Bunyi v Vassar Bros. Hosp.
2020 NY Slip Op 34990(U)
April 30, 2020
Supreme Court, Dutchess County
Docket Number: Index No. 51695/18
Judge: Maria G. Rosa
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF DUTCHESS

Present:

Hon. Maria G. Rosa, Justice

HELEN BUNYI, Individually and as Administratrix of the Estate of CAMILO BUNYI, Deceased.

Plaintiff,

-against-

VASSAR BROTHERS HOSPITAL d/b/a VASSAR BROTHERS MEDICAL CENTER, SYED NASIR, M.D., THE BRAIN CENTER OF THE HUDSON VALLEY, ALAN H. GROSS, M.D., PREMIER MEDICAL GROUP OF THE HUDSON VALLEY, P.C. and DAVIDE M. DEBELLIS, M.D.,

Defendants.

DECISION AND ORDER

Index No. 51695/18

The following papers were read on Defendants' motion for summary judgment:

NOTICE OF MOTION
AFFIRMATION IN SUPPORT
EXHIBITS A - S

AFFIRMATION IN OPPOSITION
EXHIBITS A - H
AFFIDAVIT IN OPPOSITION
EXHIBIT A

REPLY AFFIRMATION
EXHIBITS A - D

This is a medical malpractice and wrongful death action in which Plaintiff alleges the defendants failed to properly evaluate, diagnose and treat decedent Camilo Bunyi for a cerebral hemorrhage in September 2016. Defendants Alan Gross, M.D., Davide M. DeBellis, M.D. and Premiere Medical Group of the Hudson Valley move for summary judgment.

The proponent of a motion for summary judgment carries the initial burden of tendering sufficient admissible evidence to demonstrate the absence of a material issue of fact as a matter of law. Alvarez v. Prospect Hospital, 68 NY2d 320, 324 (1986). If a movant has met this threshold

burden, to defeat the motion the opposing party must present the existence of triable issues of fact. See Zuckerman v. New York, 49 NY2d 557, 562 (1980). In deciding a motion for summary judgment, the court is required to view the evidence presented "in the light most favorable to the party opposing the motion and to draw every reasonable inference from the pleadings and the proof submitted by the parties in favor of the opponent to the motion." Yelder v. Walters, 64 AD3d 762, 767 (2nd Dept 2009). A physician moving for summary judgment in a medical malpractice action must establish, *prima facie*, either that there was no departure from accepted community standards of practice or that any departure was not a proximate cause of injury. Gillespie v. New York Hospital Queens, 96 AD3d 901 (2nd Dept 2012).

In support of their motion Defendants have submitted copies of the pleadings, deposition testimony, decedent's medical records and an expert affirmation. The foregoing establishes that decedent Camilo Bunyi ("decedent") had been a patient of Defendant Premier Medical Group of the Hudson Valley, P.C. ("Premier) since the late 1990s. In 2014 Dr. Davide DeBellis became his primary care doctor at Premier. He was also treated by numerous specialists including cardiologists, neurologists, endocrinologists and urologists for his history of diabetes, sleep apnea and atrial fibrillation. Decedent underwent aortic valve replacement surgery in 2013 and a radiofrequency ablation for cardiac arrhythmia in 2014. On September 7, 2016 he underwent a second cardiac radiofrequency ablation and was thereafter treated with Coumadin to prevent clot formation due to his prosthetic valve, atrial fibrillation, atrial flutter and the cardiac ablation procedures.

On September 22, 2016 decedent presented to the emergency room at Vassar Brothers Medical Center ("VBMC") reporting that a magnetic resonance imaging ("MRI") taken that morning revealed "mini strokes." He further reported recent memory loss and confusion. His wife, Plaintiff, reported decedent had been having difficulty finding words and had been suffering with forgetfulness for the past three months. Blood tests revealed an international normalized ratio ("INR"), an indication of how well blood clots, of 2.7 which was considered high but within acceptable range for therapeutic use of Coumadin. Contact was made with decedent's outside neurologist as well as Dr. Syed Nasir, the on-call neurologist from the hospital, who recommended a computed tomography ("CT") of the head and neck. Dr. Gross was functioning as the hospitalist for Premiere on that date. At 4:06 p.m. he assumed the care of decedent and admitted him based upon a neurological consult. Dr. Gross further requested a consultation with decedent's cardiologist who had performed the ablation procedure on September 7, 2016, and wrote an order to monitor decedent's INR levels for the next three days. Neurologist Dr. Nasir evaluated decedent at approximately 10:00 p.m. His assessment included aphasia, suspected Alzheimer's disease, and that decedent had suffered a stroke despite his high INR levels.

Dr. Gross first examined decedent on the morning of September 23, 2016. Based on his review of decedent's evaluated INR levels, symptoms and MRI results of the brain showing multiple foci of high signal on a T2 weighted image (one of the basic pulse sequences in an MRI) suspicious for embolic infarcts, he diagnosed decedent as having had a stroke. His plan was for decedent to remain hospitalized until his INR reduced and then to order a transesophageal echocardiogram ("TEE") to obtain a more definite diagnosis. He further determined that decedent would need to

be administered an alternative anticoagulant once his INR decreased.

