

Tank v Westchester County Health Care Corp.
2018 NY Slip Op 34448(U)
February 20, 2018
Supreme Court, Westchester County
Docket Number: Index No. 67582/2014
Judge: Terry Jane Ruderman
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op <u>30001</u> (U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

To commence the statutory time for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

-----X
MAUREEN TANK, as Guardian ad Litem of
ZACHARY TANK, and MAUREEN TANK, Individually,

Plaintiffs,

-against-

DECISION AND ORDER
Sequence Nos. 1 - 4
Index No. 67582/2014

WESTCHESTER COUNTY HEALTH CARE
CORPORATION, MARK GOLDSTEIN, M.D.,
HASIT MEHTA, M.D., VLADIMIR PRYJDUN, M.D.,
RICHARD MAGILL, M.D. and IRLNA TANTCHOU, M.D.,

Defendants.

-----X
RUDERMAN, J.

The following papers were considered in connection with motions brought pursuant to CPLR 3212 for summary judgment dismissing the complaint, by defendant Vladimir Pryjdun, M.D. (sequence 1), defendant Mark Goldstein, M.D. (sequence 2), defendants Westchester County Health Care Corporation ("WCHCC") and Hasit Mehta, M.D. (sequence 3) and defendant Richard Magill, M.D. (sequence 4); additionally, in sequence 3, WCHCC moves pursuant to CPLR 3024(b) to strike language of the complaint and bills of particulars asserting "recklessness" and "carelessness" on the part of WCHCC:

<u>Papers - Motion Sequence No.</u>	<u>Numbered</u>
Notice of Motion, Affirmation, Exhibits A - E	1
Affirmation in Opposition, Exhibits A - F	2
<u>- Motion Sequence No. 2</u>	
Notice of Motion, Affirmation, Exhibits A - Q	3
Affirmation stating no opposition	4
<u>- Motion Sequence No. 3</u>	
Notice of Motion, Affirmation, Exhibits A - Z, Memorandum of Law	5
Affirmation in Partial Opposition, Exhibits A - F	6
Reply Affirmation, Exhibits AA - BB	7

- Motion Sequence No. 4

Notice of Motion, Affirmation, Exhibits A - J	8
Affirmation in Opposition, Exhibits A - F	9
Reply Affirmation	10

This medical malpractice action concerns the medical treatment defendants provided to Zachary Tank, following a motorcycle accident in which he was involved on July 14, 2013, when he was 18 years old. He was wearing a helmet at the time, and did not sustain head injuries or lose consciousness, but he sustained multiple fractures of the left leg and right wrist. After the accident, Tank was brought by helicopter to Westchester Medical Center. He was alert when he arrived at the emergency room at 6:00 p.m., and diagnostic studies showed no signs of a head injury. There is no mention in the hospital records as to how he was monitored during this period, or whether he was receiving supplemental oxygen. CT scans of Tank's chest and abdomen showed that his esophagus was dilated and fluid-filled and his stomach was distended, which conflicts with the anesthesia evaluation performed at 6:15 p.m. stating that he had nothing by mouth after 9:00 a.m.

Among the hospital records is a notation by a nurse indicating that at 8:40 p.m. that evening, a physician had been notified that Tank was acting confused and could no longer remember his accident. He was transferred to the holding area of the operating room by 10:30 p.m. An anesthesia note from 10:40 p.m. indicates that by that time he was sedated, had an altered mental state and was off all monitors and supplemental oxygen. By the time he was reconnected to the oxygen monitors, his oxygen level was noted to be low, and he was described as "extremely under-resuscitated."

At his deposition, defendant Vladimir Pryjduin testified that he was the surgical

anesthesiologist, and that Tank was unconscious and non-responsive when Pryjdun first saw him. Pryjdun had to vigorously shake him to wake him up, and he was very somnolent. He instructed the resident to bring an oxygen monitor and oxygen cylinder. With the additional oxygen, Pryjdun said, Tank's oxygen levels improved sufficiently to permit performing surgery. While he recognized that Tank was hypovolemic, in a state of circulatory shock, underresuscitated, and that his blood pressure was low, Pryjdun concluded that it would be more dangerous to delay surgery than to proceed.

