Armano v Hutchinson
2013 NY Slip Op 30787(U)
April 12, 2013
Supreme Court, Suffolk County
Docket Number: 07-4225
Judge: W. Gerard Asher
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SHORT FORM ORDER

INDEX No. 07-4225
CAL. No. 12-00449MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 32 - SUFFOLK COUNTY

PRESENT:

Hon. W. GERARD ASHER
Justice of the Supreme Court

MOTION DATE 8-1-12
ADJ. DATE 12-11-12
Mot. Seq. # 003 - MD

DOMINIC S. ARMANO, Individually and as the Administrator of the Estate of ANTONIA ARMANO, deceased,

Plaintiffs,

- against -

LEIGH ANN HUTCHINSON, M.D., LONG ISLAND ARRHYTHMIA ASSOC., LLC, LEIGH ANN HUTCHINSON, M.D., P.C., LAURA COUDREY, M.D., LAURA COUDREY, M.D., P.C., SOUTHSIDE HOSPITAL, NATHANIEL REICHEK, M.D. and ST. FRANCIS HOSPITAL, ROSLYN, NEW YORK,

Defendants.

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Upon the following papers numbered 1 to 40 read on this motion for summary judgment; Notice of Motion Order to Show Cause and supporting papers (003) 1-21; Notice of Cross Motion and supporting papers_; Answering Affidavits and supporting papers 22-37; Replying Affidavits and supporting papers 38-40; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (003) by defendant Southside Hospital pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims asserted against them is denied.

This medical malpractice action, Dominic Armano seeks damages for personal injuries and the wrongful death of the plaintiff's decedent while the decedent was under the defendants' care and treatment beginning on or about August 22, 2001 and continuing through July 21, 2004. Causes of action premised upon the alleged negligent departures from the standard of care, lack of informed consent, wrongful death, and additional causes of action asserted against defendants Southside Hospital and St. Francis Hospital, primarily for the negligent hiring and retention of hospital employees, staff and personnel working at their respective facilities. It is asserted that Southside Hospital failed to properly diagnose, test, evaluate, manage and treat the decedent for

ventricular tachycardia, and that Southside Hospital failed to furnish the plaintiff's decedent with experienced, qualified, and competent nursing staff, technicians, physicians, and other employees. As a result of these alleged departures from the standard of care, the plaintiff's decedent was caused to suffer traumatic damage to her heart and ventricles, ventricular tachycardia, bradycardia, asystole, cardiac arrest, extreme pain and suffering, emotional distress, and 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.,***). 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 present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (***Joseph P. Day Realty Corp. v Aeroxon Prods.***, 148 AD2d 499, 538 NYS2d 843 [2d Dept 1979]) and 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[2nd 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]).

In motion (003), Southside Hospital seeks summary judgment dismissing the complaint on the bases that it fully complied with the standard of care in rendering care and treatment to the decedent and did not proximately cause the injuries claimed to have been suffered by the decedent; that it is not liable for the malpractice of physicians; it is not vicariously liable for the alleged malpractice of a private attending cardiologist who is not in its employ; that it is not responsible for providing informed consent to the decedent; and that its medical care providers possessed the necessary skill, competence, and qualifications in rendering care and treatment to the decedent. In support of this application, Southside Hospital has submitted, inter alia; an attorney's affirmation; the affidavit of Bassiema B. Ibrahim, M.D; copies of the summons and complaints, defendants' answers and plaintiff's verified and supplemental bills of particular; the signed and certified copies of the deposition transcripts of Dominic Armano dated March 11, 2008, Leigh Ann Hutchinson, M.D. dated July 18, 2008, Laura Coudrey, M.D., non-party Kathleen Cox dated April 15, 2009, Ralph Biscari, R.N. dated April 29, 2011, and non-party Lisa Winters, R.N.; certified copies of the Southside Hospital record; various uncertified copies of medical records which are not in admissible form pursuant to CPLR 3212, (*see* ***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]).