At 11:11 a.m. on September 23, 2016 decedent called Nurse Lilia Watson to report that his left hand and arm had become weak while brushing his teeth. Nurse Watson noted that the decedent's speech was slower, he was having difficulty recalling certain words and complained of dizziness. Nurse Watson notified Dr. Nasir who ordered a stat CT scan. The scan revealed evidence of superior right medial cerebellar infarct and a lateral left cerebellar hemispheric infarct.

At 5:11 a.m. on September 24, 2016 Nurse Tamar Small documented that decedent had reported visual changes as he attempted to grab a cup, with visual loss on his right side field of vision. Nurse Small testified at her deposition that the visual changes were a new development that could be evidence of a new stroke. Nurse Small notified Dr. Nasir of this development. She states that Dr. Nasir responded that no further intervention was warranted because decedent was on Warfarin and aspirin. At 5:20 a.m. Nurse Small documented that decedent had an increased temperature and made complaints of a headache unrelieved by Tylenol. She made a notation in decedent's chart that a call was placed to an MD and she was awaiting a call back from Dr. DeBellis, the covering physician. At 6:31 a.m. lab results revealed decedent's INR was elevated to 5.3. Decedent's chart reflects that another call was placed to Dr. DeBellis and the nurse was awaiting a call back. At 7:16 a.m. decedent complained of a headache with a pain threshold of 8 out of 10. Though not reflected in the medical records, Dr. Nasir testified at his deposition that he examined decedent at approximately 7:30 a.m. He stated he observed slurred speech but no significant changes in vision or weakness warranting further intervention. At 11:24 a.m. Nurse Watson documented that decedent complained of nausea with a headache of 8/10 on the pain scale. She administered Zofran and Tylenol. Decedent vomited and continued to complain of a headache. She notified Dr. Nasir of this development. At 12:02 p.m. Nurse Watson notified Dr. Gross of the 6:30 a.m. laboratory result showing an increased INR level of 5.3. Dr. Gross examined decedent at 12:24 p.m. and ordered Vitamin K to reverse the anticoagulant effects of the Coumadin in an effort to lower the INR level down to a therapeutic goal of 2.0 to 3.0. His assessment was that decedent had probably suffered an embolic acute stroke. Pursuant to Dr. Nasir's direction, at approximately 1:15 p.m. a stat CT scan of the head was ordered. It was not performed until approximately 3:00 p.m. It showed acute and massive left occipital hemorrhage with intraventricular extension and left to right midline shift with severe obstructive hydrocephalus. Decedent was transferred to the intensive care unit and then to the operating room for placement of a right frontal ventriculostomy and external ventricular drain. Decedent remained in intensive care until October 11, 2016 when he was transferred to the respiratory unit. The following week he was admitted to a rehabilitation facility and died in hospice on January 27, 2017.

Defendants' motion for summary judgment relies primarily on the expert affirmation of Dr. Steve Slazman. Dr. Slazman is board certified in internal medicine, pulmonary diseases and critical care medicine. He asserts that at all times Dr. Gross acted in accordance with good and accepted standards of medical care. He states that it was appropriate to continue decedent on Coumadin upon his admission to VBMC based on his presentation and medical history. He notes that only one 5mg dose of Coumadin was administered on September 22, 2016 at 8:45 p.m. when decedent's INR level

was 2.7 which was within the therapeutic range for the use of Coumadin. Dr. Slazman asserts that the "holding" of Coumadin at approximately 9:45 a.m. on September 23, 2016 was indicated in anticipation of decedent having a TEE procedure in conjunction with his heightened INR level. He further asserts that it was appropriate for Dr. Gross to order Vitamin K at approximately 12:28 p.m. on September 24, 2016 based on decedent's INR level of 5.3. He asserts that Dr. Gross was not made aware of decedent's increased INR of 5.3 until 12:02 p.m. and he examined decedent at 12:28 p.m. when he ordered the Vitamin K. Dr. Slazman maintains that the symptoms decedent presented with at that examination did not warrant Dr. Gross ordering any imagining of the head. He emphasizes that a repeat brain CT scan from the previous day failed to show any changes from previous imagining. Dr. Slazman states that Dr. Gross appropriately ordered a stat CT scan of head at 1:39 p.m. and that the approximate one hour period between the 12:28 p.m. examination and the ordering of the CT scan at 1:39 p.m. had no effect on decedent's treatment options or prognosis. With respect to Dr. DeBellis, Dr. Slazman asserts that his review of the medical records and Dr. DeBellis' testimony reveals that Dr. DeBellis played no role in decedent's treatment while at VBMC.

