d 517 (2nd Dept. 2005), citing Shields v Baktidy, 11 AD3d 671 (2nd Dept. 2004); Barbuto v Winthrop Univ. Hosp., supra.

The pertinent facts are as follows:

The decedent, 24 weeks pregnant, was evaluated at Long Island Jewish Hospital ("LIJ") from February 9, 2001 to February 23, 2001 upon a referral by her doctor who had performed a Holter Monitor Study which revealed that she suffered from nonsustained ventricular tachycardia–a type of arrhythmia–after she complained of syncope (loss of consciousness), periodic lightheadedness and being off balance. At LIJ, the decedent was diagnosed as suffering from nonsustained ventricular tachycardia, mitral valve prolapse, severe mitral regurgitation, with an ejection fraction at the lower levels of normal. She was placed on Lopressor (a/k/a Metoprolol) an anti-arrhythmic medication with titrating doses up to 100 mg b.i.d. Her condition improved and at her insistence, she was discharged. She was continued on Metoprolol and instructed to carry an automatic external defibrillator. She was also instructed to look into electrophysiological testing following the birth of her child.

The decedent followed up with cardiologist Defendant Dr. Mannino at Manhasset Medical

Associates on April 5, 2001. Dr. Mannino's office record reflects that the decedent "absolutely denie[d] any frank syncope," however, copies of letters from Dr. Bruce Goldner, the Director of Cardiac Electrophysiology at Long Island Jewish dated March 15, 2001 and March 20, 2001, which are found in Dr. Mannino's chart of the decedent, state that "she was admitted for an episode of syncope" and that "the patient was admitted after a syncopal event." The decedent told Dr. Mannino that she had not been experiencing symptoms related to tachycardia since her discharge from LIJ but she still experienced occasional palpitations and dyspnea when climbing stairs or exerting herself, which she attributed to her pregnancy. She also reported having been diagnosed with gestational diabetes. Dr. Mannino noted that the decedent's father died in his 60's from a heart attack and that her siblings also had mitral valve prolapse. Dr. Mannino noted that the decedent had been diagnosed with mitral valve prolapse with regurgitation. His examination showed a "mid-systolic click audible at the apex" and "a soft murmur . . . at the left sternal border and apex. No gallop," however, it is noted to be "borderline" with a "borderline left atrial abnormality." The decedent's ECG was noted as "sinus rhythm, normal tracing." The Holter Monitor Report for the study done on April 9, 2001 showed that the decedent was experiencing sinus rhythm, periods of sinus tachycardia and frequent multiple premature ventricular contractions (PVCs) with couplets and triplets. Dr. Mannino's Impression and Plan on the date of his initial examination reads:

> History of mitral valve prolapse with regurgitation. Echocardiography at Long Island Jewish Hospital demonstrated severe regurgitation. No episodes of congestive heart failure. Nonsustained ventricular tachycardia, now controlled on Metoprolol. No history of syncope. The patient appears to be tolerating the medication well. Will continue with the above. A follow-up echocardiogram will be performed to reassess left ventricular function and degree of valvular regurgitation. A 24-hour

> Holter monitor will also be placed to evaluate her rhythm on a 24-hour basis. . . The symptoms of tachyarrhythmias were reviewed and she will notify us of any unusual episodes immediately. Further discussions will be undertaken following the delivery with regard to the management and work-up of both her tachyarrhythmias and valvular heart disease.

The decedent next saw Dr. Mannino on May 11, 2001. She reported having had a successful delivery of her firstborn child. She noted that while in the hospital she had been tapered off Metoprolol and had not had any arrhythmic events. She reported being free of chest pain, shortness of breath or palpitations since the delivery. She again denied having experienced syncope. Dr. Mannino's physical exam revealed no significant changes. While the ECG findings indicate sinus rhythm with normal tracing, once again, it is documented as "borderline" with "borderline left atrial abnormality." Dr. Mannino's chart note for that day reads:

> Clinically stable at the present time. We had a long discussion with regard to our options at this point. The fact that the patient never had a syncopal episode is very reassuring. Part of the problem may have been the cardiac response to the stress of pregnancy. I am going to have her follow-up with me in a few weeks for repeat echocardiogram and Holter monitor to assess her cardiac function at that time. It is likely that she will eventually require an electrophysiologic study. I did recommend that she have her valve repaired prior to any future pregnancies. She was instructed to notify me immediately of any unusual cardiac symptoms. She continues to possess a defibrillator that will be maintained at home for emergency purposes.

