Hubler v Lefland
2012 NY Slip Op 30850(U)
March 26, 2012
Supreme Court, Nassau County
Docket Number: 24592/09
Judge: Denise L. Sher
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SCAN

SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK

PRESENT: HON. DENISE L. SHER
Acting Supreme Court Justice

KAREN HUBLER, as Executor of the Estate of FRANK PETER HERZBERG, Deceased,

Plaintiff,

- against -

MITCHELL LEFLAND, M.D., RICHARD SCHWARTZ, D.O., NICHOLAS RAO, M.D., JERALD COHEN, M.D., JOSEPH MAZZIE, M.D., ANCA KRANZ, M.D., ISLAND CARDIAC SPECIALISTS and WINTHROP UNIVERSITY HOSPITAL,

Defendants.

TRIAL/IAS PART 31
NASSAU COUNTY

Index No.: 24592/09
Motion Seq. No.: 01
Motion Date: 12/20/11

The following papers have been read on this motion:

	Papers Numbered
Notice of Motion, Affirmation, Affidavit and Exhibits	**1**
Affirmation in Opposition and Exhibits and Affidavits	**2**
Reply Affirmation and Exhibits	**3**

Upon the foregoing papers, it is ordered that the motion is decided as follows:

Defendants Jerald Cohen, M.D. (“Cohen”), Joseph Mazzie, M.D. (“Mazzie”) and Winthrop University Hospital (“Winthrop”) move, pursuant to CPLR § 3212, for an order granting them summary judgment and dismissing plaintiff’s Verified Complaint against them. Plaintiff opposes the motion.

In the instant action, plaintiff seeks to recover damages for medical malpractice and the

wrongful death of Frank Peter Herzberg ("Herzberg"). She alleges that defendants were negligent in their care of him from December 7, 2008 through December 13, 2008 in that they failed to timely diagnosis and formulate a treatment plan for his true condition, *i.e.*, an aortic dissection.

Defendants Doctors Cohen and Mazzie, as well as defendant Winthrop, seek summary judgment dismissing the Verified Complaint against them.

The facts pertinent to the determination of this motion are as follows:

Mr. Herzberg was brought to defendant Winthrop via ambulance on December 7, 2008. Upon arrival at 11:00 a.m., he complained of having experienced left sided chest pain that radiated to his back and left jaw earlier that morning, which had lasted approximately ten minutes. His medical history included hypertension, obesity, high cholesterol and questionable coronary heart disease. He reported having had a stress test four years earlier with negative results. A chest x-ray was done at 12:29 p.m., at Mr. Herzberg's bedside, via a portable technique with him in the semi-erect position. The images were uploaded into a digital viewing system which was interpreted by diagnostic radiologist defendant Dr. Mazzie. Knowing only Mr. Herzberg's gender, age (seventy-eight years) and history of chest pain, viewing the frontal x-ray of Mr. Herzberg's chest, defendant Dr. Mazzie's impression was that there was no focal consolidation or plural effusion. Defendant Dr. Mazzie noted a small dense nodular opacity in the upper left lung zone, likely representing a calcified granuloma, for which he recommended comparison with prior studies. He additionally noted that the cardiac and mediastinal contours could not be accurately assessed due to the utilization of the portable technique. He further noted calcification of the aortic knob which was ecstatic, meaning that it was tortuous, and that the

visualized osseous structures, or bone structures, were remarkable. Defendant Dr. Mazzie testified at his Examination Before Trial ("EBT") that the trachea appeared tilted to the right on the film, but that could have been caused by the patient's rotated position. An electro-cardiogram ("EKG") was also performed which revealed that Mr. Herzberg was in sinus bradycardia. The case was discussed with cardiologist defendant Dr. Nicholas Rao ("Rao") of Island Cardiac Associates and Mr. Herzberg was admitted to defendant Winthrop and placed on oxygen. A Transthoracic Echocardiogram ("TTE"), the quality of which was technically limited, was performed at Mr. Herzberg's bedside at 7:15 p.m. It revealed normal left ventricular systolic function with an ejection fraction of 55-60% and normal right ventricular global systolic function.

