Serrano v State of New York
2017 NY Slip Op 32902(U)
February 27, 2017
Court of Claims
Docket Number: 122759
Judge: Judith A. Hard

STATE OF NEW YORK COURT OF CLAIMS

JUAN SERRANO,

Claimant, DECISION

-v-

THE STATE OF NEW YORK, **Claim No. 122759**

Defendant.

BEFORE: **HON. JUDITH A. HARD**
Judge of the Court of Claims

APPEARANCES: **For Claimant:**
Franzblau Dratch, P.C.
By: Brian Dratch, Esq.

For Defendant:
Hon. Eric T. Schneiderman, NYS Attorney General
By: Belinda A. Wagner, Assistant Attorney General,
Of Counsel

Claimant brings the instant action alleging that he was the victim of negligence and medical malpractice when employees at Shawangunk Correctional Facility (SCF) failed to timely diagnose and treat his heart attack. Following joinder of issue and discovery, a unified trial regarding defendant's liability and claimant's damages was held at the Court of Claims in Albany, New York. The Court heard testimony from claimant, the medical nurse who was on duty at SCF on the day in question, and two expert witnesses.

FACTS

At the trial, claimant testified that he was 53 years old and has been in and out of prison for most of his adult life, with the most recent sentence being 35 years to life. He stated that he has been in custody at SCF for 15 years, that he regularly participates in recreation programs there, and that, for the most part, he has not had any major health issues. On May 25, 2011, claimant was playing softball with other inmates when he experienced shortness of breath while trotting to first base from home plate. Claimant stated that he felt disoriented and saw particles of light, and that he felt pressure coming from the center of his chest across his left shoulder and extending down his bicep of the left arm as he walked. He testified that he was still out of breath and dizzy when he sat down in the grass, and reported to the outside correction officer that he did not feel well. Later that day, at approximately 3:40 p.m., claimant reported to his cell and informed his block officer that he did not feel well. The officer made two telephone calls and claimant was eventually brought to emergency sick call at 8:25 p.m., where he was examined by Mary Ann Rutty – the medical nurse on duty that day. According to claimant, Nurse Rutty took his vital signs and noted that his blood pressure was elevated. Claimant told her that he felt a heavy pressure in his chest and that he had a problem breathing. Claimant testified that Nurse Rutty told him that he was "a little dehydrated," gave him non-aspirin, and sent him back to his cell (T: 27).[1] She told claimant that if he "felt anything severe," such as pain or discomfort, he should inform his block officer (T: 27). Claimant stated that he returned to his cell at 9 p.m. and continued to experience pressure in his chest, as well as nausea, off and on throughout the night.

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[1] All references preceded by "T" are to the two-volume, consecutively paginated trial transcript.

Claimant further testified that he returned to the infirmary at 12:30 p.m. on May 26, 2011. When he explained his symptoms to the day-shift nurse, she spoke to the physician on duty, who ordered an electrocardiogram (EKG) on claimant. The physician read the EKG and requested that an ambulance take claimant to St. Luke's Hospital. Claimant testified that he was given aspirin at the infirmary and that the ambulance personnel administered nitroglycerin, which relieved his pain (Exhibit A, p.13).[2] When claimant arrived at St. Luke's, he underwent a cardiac catherization that afternoon. Claimant spent two days at St. Luke's Hospital and was then transferred to Albany Medical Center (AMC). He was discharged from AMC on June 2, 2011 and then transferred to the infirmary at SCF. Claimant stated that the physicians at AMC prescribed Lipitor, Coreg and a baby aspirin, all of which he continued to take as of the time of the trial. Claimant further stated that he sees a heart specialist every six months and does not lift weights or play sports since the incident.

Nurse Rutty was called as a fact witness for defendant. She testified that she is presently retired but, after completing nursing school in 1981, spent the majority of her career in State service as a registered nurse with the Office of People with Developmental Disabilities in group homes. Nurse Rutty stated that she also worked part-time at SCF on a per diem basis for five years and was the emergency sick call nurse working in the infirmary on May 25, 2011, when claimant arrived between 8:30 and 9 p.m. that evening. She wrote the following summary of claimant's complaints: "[Inmate] outside sprinting in yard when he felt faint and felt he was dehydrated. [Complains of] discomfort in [left] chest and shoulder. [D]enies pain" (Exhibit C, p.