Dr. Mannino next saw the decedent on June 14, 2001. She again reported to be doing very well, that she had not been suffering from chest pain, shortness of breath or palpitations and had no episode of syncope or near syncope. Dr. Mannino's physical exam of the decedent was the same. An echocardiogram performed that day showed no changes. A Holter Monitor Study revealed PVCs, atrial premature contractions and short bursts of supraventricular tachycardia. His

chart note for that day reads:

> History of mitral valve prolapse with regurgitation, moderate degree at least. Asymptomatic. History of nonsustained ventricular tachycardia during pregnancy. Remains asymptomatic. No evidence of recurrence. Will continue to monitor clinically. A Holter monitor will be placed today to assess her 24-hour rhythm. Echocardiography has not changed significantly and her left ventricular function remains satisfactory. Once again we discussed about the likely need for mitral valve repair prior to future pregnancies. She was instructed to notify me immediately of any unusual cardiovascular symptoms.

The decedent's echocardiogram of June 15, 2001 showed (1) mildly dilated left ventricle with overall normal systolic function; (2) mitral valve prolapse; and (3) valvular regurgitation. The Ejection fraction at rest was 55%. The Holter monitor of the same date revealed: (1) sinus rhythm; (2) occasional premature ventricular contractions (PVC), rare couplet, one triplet; (3) occasional atrial premature contractions (APC); (4) short bursts of supraventricular tachycardia (SVT); but otherwise, no symptoms.

The decedent was first seen at Island Medical Group on July 25, 2001. A complete history was taken and Dr. Buffa performed a complete physical including a cardiac examination. Dr. Buffa detected a mild murmur and a mid-systolic click; which is consistent with a patient with a mitral valve prolapse. The decedent's EKG revealed a normal sinus rhythm and an enlargement of her left atrium, which is also consistent with a patient with a mitral valve prolapse.

The decedent next saw Dr. Mannino on September 13, 2001, on which date she again reported to be doing well. Dr. Mannino's physical exam of the decedent was the same. While the ECG report for that visit reports a normal sinus rhythm, it also reports "Borderline Left Atrial Abnormality" and "multiple premature complexes–ventricular and supraventricular." Dr. Mannino's chart note for that day reads:

> Will continue to monitor clinically. A Holter monitor will be placed once again in the future to follow-up on her 24 hour rhythm. We discussed once again future pregnancies. I wonder if repair of her mitral valve prior to any subsequent pregnancies will improve her tolerance of the pregnancy and reduce the degree of ectopy. I recommend that she seek a second opinion with regard to conservative management versus surgical repair. In the meantime we will continue to monitor her carefully. She will notify me of any unusual cardiovascular symptoms.

Dr. Mannino's chart note for September 13, 2001 does not reflect the Holter monitor results from June, 2001, or the ECG results of that date.

The decedent was treated at the Island Medical Group on November 15, 2001 for a twisted ankle and on December 1, 2001 for a cold and a prescription was given. The decedent was seen at Island Medical Group on January 8, 2002 for back pain following snow shoveling.

The decedent's last visit with Dr. Mannino was on March 19, 2002. Once again, she reported to be doing very well clinically. Dr. Mannino noted "exercise echocardiography today, good duration, occasional isolated PVCs." Dr. Mannino's physical examination of the decedent was unchanged. Dr. Mannino's chart note reads:

> Will continue to monitor clinically. A Holter monitor will be placed once again later in the year to follow-up on her 24-hour rhythm. We discussed once again future pregnancies. I wonder if repair of her mitral valve prior to any subsequent pregnancies will improve her tolerance of the pregnancy and reduce the degree of ectopy. I recommend that she seek a second opinion with regard to conservative management versus more aggressive approach. In the meantime we will continue to monitor her carefully. She has stated that she does not want to take an aggressive approach (surgery or EP) since she feels well. She will notify me of any unusual cardiovascular symptoms.

The decedent went to Island Medical Group on March 19, 2002 with upper respiratory symptoms, congestion and a low fever and she was prescribed an antibiotic. She returned to Island

Medical Group on April 9, 2002 complaining of congestion, a cough and sore throat. She was again prescribed an antibiotic as well as nasal spray and cough medicine. While a chest x-ray was taken, the results are not reflected anywhere.