On December 8, 2008, a cardiology consult was done by Dr. Jacaruso, also of Island Cardiac Associates, who concluded that Mr. Herzberg was experiencing Acute Coronary Syndrome ("ACS") or chest pain secondary to blockages of the coronary arteries. He recommended, *inter alia*, checking Mr. Herzberg's lipid panel and cardiac enzymes, as well as a cardiac catheterization. A second TTE was performed that day and the images were interpreted by defendant Dr. Cohen at 3:05 p.m. He found indications of chest pain and hypertension. He evaluated the structure of the aortic valve and the dimensions of the aortic root and the ascending aorta to determine if the aorta was dilated. Originally, his measurements of the aorta, which the tech obtained and he signed off on, revealed that the ascending aorta was 5.1 cm and the aortic root was 4.3 cm, indicating moderate dilation. However, at his EBT, defendant Dr. Cohen testified that he re-measured the ascending aorta and found it to be 4.8 cm. He also reviewed the ejection fraction and noted that it was 60-65% and that there was Grade I diastolic function, mild

mitral regurgitation and mild tricuspid regurgitation. Additionally, his review of the heart and surrounding structures revealed the presence of mild aortic regurgitation and mild aortic sclerosis. His review of the heart did not reveal any pericardial effusion. Defendant Dr. Cohen did not recommend any further work-up since only dilated aortas measuring 5.5 cm and greater call for further work-up and there was only mild dilation of the aortic root and the ascending aorta.

A cardiac catheterization was done shortly past 4:00 p.m. and was interpreted by defendant Dr. Richard Schwartz. His report noted 60% stenosis in Mr. Herzberg's circumflex coronary artery and an 80-90% occlusion in the right coronary artery ("RCA") which was ulcerated. He recommended that a stent be inserted in the RCA and, when performed, the stent reduced the stenosis to 0%.

On December 9, 2008, at 9:20 a.m., a Nurse Practitioner recommended Mr. Herzberg's discharge with instructions to follow up at Island Cardiac Associates and with his primary care doctor. After conducting an evaluation, a Medical Attending Physician agreed and discharged Mr. Herzberg.

Mr. Herzberg was seen by defendant Dr. Rao at Island Cardiac Associates on December 10, 2008. He complained of chest pain when lying down. Dr. Rao concluded, *inter alia*, that the TTE performed that day revealed pericardial effusion at the right ventricle and that the ascending aorta was dilated at 4.8 cm. A right duplex scan of Mr. Herzberg's right groin was also performed and it revealed a pseudoaneurysm. Mr. Herzberg was referred to defendant Winthrop for admission.

Upon admission to defendant Winthrop at 1:30 p.m., on December 10, 2008, under the care of Island Cardiac Associates, Mr. Herzberg was placed on a cardiac monitor. Defendant Dr.

Kranz did a chest x-ray on which he observed "borderline cardiomegaly." Defendant Dr. Rao saw Mr. Herzberg on December 11, 2008, on which date Mr. Herzberg reported no further chest pain. The cardiac monitor revealed that Mr. Herzberg was in atrial fibrillation and defendant Dr. Rao concluded that he also had pericarditis, was status post-catheterization, had atrial fibrillation with a controlled response and renal insufficiency. Defendant Dr. Rao recommended, *inter alia*, discontinuing Dyazide (used to treat hypertension) and continuing Metoprolol (which treats coronary disease by lowering the heart rate and blood pressure). A lower extremity arterial duplex examination of Mr. Herzberg's right groin was performed which revealed a 2.1 cm hematoma and no evidence of a pseudoaneurysm.

Defendant Dr. Rao saw Mr. Herzberg again on December 12, 2008, around 9:50 a.m. Mr. Herzberg reported no further chest pain. Defendant Dr. Rao concluded that he had atrial fibrillation and pericarditis which had resolved as well as acute renal failure. In light of the finding of pericardial effusion, defendant Dr. Rao recommended another TTE and requested a renal consult. That night, at approximately 10:22 p.m., Mr. Herzberg complained of subscapular chest pain on a level of seven (7) out of ten (10). He was seen by a Telemetry Physician Assistant ("PA") who placed him on oxygen, gave him 0.4 mg of sublingual Nitroglycerin and 2 mg of Morphine, obtained an EKG STAT and ordered a cardiac profile. The EKG revealed that Mr. Herzberg was in atrial fibrillation, with a heart rate of 89 bpm. After interventions were performed, the PA noted that Mr. Herzberg's pain decreased to level "2" out of "10." Finally, as documented in the chart, the PA called defendant Dr. Schwartz and made him aware that Mr. Herzberg had complained of chest pain and the PA noted that, as per defendant Dr. Schwartz, a second cardiac profile would be repeated at 8:00 a.m.