In this medical malpractice action, it is alleged that the defendants departed from the good and accepted standards of care in performing a left ventricular ablation (burning) procedure in the chambers of the decedent's left ventricle of her heart, resulting in the death of the plaintiff's decedent. At her deposition, Laura Coudrey, M.D. testified that she first saw the decedent December 29, 2003 upon referral from Dr. Stallone, at which time the decedent complained of shortness of breath and weight gain. She performed an exercise and rest sestamibi perfusion scan which showed the decedent had a nonischemic cardiomyopathy in the left ventricle (weak heart muscle), and nonsustained ventricular tachycardia; the left ventricle was normal in size; perfusion was homgenous (even around the heart); ejection fraction was 52% (slightly reduced); and possible balanced ischemia. The MUGA scan revealed a more accurate ejection fraction of 37%, and cardiomyopathy. She set forth her additional care and treatment, referrals and results, including the report of January 2, 2004 for a cardiac catheterization which revealed cardiomyopathy and no significant coronary disease, but nonobstructive coronary disease (not obstructing the coronary arteries).

Dr Coudrey referred the decedent to an electrophysiologist, defendant Dr. Hutchinson, for evaluation due nonsustained ventricular tachycardia. Dr. Hutchinson recommended an electrophysiology study, with consideration of an implantable cardioverter-defibrillator, and radiofrequency catheter ablation. Dr. Coudrey did not object to the possible implantation and stated that it was "over her head" as a cardiologist to object to radiofrequency catheter ablation in January 2004. By letter dated February 16, 2004, she was advised by Dr. Hutchinson that she wished to have the decedent admitted and placed on a Sotalol regimen. Dr. Coudrey described the decedent as a pleasant 47 year old woman when she saw her again on April 7, 2004 to place the decedent on the Sotalol regimen, and determined from the testing that the decedent was not at risk for sudden death. She referred the decedent for a structured exercise program and to the Babylon Heart Center for cardiac rehabilitation, but on June 9, 2004, there were still multiple episodes of nonsustained VT at cardiac rehab, leading her to believe that the Sotalol regimen was not effective, prompting cessation of her rehab program. Dr Coudrey stated that she wanted the decedent to see Dr. Hoch at St. Francis to get into an ICD trial as patients can die suddenly despite their negative test results, and second opinion concerning antiarrythmic therapy. On June 16, 2004, she received a report from Dr. Hutchinson, but she could not recall if Dr. Hutchinson advised her that she was planning a cardiac ablation for the decedent. No one called her on July 21, 2004 to see the decedent, however, Dr. Hutchinson called her and advised her that the plaintiff's decedent died during the procedure.

Dr. Hutchinson testified that she performed electrophysiology studies (EPS), ablation, radiofrequency catheter ablation studies, pacemaker implantation, and ICD placement, and saw patients on hospital consults and followup concerning arrythmias. She set up the electrophysiology program at Southside Hospital as there was no such program there, and she trained the nurses to work in the program. She had no formalized duties and there was no written agreement with Southside Hospital for the program. She also had a physician's assistant who worked for the Suffolk Heart Group and trained her as well. Dr. Hutchinson first saw the decedent on January 12, 2004, on a referral from Dr. Laura Coudrey, but did not know if she had Dr. Coudrey's records when she saw the decedent. She learned that she had a previous MUGA scan, EKG, stress test, and cardiac catheterization at St. Francis Hospital. She stated that these tests demonstrated no obstructive coronary disease, and she diagnosed the decedent with cardiomyopathy, hypertension, and idiopathic ventricular tachycardia (meaning that there is no clear cut diagnosis in terms of cardiac condition and she did not know the cause). She did not know if the decedent's weakened heart muscle or cardiomyopathy was causing the ventricular tachycardia, or whether the ventricular tachycardia was causing the cardiomyopathy.

