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SHORT FORM ORDER

INDEX No. 07-17292
CAL No. 12-01604MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 47 - SUFFOLK COUNTY

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 12-17-12 (# 006)
MOTION DATE 1-11-13 (# 007)
MOTION DATE 2-20-13 (# 008)
ADJ. DATE 5-1-13
Mot. Seq. # 006 - MD
007 - MD
008 - MD

ELLEN UFFELMANN-KNIPFING, as Administratrix of the Estate of DAVID KNIPFING, deceased, and ELLEN UFFELMANN-KNIPFING, Individually,

Plaintiffs,

- against -

CLAUDIA FERNANDES, M.D., ELHAN SULEY, D.O. JOAN SCALERA, N.P., JASON WINSLOW, M.D. and NORTHSIDE PRIMARY MEDICAL CARE, P.C. AKA HEALTHWORKS OF MEDFORD,

Defendants.

SCAFFIDI & ASSOCIATES
Attorney for Plaintiffs
747 Third Avenue, Suite 10B
New York, New York 10017

KELLY, RODE & KELLY, LLP
Attorney for Defendants Fernandes, M.D., Suley, D.O., and Northside Primary Medical Care
330 Old Country Road
Mineola, New York 11530

MALAPERO & PRISCO LLP
Attorney for Defendant Scalera, N.P.
295 Madison Avenue
New York, New York 10017

STAGG, TERENZI, CONFUSIONE & WABNIK, LLP
Attorney for Defendant Winslow, M.D.
401 Franklin Avenue, Suite 300
Garden City, New York 11530

Upon the following papers numbered 1 to 80 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (006) 1 - 27; (007) 28-55; (008) 56-67; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 68-73; Replying Affidavits and supporting papers 74-78; 79-80 ; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (006) by defendant, Joan Scalera, N.P., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is denied; and it is further

ORDERED that motion (007) by the defendants, Claudia Fernandes, M.D., Elhan Suley, D.O., and Northside Primary Medical Care P.C. a/k/a Healthworks of Medford, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied; and if is further

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ORDERED that motion (008) by defendant, Jason Winslow, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied.

In this medical malpractice action, the plaintiff, Ellen Uffelmann-Knipfing, individually and as Administrator of the Estate of David Knipfing, seeks damages against the defendants premised upon their alleged medical malpractice, and lack of informed consent concerning their care and treatment of her spouse, the decedent. The plaintiff seeks damages for economic loss, and interposes a derivative claim. It is alleged that the defendants failed to properly examine, diagnose and treat the plaintiff's decedent, who had a cardiac history, resulting in his death from a myocardial infarction with rupture of the inferior wall. The decedent had been under the care and treatment of physicians and nurse practitioners employed by Northside Primary Medical Care P.C. a/k/a Healthworks of Medford (Healthworks) since June, 2000. Dr. Kao and Dr. Folan were principals of said corporation. The decedent was seen by defendant Dr. Claudia Fernandes at Healthworks on February 10, 2006, and sent to Stony Brook Hospital emergency department where he was seen by Dr. Jason Winslow for further evaluation and testing. Thereafter, the decedent received follow up care at Healthworks on February 11, 2006 with Dr. Elhan Suley, and then on March 11, 2006 with NP Joan Scalera. The decedent, a sixty-three year old man, died on March 12, 2006 at age sixty-three. It is alleged that the defendants failed to properly diagnose and treat the plaintiff's decedent and failed to recognize the signs and symptoms of an MI and ongoing cardiac ischemia; failed to properly review and interpret the electrocardiograms available and, inter alia, failed to order, obtain, or ensure an emergent cardiology consult, referral and echocardiogram which the decedent's condition and the standards of care required. It is claimed that these departures by the defendants were a proximate cause of, and a substantial factor, in causing the decedent's pain, suffering, heart rupture, and premature death.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]**; *Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical

care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

Medical records are required to be submitted in admissible form which requires that they be certified pursuant to CPLR 3212 and 4518 (***Friends of Animals v Associated Fur Mfrs.,*** *supra*). Expert testimony is limited to facts in evidence (*see also* ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]). It is noted that none of medical records, except for the Northside Primary Medical Care (Healthworks) records, have been submitted in admissible form to be considered on a motion for summary judgment and, thus, are not in evidence.

Unsigned and uncertified transcripts of the examination before trial of a non-party witness are inadmissible pursuant to CPLR 3212. (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]); the unsigned but certified transcripts of the examination before trial of the various non-party witnesses, unaccompanied by proof of service upon the party pursuant to CPLR 3116 are not considered; the unsigned but certified transcript of the examination before trial of a witness, which has not been objected to by any party is considered (***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); and the unsigned transcripts submitted by the respective moving parties are considered to be adopted as accurate by the moving defendant and are considered (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]).

In motion (006), Joan Scalera, N.P. seeks summary judgment dismissing the complaint as asserted against her on the bases that she did not negligently depart from the accepted standards of care and treatment, that there was no true "doctor-patient" relationship between her and the decedent, and that there is nothing that she did or did not do which proximately caused the injuries claimed by the plaintiffs. In support of this application, defendant Scalera has submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' answers and demands, and plaintiffs' verified bill of particulars; uncertified copies of the Stony Brook emergency department record and Brookhaven Memorial Hospital records; certified copy of the Healthworks' medical records; copy of a notarized letter dated June 27, 2011 by Jonathan H. Sumner, M.D. and his affidavit dated November 8, 2012; unsigned but certified transcripts of the examinations before trial of Ellen Uffelmann-Knipfing dated June 6, 2008, Claudia Fernandes, M.D. dated July 24, 2008, Elhan Suley, D.O. dated August 20, 2008, Michael Ryder, M.D. dated May 12, 2009, Jason Winslow, M.D. dated March 24, 2010, and Joshua Shiller, M.D. dated June 16, 2010 from Stony Brook Hospital which are not objected to; the signed transcript of the examination before trial of Joan Scalera N.P., dated September 22, 2008; unsigned and uncertified transcript of the examination before trial of non-party John Francis Folan

dated July 14, 2010; uncertified copy of the Report of Autopsy dated March 14, 2006; and the affidavit of Joan Scalera, N.P. dated October 17, 2012.

It is determined that even if the evidentiary submissions were all in admissible form, and if Dr. Sumner provided a complete affidavit setting forth his qualifications to proffer expert opinion, there are factual issues which preclude summary judgment from being granted.

The autopsy report of March 14, 2006 states the decedent's cause of death as a ruptured acute myocardial infarction of the inferior wall of the left ventricle due to severe arteriosclerotic coronary heart disease. The report also indicates that the three major vessels, except the left common coronary, show patchy atherosclerosis which has up to severe, including 80 to 85 % narrowings in the LAD and left circumflex arteries. The right coronary artery shows patchy atherosclerosis with up to 70-75% focal narrowing. An occluding thrombus was noted in the transverse sections of the left circumflex, distal aspect of an inferior wall branch at the lumen which was 65 % narrowed. The pericardial sac contained approximately 225 cc of mostly clotted blood with prominent hemorrhage into the mediastinum.

The decedent's wife, Ellen Uffelmann-Kniffing, testified that her husband's primary physician at Healthworks was Dr. Becker whom he first saw in about 2000 and continued with until Dr. Becker left the facility. She continued that her husband's family had a history of heart disease and he was worried that he might have the same. He was seen at East End Cardiology for chest pain and was previously told that he had a mild heart attack. The decedent's spouse testified that the decedent went to Healthworks for colds and for his yearly exams. He was also seen at Healthworks for a numbing pain in his left arm on and off for a couple weeks, and lightheadedness and dizziness, with shortness of breath and tiredness, and was sent to Stony Brook Hospital where he was treated and released on February 10, 2006, a month before he died. The day after the incident, her husband was seen at Healthworks for a blood pressure check, at which time he was advised that he should have an echocardiogram if he felt worse. He was told to come back in a month, which he did on March 11, 2006, presenting with a "cold" for which he was given a prescription for an antibiotic. He was very tired and slept for several hours after the visit at Healthworks. On March 12, 2006, she went out grocery shopping, and upon her return, found her husband slumped over the toilet. She called 911 and tried to administer CPR. The ambulance transported the decedent to Brookhaven Memorial Hospital where he was pronounced dead. Several days later, she received a call from Dr. Ryder from Healthworks offering his condolences. The decedent had previously seen Dr. Ryder for patient care at Healthworks.