Defendant Dr. Schwartz, along with a PA, saw Mr. Herzberg on December 13, 2008, and

concluded that he could be discharged and have the TTE performed at Island Cardiac Associates on Monday, December 15, 2008, since his pericarditis was resolving. Prior to his discharge, Mr. Herzberg was seen by a nephrologist who noted that his acute renal failure was secondary to the use of Non-Steroid Anti-Inflammatory ("NSAIDs"), his Creatine level was back to baseline without stopping all NSAIDS and IV fluids and that IV fluids could be discontinued. Defendant Dr. Schwartz approved Mr. Herzberg's discharge. Later that day, before he left defendant Winthrop, Mr. Herzberg went into cardiac arrest while he was getting dressed. He was unable to be resuscitated and was pronounced dead at 2:20 p.m. The autopsy report lists the cause of death as cardiac tamponade as a result of an ascending dissection of the proximal aorta which began 2 cm above the aortic valve or due to aortic dissection.

"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." *See Sheppard-Mobley v. King*, 10 A.D.3d 70, 778 N.Y.S.2d 98 (2d Dept. 2004), *aff'd. as mod.*, 4 N.Y.3d 627, 797 N.Y.S.2d 403 (2005), *citing Alvarez v. Prospect Hospital,* 68 N.Y.2d 320, 508 N.Y.S.2d 923 (1986); *Winegrad v. New York University Medical Center*, 64 N.Y.2d 851, 487 N.Y.S.2d 316 (1985).Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers. *See Sheppard-Mobley v. King*, *supra* at 74; *Alvarez v. Prospect Hospital*, *supra*; *Winegrad v. New York University Medical Center*, *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. *See Alvarez v. Prospect Hospital*, *supra* at 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 A.D.3d 518,

824 N.Y.S.2d 166 (2d Dept. 2006), *citing Secof v. Greens Condominium*, 158 A.D.2d 591, 551 N.Y.S.2d 563 (2d Dept. 1990).

"[T]o succeed on an action to recover damages for wrongful death, the plaintiff must prove the following elements: (1) the death of a human being born alive; (2) a wrongful act, neglect or default of the defendant by which the decedent's death was caused, provided the defendant would have been liable to the deceased had death not ensued; (3) the survival of distributees who suffered pecuniary loss by reason of the death of decedent; and (4) the appointment of a personal representative of the decedent." *Slobin v. Boasiako*, 19 Misc.3d 1110(A), 859 N.Y.S.2d 906 (Supreme Court Nassau County 2008) *quoting Chong v. New York City Transit Authority*, 83 A.D.2d 546, 441 N.Y.S.2d 24 (2d Dept. 1981).

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (quotations omitted)." *Faicco v. Golub*, 91 A.D.3d 817, 938 N.Y.S.2d 105 (2d Dept. 2012). *See also Roca v. Perel*, 51 A.D.3d 757, 859 N.Y.S.2d 203 (2d Dept. 2008); *DiMitri v. Monsouri*, 302 A.D.2d 420, 754 N.Y.S.2d 674 (2d Dept. 2008); *Flaherty v. Fromberg*, 46 A.D.3d 743, 849 N.Y.S.2d 278 (2d Dept. 2007). "Thus, [o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby." *Faicco v. Golub*, *supra* at 817. *See also Roca v. Perel*, *supra*; *Chance v. Felder*, 33 A.D.3d 645, 823 N.Y.S.2d 172 (2d Dept. 2006); *Stukas v. Streiter*, 83 A.D.3d 18, 918 N.Y.S.2d 176 (2d Dept. 2011). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to 'submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant . . . so as to demonstrate the existence of a triable issue of

fact.' " *Savage v. Quinn*, 91 A.D.3d 748, 937 N.Y.S.2d 265 (2d Dept. 2012) *quoting Alvarez v. Prospect Hospital*, *supra*. *See also Stukas v. Streiter*, *supra* at 24. "General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment (citations omitted)." *Savage v. Quinn*, *supra*. "In determining a motion for summary judgment, the court must view the evidence in the light most favorable to the nonmoving party." *Caggiano v. Cooling*, 92 A.D.3d 634. 938 N.Y.S.2d 329 (2d Dept. 2012) *citing Stukas v. Streiter*, *supra* at 23.