Dr. Hutchinson testified that to determine the decedent's risk for sudden death, she recommended that the decedent have a non-invasive electrolophysiology study (EPS), and an invasive T-wave alterans test, to see if she could induce a sustained ventricular tachycardia to evaluate her hemodynamic response. The noninvasive EPS on January 23, 2004 showed no inducible sustained ventricular tachycardia (six) which converted by itself, and a normal sinus node function, and dual AV nodal physiology. She did not have indication to recommend ICD placement at the time, and considered the decedent to be a low risk for sudden death. She thought she could have a progressive cardiomyopathy without treatment of the arrythymia. Dr. Hutchinson continued that the T-wave alterans study was done in her office on February 4, 2004. There was no pre-certification ordered. Her interpretation was indeterminate due to the increased ventricular tachycardia, ventricular ectopy and irregular rhythm. Thereafter, antiarrhythmic therapy was considered. In April 2004, Dr. Coudrey admitted the decedent to Good Samaritan Hospital for antiarrhythmic therapy with Sotalol at Dr. Hutchinson's suggestion. She had discussed the risks associated with Stotalol, including torsades (lethal arrythmias).

On June 16, 2004, Dr. Hutchinson determined the decedent was having frequent non-sustained ventricular arrythmias with low work load, and was receiving cardiac rehab. She discussed medication and radiofrequency catheter ablation for treatment of the ventricular tachycardia and discussed the procedure with her, as well as the risks of infection, bleeding, clot, heart attack, lethal arrythmia, right or left tachycardia, perforation with a more increased risk if the ablation is done on the right side, stroke if she went into the left side of her heart, or death. Dr. Hutchinson testified that she also explained to the decedent that she had EKG's which suggested that the tachycardia could be in either the right or the left side of the heart, and that there is a condition which can be missed, right ventricular dysplasia, which involves the right ventricle making her more prone to sudden death and associated with multiple different arrythmias. She explained to the decedent that the procedure would take three to six hours, and that she would place two small catheters into her femoral vein in her groin, and pass wires into her heart to stimulate the heart to see if she could produce a sustained arrythmia, and provided her with a booklet. The decedent was referred to St. Francis for a cardiac MRI scan prior to ablation to rule out right ventricular dysplasia. The scan was negative for the same, but the left ventricle showed borderline to mildly reduced left ventricular systolic function with mild apical hypokinesia, with mild dilation of the left atrium. Her conclusion was that of probable mild left ventricular cardiomyopathy (enlarged but not severely).

Prior to being admitted to Southside Hospital on July 21, 2004, for the ablation procedure, the decedent received various laboratory testing revealing mild anemia. Dr. Hutchinson testified that the medical doctor would follow and treat the anemia, and that it was not her role. She did not feel the anemia would have an effect on the procedure. Sedation was started at 11:20 a.m. and made the decedent sleep for the most part. She placed the catheters in the right and left femoral veins, sheaths were then placed through the catheters, and pacing and sensing electrode catheters were positioned into different parts of the heart. The right side of the heart had a quadripolar pacing and sensing electrode positioned into the HIS region and the right ventricular apex, and a deflectable ablation catheter in the ventricle. She had to first confirm where the arrythmia was located, and that was done by placement of the cathether inside the ventricle. She had a prior EKG of January 12, 2004 which indicated a right bundle branch block which indicated that the arrythmia might be coming from the left side of the heart. Another EKG on June 15, 2004, showed a left bundle branch block with an extra beat suggestive that it was coming from the right side of the heart. Dr. Hutchinson testified that this was the first case that she can recall where she did not have a clear understanding as to whether the arrythmia was coming from the right or the left ventricular outflow tract. After she finished mapping the right ventricle with the ablation catheter, she convinced herself that the arrythmia was originating from the left ventricle and not the right. Thus, when the catheter was placed through the right femoral vein, the sheath was placed in the ascending aorta. She decided to map the right ventricle before the left ventricle so she would not put the decedent at risk

for a stroke. Mapping the right ventricle took about an hour and a half, until about 1:20 p.m. At 2:40 P.M., Heparin was administered, indicating that she was then going to map the left side of the decedents's heart. She explained the procedure she followed and indicated that she positioned a sheath into the decedent's ascending aorta.

