Vivian v Champlain Val. Physicians Hosp. Med. Ctr.
2023 NY Slip Op 35160(U)
April 12, 2023
Supreme Court, Clinton County
Docket Number: Index No. 2019-00020054
Judge: Allison M. McGahay
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STATE OF NEW YORK
SUPREME COURT COUNTY OF CLINTON

DELORES VIVIAN, as Administrator of the ESTATE OF DAVID VIVIAN and DELORES VIVIAN, Individually,

Plaintiff,

-against-

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER and UVM HEALTH NETWORK-CHAMPLAIN VALLEY PHYSICIANS HOSPITAL,

Defendants.

DECISION AND ORDER

Index No: 2019-00020054
RJI No.: 09-1-2020-0447E

McGAHAY, J.

This action for money damages was commenced by the filing of the summons and complaint with the Clinton County Clerk on December 19, 2019. The causes of action stem from the care and treatment rendered by Defendants Champlain Valley Physician's Hospital Medical Center and UVM Health Network – Champlain Valley Physicians Hospital (hereinafter collectively referred to as CVPH) in the early morning hours on December 23, 2017, when David Vivian (hereinafter referred to as the Decedent) presented in the CVPH emergency department, and subsequently died of a myocardial infarction. Plaintiff Delores Vivian, Decedent's wife, commenced this action premised in medical malpractice and wrongful death.

Presently before the Court is the motion of defendants CVPH for summary judgment, which is decided herein upon consideration NYSCEF Document #s 43-55 and 64-76 (e-filed under Clinton County Index Number 2019-00020054)[1].

[1] The reply affirmation of Roland T. Phillips, III, M.D. (NYSCEF Doc. No. 74), although submitted one day past the deadline for submission or reply papers (see CPLR § 2214[c]), is nevertheless being considered by the Court.

Defendants move this Court for summary judgment dismissal of the complaint arguing there are no issues of fact to be decided by the fact finder at trial. In support of the motion, Defendants rely upon, *inter alia*, the affidavit of Roland T. Phillips, III, a medical doctor board certified in the fields of internal medicine and cardiovascular disease, who is licensed to practice medicine in the State of New York[2].

Dr. Phillips opined to a reasonable degree of medical certainty, that Decedent's death in the CVPH emergency department on December 23, 2017 was caused by an acute myocardial infarction, most likely secondary to the 100% occlusion of the decedent's left anterior descending coronary artery ("LAD"). Dr. Phillips states that the onset of the 100% occlusion of the decedent's LAD was at approximately 1:30 a.m. on December 23, 2017, which persisted until and was present upon his presentation to CVPH at 4:09 a.m. on December 23, 2017 and remained until the decedent collapsed and a Code 99 was called at 4:33 a.m. on December 23, 2017. Dr. Phillips states the standard of care for treatment of a 100% occluded LAD is to restore blood flow via percutaneous coronary intervention (PCI), a procedure that requires cardiac catheterization. If PCI cannot be timely initiated, thrombolytic therapy such as tPA may be used in the alternative as an attempt to break up the clot causing the occlusion and to restore blood flow. According to Dr. Phillips, the Decedent was in fact administered tPA once he collapsed and a code was called, which unfortunately failed to avert his death. Notwithstanding the foregoing, Dr. Phillips attributes the administered tPA as the reason an autopsy performed on the Decedent found a 75% occluded LAD,

[2] For the purpose of his affirmation, Dr. Phillips presumed that the Decedent did indeed present to the triage desk at the CVPH Emergency Department at 04:09 a.m. and immediately reported both chest pain and his purported belief that he was experiencing a heart attack at that time, which is a contested issue of fact in this matter.

and not the 100% occlusion of the LAD that Dr. Phillips claims existed at the time Decedent presented to Defendants' emergency department on December 23, 2017.