In a case like this, causation is established if a reasonable person could conclude that it was more probable than not that if a defendant had ordered an appropriate test to be done right away, it could have been conducted, an accurate diagnosis made and corrective surgery begun before the decedent experienced death. *See Imbierowicz v. A.O. Fox Memorial Hosp.*, 43 A.D.3d 503, 841 N.Y.S.2d 168 (3d Dept. 2007) *citing Turcsik v. Guthrie Clinic, Ltd.*, 12 A.D.3d 883, 784 N.Y.S.2d 721 (3d Dept. 2004); *Slaybough v. Nathan Littauer Hosp.*, 202 A.D.2d 773, 608 N.Y.S.2d 745 (3d Dept. 1994) *lv den.* 83 N.Y.2d 962, 616 N.Y.S.2d 13 (1994); *O'Connell v. Albany Med. Ctr. Hosp.*, 101 A.D.2d 637, 475 N.Y.S.2d 543 (3d Dept. 1984). In fact, " 'in 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 probably than not' that the defendant's deviation was a substantial factor in causing the injury." *Goldberg v. Horowitz*, 73 A.D.3d 691, 901 N.Y.S.2d 95 (2d Dept. 2010) *quoting Johnson v. Jamaica Hosp. Medical Center*, 21 A.D.3d 881, 800 N.Y.S.2d 609 (2d Dept. 2005) *citing Alicea v. Ligouri*, 54 A.D.3d 784, 864 N.Y.S.2d 462 (2d Dept. 2008); *Flaherty v. Fromberg*, *supra*; *Bunea v. Cahaly*, 37 A.D.3d 389, 829 N.Y.S.2d 638 (2d Dept. 2007); *Holton v. Sprain Brook*

Manor Nursing Home, 253 A.D.2d 852, 678 N.Y.S.2d 503 (2d Dept. 1998) *lv den.* 92 N.Y.2d 818, 685 N.Y.S.2d 42 (1999). "A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased the 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 [the] injury.' " *Goldberg v. Horowitz, supra* at 694 *quoting Alicia v. Ligouri, supra* at 786 (internal quotation marks omitted) *citing Flaherty v. Fromberg, supra* at 745; *Jump v. Facelle*, 275 A.D.2d 345, 712 N.Y.S.2d 162 (2d Dept. 2000).

A hospital cannot ordinarily be held vicariously liable for the malpractice of a private attending doctor. *See Sita v. Long Island Jewish Medical Center*, 22 A.D.3d 743, 803 N.Y.S.2d 112 (2d Dept. 2005). That is, "[w]hen supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene." *Bellafiore v. Ricotta*, 83 A.D.3d 632, 920 N.Y.S.2d 373 (2d Dept. 2011) *citing Soto v. Andaz*, 8 A.D.3d 470, 779 N.Y.S.2d 104 (2d Dept. 2004); *Costello v. Kirmani*, 54 A.D.3d 656, 863 N.Y.S.2d 262 (2d Dept. 2008); *Crawford v. Sorkin*, 41 A.D.3d 278, 839 N.Y.S.2d 40 (1st Dept. 2007).

Finally, conflicting expert opinions supported by facts in the record suffice to raise an issue of fact regarding medical malpractice. *See Hayden v. Gordon*, 91 A.D.3d 819, 937 N.Y.S.2d 299 (2d Dept, 2012).

In support of the motion for summary judgment, defendant Dr. Mazzie has submitted the Affirmation of Board Certified Diagnostic Radiologist Dr. Karen Fried. *See* Defendants Cohen, Mazzie and Winthrop's Affirmation in Support Exhibit A. Having reviewed the pertinent

medical and legal records, Dr. Fried opines that defendant Dr. Mazzie did not depart from accepted standards of medical practice in his interpretation of Mr. Herzberg's December 7, 2008 chest x-ray which is defendant Dr. Mazzie's sole role in Mr. Herzberg's care. Succinctly put, Dr. Fried opines that defendant Dr. Mazzie accurately interpreted the x-ray to the extent that he was able. Dr. Fried notes that portable x-rays do not accurately display the cardiac and mediastinal contours which defendant Dr. Mazzie duly noted. Dr. Fried opines that there was no visible evidence of an aortic dissection in that chest x-ray, that the tortuous calcification of the aortic knob (which defendant Dr. Mazzie noted) is common in elderly patients (in particular in seventy-eight year old men) and that alone is not indicative of an aortic dissection. Dr. Fried further notes that the fact that the trachea appeared tilted or displaced might have been caused by the portable technique coupled with Mr. Herzberg's position when the x-ray was done.