Pryjdun's anesthesia team proceeded with the induction of anesthesia at 10:50 p.m. Defendant Richard Magill, the orthopedic surgeon, began the surgery to repair the multiple fractures at around 11:40 p.m., and concluded approximately four hours later. Some time later, it was determined that he had suffered permanent brain damage. A post-operative chest x-ray showed aspiration pneumonia, and a post-operative CT scan was consistent with severe anoxic encephalopathy, meaning that the brain tissue was deprived of oxygen. He remains institutionalized, on a ventilator and a feeding tube, to date.

Plaintiffs commenced this action by summons and complaint filed October 10, 2014, against Westchester County Health Care Corporation, which operates the Westchester Medical Center; Mark Goldstein, M.D., an emergency room doctor; Hasit Mehta, M.D., a radiologist; Vladimir Pryjdun, M.D., an anesthesiologist; Richard Magill, M.D., an orthopedic surgeon; and Irlna Tantchou, M.D., allegedly an employee of WCHCC who provided medical care to Tank.

Four separate motions for summary judgment dismissing the complaint were submitted to this Court for decision. Plaintiffs do not oppose sequence 2, which seeks dismissal of the complaint as against Mark Goldstein, M.D., and do not oppose the branch of sequence 3 seeking

dismissal of the complaint as against Hasit Mehta, M.D. The following discussion addresses the remaining motions and issues.

Analysis

The elements of proof in a medical malpractice action are a deviation or departure from accepted practice, and evidence that the departure was a proximate cause of injury or damage (*see Thompson v Orner*, 36 AD3d 791 [2d Dept 2007]). On a motion for summary judgment, the defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or the absence of injury as a result of any alleged malpractice (*see Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). “A plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing” (*Stukas v Streiter*, 83 AD3d 18, 30 [2d Dept 2011]). “Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions” (*Aronov v Soukkary*, 104 AD3d 623, 624 [2d Dept 2013] [internal quotation marks and citation omitted]). “Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury” (*DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]; *see also Roca v Perel*, 51 AD3d 757, 759 [2d Dept 2008] [citing *Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]]). However, conclusory and unsupported allegations not supported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat summary judgment (*see Alvarez v Prospect Hosp.*, 68 NY2d 320 [1986]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]).

Motion Sequence 1 - Vladimir Pryjdun, M.D.

Pryjdun's motion for summary judgment is based upon the pleadings, the original and

amended bills of particulars, and, primarily, the submissions of co-defendant WCHCC, particularly the submitted affirmation of Dr. James Eisenkraft, who asserted that Pryjdun's care and treatment of Tank did not depart from the applicable standard of care.

Eisenkraft began his affirmation regarding Pryjdun by opining that "faced with a trauma patient, who had an open left tibial fracture as well as a fractured left femur which was causing occlusion of the distal profunda femoris, and therefore required immediate surgical intervention to save the leg from infection, sepsis, or possibly even the loss of limb," Pryjdun took appropriate steps to properly prepare Tank for surgery. He asserted that Pryjdun properly cleared the patient for the administration of general anesthesia, by addressing the issues concerning the patient's preinduction condition, and properly intubated the trachea and monitored him throughout his surgery.

Eisenkraft specified that Pryjdun proceeded properly in that he:

- "immediately addressed the patient's oxygen saturation which was 85% upon his entrance into the operating room," bringing his oxygen saturation levels up to the nineties with an oxygen mask,

- "took appropriate steps to properly intubate the patient's trachea prior to surgery.

Between each attempt to intubate the trachea, the patient's lungs were ventilated with oxygen to assure he was adequately oxygenated,"

- "reviewed the radiology studies and appreciated that the patient had a fluid filled distal esophagus[, and in view of the] risk of aspiration. . . .he used a videolaryngoscope called a GlideScope to visualize the vocal cords and facilitate the intubation. He saw clear cords and, with the aid of the GlideScope, he was able to direct the tube into the trachea and seal it to

prevent any of the contents of the esophagus from entering into the trachea,”

- “appreciated the patient’s low blood pressure of 80/30 mmHg, and appropriately administered crystalloid fluids intravenously.”