At 2:51 p.m., the first ablation (burn) in the left ventricular outflow tract was done at a power of 49, 50 being the highest. The burn time was set for 60 seconds as a max. At 15:36, Dr. Hutchinson stated, she burned for 68 seconds. She continued that if there is an arrythmia and it stops, she knows she has a good burn. However, with the decedent, the arrhythmia rarely happened, so she had to make her best estimation as to where the arrythmia was and burn during the regular sinus rhythm. She did eight burns and she thought they were good, although she noted that the Prucka Electrophysiology Recording System charted more burns, differing from the number of burns recorded by the nurse assisting her. At 6:22 p.m. she did the last burn for 31 seconds, but the decedent suddenly developed a sinus bradycardia, then severe bradycardia, then there was no heart rate. She then testified that the nurses' note at 6:25 p.m. showed the decedent was in sinus rhythm and had a blood pressure and pulse; at 6:40 she was in sinus rhythm of 91 and had a blood pressure of 124/71, but her status changed thereafter. Dr. Hutchinson stated that she remained present during the code until 55 minutes into it, when Dr. Manaris covered and she went to speak to the family to advise them that the decedent went into arrest and that she did not think the decedent would make it. The code lasted about one hour. After the decedent died, she spoke to the family and told them she did not know what happened, and that an autopsy would be needed, which Mr. Armano signed for.

Lisa Winters, R.N. testified to the effect that she was employed by Southside Hospital and worked in the EPS laboratory as a staff nurse. There were procedures and policy which had to be followed, though she did not specifically recall the same. She stated her duties and responsibilities were to review the preoperative laboratory results, including chemistries, electrolytes, CBC, PT/INR, and pregnancy tests. She would review the hemaglobin and hematocrit of the CBC to determine if a patient were anemic, and the platelets to determine if there was a risk for bleeding. The laboratory values would be forwarded to the physician prior to starting the procedure. After the decedent coded, she did not recall if Dr. Hutchinson told the code team why the decedent developed asystole. She was not present, she testified, for any conversation wherein Dr. Manaris advised Dr. Hutchinson that she should not have been in the left ventricle. After the decedent's death, she was advised verbally that no left ventricular ablations were to be performed in the EPS lab at Southside Hospital because New York State had a mandate that cardiothoracic surgery or open heart surgery had to be available in any hospital in New York when performing the procedure.

Kathleen Cox, R.N. testified to the extent that she worked at Southside Hospital since 1984, and in 2003 transferred to the cardiac cath lab in radiology, doing specials, procedures, stress lab, and EPS lab. When in the EPS lab, her role was administration of conscious sedation and taking vital signs during EP procedures, for which she stated she was certified, but was not a trained in anesthesiology. She did not recall if Dr. Hutchinson was dissatisfied with her or any of the other nurses assisting her in the EPS room.

Ralph Biscari, R.N. testified that he was employed at Southside Hospital since 1972, and worked in the cardiac cath lab for three years from 2004 to 2007. He worked in the holding area and also administered conscious sedation and monitored vital signs and reported any abnormalities to the physician. He testified that it was the responsibility of the nurse who brings the patient into the laboratory to check the pre-procedure blood work and to report any abnormalities to the physician. He stated that Helen Childs signed the note that Dr. Hutchinson was aware of the abnormal lab values. He also testified that the nursing supervisor, Joan Meuller, contacted the medical examiner after the decedent died so that an autopsy could be performed.

Bassiema B. Ibrahim, M.D., Southside Hospital's expert, has submitted an affidavit wherein it is averred that he/she is board certified in internal medicine, cardiology and cardiac electrophysiology. Dr. Ibrahim set forth the records and materials reviewed in rendering an opinion, including some inadmissible medical records as set forth above. It is Dr. Ibrahim's opinion within a reasonable degree of medical certainty that the nurses and staff at Southside Hospital did not deviate from the accepted standard of care in the field of medicine in connection with the care and treatment rendered to Antonia Armano, and that their care and treatment was not the proximate cause, and did not contribute to the injuries alleged to have been suffered by the plaintiff's decedent.