On June 17, 2002, the decedent returned to Island Medical Group and was seen by Dr. Wallach. She complained of pain in her left wrist, knees and feet. Her lungs were clear and her cardiac exam was normal. She was prescribed an anti-inflammatory Celebrex and told to see a rheumatologist if her symptoms persisted. Records of telephone calls between the decedent and Island Medical Group reflect that she reported that her joint pain was traveling and pain medications were prescribed. The decedent returned to Island Medical Group on June 24, 2002 complaining of joint pain. On examination, it was found that the swelling had migrated to her right wrist, shoulders and knees. Her vital signs were normal as was her cardiovascular exam. Dr. Buffa diagnosed her with arthralgia and urged her to follow-up with a rheumatologist.

The decedent died the next day.

In support of their motion for summary judgment, Dr. Mannino and Manhasset Medical Associates have submitted the affidavit of a cardiologist, Dr. David Farr. After reviewing the pertinent medical and legal records, Dr. Farr concluded that "at no time did Dr. Mannino deviate or depart from good and accepted medical practice in his care and treatment of the decedent and that Dr. Mannino's care and treatment of the decedent did not cause or contribute to her death." Dr. Farr explains that the decedent's cause of death, myocarditis, is an inflammation of the myocardium, the muscular part of the heart, which is generally caused by a viral or bacterial infection. He explains that it presents with chest pain, rapid signs of heart failure, or sudden death. Other signs may include fever, joint pain or swelling, fatigue, shortness of breath, leg swelling, an

inability to lie flat. It also may cause an episode of syncope or fainting, often related to arrhythmia. Dr. Farr notes that the decedent did not demonstrate any signs or symptoms of myocarditis; that her mitral valve prolapse with regurgitation was asymptomatic as was her nonsustained ventricular tachycardia while she was being treated by Dr. Mannino; and, that her echocardiogram of March 19, 2002 did not suggest myocarditis. Thus, Dr. Farr concludes that Dr. Mannino's plan to continue monitoring the decedent was appropriate. Dr. Farr also notes that Dr. Mannino repeatedly advised the decedent that her mitral valve must get repaired before any more pregnancies and that he often advised her to get a second opinion regarding conservative versus aggressive treatment, which the decedent chose not to do.

Via the affidavit of Dr. Farr, Dr. Mannino has established his entitlement to summary judgment thereby shifting the burden to Plaintiffs to demonstrate the existence of a material issue of fact.

The Plaintiffs have met their burden. They have submitted the affirmation of a New York State licensed Board Certified Internist with a sub-specialty in Cardiovascular Diseases. He reviewed the pertinent medical and legal documents. The Plaintiff's expert notes that Dr. Mannino never advocated repair of the mitral valve prolapse unless the decedent intended to get pregnant and that Mr. Bartnick testified that his wife always followed Dr. Mannino's advice. He opines with a reasonable degree of medical certainty that "it was a departure from proper and accepted medical practice for Dr. Mannino to fail to explain and firmly recommend in no uncertain terms that the patient needed to undergo mitral valve repair as soon as possible–now–not if some subsequent event such as pregnancy were to occur." He opines "that it was a departure from proper and accepted medical practice for Dr. Mannino to fail to explain and firmly recommend in

no uncertain terms that the [decedent] also needed at this time a full work up of and treatment for arrhythmia, which would have included a work-up to determine if [she] required placement of an internal defibrillator and placing [her] back on some type of anti-arrhythmic medication, such as the Lopressor." Plaintiff's expert faults Dr. Mannino for not taking steps to determine cause, severity or possible treatment modalities for the findings of potentially life threatening PVCs and to address whether the decedent required prompt treatment of the mitral valve prolapse, the regurgitation, the decedent's worsening heart function, or any of the arrhythmias that the decedent was experiencing. Dr. Mannino failed to conduct a recent Holter monitor study although the need had been mentioned six months earlier.