Also in support of their motion for summary judgment, defendants Dr. Cohen and Winthrop have submitted the affirmation of Board Certified Cardiologist Dr. Richard A. Stein. *See* Defendants Cohen, Mazzie and Winthrop's Affirmation in Support Exhibit B. Having interpreted Mr. Herzberg's TTE on December 8, 2008, Dr. Stein opines that defendant Dr. Cohen properly reviewed and interpreted said TTE and that defendant Winthrop's staff appropriately carried out Mr. Herzberg's attending doctors' orders. More specifically, Dr. Stein opines that the TTE was properly performed by the technician on December 8, 2008, and that defendant Dr. Cohen's review and interpretation of it was thorough, complete and entirely accurate. Dr. Stein opines that, since the dimensions of the ascending aorta and aortic root measured at 4.8 cm and 4.3 cm respectively and were less that 5.5 cm, in the absence of other clinical or echocardiographic findings, there was no need for further work-up. Dr. Stein further concluded that dilations observed here are common in patients of Mr. Herzberg's age. He opines

that defendant Dr. Cohen's duties were fulfilled when he reported his findings to Mr. Herzberg's doctors and that decisions regarding further testing were theirs alone to make.

Upon reviewing Mr. Herzberg's medical records, Dr. Stein also found that the care provided by defendant Winthrop's staff during both of Mr. Herzberg's admissions was medically appropriate; more specifically, the staff "acted in accordance with good and accepted medical practice by timely and appropriately carrying out Mr. Herzberg's attending doctors' orders."

In addition, both Dr. Fried and Dr. Stein concluded that, in any event, none of defendants Cohen, Mazzie or Winthrop's staff's actions were a substantial cause of Mr. Herzberg's demise.

Defendants Cohen, Mazzie or Winthrop have established their entitlement to summary judgment thereby shifting the burden to plaintiff to establish the existence of a material issue of fact.

In opposition to defendants Cohen, Mazzie and Winthrop's motion, plaintiff has submitted the Affidavits of a doctor certified in Cardiovascular and Interventional Radiology and a doctor Board Certified in Internal Medicine with a sub-speciality in Cardiovascular Medicine.

Defendants Cohen, Mazzie and Winthrop oppose this Court's consideration of said Affidavits on the grounds that these expert witnesses were belatedly disclosed. *See Construction by Singletree, Inc. v. Lowe*, 55 A.D.3d 861, 866 N.Y.S.2d 702 (2d Dept. 2008). Depositions were completed on July 19, 2011. Defendants Cohen, Mazzie and Winthrop's expert disclosures were made on August 3, 2011 and August 22, 2011. The Note of Issue was filed on September 23, 2011. Plaintiff's expert disclosure was served on October 24, 2011. This motion, however, was not filed until nearly one month later on November 22, 2011.

Standing alone, the fact that the expert disclosure was made after the Note of Issue was filed does not bar consideration thereof. *See Browne v. Smith*, 65 A.D.3d 996, 886 N.Y.S.2d 696

(2d Dept. 2009). Evidence of intentional or willful failure to disclose and a showing of prejudice by the opposing party is required. *See Browne v. Smith*, *supra* at 996 *citing Hernandez-Vega v. Zwanger-Pesiri Radiology Group*, 39 A.D.3d 710, 833 N.Y.S.2d 627 (2d Dept. 2007); *Aversa v. Taubes*, 194 A.D.2d 580, 598 N.Y.S.2d 801 (2d Dept. 1993). Neither an intentional willful failure to disclose by plaintiff nor prejudice to defendants Cohen, Mazzie and Winthrop is evident. The fact that defendants Cohen, Mazzie and Winthrop served their expert disclosure prior to receiving plaintiff's expert disclosure does not constitute prejudice on account of the late disclosure. That could have happened anyway. Nor does *King v. Gegruss Mgt. Corp.*, 57 A.D.3d 851, 870 N.Y.S.2d 103 (2d Dept. 2008), relied on by defendants Cohen, Mazzie and Winthrop, require that plaintiff's experts' affidavits be disregarded. In that case, the plaintiff's expert was not disclosed until the plaintiff was called upon to oppose the defendants' summary judgment motion which was not the case here.

Defendants Cohen, Mazzie and Winthrop further challenge plaintiff's expert radiologist's qualifications. While s/he is presently licensed in Massachusetts, s/he is certified by the American Board of Radiology in the fields of Radiology and Cardiovascular and Interventional Radiology, as well as Cardiovascular CT and Endovascular Medicine. The fact that s/he completed his/her education and training in the United Kingdom does not require that s/he be found unqualified. That factor may be considered by the jury at trial in deciding the weight to be afforded his/her testimony. Contrary to defendants Cohen, Mazzie and Winthrop's assertions, s/he has set forth an adequate basis for finding her/him qualified to render an opinion here, to wit, s/he attests that, in light of her education and training, s/he is experienced in reading and interpreting radiological studies, including radiographs and transthoracic echocardiograms ("TTEs"). S/he attests that s/he is "fully familiar with the signs and symptoms of aortic

dissections as they appear on these radiological studies [and that s/he is] further familiar with the effects of aortic dissection, including pain and death [and] aware of the duties of radiologists and echocardiologists in diagnosing and treating aortic dissections."