Eisenkraft concluded that Pryjdun’s care and treatment was within the standard of care and, further, did not proximately cause Tank’s brain injuries.

In opposition, plaintiffs rely on the opinion set forth in the affidavit of their anesthesiology expert. Plaintiffs also point to portions of Pryjdun’s own deposition testimony which they contend support their position.

Plaintiffs’ expert asserts that Pryjdun departed from the standard of good and accepted care in treating Tank, and that those departures were a substantial factor in bringing about his brain injuries. Specifically, the expert asserts that it was a departure to perform non-life-threatening orthopedic surgery before the patient could be adequately stabilized and resuscitated. Further, it is asserted that Pryjdun’s intubation of Tank caused him to aspirate the contents of his stomach into his lungs, which further diminished his lungs’ ability to take in oxygen and distribute it to the brain. In addition, plaintiffs’ experts assert that it was a departure to fail to adequately respond to Tank’s prolonged hypotension, metabolic acidosis and hypoperfusion, which resulted in cerebral hypoxia and anoxic encephalopathy. Plaintiffs’ expert also asserts that Pryjdun’s continued administering of Sevoflurane 1.2% solution throughout the surgery was a mistake in this situation, because it decreases the patient’s blood pressure.

With regard to Pryjdun’s deposition, plaintiffs observe that he conceded that the treatment of Tank as detailed in the medical record, if it were correct, would have constituted medical malpractice based on the failure to address his low blood pressure throughout the procedure; at

his deposition, Pryjdun gave an account of his treatment of Tank that contradicted the medical records. Moreover, submissions on the present motions reflect significant disagreement regarding both what steps were needed and what steps were taken by Pryjdun and the anesthesia team before and during the surgery. For instance, although Pryjdun testified that before surgery began he and Magill discussed Tank's conditions – that he was hypovolemic and in a state of circulatory shock, he was under-resuscitated and his blood pressure was low – Magill testified at his deposition that he had no recollection of Pryjdun conveying any such concerns. There is some dispute between Pryjdun's testimony and that of anesthesia resident Soon Jung about the intubation performed on Tank; moreover, Pryjdun's denial of any significant aspiration occurring during intubation is contradicted by the post-surgery diagnosis. Pryjdun and Jung also disagreed regarding the administration of vasopressors during surgery to counter Tank's low blood pressure. Further, although Pryjdun testified that the chart's blood pressure measurements had to be understood as inaccurately low because the left arm, used for measuring Tank's blood pressure, was positioned over the top of his head, this assertion was flatly contradicted by Magill's testimony that Tank's left arm was positioned across his chest.

Plaintiffs further point to records that contain evidence, in the form of the results of blood gas tests performed during the surgery, tending to indicate that Tank was experiencing mixed respiratory and metabolic acidosis, a condition in which decreased ventilation increases the concentration of carbon dioxide in the blood, decreases blood oxygen, decreases the blood's pH, and elevates lactate levels consistent with tissue hypoxia. The information in these records contrasts with the portion of Pryjdun's testimony in which he maintained that Tank was never hypoxic during the surgery.

Even assuming that Pryjdun's submissions on the motion established a prima facie showing that he did not depart from the standard of care, the competing expert opinions and conflicting evidence discussed above establish that questions of fact are presented as to exactly what Pryjdun did and what he should have done, whether he deviated from the standard of care and whether such deviation was a proximate cause of Tank's brain injuries.

Motion Sequence 4, Richard Magill, M.D.

Magill's motion for summary judgment relies on the pleadings and bills of particulars, his own deposition testimony, portions of Pryjdun's deposition testimony, the expert affirmation of orthopedic trauma surgeon Kenneth A. Egol, M.D., and hospital records. Further, Magill incorporates by reference arguments made by WCHCC that no act or omission on Magill's part was a proximate cause of Tank's injuries.