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[2] According to the records from Mobile Life Support Services, Inc., claimant's pain level was initially a 6 out of 10 that was reduced to 0 out of 10 after nitroglycerine was given at 2:23 p.m. (Exhibit A, p. 13).

85). Nurse Rutty then took claimant's vitals, which included a blood pressure reading of 128/100, and determined that his vitals were within normal range. Upon review of claimant's medical records, Nurse Rutty found that he had complained of left shoulder pain in the past. She testified that claimant was not short of breath nor sweating when he arrived in the infirmary, and he did not complain of any nausea or vomiting at that time. She checked his range of motion in his left shoulder and found that it was not problematic. Nurse Rutty stated that she told claimant to drink more fluids and to limit exercise until he was seen by the physician on June 3, 2011, but instructed him to return to the infirmary if his symptoms became painful. Nurse Rutty testified that she did not administer aspirin or non-aspirin to claimant, and the medical documents submitted by defendant do not reflect that she administered any medication to him (Exhibit C, p. 85). She further testified that, if she had believed that claimant was having a cardiac event, she would have used the Tele-Med system to obtain the advice of a physician, and conceded that an EKG machine was available for her use that evening if she thought it was needed.

Dr. Bruce Charash testified as claimant's expert witness.[3] Dr. Charash explained that classic cardiac pain is dull, like a squeezing pressure or a heavy tightness, and that the most common symptom of a cardiac event is discomfort in the left side of the chest radiating to the left shoulder. Dr. Charash further explained that there are two types of heart attacks. One involves a closed artery, which generates continuous severe unremitting pain. When the artery closes, heart

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[3] Dr. Charash graduated from Cornell Medical School in 1981. From 1981-1984 he completed his internship at Mount Sinai Hospital in New York in internal medicine. In 1984 he became board certified in internal medicine. From 1984-1987, he did a fellowship at New York Hospital in cardiology and was board certified thereafter. From 1987-1991, he was an assistant professor of medicine at Cornell University Medical College and the assistant director of the cardiac intensive care unit at Cornell. From 1991-2005, he was the chief of the cardiac care unit at Lenox Hill Hospital in New York. He has been in private practice since 2006.

cells die and release certain protein enzymes (troponin) into the body. Dr. Charash stated that it can take a long time for the enzymes to leak into the blood because there is no circulation, and it can take up to 12-18 hours for the enzymes to reach a peak level in the blood (T: 101). The other type of heart attack – known as a stuttering heart attack – occurs when the artery intermittently opens and closes. With a stuttering heart attack, there are multiple recurrent episodes of pain, and the enzymes wash out more quickly because the artery keeps opening. Dr. Charash stated that claimant's first enzyme draw at St. Luke's Hospital was his highest.[4] Thereafter, claimant's enzyme level dropped, which Dr. Charash believes implied that the peak level had occurred at least 12 hours before his arrival at St. Luke's (T:101).[5] Dr. Charash further stated that, after claimant's cardiac catherization, St. Luke's initially made the differential diagnosis of: (1) a heart attack or (2) Takotsubo syndrome, also known as acute stress cardiomyopathy.[6] However, the dignosis of Takotsubo syndrome was ruled out when claimant was transferred to AMC (Exhibit A, pp.1, 8). Dr. Charash stated that the catherization showed no obstructions in claimant's heart but that he had a severe hypokinesis and an ejection fraction of only 25% (Exhibit A, p. 45). The ejection fraction measures the amount of blood pumped from the left ventricle of the heart to the

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[4] From the hospital records, it appears that this was some time near the time of claimant's catherization at approximately 3:45 p.m. on May 26, 2011 (Exhibit A, p. 36).

[5] Claimant arrived at St. Luke's Hospital at approximately 2:45 p.m. (Exhibit A, p. 34).