In opposition to defendant Cohen, Mazzie and Winthrop's motion, having reviewed the pertinent legal and medical records, plaintiff's expert radiologist opines that "[a]ortic dissection is a deadly condition marked by tears between the layers of the aorta." S/he explains that "[t]he inner aortal layer (the intima) tears first causing blood to leak to through to the next layer (the media). The leaking blood creates a separation between the intima and the outer layers thereby expanding the aorta. The tears also cause pain that follows the path of the aorta. Thus, when a patient feels the aortal tear, the pain typically radiates towards the back." S/he explains that an "aortic dissection manifests itself in many ways. Among symptoms are radiating chest pain and back pain, fainting, shortness of breath, and/or abdominal or leg pain. The radiographic signs include dilation of the aortic arch; dilation of the ascending aorta and aortic root; widening of the mediastinum; separation of aortic calcification from edge of the aortic knob; and deviation of the trachea."

S/he opines to a reasonable degree of medical certainty that defendant Dr. Mazzie, and concomitantly defendant Winthrop, deviated from good and accepted standards of medical practice in their care of Mr. Herzberg by failing to render a differential diagnosis of aortic dissection when the x-ray was read on December 7, 2008, and in not recommending further radiological studies including a CT angiography, MR angiogram or Transesophagel Echocardiogram ("TEE") **"given Herzberg's chest pain that radiated to his back** and [as shown on the December 7th x-ray] a widening of the mediastinum, a deviated trachea and a greater than 5 millimeter separation of calcification from the edge of the aortic arch (emphasis

added)." S/he bases the finding of Mr. Herzberg's radiating chest pain from his complaint upon admission at 11:00 a.m., at which time he complained of "severe chest pain on his left side that radiated to his back and left jaw." S/he further explains that "a patient suffering from aortic dissection typically experiences chest pain that radiates towards the back: The patient feels pain as the aortic wall tears and pain from aortic dissection radiates towards the back because it follows the path of the aorta, which transports blood towards the back and then downward." S/he opines "with a reasonable degree of medical certainty that radiologists and echocardiologists must take into account any reports of pain while interpreting radiological studies, because it allows for the most accurate diagnosis of the patient's condition."

S/he additionally states that in examining the first x-ray read by defendant Dr. Mazzie on December 7, 2008, s/he observes a "widening of the mediastinum; separation of calcification from the edge of the aortic knob; and deviation of the trachea [which] are highly suspicious of aortic dissection" and that defendant Dr. Cohen erred in simply attributing these findings to Mr. Herzberg's position and not reporting them in his x-ray report. S/he explains that "[h]ad Dr. Mazzie made these findings, aortic dissection would have been suspected as early as December 7, 2008. Widening of the mediastinum (the space in between the right lung and the left lung) is consistent with widening of the aorta, because the aorta pushes the mediastinum as it expands. The widened aorta also can push the trachea causing deviation or tilting, as is now indisputably seen in Herzberg's [December 7th] chest x-ray."

S/he further opines that separation of calcification is another sign of aortic dissection and, in Mr. Herzberg's first chest x-ray, the calcification was five (5) to eight (8) millimeters away from the outer wall indicating dilation of the outer walls of the aorta. Coupled with radiating chest pain, these observations should have caused defendant Dr. Mazzie to suspect dissection and

it was error for him not to include it in his differential diagnosis. S/he further opines that "[o]nce signs of aortic dissection are observed, the patient must undergo an immediate . . .TEE, CT angiography ("CTA") or MR angiogram (MRA) [and that] Dr. Mazzie's **failure to suggest an immediate TEE or CTA or MRA** was a deviation from good and accepted medical practice."