Magill emphasizes at the outset that it is undisputed that the surgery itself was performed properly. His expert, Egol, asserts that the care and treatment rendered by Magill was consistent with the standard of care, and that as the orthopedic surgeon, Magill was entitled to rely on the decision of the anesthesiologist and attending trauma surgeon who initially cleared the patient for surgery. Egol refers to Pryjdun's deposition testimony to assert that it was Pryjdun's decision to proceed with the emergency surgery because it would have been more dangerous for the patient to delay it, and that he would handle the necessary fluid resuscitation during the surgery. Egol also references Magill's own deposition testimony that the decision of whether to commence surgery on an under-resuscitated patient is exclusively that of the anesthesiologist. Egol acknowledges in his affirmation, but does not further discuss, Pryjdun's deposition testimony

that he discussed the patient's conditions with Magill, and that "*they* decided to proceed with the surgery."

With regard to Magill's continuation of the surgery when results of blood gas tests indicated a need to take immediate responsive action, Magill takes the position that in the course of performing orthopedic surgery, he did not have a duty to inquire as to the results of the monitoring of the patient's hemodynamic status, but rather, was entitled to, and did rely on the anesthesia team to convey to him anything that would require him to truncate, expedite or stop the procedures.

In opposing Magill's motion, plaintiffs do not specifically refer to the assertions made in the affirmation of Magill's expert, Egol; rather, they counter the assertions made by a different expert, Herbert S. Sherry, M.D., an orthopedic surgeon whose affidavit was submitted by WCHCC in support of the hospital's claim that Magill did not depart from good and accepted medical practice in the treatment he provided to Tank. However, their opposition appropriately focuses on the central points at issue, and they submit an affidavit by an unnamed orthopedic expert who supports their claim against Magill. Their expert asserts that "assuming the truth of Dr. Pryjdun's deposition testimony as to what he conveyed to Dr. Magill both before and during surgery, Dr. Magill departed from the applicable standard of care by starting and continuing the surgical procedure when he knew or should have known of Zachary Tank's diminished status." More specifically, with regard to the assertion that Magill's decision to begin surgery was a departure, he relies on Pryjdun's assertion that the two physicians, together, considered Tank's compromised condition and decided to nevertheless proceed with the surgery. Plaintiffs' expert emphasizes that Magill recognized that the surgery could have been safely delayed at that point.

With regard to Magill's conduct during the course of the surgery, plaintiffs' expert points to Pryjdun's deposition testimony recounting how, during the surgery, he became concerned by the high potassium levels (hyperkalemia) in Tank's blood gas results at 12:57 a.m., and that he spoke to Magill about this high-priority, "life-threatening situation," and Magill replied, "well, I'm in the middle of the surgery and what are you going to do?" Pryjdun said he responded that he would treat it, and allowed the surgery to proceed to the end without making any further demands. Plaintiffs' expert points out that according to Magill's own approximate time line for the surgery, it was not long after Pryjdun reported the "life-threatening situation" that Magill reached the stage where the first phase of the surgery was completed – somewhere between 1:10 a.m. and 1:35 a.m. – and yet, Magill had no memory of pausing at that point to determine whether the patient's condition should be addressed before surgery proceeded. Based on this apparent failure to pause the surgery at that point, the expert maintains that Magill departed from the standard of care.

Although Magill presented evidence that it was not his duty, but solely the duty of the anesthesiologist, to determine whether the surgery should proceed, questions of fact are presented regarding whether he comported with the applicable standard of care. The issues are created based on the testimony of plaintiffs' expert, who explained that two aspects of Pryjdun's testimony form the basis for claims of breach of the standard of care: first, that the two physicians together made the decision to proceed, and second, that although he informed Magill of an emergent condition during the surgery, Magill did not pause the surgery, although Magill's own testimony supports the suggestion that he could have paused shortly thereafter.