[6] Takotsubo is also known as the "broken heart syndrome" based upon the theory that, if a person has a rush of adrenaline due to a shocking moment – usually a singular identifiable event (i.e., the death of a loved one) – the adrenaline surge may stun the heart and make it appear as if the person suffered a heart attack. According to Dr. Charash, there are approximately 1 million heart attacks per year but only a few thousand cases of Takotsubo syndrome. With Takotsubo, a person experiences a blast of unremitting pain for hours, never an off and on pain. Dr. Charash testified that claimant's EKG at St. Luke's showed that the "T wave" was inverted, which is a classic sign of a heart attack (T: 131-132). If claimant was suffering from Takotsubo syndrome, the T wave would have been upright (T:132). Also supportive of the finding that claimant suffered a heart attack is that the catheterization and the echocardiogram showed that his apical wall of the heart – the rounded part of the ventricle – was weakened (T:118). Further, his ejection fraction, which measures the amount of blood that is pumped into the aorta, was very low – 25%, whereas most people are at 60.

aorta. An ejection fraction of 60% is normal, and the lowering of that number indicates damage to the heart muscle (T: 113). Dr. Charash stated that the hypokinesis in claimant's left ventricle indicated a weaker than normal heart function (T: 117-118). A subsequent echocardiogram was performed at AMC on May 29, 2011, which revealed that claimant's heart strength had improved but was still not normal. AMC's discharge summary indicated that claimant had a myocardial infarction (heart attack) with non-obstructive coronary artery disease (Exhibit B, p. 4). According to Dr. Charash, this type of heart attack, which thousands of people suffer each year, can occur from a sudden blood clot (T: 137). An echocardiogram performed in April 2012 showed that claimant's ejection fraction was 55% with apical hypokinesis (a residual weakening of the apical wall) (Exhibit C, p. 158). During a follow-up examination in September 2014, claimant still had non-ischemic cardiopathy (Exhibit C, p. 156). In May 2015, claimant's prison healthcare records also indicated that he still had non-ischemic cardiomyopathy (Exhibit C, p. 27).

In Dr. Charash's opinion, a male in his forties who presents with an abrupt onset of chest pressure and discomfort to the left shoulder with dizziness mandates an immediate evaluation by a physician, an EKG, and admission to a monitored facility – none of which occurred in this case. He stated that not all patients suffering a heart attack experience shortness of breath (T: 152), and emphasized that once claimant was given aspirin in the infirmary and nitroglycerin by the ambulance personnel, his pain subsided because those drugs opened the clot. Dr. Charash opined that, if claimant had received the aspirin and nitroglycerin earlier, the damage to the heart that occurred between the evening of May 25, 2011 and the morning of May 26, 2011 would not have been as severe. According to Dr. Charash, Nurse Rutty should have performed an EKG and called a physician when claimant arrived in the infirmary on the evening of May 25, 2011.

Morever, he stated that the facility should have a protocol in place for patients exhibiting chest pain, so that physicians and not nurses make a diagnosis regarding those patients. Dr. Charash stated that claimant's condition could lead to arrhythmia in the future and opined, within a reasonable degree of medical certainty, that the damage to claimant's heart caused by the heart attack was permanent. According to Dr. Charash, although claimant has since recovered much of his heart's strength, the rest of the heart will have to work harder to maintain a good ejection fraction. Overall, however, he believes that claimant has a relatively normal life expectancy.

Defendant called Dr. Jerel Zoltick as its expert witness.[7] He compared claimant's first EKG taken at SCF at 12:59 p.m. on May 26, 2011 with the next EKG conducted at St. Luke's Hospital at 3:04 p.m., and opined that an acute coronary event was occurring during that time. Dr. Zoltick noted that the cardiac catheterization showed a non-functioning apex with an ejection fraction of 25%, which means that the heart was barely contracting. Dr. Zoltick opined that at some time one to two hours prior to the catheterization, claimant suffered a high grade obstruction that opened up by itself prior to the procedure. He noted, however, that claimant's next echocardiogram at AMC on May 29, 2011 showed a marked improvement with an ejection fraction of 47% with a mild apical hypokinesis (T: 244). Dr. Zoltick further stated that, by September 2014, claimant's ejection fraction was 73% with no wall motion abnormality and

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[7] Dr. Zoltick received his medical degree from Columbia University College of Physicians and Surgeons in 1976. He did his internship and residency at St. Luke's Roosevelt Hospital in New York City from 1976-1979. He was an attending and a cardiology fellow at Georgetown University Hospital from 1979-1981. Initially, he worked as an attending assistant professor at Georgetown University but soon was hired by the United States Surgeon General's Office to conduct studies regarding cardiac death that was exercise related. He remained there for 25 years and obtained the rank of Colonel. During this time he was an attending at Walter Reed Army Medical Center. Presently, he is an Associate Chief of Cardiology at Bassett Healthcare in Cooperstown, New York. He is licensed to practice medicine in New York, the District of Columbia, and Maryland.