The Plaintiff's expert notes that on the date the decedent last saw Dr. Mannino, she also saw Dr. Buffa. The Plaintiff's expert further explains "[b]ased on the [decedent's] history of ventricular tachycardia, the fact that the [decedent] continued to experience symptomatology, including PVCs and evidence of other arrhythmias, Dr. Mannino was required, pursuant to accepted standards of medical care to inform the [decedent] that even absent symptomatology, her underlying condition absolutely required prompt and complete work-up and treatment and that same must be followed closely on a continuing basis. It is clear that Dr. Mannino allowed himself to be misled by the relative absence of symptomatology so that he did not act with urgency to have the [decedent] worked up fully and appropriately." He opines that "[t]he failure of Dr. Mannino to appropriately impart information to the [decedent] regarding the potential complications she was facing on each and every visit he had with her was a departure from accepted standards of care as they existed in 2001 and 2002." He further opines that "[b]ased on [the decedent's] history of ventricular tachycardia, the fact that the [decedent] continued to experience arrhythmias, including

PVCs and ventricular ectopy which were worsening, the fact that the [decedent] had documented severe regurgitation and the fact that the [decedent's] heart functioning was diminishing as evidenced on echocardiogram by the increase in left ventricular size, left atrial enlargement, now normal ejection fraction, increased septum wall thickness, increase in the right ventricle size and high pulmonary artery pressures over the course of time that Dr. Mannino was treating this [decedent], Dr. Mannino departed from accepted standards of care by only 'clinically monitoring' the [decedent]."

He concludes that "[p]ursuant to accepted standards of care, Dr. Mannino was required to properly recognize that [the decedent] was at risk for a multitude of complications and risks including congestive heart failure, worsening heart function, fatal arrhythmias and cardiomegaly. Based on these risks, it was Dr. Mannino's obligation to immediately recommend–in no uncertain terms–that the [decedent] undergo mitral valve repair as soon as possible. Dr. Mannino's failure to do this was a departure from good and accepted practice and this departure was a substantial factor in causing the injury to this patient." He opines that "Dr. Mannino, as well, was required to recommend that as soon as possible, a full work-up of and treatment for arrhythmia be performed, which would have included a work-up to determine if the [decedent] required placement of an internal defibrillator and placing the [decedent] back on some type of anti-arrhythmic medication, such as the Lopressor the patient was previously on which had a documented positive effect. Dr. Mannino's failure to do this was a departure from good and accepted practice and this departure was a substantial factor in causing injury to this patient."

In conclusion, the Plaintiff's expert also states that in light of test results, basing the treatment plan on the decedent's reported lack of symptomatology was a departure from accepted

standards of care. The Plaintiff's expert opines that the care–of lack thereof–rendered by Dr. Mannino was a substantial contributing factor of the decedent's death. He explains that had the decedent undergone repair of her mitral valve and/or the administration of anti-arrhythmic agents and/or the implantation of an internal pacemaker, "the effects that the worsening heart condition described above (cardiomegaly; increase in ventricular size; worsening pulmonary artery pressures; reduced ejection fraction, worsening arrhythmia **would have been reduced or eradicated**, thereby giving the [decedent's] heart the ability to withstand other potential stressors, i.e., myocarditis, arrhythymias, particularly life threatening ones (emphasis added)." He explains the heart, when in proper working order, can often times fight off the effects of myocarditis, thereby allowing the myocarditis to essentially run its course and resolve. However, he explains that the decedent was left with a weakened heart that continued to worsen in condition, with arrhythmias that not only contributed to the worsening heart function, but placed her at risk for life threatening arrhythmias. Thus, Plaintiff's expert concludes that the decedent was not able to withstand the myocarditis superimposed on all of the other conditions she was suffering from without receiving treatment.

The Plaintiffs' expert's opinion establishes that there are issues of fact as to whether Dr. Mannino's care of the decedent was in accordance with good and accepted standards and whether the decedent's chance of survival was compromised due to his neglect.

In support of their motion for summary judgment, Island Medical Group and Dr. Buffa have submitted the affidavit of Philip Gelber, M.D., a New York State licensed board certified internist with a subcertification in cardiovascular diseases. After reviewing the pertinent medical and legal records, he opines "with a reasonable degree of medical certainty that Dr. Buffa's and

Island Medical Group, P.C.'s care and treatment of the decedent, Vivian Bartnick, was at all times in accordance with good and accepted medical practice." He states that "[a]t no time did they commit any departures from good and accepted practice which were a substantial factor in causing the patient's death." He explains that the decedent never presented to Island Medical Group with signs of myocarditis. He admits that while "she did present with joint and swelling which can sometimes be associated with myocarditis, these complaints in the absence of any cardiac abnormalities are more consistent with a non-cardiac related condition and [that] it was reasonable for Dr. Buffa and Island Medical Group to suspect arthralgia/arthritis and refer the patient to a rheumatologist when her condition did not improve after a course of anti-inflammatories."