Dr. Ibrahim set forth the decedent's history, and stated that the decedent was seen by Dr. Coudrey on December 29, 2003, and was diagnosed with non-ischemic cardiomyopathy and non-sustained ventricular tachycardia, including a 22 beat run, with no evidence of coronary artery disease. The multiple episodes of non-sustained ventricular tachycardia stopped on their own. Dr. Coudrey referred the decedent to Dr. Berke, who performed a cardiac catheterization at St. Francis Hospital on January 2, 2004, revealing unremarkable coronary arteries indicating non-obstructive coronary disease. On January 7, 2004, Dr. Berke performed a MUGA scan which revealed an ejection fraction of 37%. Due to the non-sustained ventricular tachycardia, Dr. Coudrey referred the decedent to Dr. Hutchinson for an electrophysiology study. Dr. Hutchinson saw the decedent on January 12, 2004. On January 23, 2004, Dr. Hutchinson performed an electrophysiology study at Southside Hospital, which Dr. Hutchinson interpreted to indicate that Ms. Armano did not meet the criteria for ICD (implantable cardioverted defibrillator) implantation.

Dr. Ibrahim continued that on February 4, 2004, Dr. Hutchinson performed a T-wave alteran study which was indeterminate due to too much non-sustained ventricular tachycardia. The decedent was thereafter admitted to Good Samaritan Hospital under the care of Dr. Coudrey to initiate the antiarrhythmic therapy with Sotalol. She was thereafter sent to Babylon Heart Center for Cardiac Rehabilition, and was seen by Dr. Coudrey on June 9, 2004, due to multiple episodes of non-sustained ventricular tachycardia. On June 16, 2004, the decedent was seen by Dr. Hutchinson and a discussion was had with respect to the possibility of a radio frequency catheter ablation procedure for treatment of the ventricular tachycardia. While Dr. Ibrahim stated that the risks, benefits and alternatives were discussed with the decedent by Dr. Hutchinson, Dr. Ibrahim does not indicate what specifically was discussed and what the risks, benefits and alternatives were. In advance of the procedure, the decedent was sent to St. Francis Hospital where right ventricular dysplasia was ruled out, but the testing revealed mild left ventricular cardiomyopathy. Pre-operative blood work revealed mild anemia with a hemoglobin level of 9.7. Dr. Ibrahim stated that Dr. Hutchinson appreciated all the pre-operative testing, however, Dr. Ibrahim does not comment on the anemia and the relationship, if any, to the procedure or outcome.

Dr. Ibrahim stated that on July 21, 2004, the decedent presented to Southside Hospital for the radiofrequency ablation procedure, and that Dr. Hutchinson placed catheters in the right and left femoral vein and in the left femoral artery at 12:00 p.m., that the decedent was monitored during the procedure, and the procedure was described. Dr. Hutchinson ordered the medications administered during the procedure and determined placement of the catheters, how much power was to be used, and the burn time for each ablation. Dr. Ibrahim stated that Dr. Hutchinson testified that the nurses followed her instructions in a timely fashion. During the procedure, during the thirty-first burn, the decedent developed sinus bradycardia and the burn was stopped after thirty-one seconds due to ST elevations, however, the decedent developed more severe bradycardia and progressed to asystole and cardiopulmonary arrest. The external pacer was connected and CPR was initiated and controlled by Dr. Hutchinson. The code was unsuccessful and the decedent was pronounced dead. Dr. Ibrahim does not comment on the number of burns utilized, whether it was customary to perform that number of burns, and the effect of thirty-one burns. Nor does Dr. Ibrahim comment on the location of that last

burn when the plaintiff went into bradycardia and asystole, which side of the heart the burn was on, and whether it was appropriate at that time to enter into the left side of the heart and perform left ventricle ablation.