The foregoing is sufficient to establish Dr. Gross' *prima facie* entitlement to summary judgment. Dr. Slazman asserts that Dr. Gross rendered appropriate medical treatment upon examining decedent at 12:02 p.m. on September 24, 2016. While Dr. Slazman fails to address Plaintiff's claim that Dr. Gross should have rendered medical care earlier that day based on being the admitting doctor on the hospital list for Premiere, Dr. Slazman asserts that at the time of the examination Dr. Gross did not deviate from good and accepted standards of care by not ordering imaging of the head. He bases this assertion on a claim that at the time of the examination decedent's speech had gotten better and he was no longer making complaints of headaches. He further asserts that Dr. Gross appropriately ordered Vitamin K to be administered based upon the elevated INR level. While Dr. Slazman does not expressly state that Dr. Gross had no obligation to examine decedent earlier that day based upon his elevated INR level and complaints of headache, nausea, vomiting and dizziness, he concludes that any such failure was not a causal factor of decedent's injuries because imagining of the head would not have been warranted based upon those symptoms largely resolving. His affidavit in conjunction with the record, however, is insufficient to establish Dr. DeBellis' *prima facie* entitlement to summary judgment. Dr. DeBellis' motion is premised on allegations that he did not render any care to the decedent. He acknowledges he was on call for Premiere on the evening of September 23, 2016 through the morning of September 24, 2016. He denies receiving a phone call from Nurse Small at 5:20 a.m. on September 24, 2016 reporting that the decedent had complained of headaches and an increased temperature. He further denies ordering the administration of ibuprofen at approximately 6:23 a.m. or receiving a call at 6:35 a.m. alerting him to an increased INR value of 5.3. As testified to Nurse Small during her deposition, decedent's medical records reflect that a call was placed to Dr. DeBellis at 5:20 a.m. to report decedent's change of condition, and again to report an increased INR value. The chart further states that Dr. DeBellis ordered the administration of ibuprofen. Although Dr. DeBellis ultimately refused to electronically sign a document acknowledging he ordered the administration of ibuprofen, the record viewed in its entirety contains issues of fact as to whether Dr. DeBellis was notified of decedent's condition while on call and failed to respond accordingly. In adjudicating a motion for summary judgment this court is required to draw all inferences in favor of the non-moving party.

The medical records of decedent's treatment constitute competent evidence from which a jury could infer that Dr. DeBellis was contacted and failed to respond. Moreover, there is nothing in the record reflecting that an earlier invention would not have changed decedent's prognosis.

Plaintiff's opposition is sufficient to create a material issue of fact on her malpractice claims against Dr. Gross and Dr. DeBellis. Plaintiff has submitted an expert affidavit that at approximately 5:11 a.m. on September 24, 2016 decedent exhibited the first signs of a cerebral hemorrhage and change in neurological status. He states that the finding of visual loss on the right side field of vision was a new finding and outside the area of known injury. This, in conjunction with a headache unrelieved by Tylenol, an increased temperature and an elevated INR level of 5.3 reported at 6:30 a.m required an immediate medical response. He states that Dr. DeBellis, in his capacity as the on-call attending physician, failed to respond to hospital communications which resulted in a failed immediate evaluation, imaging and repeat laboratory studies. He further states that Dr. DeBellis departed from accepted standards of care by failing to communicate with hospital staff and Dr. Nasir during this time period to ensure coordination of care and timely evaluation, diagnosis and treatment. Plaintiff's expert further asserts that Dr. Gross failed to inform himself about decedent's change in status upon beginning his shift at approximately 8:00 a.m. on the morning of September 24, 2016. He asserts that the standard of care required immediate evaluation, imagining and repeat of lab studies, and that Dr. Gross' failure to evaluate decedent for over six hours from the onset of acute neurological changes constituted malpractice. He further asserts that when Dr. Gross did examine decedent at approximately 12:00 p.m., his examination was inadequate. Dr. Gross admitted at his deposition that he failed to review nursing notes recording a change in condition. Plaintiff's expert asserts that Dr. Gross failed to perform a comprehensive neurological examination, including a visual field exam, which would have uncovered a deficit and lead to necessary and appropriate imaging studies. Finally, plaintiff's expert maintains that the foregoing deviations from the appropriate standard of medical care more likely than not resulted in a diminished prognosis. He asserts it was a catastrophic delay in diagnosis and treatment that deprived decedent of a chance to survive his underlying condition or, at least, obtain a more favorable outcome. The foregoing is sufficient to create a material issue of fact as to whether the defendants deviated from rendering appropriate medical treatment and whether such deviation was a causal factor of injury. Based on the foregoing, it is

ORDERED that Defendants' motion for summary judgment is denied. The court will schedule a pre-trial conference when the courts re-open following N.Y. Pause due to COVID-19. For now the matter is scheduled for control purposes only (no appearances) on May 29, 2020.

The foregoing constitutes the decision and order of the Court.

Dated: April 30, 2020 ENTER:
Dutchess County, New York

Maria G. Rosa
MARIA G. ROSA, J.S.C.

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Pursuant to CPLR §5513, an appeal as of right must be taken within thirty days after service by a party upon the appellant of a copy of the judgment or order appealed from and written notice of its entry, except that when the appellant has served a copy of the judgment or order and written notice of its entry, the appeal must be taken within thirty days thereof.

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