opined that this improvement indicated that there had been no irreversible damage to the cardiac function of claimant's heart (T: 245-246). He noted that the AMC medical records regarding claimant's discharge indicated that he could progressively return to normal activities (T: 248). When asked if Nurse Rutty should have done more for claimant on the evening of May 25, 2011, Dr. Zoltick stated that any comments in that respect would be speculative because there is no way of knowing what, if anything, an EKG would have shown at that time. He was also unsure whether the administration of an aspirin on May 25, 2011 would have made a difference in claimant's outcome. Dr. Zoltick also emphasized that, if claimant had been dehydrated, as Nurse Rutty believed, the administration of nitroglycerin could have been harmful. Dr. Zoltick did state, however, that as a cardiologist he would have opted for more testing on the evening of May 25, 2011 (T: 250). He testified that claimant's troponin levels were at a high level when he first arrived at St. Luke's Hospital, which is indicative of a myocardial injury, but noted that the levels declined over the next day and a half. Accordingly, he opined that the episode did not cause a significant amount of irreversible muscle damage to claimant's heart.

Upon cross-examination, Dr. Zoltick admitted that claimant suffered a heart attack and that the pain in the left chest and shoulder of which he complained on the night of May 25, 2011 could have been symptoms of the heart attack. He stated that Nurse Rutty's assessment of claimant that evening did not seem to indicate concern about claimant's heart, and acknowledged that it is within the medical standard of care to perform an EKG on a patient who presents with left chest and left shoulder pain (T: 265). Dr. Zoltick stated that there was insufficient information to discern whether claimant's heart attack occurred between his visit to the infirmary on May 25, 2011 and when he arrived at St. Luke's Hospital the following day. Even if it did

occur during that time, however, Dr. Zoltick believed that the only residual damage to claimant's heart would be a very small scar within the cardiac tissue. Dr. Zoltick further opined, based upon the EKGs, that most of the acute event happened on the morning of May 26, 2011 because, if it had occurred before then, claimant's ejection fraction would have stayed at 25-30% for a longer period of time and his troponin levels would have been much higher (T: 272-273).

LAW AND ANALYSIS

"It is fundamental law that the State has a duty to provide reasonable and adequate medical care to the inmates of its prisons" (Rivers v State of New York, 159 AD2d 788, 789 [3d Dept 1990], lv denied 76 NY2d 701 [1990]; accord Auger v State of New York, 263 AD2d 929, 931 [3d Dept 1999]). "Where an inmate alleges that defendant abdicated its duty to provide adequate medical care, he or she must present competent evidence demonstrating defendant's common-law negligence or that it departed from accepted standards of care and that such deviation was the proximate cause of the sustained injuries" (Knight v State of New York, 127 AD3d 1435, 1435 [3d Dept 2015]). The distinction between a cause of action sounding in medical malpractice and one alleging medical negligence "is a subtle one, for medical malpractice is but a species of negligence and no rigid analytical line separates the two" (Martuscello v Jensen, 134 AD3d 4, 10 [3d Dept 2015] [internal quotation marks and citations omitted]; accord Weiner v Lenox Hill Hosp., 88 NY2d 784, 787 [1996]). "The issue devolves to whether medical judgment is required or not; where the underlying claim arises from the failure to follow a medical order previously made or to apply standards of ordinary care, then it is negligence, without regard to whether expert testimony is deemed helpful to the resolution. However, where the conduct involves a standard established by means of the exercise of medical

judgment, then it is malpractice" (Martuscello v Jensen, 134 AD3d at 11; see Weiner v Lenox Hill Hosp., 88 NY2d at 788; Moore v St. James Health Care Ctr., LLC, 141 AD3d 701, 702 [2d Dept 2016]).