Dr. Folan testified that in 1999, he formed Northside Primary Medical Care, P.C. with Dr. Kao, and has been a shareholder since. The d/b/a for the P.C. was Healthworks, an S corporation, for both the Islandia and Medford offices. If a patient was to come in for a visit, the appointment is made with whomever is free, depending upon who was in the office. His office offered "same day appointments" and did not term them as "walk-ins" as is done with the "doc-in-the-box." Dr. Folan testified that Dr. Ryder managed the co-signing of charts in Medford as he was the doctor there who would be overseeing his own patients and charts, and review charts to evaluate the performance of the NPs and PAs. However, he continued that any physician there could do so as well.

Dr. Folan testified that the decedent, David Knipfing never became a patient of the group and he was not his patient, although he was seen at Healthworks many times. He had no independent recollection of the decedent. He initialed the notes of November 24, 2003, October 17, 2003, and July 8, 2003, indicating that he reviewed them. He did see the decedent and wrote a clinical note, on June 9, 2003, at which time he

noted that the decedent's blood pressure was 138/90 on the right, and 126/100 on the left. Dr. Folan advised, among other things, that the decedent take red yeast rice as they likely had a conversation about cholesteral and maybe heart risks. Dr. Folan stated that he also reviewed the note of July 8, 2003 by Dr. Francis DiPalo, a temporary physician who provided care in the Medford office. He did not know why he co-signed the note. He also signed the November 24, 2003 note by Dr. Ryder, but did not know why. Upon learning of Mr. Knipfing's death, he had conversations amongst providers involved, including NP Scalera and Dr. Ryder, and perhaps Dr. Kao, but he could not remember the sum and substance of those conversations. Dr. Folan testified that he gave general oversight and monitoring of NP Joan Scalera. From 2003 through 2006, he was Scalera's mandatory collaborating physician, as per the law, and they were colleagues in the practice of medicine. However, he continued, he did not consider himself to be responsible for the diagnosis and treatment of the patients that NP Scalera saw.

Dr. Michael Ryder testified that he has been an employee of Healthworks since 2003. He was not a collaborating physician for the Nurse Practitioners at Healthworks. He had his assigned patients. Walk-in patients were distributed between him and the other providers at Healthworks. His job with walk-in patients was to treat their complaints and give good medical advice for the condition that he was seeing, including, making a diagnosis and providing treatment, which included a history and physical examination, but not a complete physical examination. The physician for a walk-in patient may or may not have been affiliated with Healthworks. Documentation on the chart at the time of the visit would be the same, irrespective of whether or not their physician is with Healthworks. Drs. Robin Dacosta, Folan, Suley, Fernandes, and Kao, PA Squittieri, and NP Scalera staffed the Medford and Hauppauge offices in 2006. Dr. Ryder testified that he was responsible for the patients in the group at Medford where the decedent came for his medical care.

Dr. Ryder testified that he saw the decedent on October 17, 2003 and for five other visits, however, he stated that the decedent never established himself as his patient on an "establishing visit with a check up" "for true medical follow-up care", and only presented for acute symptoms. Thus, stated Ryder, he did not consider the decedent to be his patient. The PAs and NPs could not act as primary physicians. Usually their records were reviewed by the patient's primary care physician or by Dr. Folan. If any of his patients were seen by the PA or NA, he would review the chart. In 2006, there was no mechanism in place to obtain the medical records for a patient who was a walk-in without a primary care physician. He had no independent recollection of the decedent.

Dr. Ryder testified that on the October 17, 2003 visit, he considered the decedent to have borderline high blood pressure. A flu shot and a prescription for Ambien were given. On November 24, 2003, he prescribed an antibiotic for sinusitis and upper respiratory infection. The decedent's blood pressure was 132/92, which he considered high. Dr. Folan signed his note at the bottom. When he saw the decedent on May 13, 2004 for an upper respiratory infection, his blood pressure was 138/90, but upon recheck, it was documented to be 128/84. He again felt the decedent had borderline high blood pressure, potentially attributable to his weight and smoking, though it is noted that the records indicate that the decedent had stopped smoking many years prior. He thought the decedent might have told him he was taking DayQuil, and told him to stop it. However, that was not documented in the decedent's record. On September 4, 2004, the decedent was treated for poison ivy. His blood pressure was 125/80, which he considered borderline. The decedent was not taking cold medication at that time. On the November 29, 2004 visit, the decedent's blood pressure was 126/88, which Dr. Ryder again considered to be borderline high. He testified that he told the decedent of the need for a physical and blood work, but then crossed out "needs physical." Dr. Ryder testified that although he did not write it down, he probably had a differential diagnosis as to the underlying

cause for the borderline blood pressure. He did not know why the decedent was taking aspirin as a prophylaxis. He was concerned about the decedent's overall well-being and classified him as being at moderate risk at the last two visits. He did not speak to the decedent after August 18, 2005.

Claudia Fernandes, M.D. testified to the extent that she completed her residency in June 2005, and in August 2005, pursuant to a contract, became a salaried employee of Healthworks through May 2007. She saw David Knipfing as a patient on one occasion in the Medford office on February 10, 2006, as an acute walk-in. He presented with pain in his left arm, high blood pressure of 200/110, and lightheadedness. No murmurs were noted and heart exam revealed S1 and S2 with regular rate and rhythm. The EKG showed no changes when compared to the EKG of October 14, 2002, however, she did note some non-specific ST depressions in some of the leads, less than one millimeter. She called Stony Brook Hospital emergency room to have them see the decedent for evaluation. Her differential diagnosis was that of MI, stroke, or muscle pain. She stated that the elevated blood pressure, the pain in the left arm, numbness in the left arm, and lightheadedness can all be signs of an MI. She sent the decedent to the emergency room with a copy of his progress note and EKG. She received no call back from Stony Brook University Hospital emergency room about the decedent, and did not see the decedent thereafter, or obtain his records from the Stony Brook visit. She did not know who his primary doctor was at Healthworks as he saw basically everyone in the practice. Dr. Fernandes testified that when she saw the decedent on February 10, 2006, she reviewed his chart, and on the problem sheet noted that in 1997, he had a negative stress test. She further testified that she considered the decedent to be a patient of the practice of Healthworks and Northside Primary. Echocardiograms and blood work could be obtained at Healthworks premises. The echocardiogram would be sent to a cardiologist for review, and the blood work would be sent to a laboratory.

Jason Winslow, M.D testified to the effect that in May 2006, he became employed at Good Samaritan Hospital as director of emergency medical services and the assistant director for trauma care. Prior to then, he worked at Stony Brook Hospital as a salaried employee in the emergency room. For the purpose of Dr. Winslow's testimony, neither the original Stony Brook emergency room record nor the original chest x-ray films were produced. Dr. Winslow testified that the decedent was his patient in the emergency room on February 10, 2006, but he did not have an independent recollection of him. The decedent was in the emergency department from 1:15 p.m. to about 3:00 p.m. when he was discharged. After the decedent was seen by nursing, an EKG was taken at 1:18 p.m. The decedent was next seen in the emergency room at 1:23 p.m. by the resident, Joshua Shiller, who obtained the history and assessment and formulated a plan. He thought he saw the decedent about ten minutes later.