According to Dr. Phillips, by the time the Decedent presented to the emergency department complaining of chest pain, there was no intervention that could have been performed or treatment initiated that could have prevented his death or provided him with a chance of a better outcome. In this regard, he affirms that the standard of care required an EKG to be performed and interpreted within ten minutes of the decedent's report of chest pain as a necessary predicate in order to determine whether the decedent was indeed suffering from an acute myocardial infarction. He states that presuming the EKG was immediately performed in accordance with the standard of care, the time would have then been between 4:14-4:19 a.m.. At this point, presuming the EKG unequivocally demonstrated an acute ST Elevation Myocardial Infarction, the emergency department physician would start an IV and administer aspirin and collect blood for further studies, which per the standard of care may take between fifteen and thirty minutes, and simultaneously mobilize the facility's Cardiac Catheterization Laboratory ("cath lab"), which requires at least forty-five minutes under the best possible circumstances. He states the standard of care requires the cath lab be mobilized within sixty minutes, and that the patient be on the table and the procedure started within ninety minutes. He notes that in the most ideal of circumstances, the cath lab would still not have been ready or able to perform percutaneous coronary intervention in an effort to save the Decedent's life. He further states that the only alternative attempt that could have been initiated in hopes of clearing the occlusion would be the administration of thrombolytic therapy such as tPA; and, as noted above, the medical records reflect the Decedent was in fact administered tPA once he collapsed and a code was called, which unfortunately failed to avert his death. Based upon the foregoing, he opines, within a reasonable degree of medical certainty, that

at the time the Decedent presented to CVPH on December 23, 2017, his death could not have been prevented or avoided and that the Decedent had a 0% chance of survival.

In opposition to summary judgment, the Plaintiff has submitted the affidavit of her medical expert, an Emergency Medicine Physician at a major Tri-State Area Metropolitan Hospital, board certified in emergency medicine, who has diagnosed, cared for, managed, and treated several thousand patients who have suffered acute myocardial infarctions and cardiac arrest. His opinions contained in the affidavit are made within a reasonable degree of medical certainty.

Plaintiff's expert, at the outset, states that Dr. Phillips' opinions concerning proximate cause are based on the false premise that the Decedent had 100% occlusion of the LAD at the time he presented to the Defendants' emergency department on December 23, 2017. He notes that the autopsy report revealed that the Decedent had 75% occlusion of the LAD, and states that Dr. Phillips' claim of 100% occlusion is speculative and unsupported by the record.

According to Plaintiff's expert, when Decedent presented to the emergency room on December 23, 2017 with complaints of chest pain and severe weakness, the standard of care required an EKG to have been performed within ten minutes of his arrival. He states that within a few minutes, the EKG would have shown Decedent was suffering from an acute myocardial infarction. Plaintiff's expert opined that a cardiac enzyme panel to test Decedent's troponin levels should also have been taken and would have further demonstrated that he was having a heart attack; however, the EKG alone would have sufficiently and timely shown that he was having a heart attack so that cardiac intervention and treatment could be commenced. Plaintiff's expert states an IV line should then have been placed for the administration of intravenous medication and the cath lab alerted so that it could mobilize and prepare to perform a percutaneous coronary intervention, also known as an angioplasty with stent.

According to Plaintiff's expert, by Defendants' timeline, between 4:14 a.m. and 4:19 a.m., the standard of care required the administration of aspirin, heparin, and/or nitroglycerin. According to Plaintiff's expert, Aspirin, when administered orally and crushed or chewed, begins to work within five minutes; Heparin, when administered via an IV, also begins to work within minutes; and Nitroglycerin begins to work within four minutes of sublingual administration. He states a patient can receive up to three doses of nitroglycerin, given five minutes apart. He opines that had Defendants acted in accord with the standard of care, there would have been therapeutic levels of aspirin, nitroglycerin, and/or heparin in Decedent's bloodstream working to restore blood flow to his heart that, to a reasonable degree of medical certainty, would have prevented his death.