Motion Sequence 3, WCHCC

Westchester County Health Care Corporation argues that it cannot be held vicariously liable for any malpractice on the part of Drs. Pryjdun or Magill, because those physicians are neither employees nor agents, but rather, are independent private physicians: “Generally, a hospital cannot be held vicariously liable for the malpractice of a private attending physician who is not its employee” (*Schultz v Shreedhar*, 66 AD3d 666, 666 [2d Dept 2009]). However, “an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing” (*Salvatore v Winthrop Univ. Med. Ctr.*, 36 AD3d 887, 888 [2d Dept 2007]). Therefore, here, although neither Pryjdun nor Magill was employed by WCHCC – in 2013, Pryjdun was employed by North American Partners in Anesthesia (NAPA) and Magill was employed by University Orthopedics, P.C. – the hospital cannot avoid vicarious liability on that basis, since Tank sought treatment from the hospital through the emergency room, and did not seek treatment specifically by those private physicians.

It further argues that even if there are issues of fact concerning the claims of medical malpractice against Pryjdun and Magill, the hospital cannot be concurrently liable for the acts of its residents and nursing staff who acted under the direct supervision of those attending physicians, pursuant to orders that were not contraindicated by normal practice. It may only be liable if hospital employees committed independent acts of negligence (*see Vaccaro v St. Vincent's Med. Ctr.*, 71 AD3d 1000, 1002 [2d Dept 2010]). Given Pryjdun's and Jung's conflicting testimony regarding what actions were and were not taken and whether the steps taken were properly documented in the chart, and given Pryjdun's testimony regarding a “life-threatening situation” that may not have been successfully addressed, issues of fact are presented

as to whether hospital employees had a duty to take any independent action at any point.

Finally, the branch of WCHCC's motion to strike certain language in the complaint and bills of particulars pursuant to CPLR 3024(b) is denied. "In reviewing a motion pursuant to CPLR 3024 (b), the inquiry is whether the purportedly scandalous or prejudicial allegations are relevant to a cause of action. Matters that are unnecessary to the viability of the cause of action and would cause undue prejudice to the defendants should be stricken from the pleading or bill of particulars" (*Irving v Four Seasons Nursing & Rehabilitation Ctr.*, 121 AD3d 1046, 1047-1048 [2d Dept 2014]). However, the assertion that a defendant's handling of a patient's treatment was "careless" or "reckless" is not scandalous; it is a legitimate legal position in a medical malpractice action. This is particularly so where submitted experts' affirmations employ that language. Even assuming that plaintiffs' employment of the term "reckless" exceeds the mental state that plaintiffs must prove to establish the cause of action, since the allegations do not rise above ordinary negligence, that does not render the term scandalous. While much of WCHCC's argument seems to be that the such language could be used to support a claim for punitive damages, no such relief has been sought here.

Based upon the foregoing, it is hereby,

ORDERED that the motion of defendant Vladimir Pryjdun, M.D., for summary judgment dismissing plaintiffs' complaint against him pursuant to CPLR 3212 (sequence 1) is denied; and it is further

ORDERED that the motion of defendant Mark Goldstein, M.D., for summary judgment dismissing plaintiffs' complaint against him pursuant to CPLR 3212 (sequence 2) is granted as unopposed; and it is further

ORDERED that the motion of defendants Hasit Mehta, M.D. and Westchester County Healthcare Corporation for summary judgment dismissing plaintiffs' complaint as against them pursuant to CPLR 3212 (sequence 3) is granted only insofar as the complaint is dismissed as against Hasit Mehta, M.D., and is otherwise denied; and it is further

ORDERED that the motion of defendant Richard Magill, M.D., for summary judgment dismissing plaintiffs' complaint against him pursuant to CPLR 3212 (sequence 4) is denied; and it is further

ORDERED that the remaining parties are directed to appear on Tuesday, April 10, 2018 at 9:15 a.m., in the Settlement Conference Part of the Westchester Supreme and County Courthouse located at 111 Dr. Martin Luther King, Jr. Boulevard, White Plains, New York 10601.

This constitutes the Decision and Order of the Court.

Dated: White Plains, New York
February 20, 2018


HON. TERRY JANE RUDERMAN, J.S.C