S/he also opines that defendant Dr. Cohen, and concomitantly defendant Winthrop, deviated from good and accepted standards of medical care in their care of Mr. Herzberg by failing to render a differential diagnosis of aortic dissection and by recommending further radiological studies including a CT angiography, MR angiogram and TEE when the December 8, 2008 TTE was read by defendant Dr. Cohen "given [his] findings of an ascending aorta measured at 5.1 cm in diameter and an aortic root measured at 4.3 cm in diameter." S/he disagrees with defendants Cohen, Mazzie and Winthrop's expert's conclusions regarding the acceptable measurement of normal ascending aorta and aortic root. S/he opines that Mr. Herzberg's measurements were well outside the acceptable range because an ascending aorta should not exceed 4.3 cm in diameter and an aortic root should not exceed 4 cm in diameter. S/he goes on to opine "**[w]hen a patient reports chest pain that radiates to the back** and has an aortic root diameter that exceeds 4 centimeters and an ascending aorta diameter that exceeds 4.3, an immediate suspicion of aortic dissection should be raised [and that] it is [her/his] opinion with a reasonable degree of medical certainty that it was a departure from good and accepted medical practice for Dr. Cohen to fail to suggest a differential diagnosis of aortic dissection (emphasis added)." S/he further opines that once a suspicion for aortic dissection is raised in a TTE, it is good and accepted medical practice for an echocardiologist to recommend a TEE, CTA or MRA and that defendant Dr. Cohen's failure to do so was a deviation from good and accepted medical practice.

S/he also opines that defendant Dr. Kranz, and concomitantly defendant Winthrop, deviated from good and accepted standards of medical care in their care of Mr. Herzberg by not rendering a differential diagnosis of aortic dissection and recommending further radiological studies including a CT angiography, MR angiogram or TEE when defendant Dr. Kranz read Mr. Herzberg's x-ray on December 10, 2008. S/he states that s/he observes even more pronounced widening of the mediastinum, deviation of the trachea and separation of calcification from the aortic arch on Mr. Herzberg's December 10, 2008 x-ray and states that the separation of calcification is over eight (8) mm, "well over the normal distance between the intima and outer wall of the aorta." In light of this, s/he opines that defendant Dr. Kranz erred in failing to recommend further radiological studies including a CT angiography, MR angiogram or TEE.

In sum, based upon Mr. Herzberg's "radiating chest pain" and the December 7, 2008 x-ray, plaintiff's expert opines that Mr. Herzberg was experiencing acute aortic dissection beginning on December 7, 2008. S/he further notes that radiographic and echocardiographic signs, namely the widening of the mediastinum, separation of the calcification from the aortic knob, deviation of the trachea and the prominence of the ascending aorta and aortic dilation of over four centimeters, all indicate that Mr. Herzberg was suffering from an acute aortic dissection. Thus, s/he opines that had a TEE, CTA or MRA been performed, a proper diagnosis could have been made. S/he opines that the above mentioned errors "more likely than not prevented Herzberg from undergoing immediate surgery on his dissected aorta that would have resulted in survival, not death."

Having reviewed the pertinent legal and medical records, such as plaintiff's radiologist expert, plaintiff's cardiologist expert opines that "if Dr. Cohen, Dr. Kranz and/or Dr. Mazzie diagnosed Herzberg with a dissected aorta or at least ordered further studies to accurately

diagnose a dissected aorta, under the standard of care, **Herzberg would have undergone life saving emergency surgery and would have survived.**" S/he explains that once an acute proximate aortic dissection is detected, surgery must be performed because any delay is too dangerous. S/he further opines that patients who undergo surgery to repair or bypass dissected aortas early are more likely to survive.

Plaintiff's expert cardiologist concurs with plaintiff's expert radiologist that the x-rays and second TTE test results "combined with the radiating chest pain [were] highly suspicious of dissection." S/he also opines that the findings from the second chest x-ray were also suspicious of aortic dissection.

Plaintiff's expert cardiologist also opines that defendant Winthrop's hospital staff departed from good and accepted medical standards on December 12, 2008, when they failed to ascertain the cause of Mr. Herzberg's severe chest and subscapular pain. S/he also agrees with plaintiff's expert radiologist's analysis and conclusions, in particular the conclusion that Mr. Herzberg was suffering from aortic dissection as early as December 7, 2008, and that a TEE or CTA should have been performed to confirm said condition. S/he opines Mr. Herzberg's radiating chest pain which followed the path of the aorta, and the radiographic signs of dilation of the aorta suggest that his aortic wall was torn and being widened by the subsequent leaking of blood. S/he further opines, to a reasonable degree of medical certainty, that, had the aortic dissection been confirmed sooner, Mr. Herzberg would have undergone immediate emergency surgery and, more likely than not, survived.