Dr. Winslow testified [1] that the decedent was a sixty-three year old male who presented with left arm pain in the biceps area, all day, with full range of motion and a good pulse. He had no chest pain or shortness of breath. The chest x-ray and the EKG were normal. S1 and S2 were noted during the cardiac exam. He did not notice a heart murmur. The decedent's blood pressure was elevated to 170/98, 158/97, and 169/102. Winslow state that he read the EKG which was taken elsewhere and had a written notation on it that stated "Okay." No changes were noted on that EKG when compared to the EKGs of 10/14/02. He felt both were normal. Dr. Winslow stated that he was not sure at the time if the decedent had a muscle pull or some underlying condition that was not exposed at the time of presentation. He discharged the decedent with the diagnosis of left arm pain with specific instructions to return if he had chest pain or shortness of breath, and

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[1] It is noted that page 117 of Dr. Winslow's deposition transcript is missing.

to follow up the next day to arrange for consideration of blood pressure management. He continued that he felt he did a good job of ruling out heart pain from a heart attack, which he did with the EKG, physical exam, and being able to reproduce the tenderness in his left arm. The arm pain was relieved with Motrin. Dr. Wilson testified that he cancelled the cardiac panel for blood/laboratory work which was ordered by someone, possibly the resident. He continued that the blood work/cardiac panel-enzymes were not necessary as he felt they would be normal. They would not have helped him rule out a cardiac cause for the arm pain, and he could have them done on an outpatient basis. A troponin level could have ruled in an MI (myocardial infarction), however, he used the EKG to rule it out instead.

Dr. Winslow stated that the plaintiff had risk factors of heart disease, including smoking, family history, and plus or minus cholesterolemia, but did not present with signs of an acute heart attack-like problem. He then testified that the decedent quit smoking a long time ago as per the resident's note. He did not feel the plaintiff's lightheadedness was a great historical feature. He did not order a cardiology consult as most of the cardiologists would have been in their offices, and the decedent could have driven there or followed up the next day with a cardiologist.

Joshua Schiller, M.D. testified to the extent that on February 10, 2006, he was employed as a resident physician at Stony Brook University Hospital in the emergency department since July 2005. He had no independent recollection of David Knipfing's presentation to the emergency department on February 10, 2006. His duties and responsibilities were to take a history, perform a physical, order appropriate exams, and ultimately discuss the patient with the attending and defer to the attending. Custom provided that he would see the patient prior to the attending and form his own impression. He had the authority to order tests, exams, or labs. He ordered a cardiac blood panel test, however, he testified, someone with the initials "M.P." crossed it out. The cardiac panel, which was not done, consisted of a complete blood count, cardiac enzymes (myoglobin, troponin, and CKMB), probably a chemistry 7, and a coagulation series, plus a chest x-ray, which he ordered to rule out a cardiac cause for decedent's symptoms. Had he felt the patient needed to be seen by a specialist, he could have ordered it, but would have deferred to the attending. Had a cardiology consult been called, the decedent would have been seen by a fellow. He stated the decedent's blood pressure was 170/98, which he considered to be high. He was concerned about a cardiac source for the decedent's left arm pain. Dr. Shiller testified that he did not know Dr. Winslow, the attending, but presented his findings concerning the decedent to him. He was not involved in the discharge of the decedent from the emergency room.

Elhan Suley, D.O. testified that he became a salaried employee at Healthworks in July 2004 through December 2006 pursuant to a contract. He had an independent recollection of the decedent as a thin man in his sixties, a nice gentleman, whom he saw on February 11, 2006. He stated that the decedent came in with his wife for follow up for his high blood pressure after his visit to the emergency room at Stony Brook Hospital the day before. Dr. Suley stated that the decedent had an EKG and blood work in the emergency room. He reviewed the decedent's chart and thought that either Dr. Yeder or Robin DeCosta was the primary doctor since they worked in that office in Medford. He noted that the decedent had not had a complete physical examination in a long time. After he reviewed the discharge summary from Stony Brook Hospital, he did not do anything to ascertain what was done, or obtain the results of the blood work. He testified that the decedent told him that everything was normal. He previously had Stony Brook Hospital fax him copies of other patient's records, but did not do it this time.

Dr. Suley, upon examining the decedent, noted that he had a mild systolic murmur. He documented no other history of the decedent. He ordered an echocardiogram. He stated that the echocardiogram could be done at Healthworks or the patient can be sent to the hospital. Blood work could be drawn at Healthworks or elsewhere with a laboratory reporting the results. On February 11, 2006, he gave the decedent requisitions for a complete blood count, complete metabolic panel, and PSA. He did not consider sending the decedent to the cardiologist that day for an echocardiogram. Dr. Suley testified that an MI can cause the onset of a new murmur due to damage to the papillary muscles holding the valves. He advised the decedent that he needed a complete physical examination, and the decedent's wife, who was present, advised that he would be seeing his cardiologist. Dr. Suley thought the decedent was going to call into Healthworks for an appointment as he did not know his schedule.

Dr. Suley testified that evaluation for a heart attack would consist of a stress exam, echocardiogram, cardiac angiography, blood work, EKGs, and cardiology evaluation. He continued that the cardiac enzymes needed to be evaluated along with the risk factors, such as cholesterol levels, family history, smoking, prior heart attack, and stress. An EKG should be done if there is a problem with blood pressure, change of mental status, or anything suggesting that there could be something wrong with the heart. Dr. Suley testified, in reviewing the two prior EKGs of February 10, 2006 and February 14, 2002, that they both demonstrated slightly depressed ST segments at V5 and V6, indicating possible ischemia. It was Dr. Suley's opinion that the decedent did not have a heart attack on February 10, 2006, and that he did not have significant atherosclerotic heart disease. He did not intend to follow up on the echocardiogram as he believed the decedent was going to follow up with his cardiologist, and that another unnamed physician at Healthworks would follow up on the laboratory work.

Nurse Practitioner Joan Scalera testified to the extent that she had been employed by defendant Healthworks as an adult nurse practitioner since 1995 pursuant to a practice agreement with Dr. Folan. She had previously worked as a registered nurse since 1982. She stated that Healthworks was previously known as North Shore Primary Medical. She worked mainly in the Islandia and Medford offices. Scalera testified that Dr. Becker was the decedent's primary physician. Scalera testified that she saw the decedent in the Medford office as an office patient who came in for an urgent visit on March 11, 2006. She had seen him on a number of occasions, December 31, 2002, June 24, 2003, November 10, 2004, and March 21, 2005. She did not have a "clear independent recollection" of the decedent, just that he had dark hair.

Scalera read the notes from those visits, indicating that at the November 10, 2004 visit, the decedent had an elevated blood pressure of 134/90, and that he was to be rechecked in one month, although her opinion was that the elevated blood pressure was due to the over-the-counter medication. She did not know what that medication was and instructed him to refrain from using over-the-counter medication. On March 21, 2005, his blood pressure was 130/80. She noted that on January 24, 2006, Dr. Dacosta told the decedent to follow up for a physical. On March 11, 2006, the decedent's blood pressure was 128/90 with a large cuff. She did not indicate that previous blood pressures were obtained with a large cuff. She continued that the size of the cuff can alter the blood pressure. She indicated that his blood pressure was elevated, however, she did not indicate that the decedent was taking any over-the-counter medication at the time. He was to have a recheck in one month. She did not know where his pain was that he complained of that visit. She told the decedent on the March 11, 2006 visit to get blood work and ordered a comprehensive metabolic panel, CBC, lipids, PSA, and TSH. She did not recall whether or not she was aware that the decedent had been sent by Healthworks to be seen at Stony Brook Hospital for chest pain by Dr. Suley on February 10, 2006. She was aware that Dr. Suley told the decedent to get an echocardiogram due to a faint heart murmur. She had the

authority to order the Stony Brook records for that hospital visit, but did not do so. She did not recall a discussion with the decedent about that hospital visit and did not document anything about that visit on his record. She thought that it was probably because it was resolved, or it seemed resolved, or because he had followed up. She never noted that the decedent had a heart murmur.