Here, although the claim sounds in medical negligence, the gravamen of the claim is that defendant failed to properly diagnose and treat claimant's heart attack when he presented at the infirmary on the evening of May 25, 2011, and that such failure caused him significant pain and suffering and resulted in permanent damage to his heart. Inasmuch as the question of whether the care given to claimant and/or the alleged delay in rendering such care affected or exacerbated claimant's condition is not a matter of common knowledge that could be decided in the absence of expert testimony, the Court finds that the claim plainly sounds in medical malpractice (see Martuscello v Jensen, 134 AD3d at 11-12; see e.g. Janvier v State of New York, UID No. 2016-015-165 [Ct Cl, Collins, J., Oct. 19, 2016]; Ashby v State of New York, UID No. 2016-032-122 [Ct Cl, Hard, J., April 13, 2016]).

Accordingly, claimant "must demonstrate that [defendant] deviated from acceptable medical practice, and that such deviation was a proximate cause of [his] injury " (James v Wormuth, 21 NY3d 540, 545 [2013]; see Mazella v Beals, 27 NY3d 694, 705 [2016]). "[T]o establish proximate causation, [claimant] must demonstrate that . . . defendant's deviation from the standard of care was a substantial factor in bringing about the injury" (Clune v Moore, 142 AD3d 1330, 1331 [4th Dept 2016] [internal quotation marks and citation omitted]; see Wild v Catholic Health Sys., 21 NY3d 951, 954-955 [2013]). "It is well settled that, [w]here, as here, the [claimant] alleges that the defendant negligently failed or delayed in diagnosing and treating a condition, a finding that the negligence was a proximate cause of an injury to the patient may be

predicated on the theory that the defendant thereby diminished [the patient's] chance of a better outcome" (Majid v Cheon-Lee, 147 AD3d 66, 71 [3d Dept 2016] [internal quotation marks and citations omitted]; see Clune v Moore, 142 AD3d at 1331-1332; Wolf v Persaud, 130 AD3d 1523, 1524-1525 [4th Dept 2015]; Goldberg v Horowitz, 73 AD3d 691, 694 [2d Dept 2010]; Alicea v Ligouri, 54 AD3d 784, 786 [2d Dept 2008]; Borawski v Huang, 34 AD3d 409, 410 [2d Dept 2006]).

Applying these principles here, the Court finds that the testimony of both expert witnesses indicates that defendant departed from accepted medical practice in failing to refer claimant to a physician or perform an EKG when he presented with chest and shoulder pain on the evening of May 25, 2011 (see Semel v Guzman, 84 AD3d 1054, 1056 [2d Dept 2011]; Goldberg v Horowitz, 73 AD3d at 694; Alicea v Ligouri, 54 AD3d at 785; Wong v Tang, 2 AD3d 840, 840-841 [2d Dept 2003]). Notably, Dr. Charash opined that the course of action taken when claimant returned to the infirmary on May 26, 2011 – specifically, the administration of aspirin, oxygen, and performance of an EKG, as well as the transfer of claimant to an emergency facility – should have been followed the previous evening (T: 96-97). Although Dr. Zoltick's testimony was more equivocal with respect to whether claimant should have been transferred to an emergency facility at that time, he stated that, as a cardiologist, he would have been "apt to do more testing" (T: 250). Moreover, when asked upon cross-examination whether defendant "deviated from the standard of care in treating a patient who complains of . . . left chest discomfort and left shoulder discomfort with its failure to perform an EKG," Dr. Zoltick responded in the affirmative (T: 265).

In light of the above, the sole remaining issue to be resolved is whether "there was a substantial possibility that [claimant] was denied a chance of the better outcome as a result of . . . defendant's deviation from the standard of care" (Clune v Moore, 142 AD3d at 1331-1332 [internal quotation marks and citation omitted]). Upon consideration of all the evidence, including a review of the exhibits, listening to the witnesses testify, and observing their demeanor as they did so, the Court finds that claimant established by a preponderance of the credible evidence that he would have had a better outcome had he been referred to a physician and more thoroughly examined on the night of May 25, 2011. The Court finds the theory posited by Dr. Charash to be logical and credible; because claimant's enzyme levels reached a peak at approximately 3:00 p.m. on May 26, 2011, and the enzymes are typically released 12-18 hours before they became detectable in the blood, claimant's cardiac event most likely occurred at some point between 9:00 p.m. on May 25, 2011 and 2:00 a.m. on May 26, 2011. It therefore follows that the administration of aspirin and/or nitroglycerin at or around 8:30 p.m. on May 25, 2011 would have helped alleviate claimant's pain during that time, especially considering the ameliorative effect that the drugs had upon claimant when they were administered in the early afternoon of May 26, 2011. Notably, Dr. Zoltick also opined that the cardiac obstruction was alleviated 1-2 hours prior to the catherization, which places the relief from the obstruction after the administration of aspirin and nitroglycerin. Moreover, even crediting the testimony of Nurse Rutty that she believed claimant's complaints to be muscular or the result of dehydration, it is