Plaintiff's expert cardiologist further opines, with respect to defendant Winthrop, that Mr. Herzberg's "chest and subscapular pain of 7 out of 10 (on December 12th) should have raised immediate cause for concern" in light of his medical history, *i.e.*, pericarditis, dilation of the

aorta and atrial fibrillation. S/he explains that "a patient that has just undergone a cardiac catheterization should not have severe chest pain unless there is something wrong with the stent or another aspect of the heart. Therefore, [s/he opines] with a reasonable degree of medical certainty that the pathology of the pain must be ascertained immediately [and] that it was a departure from good and accepted medical practice for staff at [Winthrop] to **not even consider the pathology of the pain**." S/he opines that an immediate EKG and a TEE or CTA or MRA should have been done and defendant Winthrop's staff's failure to perform one of those tests was a deviation from good and accepted medical practice. S/he additionally opines that, had an EKG, TEE or CTA been done, Mr. Herzberg's aortic dissection would have been diagnosed and most likely treated with surgical intervention.

It is not disputed that defendant Dr. Mazzie was not advised of Mr. Herzberg's "radiating chest pain" when he read the December 7, 2008 x-ray. To the extent that this is a factor relied on by plaintiff's expert in attributing negligence to him, plaintiff has failed to establish the existence of a material issue of fact regarding his care of Mr. Herzberg. Nevertheless, other findings by plaintiff's radiologic and cardiologist experts, *i.e.*, the failure to report a widening of the mediastinum, separation of calcification from the edge of the aortic knob and deviation of the trachea, which they opine are highly suspicious of aortic dissection and, when the x-ray was read on December 7, 2008, were independent of defendant Dr. Mazzie's lack of knowledge regarding Mr. Herzberg's radiating chest pain. Accordingly, plaintiff has established the existence of a material issue of fact with respect to defendant Dr. Mazzie's involvement in Mr. Herzberg's care.

Plaintiff has also established the existence of a material issue of fact with respect to defendant Dr. Cohen's involvement in the care provided to Mr. Herzberg. Plaintiff's failure to specifically allege in her Bill of Particulars that defendant Dr. Cohen erred in failing to

recommend a TEE or CTA when he read the TTE on December 8, 2008 does not bar her from alleging so here. She alleged in her Bill of Particulars that defendant Dr. Cohen failed to appreciate the studies indicating an enlarged aortic diameter, in failing to enter into the process of differential diagnosis, in failing to order an MRA, in failing to take heed of the ascending aorta and the aortic root upon diagnostic studies, in negligently depriving Mr. Herzberg of an opportunity of cure and treatment of his condition, in negligently allowing his condition to progress to the point at which he suffered a dissected aorta and death. That defendants Cohen, Mazzie and Winthrop's expert, Dr. Stein, concurred in defendant Dr. Cohen's assessment does not change the fact that plaintiff's expert clearly disagrees, which suffices to establish the existence of an issue of fact. Similarly, the fact that a third TTE was done on December 10, 2008, which gave the same measurements and was read by a defendant Dr. Kranz, who also failed to act, does not eradicate defendant Dr. Cohen's contributory role here.

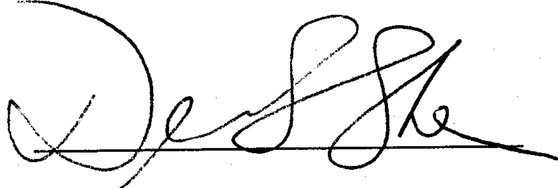
Plaintiff also established the existence of a material issue of fact regarding defendant Winthrop's staff's care of Mr. Herzberg. First, defendant Winthrop's doctor's failure on December 7, 2008 to communicate all of Mr. Herzberg's crucial symptoms, *i.e.*, radiating chest pain to radiologist defendant Dr. Mazzie. Also, defendant Dr. Krantz's reading of the December 10, 2008 x-ray. Finally, defendant Winthrop's staff's response to Mr. Herzberg's symptoms on December 12, 2008. While an EKG was done, plaintiff's cardiology expert opines that further testing was called for under the circumstances.

Accordingly, defendants Cohen, Mazzie and Winthrop's motion, pursuant to CPLR § 3212, for an order granting them summary judgment and dismissing plaintiff's Verified Complaint insofar as asserted against them is hereby **DENIED**.

All parties shall appear for Trial Conference in Nassau County Supreme Court, Differentiated Case Management Part (DCM) at 100 Supreme Court Drive, Mineola, New York, on April 25, 2012, at 9:30 a.m.

This constitutes the Decision and Order of this Court.

ENTER:



DENISE L. SHER, A.J.S.C.

ENTERED
MAR 29 2012
NASSAU COUNTY
COUNTY CLERK'S OFFICE

Dated: Mineola, New York
March 26, 2012