When asked whether on March 11, 2006 the decedent had any risk factors for heart disease, Scalera stated that he had no recent labs, his blood pressure was borderline, and otherwise, no. She read Dr. Fernandes' note that the decedent was having numbness in his left arm. Scalrea testified that this could be a potential sign of an MI (myocardial infarction-heart attack), but it could also be from a pinched nerve in his neck. She did not recall if on March 11, 2006, she had an opinion concerning Dr. Fernandes's findings and note, whether those findings were cardiac related or not. She did not recall ascertaining whether or not the decedent followed up for the echocardiogram or with a cardiologist. The decedent had a cough on March 11, 2006. Scalera testified that a cough could be caused by cardiac conditions or congestive heart failure. She further testified that she did not consider any underlying cardiac conditions for any of the signs or symptoms that the decedent presented with on March 11, 2006. She then testified that she ruled out any cardiac condition as he had no shortness of breath or other condition such as chest pain. In reviewing the decedent's EKG of February 10, 2006, she stated that there was nothing of significance on it. She continued that she saw no changes over the February 2002 EKG. She stated that none of his signs or symptoms on March 11, 2006 were related to his cardiac condition. On that date she had the authority to order an EKG, but did not. She considered him her patient for that date.

In her affidavit, NP Scalera avers that she has been a licensed nurse practitioner in New York State since 1990. She avers that she did not serve as David Knipfing's doctor with regard to any care and treatment for the alleged cardiac condition or with regard to her examinations of him. She avers that instead, she merely served as one of several medical professionals whom the decedent visited during his several walk-in visits to the medical facility at Healthworks over a period of three years from 2003 to 2006, when he was treated for head and chest congestion, sinus infection and assorted insect bites and skin ailments. She stated that the decedent's designated cardiologist was Dr. Shlofmitz, who was not with Healthworks. On the dates that she saw and examined the decedent, he never complained of, or exhibited, symptoms associated with any cardiac condition as all was found to be normal, including his blood pressure. She indicated that her review of the decedent's chart failed to disclose any notation which would cause her to direct Knipfing to undergo any further medical treatment for his alleged cardiac condition as each time he appeared for his visits with her, he was not exhibiting any symptoms of such condition. It is noted, however, that Dr. Fernandes testified that when she saw the decedent on February 10, 2006, she reviewed his chart, and on the problem sheet she noted that in 1997, the decedent had a negative stress test. When Dr. Fernandes directed the decedent to Stony Brook Hospital on February 10, 2006, he was discharged the same day from Stony Brook as his EKG revealed normal results. She continued that she acted within the requisite standard of care, and that no doctor-patient relationship existed between her and the decedent. Scalera avers that the decedent's elevated blood pressure was normal, and considered that it was elevated due to decongestants he was taking. The record does not reflect, what, if any decongestants the decedent was actually taking at the time of his visits.

Defendant Scalera's expert witness, Jonathan H. Sumner, M.D., averred that he is a board certified cardiologist, however, he does not set forth whether he is licensed to practice medicine in any state. He has not set forth his education or training, or experience to qualify as a witness in this matter, and his further affidavit contained in the reply papers does not shed additional light on his qualifications. "To qualify as an

expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Based upon the paucity of Dr. Sumner's affidavit, it can not be determined by this court if he nevertheless possesses the requisite knowledge necessary to make a determination on the issues presented (***Humphrey v Jewish Hospital and Medical Center of Brooklyn***, 172 AD2d 494, 567 NYS2d 737 [2d Dept 1991]; ***Joswick v Lenox Hill Hospital***, 161 AD2d 352, 555 NYS2d 104 [1st Dept 1990]), or if he is licensed to practice medicine. Additionally, Dr. Sumner set forth that he reviewed "other medical records" but has not identified which other records were reviewed, and the records which were submitted are not in admissible form, except for the Healthworks record.

Dr. Sumner set forth that NP Scalera examined the decedent on five separate occasions at Healthworks from December 31, 2002 through March 11, 2006. Dr. Sumner does not indicate in his affidavit whether or not the decedent was referred to another primary physician at Healthworks by Scalera or anyone else after Dr. Becker left the practice, and he does not state the standard of care or practice when the patient's primary physician leaves the practice. Dr. Sumner continued that on the occasions the decedent presented to Healthworks, he did not complain of any cardiac related condition, and instead complained of sinus or head and chest congestion and other minor ailments, however, he does not indicate what those minor ailments were, or that they were unrelated to any cardiac condition. Dr. Sumner stated that the decedent had visited with a cardiologist, Dr. Richard Shlofmitz, prior to his having walk-in visits with Healthworks, and that such visits with Dr. Shlofmitz disclosed the decedent's cardiovascular system was normal. However, he does not indicate upon what basis such determination was made and has not provided those records. Dr. Sumner opined that on each visit with defendant Scalera, the decedent's blood pressure, head, eyes, ears, nose and throat were all normal. However, he does not indicate the procedure or method by which the defendant examined the decedent's heart or what is meant by normal blood pressure, and the record and testimony belie that the blood pressure was not elevated at the various visits.

Dr. Sumner stated that on February 10, 2006, the decedent experienced an elevated blood pressure for which he went to Stony Brook Hospital. When Scalera saw the decedent on March 11, 2006, she concluded that his elevated blood pressure was from taking over-the-counter cold medication. However, in reviewing the record, it is noted that it does not indicate that he was taking any over-the-counter cold medication, and indicated only that he started taking a leftover antibiotic, Augmentin, which Scalera continued. Dr. Sumner did not indicate what the decedent's blood pressure was, or the standard of care for following up and monitoring an elevated blood pressure, and whether such standard of care was complied with by Sclera. Additionally, he does not indicate whether the elevated blood pressure was considered in a differential diagnosis by Sclera, and what was done to rule its causes in or out. While Dr. Sumner stated that the decedent had not established a patient-doctor relationship with any doctor at Healthworks, and that he merely presented as a walk-in, he does not indicate whether or not there was a patient-doctor relationship with defendant Scalera who saw him on six occasions. He does not set forth what constitutes a doctor-patient relationship. Nor does he comment on whether the standard of care for treating a patient is any different, whether there is one walk-in visit or multiple visits by a patient. He has not established the procedure for assigning a physician at Healthworks. Dr. Sumner's further affidavit served with the reply papers does nothing to change this court's determination.

It is determined as a matter of law that a physician-patient relationship existed between defendant NP Scalera and the moving defendants, and the decedent. To maintain an action to recover damages arising from medical malpractice, a doctor-patient relationship is necessary. This relationship is created when

professional services are rendered and accepted by another person for purposes of medical or surgical treatment, and may be based either on an express or implied contract. In general, this relationship is not formed when a doctor examines a patient solely for purposes of rendering an evaluation for an employer or potential employer, which is not the case in the instant action (*see* ***Heller v Peekskill Community Hospital***, 198 AD2d 265, 603 NYS2d 548 [2d Dept 1993]). The physician, by taking charge of a case, represents that he will use reasonable care and his best judgment in exercising his skill, and the law implies that he represents his skills to be such as are ordinarily possessed by physicians in the community. The physician-patient relationship is a consensual one, and while it may arise out of a contract, the existence of the relationship does not depend upon the existence of any express contract. The relationship is created when the professional services of a physician are rendered to and accepted by another person for the purpose or purposes of medical or surgical treatment (*see* ***Lee v City of New York***, 162 AD2d 34, 560 NYS2d 700 [2d Dept 1990]).

Here, defendant Scalera did not examine the plaintiff's decedent solely for rendering an evaluation for an employer or potential employer, or on behalf of the Worker's Compensation Board. Although there is no express or written agreement between the decedent and the defendant, here, the doctor-patient relationship was created when the professional services by Scalera and the examining physicians were rendered to, and accepted by, the decedent, for the purpose of providing medical care and treatment. Thus, any claim by the defendants that there was no doctor-patient relationship between them or Scalera and the decedent is without merit.