noted the administration of an aspirin on the evening of May 25, 2011 would have covered her musculoskeletal concerns as well as potential heart issues.[8]

In light of the foregoing evidence regarding claimant's condition between the hours of 9:00 p.m. on May 25, 2011 until approximately 3:00 p.m. the next day, and the pain and discomfort associated therewith, the Court will award claimant reasonable compensation for his suffering during that time (see CPLR 5501 [c]; Wolf v Persaud, 130 AD3d at 1526). In that respect, claimant is entitled to compensation for the injury, pain and suffering he sustained, as well as for any special damages incurred (see Tirado v State of New York, UID No. 2010-030-023 [Ct Cl, Scuccimarra, J., July 19, 2010]). Such an award should compensate for the physical and emotional effects of claimant's injury (see McDougald v Garber, 73 NY2d 246 [1989]; Lamot v Gondek, 163 AD2d 678 [3d Dept 1990]), and must fall within a range that does not "deviate[] materially from what would be reasonable compensation," which range may be determined by reference to similar cases in which damages were awarded (CPLR 5501 [c]; see Osiecki v Olympic Regional Dev. Auth., 256 AD2d 998, 1000 [3d Dept 1998]). Taking into account both the similarities and distinctions between this matter and the cases considered, the Court awards damages on this cause of action for claimant's past pain and suffering in the amount of $15,000.00 (see Wolf v Persaud, 130 AD3d at 1526; Johnson v State of New York, UID No. 2016-038-109 [Ct Cl, DeBow, J., July 6, 2016]; Becoate v State of New York, UID No.

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[8] The Court notes that it found Nurse Rutty's apparent lack of concern as to claimant's heart condition on the evening of May 25, 2011 to be troubling. Her diagnosis of claimant as merely dehydrated and/or suffering from muscular pain appeared uninformed and reflected a lack of experience, especially in light of the testimony of the two expert witnesses regarding the classic symptoms of a cardiac event, which a nurse should know.

2013-040-044 [Ct Cl, McCarthy, J., June 24, 2013]; Whitehead v State of New York, UID No. 2003-015-583 [Ct Cl, Collins, J., Oct. 9, 2003]).

With respect to claimant's allegations of future pain and suffering, however, the Court credits the testimony of Dr. Zoltick that the evidence does not indicate any significant, permanent damage to claimant's heart arising from this incident. Despite defendant's failure to render timely treatment, claimant's September 2014 echocardiogram shows an ejection fraction of 73%, which is well above the normal range, as testified to by both medical experts. Furthermore, although claimant testified that he has not exercised since the incident, the discharge note from AMC indicated that claimant could progressively return to normal activities. While the Court finds credible the opinion of Dr. Charash that claimant may develop an arrhythmia in the future, any award of damages in relation thereto would be overly speculative at this juncture (see Porter v State of New York, UID No. 2008-015-509 [Ct Cl, Collins, J., Dec. 8, 2008]). Additionally, as no evidence was presented to substantiate any medical expenses or lost wages incurred or to be incurred in the future by claimant, no damages are awarded for either of those items.

Therefore, the Court finds Defendant 100% liable and awards claimant $15,000.00 in damages for the pain and suffering that he endured during the evening and morning hours of May 25, 2011 through May 26, 2011. In addition, claimant is entitled to the actual amount of any fee paid to file the claim, as a taxable disbursement pursuant to Court of Claims Act § 11-a (2). All motions upon which the Court reserved decision at trial are hereby denied.

The Chief Clerk is directed to enter judgment accordingly.

Albany, New York
February 27, 2017

Judith A. Hard

JUDITH A. HARD
Judge of the Court of Claims