Dr. Ibrahim opined that the nursing staff took a timely and proper history of the decedent, including the that she had a non-sustained ventricular tachycardia. The decision to perform a cardiac ablation procedure, choice of procedures or medications, and diagnostic studies, did not rest with any of the staff at Southside Hospital, but with Dr. Hutchinson. Dr. Hutchinson placed the catheters utilized during the procedure, and manipulated and controlled them. She also mapped the right and left ventricles, and utilized 3D imaging. The nurse's role was limited to pressing the buttons to initiate and terminate the energy application during the ablation procedure. The timing, temperature, and energy setting were all determined by Dr. Hutchinson. There were three nurses present during the procedure. They timely and properly performed the radiofrequency energy applications to the area of the mitral annulus and aortic valve annulus. Dr. Ibrahim continued that the nursing staff was competent, skilled and qualified, and that they were properly trained. Dr. Ibrahim continued that in July 2004, good and accepted medical practice did not require the presence of an anesthesiologist during an ablation procedure, or the presence of cardiothoracic backup, and did not require a patient undergoing cardiac catheterization to be admitted to a tertiary care and/or academic medical center in order to undergo a cardiac ablation procedure, but does not set forth the standard of care and policy or protocols in effect at the time. Dr. Ibrahim does not comment on the policy and procedure manual effective January, 18, 2002 (pages 1-6) which was submitted by the defendant hospital.[1] The document set forth in pertinent parts that laboratory values outside the normal range are relative contraindications to the procedure, but Dr. Ibrahim does not indicate the hospital staff's role or policy in enforcing this policy. Another section set forth that the decision to recommend intervention will be made by the electrophysiologist in collaboration with the private attending physician. It is unclear whether this was done.

Dr. Ibrahim continued that Dr. Hutchinson assisted in the opening of the electrophysiology department at Southside Hospital and made recommendations regarding the equipment to utilize, including the EPS recording system and the EP stimulator, and trained the nurses working in the electrophysiology lab at Southside Hospital. However, Dr. Ibrahim has not referred to the protocol or the hospital policy and procedure to be followed in this circumstance, has not provided copies of the same, and has not demonstrated that the same were appropriately followed by the staff at Southside Hospital, and how the standards of care were met. While Dr. Ibrahim stated that the plaintiff refused an autopsy, Mr. Armano testified that after his wife died, he advised the hospital staff that they could do an autopsy, but when he returned home, he received a call from the hospital advising him that the coroner was too busy and that they were not going to perform an autopsy. Mr. Armano further testified that Dr. Hutchinson advised him that she did not know what went wrong and that his wife went into cardiac arrest and died. He continued that Dr. Hutchinson did not tell him and his wife about the risks and benefits, and that she just said it was "99.999 fail safe." He did not understand why Dr. Hutchinson went into the right side of his wife's heart during the procedure when she told him that the problem was on the left side. Mr. Armano testified that he was not aware that Dr. Coudrey disapproved of the procedure performed by Dr. Hutchinson or that his wife might have qualified for a defibrillator at St. Francis Hospital instead. Dr. Ibrahim does not comment on the cause of death to opine that the hospital staff did not cause or contribute to the decedent's death. Nor does Dr. Ibrahim address the failure of Southside Hospital to obtain the autopsy when Mr. Armano testified that he

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[1] The document is not authenticated or certified to be a true copy existing at the time of the decedent's ablation procedure, and there are handwritten entries which are not explained. However, the plaintiff has not objected and has submitted a copy of the same with the opposition papers.

signed for the same and that the medical examiner was too busy. Additionally, Dr. Ibrahim does not comment on the discs purportedly generated during the EP ablation procedure, and does not indicate that the same were provided for review.

Based upon careful review and consideration of the evidentiary submissions, it is determined that the defendant has not established prima facie entitlement to summary judgment dismissing the complaint and any cross claims asserted against Southside Hospital, as there are factual issues in the moving papers which preclude the same, and the plaintiff's expert has raised further factual issues which preclude summary judgment from being granted to Southside Hospital.