Thus remaining are the factual issues which preclude summary judgment concerning whether or not defendant Scalera followed the standard of care when the decedent returned on each visit, including the visit of March 11, 2006 after his having been sent by Dr. Fernandes to Stony Brook Hospital; whether his ongoing elevated blood pressure was associated with his cardiac condition, and if further testing, following, or evaluation of his blood pressure should have been undertaken at Healthworks by defendant Scalera; and whether she should have referred the decedent to one of the physicians or to a cardiologist. The defendant's expert, Dr. Sumner, does not set forth the standard of care and merely sets forth that the defendant complied with it.

Accordingly, motion (006) by defendant, Joan Scalera, N.P., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is denied.

In support of motion (007), Claudia Fernandes, M.D., Elhan Suley, D.O., and Northside Primary Medical Care P.C. have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' respective answers, plaintiff's verified bill of particulars and supplemental verified bills of particulars; the unsigned but certified transcripts of the examinations before trial of Ellen Uffelmann-Knipfing dated June 6, 2008, Joan Scalera N.P. dated September 22, 2008, Michael Ryder, M.D. dated May 12, 2009, non-party John Francis Folan dated July 14, 2010, and Jason Winslow, M.D. dated March 24, 2010; certified copy of the record of Healthworks; uncertified copies of the records of East End Cardiology from 1996, Stony Brook University Hospital, Interventional Heart Group, Brookhaven Memorial Hospital; uncertified copy of the Autopsy Report; affirmations of Wei Kao, M.D.[2] and Jerome W. Lehrfeld, M.D. and the affidavit of Jonathan H. Sumner, M.D.

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[2]Wei Kao, M.D., a principal of defendant Northside Primary Medical Care, P.C. has submitted an affirmation instead of an affidavit pursuant to CPLR 2106, but the same is considered as the submission of an affirmation instead of an affidavit is a technical fault.

In motion (007), the moving defendants seek summary judgment dismissing the complaint on the bases that although the decedent had a Thallium stress test in 1995 which suggested mild posterobasal myocardial ischemia; a history of angina documented by Fulvio Mazzucchi, M.D. in August 30, 1995; was diagnosed with coronary artery disease by Dr. Ballego at the ambulatory service of Stony Brook University Hospital; and was seen by cardiologist Dr Shlofmitz at Interventional Heart Group for routine evaluation which cardiac evaluation was normal, the decedent failed to provide such cardiac history to his medical care providers at Healthworks. The moving defendants argue that Dr. Kao never provided treatment to the decedent; that Dr. Folan's care and treatment is outside the alleged negligent acts and omissions; that defendant Scalera did not depart from the standard of care and thus Dr. Kao and Dr. Folan have no vicarious liability for her acts or omissions; and that the moving defendants did not depart from good and accepted medical practice.

Dr. Kao affirmed that he is a principal of Northside Primary Medical Care, P.C. a/k/a Healthworks of Medford, that he had no contact with the decedent, and that he had no contact with defendant Scalera concerning David Knipfing.

Jerome W. Lehrfeld, M.D. affirmed that he is licensed to practice medicine in New York State, and was board certified in family practice until 2010. His current certification and licensing status has not been documented. He has not set forth his education and training, and has not demonstrated a basis to proffer an expert opinion in this matter, nor has he provided a copy of his curriculum vitae. It is Dr. Lehrfeld's opinion that Dr. Fernandes, Dr. Suley, and Healthworks by its agents and employees, conformed to accepted medical standards of practice in their care and treatment of the decedent, and that their care and treatment did not proximately cause the decedent's alleged injuries. He set forth the decedent's history, in part, stating that the decedent was in generally good health with a family history of heart disease, but he had no symptoms of chest pain or shortness of breath. While Dr. Lehrfeld stated that a physical examination was documented as normal, and a stress test ordered by Dr. Shlofmitz revealed the decedent had no significant perfusion defects, Dr. Lehrfeld has not addressed Dr. Mazzucchi's findings that the decedent had a history of angina, and that he had a thallium stress test in or about 1995 which showed a possible old inferior infarction with a small degree of peri-infarct ischemic, thus creating factual issues with regard to his opinion.

Dr. Lehrfeld stated in a conclusory manner that the decedent failed to provide such cardiac history to his medical care providers at Healthworks, but then stated that the decedent provided a family history of heart disease and stroke. The Healthworks record dated June 2, 2000 set forth that the decedent's brothers had by-pass surgery and enlarged hearts; his mother had a stroke; and his father had heart disease. There was also a family history of high blood pressure. Dr. Lehrfeld does not set forth the standard of care for treating a patient with a family history of heart disease and stroke. He does not set forth the standard of care for eliciting such prior history, or that the moving defendants obtained the same. He does not indicate the physician's responsibility for obtaining medical records from prior treating physicians to determine the patient's history where the patient had been presenting to Healthworks for a period of years, thus raising factual issues precluding summary judgment.

Dr. Lehrfeld set forth the decedent's presentation to Healthworks and stated that the decedent failed to undergo, on multiple occasions, an annual complete physical, and therefore never established himself with a primary care physician at Healthworks. It appears that the decedent first presented to Healthworks in 2000 for various diagnostic studies, blood work, colonoscopy exam, and immunizations. It is noted, however, that the Healthworks record for referral to North Shore Ortho, dated October 14, 2002, set forth that Dr. Aida

Becker is the decedent's primary care physician, thus raising a factual issue as to whether he had a primary physician at the facility. Dr. Lehrfeld does not opine that the standard of care should be any different based upon the patient being established or without a primary physician. It is noted that on June 6, 2003, the decedent presented with a blood pressure of 138/96 and 136/100; on November 24, 2003, the plaintiff presented with a blood pressure of 138/94; and on May 13, 2004, the decedent presented with a blood pressure of 138/90. Dr. Lehrfeld does not comment on these blood pressures and stated only stated that on September 9, 2004, that the decedent presented to defendant Scalera with a normal blood pressure. He does not indicate what the blood pressure was, or what he considers to be a normal blood pressure or an elevated blood pressure. He continued to discuss the November 10, 2004, visit but failed to address that the decedent had a blood pressure of 134/90, and the significance, if any. It is noted that NP Scalera advised the decedent to have the blood pressure rechecked in one month. On March 11, 2006, the decedent's blood pressure was 128/90 with a large cuff. NP Scalera did not indicate that previous blood pressures were obtained with a large cuff, and testified that the decedent's blood pressure was elevated. Dr. Larkfeld does not reconcile his opinions that the decedent's blood pressures were normal with the testimony of NP Scalera that the decedent's blood pressures were elevated. He does not set forth the standard of care for treating or managing an elevated blood pressure and does not opine that the defendants comported with such standard of care.

Dr. Lehrfeld opined that Dr. Fernandes comported with the standard of care when the decedent presented on February 10, 2006. He also opined that Dr. Suley comported with the applicable standard of care on the February 11, 2006 follow up visit. He does not opine as to the standard of care, whether Dr. Fernandes or Dr. Suley should have obtained those records relating to decedent's visit to Stony Brook University Hospital on February 10, 2006, and to ascertain the results of the blood work or other studies which the decedent advised Dr. Suley had been taken. Dr. Shiller testified that he ordered cardiac enzymes to rule out a cardiac cause for decedent's symptoms. Dr. Winslow then canceled that order. Neither Dr. Fernandes nor Dr. Suley called, or otherwise inquired into those laboratory studies, which the decedent advised were done, to determine if the cardiac enzymes were normal to rule out a heart attack. Dr. Lehrfeld opined that both Dr. Fernandes and Dr. Suley did not need to obtain a copy of the emergency room chart from Stony Brook Hospital concerning the February 10, 2006 visit as Fernandes and Suley were covering acute walk-in patients. He does not set forth the standard of care, irrespective of whether the decedent was an acute walk-in or a regular patient, with regard to the physician's duties and responsibilities in obtaining medical records and tests results and laboratory studies undergone by the decedent who presented for follow up care to that hospital visit. While Dr. Lehrfeld opined that the defendants properly relied upon the summary from Stony Brook, he does not indicate what was contained in the summary and what was relied upon by Fernandes and Suley with regard to the cardiac enzymes.