Plaintiff's expert further elaborates that had Decedent been placed on a continuous cardiac monitor, which likely would have showed an irregular heart rhythm, a defibrillator could have been timely used to shock his heart to a normal rhythm. He notes, however, as demonstrated by the Code 99 Flow Sheet, a defibrillator was not placed on Decedent until after he had already coded, and his heart was no longer beating. According to Plaintiff's expert, a defibrillator is only successful when there is still a heart rhythm. As such, it is his opinion to a reasonable degree of medical certainty that the failure to timely utilize a defibrillator was a substantial contributing factor for Decedent's death.

Plaintiff's expert ultimately opined that had the aforementioned measures been taken, Decedent would not have gone into cardiac arrest at 4:33a.m., giving the cath lab time to mobilize and perform a PCI, and to a reasonable degree of medical certainty, Decedent would have survived.

Summary judgment will be granted where the Court has determined that there is no substantial issue of fact in the case (*Sillman v. Twentieth Century-Fox Film Corp*., 3 NY2d 395, 404 [1957]). To obtain summary judgment, it is necessary that the movant establish, through

evidentiary proof in admissible form, its cause of action or defense sufficiently to warrant the court as a matter of law in directing judgment in its favor (*Zuckerman v. City of New York*, 49 NY2d 557, 562 [1980]). The Court is thus faced with finding issues rather than determining them. *(Sillman v. Twentieth Century Fox Film Corp.*, 3 NY2d at 404). In making this determination, the court must view the evidence in the light most favorable to the non-moving party and accord the non-moving party the benefit of every reasonable inference. *(Negri v. Stop and Shop, Inc.*, 65 NY2d 625 [1985]).

In a medical malpractice action, the plaintiff bears the burden of establishing that the defendant "deviated from acceptable medical practice, and that such deviation was a proximate cause of the plaintiff's injury" (*Gallagher v. Cayuga Med. Ctr*., 151 AD3d 1349, 1351 [3d Dept 2017] [internal quotation marks and citation omitted]; see *Butler v. Cayuga Med. Ctr*., 158 AD3d 868, 869 [3d Dept 2018]). Accordingly, on a motion for summary judgment, the defendant must establish "either that there was no departure from accepted standards of practice in the plaintiff's treatment or that any such deviation did not injure the plaintiff" (*D'Orta v. Margaretville Mem. Hosp*., 154 AD3d 1229, 1231 [3d Dept 2017]).

Where the movant meets the initial burden, the burden then falls on those opposing the motion to demonstrate, by evidentiary proof in admissible form, the existence of facts sufficient to require a trial (*Burton v. Ertel,* 107 AD2d 909, 910 [3d Dept1985]).

Here, while the Court finds the Defendants met their initial burden for summary judgment dismissal of the Complaint, the Plaintiff has nevertheless established that there are several relevant issues of fact to decided by the fact finder at trial, to include: 1) the time at which the Decedent presented to the CVPH emergency department; 2) whether the Decedent and/or his wife, upon presentation to the CVPH emergency department, notified the triage nurse that Decedent believed

he was having a heart attack, and/or that he was experiencing chest pain; 3) whether there was 100% occlusion of the Decedent's LAD at any point prior to, or during, the time he presented to the CVPH emergency department; and 4) whether, by the time the Decedent presented to the CVPH emergency department, there was any intervention that could have been performed, or treatment initiated, that could have prevented his death or provided him with a chance of a better outcome. Accordingly, and for the foregoing reasons, it is hereby

ORDERED that Defendants' motion for summary judgment be, and hereby is, denied; and it is further

ORDERED that this original decision and order is being uploaded to NYSCEF and counsel for Plaintiff shall, within twenty (20) days of the date hereof, serve a copy of this Decision and Order, with notice of entry, upon all individuals and/or entities entitled to notice under the law, and shall thereafter file proof of service.

SO ORDERED.

Dated: April 12, 2023

Hon. Allison M. McGahay, J.S.C.