Defendants Island Medical Group and Dr. Buffa have also established their entitlement to summary judgment thereby shifting the burden to Plaintiffs to establish the existence of a material issue of fact.

Once again, the Plaintiffs have met their burden. In opposition to Island Medical Group and Dr. Buffa's motion, the Plaintiffs have submitted the affirmation of a New York State licensed board certified surgeon and fellow of the American College of Cardiology. He affirms that he is familiar with the evaluation, monitoring, diagnosis and treatment of patients who present with new signs, symptoms and complaints of myocarditis, as well as the specific standards of care as they exist for such a patient who is simultaneously under the care of a specialist for mitral valve prolapse, mitral valve prolapse with regurgitation and the standards of care pertaining to such patients from the standpoint of an internist as they relate to cardiologists as they existed in the years 2001 and 2002. After reviewing the pertinent medical and legal records, he concluded that Defendants Island Medical Group, P.C. and Peter Buffa, M.D. departed from said standards

of care with regard to the treatment of the decedent, most specifically in June, 2002, they departed from good and accepted medical practices and that such departures were substantial contributing factors in causing and/or contributing to the decedent's injuries, including her death. More specifically, Plaintiffs' expert explains that "[g]ood and accepted practice in the years 2001 and 2002 required that a physician presented with a patient making complaints of joint pain, a history of diarrhea, a rapid or abnormal heartbeat (arrhythmia); joint pain; diarrhea; fluid retention, with swelling of the legs, ankles and feet; vague chest pains; headache; body aches, fever; and swelling consider the possibility that such patient may be suffering from myocarditis." He emphasizes that "[t]his is particularly true if the patient recently had a viral or other type infection, as such an infection may go on to cause myocarditis." He opines that a differential diagnosis was called for here, and in light of the decedent's symptoms, myocarditis should have been considered. He explains:

> "Pursuant to the standard of care in the year 2001 and 2002, when a physician was faced with a patient who presents with signs and symptoms consistent with myocarditis that physician was required to take an appropriate medical history, perform a physical examination, including listening to the heart to detect abnormal heart rhythms and sounds, including murmurs; order and/or perform an electrocardiogram; order and/or perform a chest x-ray; order and /or perform an echocardiogram; and order and/or perform blood tests, including blood testing to measure the white and red blood counts, and the levels of enzymes that indicate damage to the heart muscle. Blood tests can also detect antibodies against viruses and other organisms that may indicate a myocarditis-related infection. The failure of an internist to meet the standard of care as outlined above is a departure from accepted standard of care.

He also affirms that under the circumstances, the decedent's cardiologist should have been notified and the decedent should have been told that she may have a serious heart condition with possible grave consequences and told to seek care from a specialist or an emergency room. It is

the Plaintiffs' expert's opinion with a reasonable degree of medical certainty that Defendant Island Medical Group and Dr. Buffa's failures were departures from accepted standards of care and substantial contributing factors in the decedent's death. He concludes:

> "Had Defendants Island Medical Group and Peter Buffa, M.D. timely and properly evaluated Vivian Bartnick, timely and properly investigated the [decedent's] condition and properly followed the standards of care as outlined above, the [decedent] would have been evaluated by her cardiologist and in a hospital setting, where her myocarditis would have been diagnosed, the cause for same be identified and treated. Importantly, the [decedent] would also have had a thorough cardiac evaluation performed, as would have been required by the standards of care for a patient such as this. The [decedent's] cardiac condition would have been addressed and all precautions would have been in place to ensure that the patient did not suffer from acute cardiac failure, thereby averting the [decedent's] untimely death on June 25, 2002.

The Plaintiffs' expert's opinion also establishes that there are issues of fact as to whether Island Medical Group and Dr. Buffa's care of the decedent was in accordance with good and accepted standards and whether the decedent's chance of survival was compromised due to their neglect.

The Defendants' motions (Seq. Nos. 02 & 03) for Summary Judgement are **denied.**

ORDERED, the parties are directed to appear for trial in CCP on April 9, 2008 at 9:30 a.m.

This constitutes the **DECISION** and **ORDER** of the Court.

DATED: February 26, 2008
Mineola, New York

ENTER:

HON. MICHELE M. WOODARD
J.S.C.

G:\Bartnick v Mannino-MLP.wpd