Based upon the foregoing, the moving defendants in motion (007) have failed to establish prima facie entitlement to summary judgment dismissing the complaint against them. Even if Dr. Lehrfeld had submitted his curriculum vitae or set forth the basis for his expertise to proffer testimony in this action, the factual issues raised in the moving papers preclude summary judgment. Additionally, motion (006) by defendant Scalera was denied due to failure to establish prima facie entitlement to summary judgment dismissing the complaint.

While Dr. Kao affirmed that he did not treat the decedent, and Dr. Folan argues that his care and treatment of the decedent is outside the alleged negligent acts and omissions, both Dr. Kao and Dr. Folan, as principals of Healthworks and Northside Primary Medical Care, are vicariously liable for the negligent acts or omissions of their employees. Here, Kao and Folan are the employers of defendants Scalera, Fernandes,

Ryder, and Suley, as per their unrefuted testimony. It has not been established that their employees were not negligent in their care and treatment of the plaintiff's decedent.

Liability in negligence rests on a defendant's own fault. Underlying the doctrine of vicarious liability, the imputation of liability to defendant for another person's fault, is the notion of control. The person in a position to exercise some general authority or control over the wrongdoer must do so or bear the consequences. For example, liability of an employer for the acts of its employees within the course of employment illustrates the public policy for vicarious liability. Risk is allocated to an employer who is better able than an innocent plaintiff to bear the consequences of employees' torts. Thus, an employer is also encouraged to act carefully in the selection and supervision of its employees. Vicarious liability applies to hospitals and physicians. "In the absence of some recognized traditional legal relationship such as a partnership, master and servant, or agency, between physicians in the treatment of patients, the imposition of liability of one for the negligence of the other has been largely limited to situations of joint action in diagnosis or treatment...," or some control of the treating physician by the regular physician (*see generally* ***Kavanaugh v Nussbaum***, 71 NY2d 535, 528 NYS2d 8 [1988]). Here, the defendants were salaried employees.

In support of motion (008), Jason Winslow, M.D. submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' answers, and plaintiff's supplemental bill of particulars and expert witness disclosure; uncertified copies of the plaintiff's medical records which are not in admissible form; transcript of the examination before trial of Jason Winslow, M.D.; and the affidavit of Stephan Gordon Lynn, M.D.

Dr. Winslow seeks summary judgment on the basis that he did not depart from good and accepted standards of care and did not proximately cause the injuries claimed by the plaintiff's decedent. Dr. Winslow submitted the duly notarized affidavit of his expert, Stephan Gordon Lynn, M.D. who affirmed that he is licensed to practice medicine in New York State and is board certified in emergency medicine. He set forth his education and training, and work experience, and set forth the materials and records which he reviewed. Dr. Lynn opined within a reasonable degree of medical certainty that Dr. Winslow did not depart from any standards of care as pertaining to an attending emergency room physician when he discharged the decedent without conducting additional cardiac testing, procedures or consults, such as cardiac enzymes, echocardiogram, cardiac catheterization, cardiac MRI, cardiac CT angiogram, intra-aortic balloon pump counterpulsation, coronary revascularization with balloon angioplasty, stents or bypass surgery.

Dr. Lynn set forth that the standard of care required Dr. Winslow to formulate a differential diagnosis which included ruling out that a myocardial infarction had occurred, or was in the process of occurring. There are factual issues concerning Dr. Lynn's opinions, especially with regard to Dr. Shiller's testimony wherein he stated that he ordered the cardiac enzymes to rule out a cardiac cause when the decedent presented to Stony Brook Hospital emergency department on February 10, 2006. Dr. Lynn does not set forth how the cardiac enzymes ordered by Dr. Shiller would or would not have helped determine whether or not the plaintiff had, or was in the process of having, a myocardial infarction. Nor does Dr. Lynn set forth the standard of care in ruling out an acute condition, as opposed to what he deems to be a non-acute condition such as atherosclerosis or narrowing of the arteries. Dr. Lynn opined that the autopsy report, which is not certified, revealed that the decedent died on March 12, 2006 of an acute ruptured myocardial infarction of the interior (*sic*) wall of the left ventricle caused by an acute thrombosis. However, Dr. Lynn does opine as to

the cause of the thrombosis and whether or not it was related to the atherosclerosis and partially occluded vessels described in the autopsy report.

Dr. Lynn set forth in his affidavit that the decedent reported that he had occasional to rare atypical chest discomfort, but was usually very physically active on a regular basis, and that he hiked many miles a week. That the decedent suffered occasional to rare atypical chest discomfort conflicts with the opinion of Dr. Sumner, co-defendants' expert, who set forth that the decedent did not at any time experience chest pain. While Dr. Lynn stated that there is no evidence that Dr. Winslow advised the decedent that he did not have a "silent" underlying cardiovascular disease, there are factual issues concerning whether Dr. Winslow should have advised the decedent of the same, given decedent's past medical history and family history. Dr. Lynn did not set forth the standard of care with regard to Dr. Winslow discharging the decedent without apprising the decedent that he cancelled the cardiac enzymes, and what such testing would have ruled in or out. Dr. Lynn does not opine as to what information, if any, such cardiac enzymes would have contributed to rule in or to rule out cardiac causes for the decedent's presenting symptoms. Based upon Dr. Suley's testimony, the decedent erroneously believed that all his blood work was normal in support of the diagnosis by Dr. Winslow that he did not have a heart attack or cardiac cause for his symptoms on February 10, 2006.

Based upon the foregoing factual issues and conclusory opinions raised in the moving papers, it is determined that Dr. Winslow has not established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

In opposition to these motions, the plaintiffs have submitted the redacted affirmations of their expert physicians, but have not provided unredacted copies of the affirmations to this court as required (***Marano v Mercy Hospital***, 241 AD2d 48, 670 NYS2d 570 [2d dept 1998]). However, it is determined that had the moving defendants established prima facie entitlement to summary judgment, and the unredacted copies of the plaintiff's expert were provided, that there are factual issues and conflicting opinions raised by the plaintiff's experts which preclude summary judgment.

The plaintiffs' first expert set forth that he is licensed to practice medicine in New York State, and that he is board certified in internal medicine, pulmonary medicine, and critical care medicine. He set forth his current employment and area of practice and familiarity with the standards of care, treatment and management of patients with ateriosclerotic heart disease, coronary artery disease, sinusitis, sinus infection, hypertension, bronchitis, bronchiolitis, and myocardial infarction, such as the decedent suffered. He continued that he is also familiar with the standard of medicine applicable in situations in which a nurse practitioner participates in the diagnosis, care and management of a patient as NP Scalera did with regard to the decedent. The plaintiff's first expert set forth his opinions within a reasonable degree of medical certainty and the history and events concerning the decedent's medical condition, care and treatment. He disagreed with the defendants' experts and opined that during the respective visits with the decedent on February 10, 2006, February 11, 2006, and March 11, 2006, the moving defendants departed from good and accepted standards of medical practice by failing to recognize the signs and symptoms of an MI and ongoing cardiac ischemia; by failing to properly review and interpret the electrocardiograms available and recognize, inter alia, ongoing cardiac ischemia including ST segment depressions in V4, V5, and V6, and T wave changes in leads III, AVF, and V1; in failing to order, obtain, or ensure an emergent cardiology consult and echocardiogram which the decedent's condition and the standards of care required; in failing to diagnose and treat the decedent's MI and ongoing cardiac ischemia, or to put him in the hands of those who could make the diagnosis and initiate proper treatment. He continued that the departures by NP Scalera, and Drs. Suley

and Fernandes, were a proximate cause of, and a substantial factor, in causing the decedent's pain, suffering, heart rupture, and premature death.