Assuming arguendo that the defendant established its prima facie entitlement to summary judgment, then in order 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]).

Here, the plaintiff's expert is a physician board certified in internal medicine, cardiology and electrophysiology, is licensed to practice medicine in New York State, and set forth his/her work experience and training and basis for familiarity with the standards of care at the time relative to, inter alia, radiofrequency cardiac ablation procedures, techniques, and other aspects of treatment, protocols, and the experience necessary to perform cardiac ablations, particularly, left ventricular ablation procedures. The plaintiff's expert, Dr. Jeffrey Snow, set forth the materials and records reviewed, and opined within a reasonable degree of medical certainty.

The plaintiff's expert's set forth that Dr. Hutchinson became affiliated with Southside Hospital when there was no Electrophysiology program, and that she set up the Cardiac Electrophysiology Laboratory by making recommendations to the Southside Hospital Administration as to the laboratory equipment to be purchased so that electrophysiology studies and radiofrequency cardiac ablations could be performed there. Southside Hospital thereafter appointed Dr. Hutchinson as Director of Southside Hospital Electrophysiology Laboratory, and as such, she trained hospital employees who were assigned to work in the Electrophysiology Laboratory to assist her with cardiac procedures, including radiofrequency ablation procedures.

The plaintiff's expert continued that when Dr. Hutchinson scheduled the ablation procedure on July 14, 2004, there were pre-procedure blood studies obtained, one of which revealed a decreased hemoglobin level of 9.7 (normal 12-15 gm/dl), and a decreased hematocrit level of 32 (normal 36-46%) and a MCV (mean corpuscular volume) of 60 (normal level 81-99). The plaintiff's expert opined that the MCV value of only 60 is usually seen with some source of slow, chronic bleeding, which is significant in that the left ventricular ablation procedure requires administration of large does of Heparin to thin the blood to minimize risk of a stroke. When there is already an ongoing slow bleeding process prior to the ablation, the administration of Heparin can convert that slow bleed into a massive, potentially life threatening bleed.

It is the plaintiff's expert's opinion that it was a departure from the accepted standard of cardiac ablation procedure to undertake an elective, non-urgent cardiac ablation and, specifically, a left ventricular cardiac ablation, which required the large infusion of Heparin without first determining the cause of the patient's decreased hemoglobin, hematocrit, and MCV level, and to provide treatment if necessary. Although Dr. Hutchinson was aware of these abnormal laboratory values, she continued with the right ablation procedure and

extended it into a very high-risk left ablation procedure, without any documentation as to why it was deemed necessary to proceed with the ablation procedure on that date with abnormal laboratory values.

The plaintiff's expert further opined that prior to the ablation procedure, Dr. Hutchinson had no clear understanding as to whether the patient's arrythmia was originating in the right ventricle or left ventricle of the heart, and that this fact alone was reason not to proceed with this elective cardiac ablation procedure at Southside Hospital, a community hospital without a cardiac surgery center. Dr. Hutchinson was aware in her role as Director of Electrophysiology Laboratory, that she and her staff would be undertaking a very high-risk left ventricular ablation at a non-cardiac surgery center without proper medical indication and with a very low likelihood of success, and that she should have referred and/or transferred the decedent to a cardiac surgery center or tertiary care hospital for any cardiac ablation procedure which she felt had even the possibility of requiring left ventricular exploration or ablation.