The plaintiff's first expert continued that only two of the defendants' experts, Dr. Lehrfeld and Dr. Lynn, offer opinions regarding the ECG, each of whom believed the ECGs were properly interpreted and were no cause for concern. The plaintiff's first expert disagreed and opined that the decedent's ongoing ischemia was cause for concern. He continued that none of the defendant's experts, except Dr. Lynn, addressed the autopsy report which supports the plaintiff's first expert's opinion and demonstrates that the defendant suffered an MI and ongoing cardiac ischemia. The plaintiff's first expert stated that Dr. Lynn opined that the autopsy report showed that the decedent suddenly developed a new or acute blood clot, which, in turn, "caused a laceration of the interior (*sic*) wall of the left ventricle" based upon the autopsy finding of approximately 225 cc of "mostly clotted fresh blood in the pericardial sac." The plaintiff's first expert disagrees as he states that the autopsy report neither says nor implies that an acute thrombosis (blood clot) caused the rupture of the inferior wall of the left ventricle, and the report nowhere states or describes that the inferior wall was "lacerated" as claimed by Dr. Lynn. Instead, he continued, the ruptured wall was due to, and a consequence of the MI and ongoing cardiac ischemia, both of which went undiagnosed and untreated at the hands of the defendants.

The plaintiff's first expert set forth that the record from Healthworks clearly established that Dr. Aida Becker was assigned as the decedent's primary care physician, however, after Dr. Becker left the group, the decedent had no primary care physician assigned to him, which failure by the defendants was a departure from the standard of care. Additionally, the plaintiff's first expert opined that whether the decedent was a walk-in patient, or a patient of a primary care physician, the defendants' duties and obligations as physicians required that they each take a proper history, perform a proper physical examination, perform appropriate testing, arrive at a diagnosis or differential diagnosis, and take the proper actions based upon the circumstances then present. This, he stated, is supported by Dr. Suley's testimony that he was the covering physician, and as such, there was no difference between his duties and responsibilities to a patient, from those of the primary care physician, except that the primary care physician is to see the patient again.

The plaintiff's first expert set forth the decedent's medical history and care and treatment rendered to the decedent during visits with various physicians, visits at Healthworks, and at Stony Brook Hospital, and opined that the standard of care for a patient with the symptoms and findings, such as the decedent presented, required that the patient be treated as if they had an ongoing MI until such time the MI was ruled out by virtue of cardiology consult, cardiac biomarker panel (a/k/a cardiac panel), echocardiogram, and if need be, all in conjunction with a calcium score. He opined that this was not done.

Plaintiff's first expert opined that Dr. Fernandes departed from good and accepted practice of adult medicine on February 10, 2006 in that she improperly interpreted and documented the ECG of February 10, 2006; failed to recognize and note the changes when compared to the ECG of October 14, 2002; failed to recognize and document the decedent's new onset cardiac murmur on physical examination; sent the February 10, 2006 ECG to the emergency room at Stony Brook bearing her notation of "Okay. No changes compared to October 14, 2002," without sending the ECG of October 14, 2002 as well; and failed to provide to the emergency department at Stony Brook the decedent's history and multiple and significant risk factors for cardiac disease, including his blood pressure of 200/110 at work, and her concern that the decedent was having an MI which was at the top of her differential and needed to be ruled out. The plaintiff's first expert disagreed with defendants' experts and opined that the ECG of February 10, 2006, was not normal and

clearly demonstrated acute changes suggestive of ongoing cardiac ischemia, as evidenced by including ST segment depressions in V4, V5, and V6, and T wave changes in leads III, AVF, and V1. Dr. Fernandes' expert opined that three ECGs demonstrated non-specific ST changes which were not significant, and Dr. Winslow's expert opined that the ECGs were not suggestive of ongoing cardiac ischemia and were negative for prior or ongoing myocardial infarction, demonstrating factual issues concerning whether Dr. Fernandes departed from the standard of care.

With regard to Dr. Suley, the plaintiff's first expert opined that Dr. Suley departed from the standard of care on February 11, 2006, in failing to document on the decedent's chart that the decedent's wife told him that the decedent was going to see his own cardiologist, however, the plaintiff testified that she did not accompany her husband on this visit. He continued that Dr. Suley did not properly evaluate, manage, treat, and make recommendations for follow up and echocardiogram based upon his detecting a systolic murmur, and did not send the decedent to a cardiologist for consult. He continued that Dr. Suley improperly relied upon Stony Brook Hospital emergency room staff to have done a complete and proper work up, and improperly counseled the decedent. He disagreed with defendants' expert Dr. Lehrfeld and opined that it was a departure from the standard of care for Dr. Suley and Healthworks not to have obtained a copy of the Stony Brook emergency room chart of February 10, 2006 when he saw the decedent the next day. Had he done so, it could be determined what work up was done and the results of the same. If Dr. Suley had done so, he would have ascertained that the cardiac panel which he had assumed was performed had been cancelled by Dr. Winslow, and should have, thus, made an immediate cardiology consult, cardiac biomarker testing, and echocardiogram.

Additionally, plaintiff's first expert stated that Dr. Ryder testified that it was good practice to obtain the emergency room record and that it would be a departure from the standard of care to fail to do so. The first expert opined that it was a further departure by Dr. Suley to have relied upon the emergency room staff at Stony Brook to have done a complete and proper work up and to assume that if the decedent had an MI that he would have been admitted to the hospital instead of being discharged. The plaintiff's first expert further opined that he disagreed with Dr. Suley and Dr. Suley's expert opinion that an MI was ruled out on February 11, 2006 based upon his physical examination findings and because the decedent had a complete physical at Stony Brook, including blood work and EKG. This is so, stated plaintiff's first expert, because Dr. Suley's examination could not rule out an MI or its aftermath, nor could it rule out ongoing cardiac ischemic which required immediate treatment, and none of the things which Dr. Suley relied upon, either individually or collectively, rule out an MI or its aftermath. Dr. Suley, at his deposition, testified that in the case of an MI, an evaluation consisting of blood work which included cardiac enzymes and cholesterol, EKG, echocardiogram, cardiology consult, stress test, cardiac risk assessment, stress assessment, and cardiac angiography are required, and were not done. The plaintiff's first expert stated that Dr. Suley further departed from the standard of care by not recognizing the changes between the EKG of February 10, 2006 and October 14, 2002, and failing to refer the decedent to a cardiologist; by failing to obtain a proper history from the decedent; failing to recognize the significance of a new onset systolic murmur which can be caused by an MI; and failing to properly interpret the ECGs of February 10, 2006 and October 14, 2002.

Turning to defendant NP Sclera, the plaintiff's first expert opined that she departed from good and accepted medical practice by failing to obtain a proper history, including fatigue, tiredness, reduced activity level, and shortness of breath; failing to ascertain whether an echocardiogram had been performed or whether the decedent had been seen by a cardiologist since February 10, 2006; failing to take heed of the decedent's significant risk factors and family history for heart disease and diagnosis of a systolic murmur by Dr. Suley;

failing to perform a proper physical examination; failing to recognize the signs and symptoms of congestive heart failure on March 11, 2006, and misdiagnosing the decedent with bacterial sinusitis instead; failing to educate the decedent and explain the need for immediate medical care, including hospitalization, intravenous diuretics, antihypertensive medication; vasodilator therapy with nitroglycerin; noninvasive cardiac monitoring; electrocardiographic telemetry monitoring; use of angiotensin converting enzyme inhibitors and beta-blocker therapy; failing to ensure that the decedent was taken immediately to an emergency room for admission, or being admitted by an attending from Healthworks. The plaintiff's first expert continued that the autopsy report establishes the presence of significant cardiac disease during the time in issue. While defendants' expert, Dr. Sumner, opined that the decedent had a normal cardiovascular system and did not have an underlying cardiac condition, the plaintiff's first expert opined that the pertinent findings as set forth in the autopsy report belie such opinions by Dr. Sumner, as the same was present on his date of death, and would have been present on the day before when the decedent was seen by defendant Scalera, and that Dr. Sumner failed to address those findings in the autopsy report.