The plaintiff's expert continued that cardiac ablation of the left ventricle is very high-risk and complex and should only be performed in specialized medical centers by highly experienced clinical electrophysiologists. By her own admission, Dr. Hutchinson had performed only one other left ventricular ablation procedure in the two years before undertaking such a high risk procedure at Southside Hospital. The plaintiff's expert continued that while Dr. Hutchinson may have been competent to perform a right cardiac ablation, she did not have the competence or expertise to perform the high-risk left ablation, and that she was fully aware of her own lack of experience. As the administrator of the EPS, she failed to set and maintain a minimum level of competency for performing high-risk left ventricular ablation. The Adult Intracardiac Catheter Ablation Protocols for the Southside Hospital Cardiac Electrophysiology Laboratory provides that cardiac ablation catheters shall only be placed in the right heart chambers, and makes no provisions for placing a catheter in the left ventricle, much less performing a complex, high-risk left ventricular cardiac ablation procedure on the decedent.

The plaintiff's expert stated that neither Dr. Hutchinson nor the staff from the EPS were experienced or trained to perform or assist with this very complex procedure, and that there was no compliance with the protocols in effect on July 21, 2004, which Dr. Hutchinson developed. The failure of Dr. Hutchinson as director of the EPS laboratory to require minimum levels of electrophysical competence, and the failure to enforce laboratory protocols was a clear departure from the good and accepted standards of medical care and a proximate cause of the decedent's cardiac arrest and death. Dr. Hutchinson never apprised the patient or family of her lack of experience to undertake a high-risk left ventricular ablation procedure at Southside Hospital, or advise that the protocols made no provision for the performance of left verntricular ablation procedure by the Southside Hospital personnel. There was no attempt to transfer the decedent to a tertiary care hospital or cardiac surgery center with electrophysiologists who had the experience and expertise to perform the procedure on the left ventricle. Nor did Dr. Hutchinson inform the decedent or her family of the pre-procedure abnormal laboratory findings which should have precluded this elective procedure, again departing from good and accepted standards of medical care and treatment in 2004.

The plaintiff's expert opined that the amount of sedation given to the decedent by the nursing staff during this high-risk left ventricle ablation without an anesthesiologist being present was excessive in that Versed 24 mg. and Fentanyl 300 mg. were administered in divided doses, which dosages can result in cardiac and/or respiratory depression. The nurse who administered the sedation during the procedure had no formal anesthesia training, thus, Dr. Hutchinson failed to provide adequately trained staff with proper certification, including herself, and failed to have proper anesthesia backup during the six and one-half hour procedure. Although the decedent went into cardiac arrest at 6:22 p.m. during the thirty first radio frequency ablation in the left ventricle, a hospital code was not called until 6:41 p.m., nineteen minutes after the arrest, during which time

Dr. Hutchinson and the nursing staff tried to resuscitate the decedent without immediately calling for help and anesthesia backup. The plaintiff's expert opined that when a patient goes into arrest, there should be no delay in a hospital setting to call the code team to assist, and that this was a failure to conform with generally accepted medical and hospital protocol.

The plaintiff's expert stated that when the decedent arrested, that Dr. Hutchinson performed an unnecessary pericardiocantesis (needle into the heart) even though it appeared that the post-arrest echocardiogram was negative for fluid. Dr. Hutchinson interpreted that echocardiogram herself. Had the procedure been properly performed in a facility properly staffed and equipped for this type of procedure, an echocardiologist could have been summoned to properly interpret the echocardiogram, and there would have been backup from cardiothoracic surgery and the anesthesia department during the procedure and the cardiac arrest. The inability to properly interpret the echocardiogram and the performance of the unnecessary pericardiocentesis caused a delay in the resuscitation efforts and was another demonstration that Dr. Hutchinson was not competent under the circumstance she created. The plaintiff's expert concluded that Southside Hospital failed to verify the competence of Dr. Hutchinson, as director of EPS, and the competence and proper training of the hospital nursing staff, thus proximately causing, and a substantial factor in the death of the plaintiff's decedent.

Based upon the foregoing, the plaintiff's expert has raised factual issues, as set forth above, which preclude summary judgment from being granted to defendant Southside Hospital.

Accordingly, motion (001) by Southside Hospital for summary judgment dismissing the complaint and cross claims asserted against it is denied.

Dated: April 12, 2013

W. Gerard Asher
J.S.C.

_____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**