The plaintiff's first expert further opined that NP Scalera was required pursuant to her clinical practice agreement to practice adult medicine or internal medicine by the same standard as required of those physicians practicing adult or internal medicine, and was further required to collaborate with the physician, Dr. John Folan, who supervised her care and treatment by general oversight and subjective monitoring, as well as other ways as set forth. However, Dr. Folan testified that Scalera was responsible for the diagnosis and treatment of the patients she saw on any given day, and he did not consider himself to be responsible for the diagnosis and treatment of the patients she saw. This, plaintiff's first expert opined, is a departure from the accepted standard of care and does not constitute a proper collaborative nurse practitioner practice, and Scalera should have collaborated or consulted with Dr. Folan or another physician on March 11, 2006, the day before the decedent died.

Based upon the foregoing, the plaintiff's first expert has raised multiple factual issues and presented multiple conflicting expert opinions which preclude summary judgment, had the defendants in motions (006) and (007) established prima facie entitlement to summary judgment dismissing the complaint.

Accordingly, motion (006) by Joan Scalera, N.P. and motion (007) by the defendants, Claudia Fernandes, M.D., Elhan Suley, D.O., and Northside Primary Medical Care P.C. a/k/a Healthworks of Medford, for summary judgment dismissing the complaint as asserted against them are denied.

Turning to motion (008), the plaintiff's second expert has affirmed that he is licensed to practice medicine in New York State and is board certified in emergency medicine. It is plaintiff' second expert's opinion within a reasonable degree of medical certainty that Dr. Winslow departed from good and accepted medical and emergency room practice by improperly interpreting the ECGs; improperly performing the physical examination; failing to recognize and take proper heed of the decedent's risk factors for MI including his strong family history, his past medical history, and cardiac risk factors, as well as his complaints and symptoms; in canceling the cardiac panel that had been ordered by Dr. Shiller; in failing to diagnose the decedent's MI and ongoing cardiac ischemic; in failing to admit the decedent and order an echocardiogram and cardiology consult; and in reassuring the decedent that he was fine and that no further testing was warranted. He concluded that the departures by defendant Winslow were a proximate cause and substantial factor in the pain, suffering, heart dissection and rupture, and death of the decedent.

The plaintiff's second expert set forth the care and treatment administered by Dr. Winslow, as well as

the subsequent medical care and treatment at Healthworks, and the results of the autopsy contained in the autopsy report. He continued that Dr. Winslow departed from the accepted standards of care and treatment. He disagreed with Dr. Winslow and his expert, Dr. Lehrfeld, in their contentions that the decedent did not have an MI as Dr. Winslow ruled it out; that there was no ongoing cardiac ischemic; that the decedent was stable, and in a non-emergent condition at the time of discharge; that Dr. Winslow's diagnosis and opinions are supported by the autopsy; that there is no evidence that Dr. Winslow lulled the decedent into a false sense of security or played a role in the lack of a cardiology consultation or an echocardiogram prior to the decedent's death.

The plaintiff's second expert further opined that Dr. Winslow departed from the good and accepted standard of emergency medicine and practices on February 10, 2006 by, inter alia, failing to ascertain and document the new onset murmur; failing to take proper steps to rule in or rule out an MI; and in advising the decedent that further testing beyond Winslow's history, physical examination, and review of the ECGs was not warranted and that his heart was fine. He continued that it was Dr. Winslow's responsibility to undertake a proper work up in an attempt to rule in or rule out the MI or other acute cardiac event, but he failed to do so. This is so, continued the plaintiff's second expert, in that Winslow attempted to rule out the MI without the benefit of the cardiac panel, and instead ruled it out based on the just the history, physical examination, and ECGs. The expert continued that an MI cannot be ruled out or excluded from a differential diagnosis in the manner testified by Winslow or suggested by his expert. The same, plus the "gestalt" received from the patient, as testified to by Winslow, does not exclude the MI.

The plaintiff's second expert stated that a blood test would have included a CBC, PT/PTT, Chem 8, liver panel, amylase, lipase, and sedimentation rate, and would have included cardiac enzymes myoglobin, troponin and CKMB, which would provide a better and proper basis upon which to attempt to determine whether or not the decedent suffered an MI. The cardiac panel, was available in 2006 and was the accepted medical and emergency practice that require such testing be done. The troponin level, a complex of three proteins integral to contraction in the cardiac muscle of the heart are highly specific biomarkers with respect to the cardiac muscle and damage to that muscle. With an MI, the serum troponin levels (1, T and C) elevate, which is why this test is routinely used in the emergency room setting where there is concern for possible MI or acute coronary syndrome. Had Dr. Winslow not canceled the cardiac panel, the cardiac enzymes would have come back elevated, consistent with an MI or acute coronary syndrome. While Dr. Winslow testified that he cancelled the test because it takes four hours to get the results, the plaintiff's expert disagrees on the time. He continued that when a patient presents to the emergency room with the decedent's, symptoms, the standard of care requires that the patient be treated as if he had an ongoing MI until such time as an MI is ruled out by virtue of a cardiology consult, cardiac biomarker panel, echocardiogram, and if need be, all of the foregoing in conjunction with a calcium score.

The plaintiff's second expert also opined that while Winslow testified that the ECG taken in the emergency room on February 10, 2006 was normal, as was the one taken by Dr. Fernandes, and that they were identical, the same is not so as the ECGs were clearly suggestive of ongoing cardiac ischemic, evidenced by ST segment depressions in V4,V5 and V6 and T-wave changes in leads III, AVF, and V1. Dr. Winslow's failure to recognize and document these findings were departures from the standard of care. Further, the ECGs should have been presented to a cardiologist for review, and the failure to do so was a further departure from the standard of care.

While Dr. Winslow testified that the decedent's pain in his left arm improved with Motrin administered in the emergency room, the plaintiff's expert noted that Winslow ordered the Motrin at 2:00 p.m., it was administered at 2:10 p.m., and the decedent left at 2:15 p.m. The nurses note of 1:15 p.m. indicted that the decedents left arm pain had resolved prior to the Motrin being administered. Winslow's admitted lack of an etiology for the decedent's left arm pain required that he call a cardiology consult, and such failure constituted a departure from the good and accepted standard of care. While Winslow and his expert opined that an absence of a "constellation of symptoms" excluded an MI, the plaintiff's expert disagrees and opined that absence of such constellation does not exclude an MI, especially where the plaintiff had signs and symptoms of an MI and ongoing cardiac ischemia, including dizziness, lightheadedness, arm pain, and elevated blood pressure. The decedent was discharged in the midst of an MI with ongoing cardiac ischemic which required that he be admitted, seen by cardiology, and treated accordingly. He continued that the decedent was lulled into a false sense of security by being advised by Dr. Winslow that he needed no further testing and that his arm pain was likely from his sleeping on it. This was a departure by defendant Winslow because the decedent required urgent cardiological treatment, and such reassurance was made to the decedent without sufficient medical basis.

The plaintiff's second expert disagrees with Dr. Lehrfeld as to causation in that the plaintiff's expert opines that the decedent did not suddenly develop a new or acute blood clot which caused a laceration to the interior wall of the decedent's heart, and that the autopsy report does not imply the same, and nowhere states that the wall was "lacerated." Rather, the inferior wall was ruptured due to and as a consequence of, inter alia, the MI and ongoing cardiac ischemia, both of which went undiagnosed and untreated at the hands of the defendants, including Dr. Winslow on February 11, 2006. The clots found in the pericardial sac were a consequence of the rupture and not the cause of it.

Based upon the foregoing, the plaintiff's second expert has raised factual issues which would preclude summary judgment from being granted had Dr. Winslow established prima facie entitlement to summary judgment dismissing the complaint in the first instance, which he did not.

Accordingly, motion (008) by defendant, Jason Winslow, M.D., for summary judgment dismissing the complaint as asserted against him is denied.

Dated: 5/29/13

J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION