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Short Form Order

SUPREME COURT - STATE OF NEW YORK
TRIAL TERM, PART 25 NASSAU COUNTY

PRESENT:

Honorable Karen V. Murphy
Justice of the Supreme Court

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BENTLEY MAYS, as Administrator of the Estate of REGINA RENEE MAYS, deceased, BENTLEY MAYS, CHRISTOPHER MAYS, KYLE MAYS, and BENTLEY MAYS, JR., Individually,

Plaintiffs,

-against-

NORTH SHORE UNIVERSITY HOSPITAL AT MANHASSET, SHERON LATCHA, M.D., DANA R. LUSTBADER, M.D., NORTH SHORE LONG ISLAND JEWISH HEALTH SYSTEM, NORTH SHORE HOME CARE, MARIE PRICE, R.N., SETLIDZ SAINT-LOUIS, R.N., and GILDHARRY DINANATHSINGH, R.N.,

Defendants.

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Index No. 4982/05

Motion Dated: 5/15/07
Motion Submitted: 7/03/07
Motion Sequence: 002

The following papers read on this motion:

Notice of Motion/Order to Show Cause.....X
Answering Papers.....X
Reply.....X
Briefs: Plaintiff's/Petitioner's.....
Defendant's/Respondent's.....

This motion by defendants North Shore University Hospital at Manhasset, Sheron Latcha, M.D., Dana R. Lustbader, M.D., North Shore Long Island Jewish Health System, North Shore Home Care, Marie Price, R.N., Setlidz Saint-Louis, R.N. and Gildharry Dinanathsingh, R.N., for an order pursuant to CPLR § 3212 granting them summary judgment dismissing the complaint is denied.

In this medical malpractice action, the plaintiffs, the husband and sons of decedent Regina Mays, allege that the defendants negligently caused her wrongful death by failing to timely and appropriately treat her wound infection and peritonitis. They allege that she was prematurely discharged from the hospital before her infection had cleared and she was medically stable. They further allege that the defendants failed to adequately monitor her medical status following her discharge, more specifically, the condition of her wounds and the effectiveness of her antibiotic therapy, which resulted in a delay in diagnosing, *inter alia*, her continuing wound infection, sepsis and hypotension and caused a delay in her re-hospitalization, work-up and treatment for these conditions, as well. The plaintiffs allege that these acts of malpractice not only led to a worsening of the decedent's medical conditions but ultimately caused her death.

Defendants seek summary judgment dismissing the complaint.

The pertinent facts are as follows:

The decedent suffered from end-stage renal disease. A catheter had been surgically implanted in her lower abdomen and she was placed on home peritoneal dialysis many years before the events that gave rise to this lawsuit. In fact, the decedent had a history of exit site infection and suffered from peritonitis in 1998.

The decedent was seen at the North Shore University Hospital Nephrology Clinic-Dialysis Center on May 22, 2003 by defendant Dr. Latcha, at which time she was diagnosed with a catheter exit site infection and prescribed Levaquin, an antibiotic. Dr. Latcha told the decedent that her catheter needed to be surgically replaced and gave her the name and number of a surgeon. The decedent contacted Dr. Latcha's office the following day complaining of cloudy pulmonary dialysis fluid. She was told by a nurse to go directly to the Emergency Room but went to the Nephrology Clinic instead. Upon examining the decedent and observing the cloudy peritoneal dialysis fluid, which is suggestive of peritonitis, Dr. Latcha instructed the decedent to go immediately to the Emergency Room.

The decedent presented to the Emergency Room on the morning of May 23, 2003, complaining of "peritonitis." She was admitted to the hospital where the catheter was surgically removed and she was put on an intensive course of IV antibiotics. The cultures of peritoneal fluid revealed a catheter infection. The decedent was seen by an infectious disease consultant, received hemodialysis and was provided with a nutritional assessment. Her medical record shows that on May 30, 2003, she was feeling better and her IV consultant found her to be clinically stable with no signs of infection at the surgical/exit wound site. On June 2, 2003, the decedent expressed distaste with her restricted diet and expressed a desire to go home. Her wound showed no pus and only clear fluid drained. The attending

nephrologist, Dr. Mallappallil, determined that the decedent could be discharged once hemodialysis had been arranged for and the infections disease consultant determined her course of antibiotics. The infectious disease consultant discontinued IV antibiotics and prescribed the antibiotic Cipro upon discharge. He concurred in the decedent's discharge but recommended daily packing changes of her wound. On June 3, 2003, Dr. Mallappallil placed a femoral catheter to enable the decedent to receive out-patient hemodialysis. On June 4, 2003, Dr. Mallappallil discharged the decedent on Cipro, with home visiting nurse wound packing changes and out-patient hemodialysis arranged for.

The decedent's medical records show that defendant Nurse Saint-Louis saw her at home daily from June 5 through the 11th, at which time she assessed her complaints, physical condition, diet and medications. She documented the cleaning, dressing and repacking of the decedent's abdominal wound site each time. On June 12th, the decedent was seen by Nurse Angela Trotman.

In the early morning hours of June 13th, plaintiff Mr. Mays brought the decedent to the Emergency Room. She complained of sharp chest pain when she belched. On examination by the emergency department attending physician, the decedent was found to be alert, but chronically ill, appearing very fatigued and weak. She reported a positive weight loss. The decedent was promptly started on IV hydration, oxygen via nasal canula and was immediately sent for an EKG followed by chest x-rays, and blood was drawn for complete clinical chemistry panels and hematology. The decedent's laboratory results showed numerous abnormal/out of range values, some of which fell in the critical range and changes in her EKG when compared to the previous study of May 23rd (three weeks earlier). Her blood pressure was recorded at a low 83/54, which the nurse noted, according to the husband, was "normal for the patient." Based upon her condition and the diagnostic/laboratory results, the emergency department physicians were about to admit the decedent to the nephrology/medicine service of Dr. Mallappallil, but Mrs. Mays declined admission and insisted on leaving against medical advice. In this respect, the emergency department attending entered a note under the "Comments/Procedure/Reassessments" portion of the Emergency Room record timed at 6:22 a.m. in which he wrote:

> "Mrs. Mays does not want to be admitted to the hospital. The risks of leaving AMA were discussed with her and her husband in detail–and also discussed with Dr. Ali of Nephrology. The patient understands the risks (infection, cardiac, pulmonary, etc.) including serious morbidity and *even death*. Patient still does not want admission–wants to leave AMA. . . ."

The decedent was advised to return to the ER immediately for any change or worsening of her symptoms (and even call 911, if necessary). She was to follow up with Dr. Ali and the nephrology doctors.

At his deposition, Mr. Mays denied that anyone at the hospital Emergency Room ever recommended that his wife be admitted on June 13th and he denied that his wife left against medical advice. He said that his wife was seen by a visiting nurse later that day and she was still weak and had pain in the wound area.

On the evening of June 13th, the decedent had a home nursing visit. She did not have one the following day June 14th because, according to the records, the "patient's spouse" refused a visit and deferred to the following day because his wife was sleeping.

Mr. Mays testified at his examination-before-trial that on the morning of June 15th, his wife was in a great deal of pain in the stomach area and placed herself in a fetal position in order to attempt to lessen the abdominal pain. He said that she simply wasn't getting any better and that the pain that morning was even greater than the days before and that she was "screaming in pain." At 12:45 p.m. that day, the decedent was seen at home by Nurse Gildharry Dinanathsingh who found that while she was alert and oriented, she was depressed, weak, bed bound, and only able to ambulate with assistance. The decedent complained of lower back pain and her blood pressure was her typical 90/60. The packing was changed which was noted to have been tolerated well. The home care records reflect that Mr. Mays was present for this visit and told the visiting nurse that his wife may be re-admitted to the hospital that day.

That day, the decedent returned to the hospital's Emergency Room. On examination, the attending recorded that the decedent appeared weak, thin, cachectic and chronically ill appearing. She was diagnosed with anemia, thrombocytopenia, hypoglycemia, a right lower lobe infiltrate (pneumonia), end stage renal disease, and to rule out sepsis. The decedent was seen in a critical care consult by Dr. Lustbader at around midnight, who noted Mrs. Mays' chronic renal failure and that she was presently in DIC (coagulation/bleeding disorder), sepsis and acidosis. She was admitted to the ICU under Dr. Lustbader's care. By late the following morning, she had to be intubated by the anesthesiologist because of respiratory distress and required placement of central and arterial lines in order to monitor her and administer medications.

The decedent's condition steadily declined and she died at 3:05 a.m. on June 19, 2003.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." (***Sheppard-Mobley v. King***, 10 A.D.3d 70, 74, 778 N.Y.S.2d 98 (2d Dept., 2004), *aff'd. as mod.*, 4 N.Y.3d 627, 830 N.E.2d 301, 797 N.Y.S.2d 403 (2005), *citing* ***Alvarez v. Prospect Hosp.***, 68 N.Y.2d 320, 324, 501 N.E.2d 572, 508 N.Y.S.2d 923 (1986); ***Winegrad v. New York Univ. Med. Ctr.***, 64 N.Y.2d 851, 853, 476 N.E.2d 642, 487 N.Y.S.2d 316 [1985]). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." (***Sheppard-Mobley v. King, supra***, at p. 74; ***Alvarez v. Prospect Hosp., supra; Winegrad v. New York Univ. Med. Ctr., supra***). Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. (***Alvarez v. Prospect Hosp., supra***, at p. 324) . The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. (See, ***Demshick v. Community Hous. Mgt. Corp.***, 34 A.D.3d 518, 824 N.Y.S.2d 166 (2d Dept., 2006), citing ***Secof v. Greens Condominium***, 158 A.D.2d 591, 551 N.Y.S.2d 563 [2d Dept., 1990]).

The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damages. (***Ramsay v. Good Samaritan Hosp.***, 24 A.D.3d 645, 808 N.Y.S.2d 374 (2d Dept., 2005); see also, ***DiMitri v. Monsouri***, 302 A.D.2d 420, 421, 754 N.Y.S.2d 674 (2d Dept., 2003); ***Holbrook v. United Hosp. Med. Ctr.***, 248 A.D.2d 358, 359, 669 N.Y.S.2d 631 [2d Dept., 1998]). "In a medical malpractice action, the party moving for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant physician [and/or hospital] were negligent." (***Taylor v. Nyack Hosp.***, 18 A.D.3d 537, 795 N.Y.S.2d 317 (2d Dept., 2005) citing ***Alvarez v. Prospect Hosp., supra.***) Thus, a moving defendant doctor or hospital has "the initial burden of establishing the absence of any departure from good and accepted medical malpractice or that the plaintiff was injured thereby." (***Williams v. Sahay***, 12 A.D.3d 366, 368, 783 N.Y.S.2d 664 (2d Dept., 2004), citing ***Winegrad v. New York Univ. Med. Ctr., supra***; see also, ***Thompson v. Orner***, 36 A.D.3d 791, 828 N.Y.S.2d 509 [2d Dept., 2007]).

In support of their motion for summary judgment, the defendants have submitted an Expert Affirmation by Louis J. Imbriano, a Board Certified Internist and Nephrologist. He

attests to having reviewed the pleadings in this case, the Bills of Particulars, the deposition transcripts and the decedent's hospital and medical records. It is his opinion "that the medical care and treatment rendered to the decedent, Regina Mays, by each and everyone of the defendants was, at all times, and particularly from April 2003 up to and including the time of the decedent's demise on June 19, 2003, every way appropriate and entirely consistent with good and accepted standards of medical and nephrological care."

Dr. Imbriano affirms that the treatment rendered by Dr. Lachta on May 22nd and 23rd and the hospital from May 23rd through June 4th was entirely proper. As for her discharge, he notes that she was clinically stable, her peritonitis was "under control" as all cultures had been negative, her nutritional needs had been addressed, the Infectious Disease consultant had cleared her for discharge and she was feeling better and wanted to go home. Thus, Dr. Imbriano saw no contraindication to the decedent's discharge. He notes that arrangements had been made for daily home nurse visits and out-patient hemodialysis.

Dr. Imbriano succinctly concludes that North Shore Home Care's records indicate that the decedent was appropriately cared for at each visit.

As for the decedent's June 13th visit to the Emergency Room, Dr. Imbriano notes that the hospital records clearly indicate that the decedent was advised of her serious condition but elected to leave against medical advice. This, Dr. Imbriano opines, "may well have spelled the difference in her failure to survive. . . ."

As for the decedent's June 15th admission to the hospital, Dr. Imbriano notes that her medical records indicate that "she was septic, severely hypotensive, in metabolic acidosis, severely uremic (a toxic condition associated with her renal failure/ESRD), had severe cardiac dysfunction (per echocardiogram), severely anemic with a bleeding disorder (thrombocytopenia) requiring multiple transfusions and in respiratory distress for which she required intubation rather early on." In short, and unfortunately, from the very outset of her Emergency Room presentation, Dr. Imbriano believed that the decedent's condition was grave and her prognosis for survival poor. He further opines that the Hospital's records demonstrate that the care and treatment rendered to the decedent from the time of her June 15th admission through her demise on June 19th was consistent with good and accepted standards of medical, hospital and nephrological care. He opines that every available therapeutic modality was tried, and he saw nothing that might suggest a departure from those standards. It is also his opinion that the decedent's demise was in no way caused, hastened or contributed to in any way, by the defendants' care and treatment of her during this admission of June 15th, her prior admission of May 23rd or at any other time as was alleged in the various Bills of Particulars.

The defendants have established their entitlement to summary judgment thereby shifting the burden to plaintiffs to establish the existence of a material issue of fact.

In opposition to the defendants' motion, the plaintiffs have submitted an affirmation of Robert W. Gluck, M.D., a Board Certified Urologist. He, too, attests to having reviewed, *inter alia*, all of the decedent's pertinent medical records. He faults defendants in several ways regarding the care they provided the decedent. First, Dr. Gluck faults defendants for discharging the decedent prematurely on June 4, 2003. He notes that during decedent's hospitalization, which began on May 23, 2003, she was treated for peritonitis and an infection. Her CBC performed on May 29, 2003 revealed the presence of bandemia, consistent with infection. He notes that her repeat CBC performed on June 3, 2003 revealed an elevated white blood cell count, yet no band count was done. Thus, Dr. Gluck opines that "the agents, servants, employees and/or associates of North Shore departed from the applicable standard of medical care by failing to order and/or repeat a CBC with differential to determine the continued need for hospitalization" [and that] "based upon the laboratory data, [the decedent] should not have been discharged from North Shore on June 4, 2003 with an active peritonitis." He further opines that "it was a departure from accepted medical practice to have discharged [the decedent] from North Shore on June 4, 2003 without any objective evidence that her peritonitis was either resolved or resolving," [and that] "it was a departure from accepted medical practice to have discharged [the decedent] without her being on a course of IV antibiotics."

Dr. Gluck also faults North Shore Home Care, Dr. Latcha and the defendant nurses who cared for the decedent at home for not investigating or obtaining treatment for a purulent discharge that was noted by the visiting nurses on June 5th, 6th, 7th, 8th, 9th, 10th, 11th and 12th. He opines that under these circumstances, the failure to perform wound or drainage cultures, obtain a CBC with differential or have the decedent seen by a doctor was a departure from accepted medical practices, as these things should have been done to evaluate the status of the decedent's peritonitis.

Dr. Gluck further faults defendants for the care provided the decedent when she presented at the hospital on June 13, 2003. He attempts to cast doubt on the decedent's discharge "against medical advice" by noting that while it was her husband who authorized treatment upon her admission, which raises a question about the decedent's ability to make such decisions, the discharge form was executed by her. Moreover, the discharge form was not accompanied by a physicians' certification, per normal procedure. Dr. Gluck further notes that the decedent was not discharged "against medical advice" on June 4, 2003, despite

her unresolved peritonitis, thus making it unclear to him that she was discharged "against medical advice" on June 13, 2003. As for the treatment provided on June 13, 2003, Dr. Gluck states that the decedent presented with abdominal pain that is consistent with continuing peritonitis but no culture of the drainage was performed, which, he concludes, was also a departure from accepted medical practice. And, he further notes that while a CBC was drawn on June 13th, the results were not reviewed until June 14th or 16th, belatedly revealing a continued presence of infection with a left shift. Thus, Dr. Gluck opines the decedent's blood work was not timely reviewed or acted on. He opines that "[d]ischarging Mrs. Mays from the [Emergency Room] of North Shore on June 13, 2003 without either timely determining or timely and appropriately acting upon her abnormal white blood count and/or the presence of a shift toward immature white blood cells was a departure from accepted medical practice."

Finally, Dr. Gluck concludes that the decedent succumbed to the effects of overwhelming sepsis and septic shock as a result of the peritonitis, which the defendants failed to properly treat. He opines that "there is no indication that the decedent's death was due to renal failure," and that the decedent's death caused by sepsis was foreseeable and avoidable had defendants exercised due care. The plaintiffs have established the existence of a material issue of fact.

In reply, defendants maintain **via their attorney** that standing alone, the decedent's elevated white blood count, did not require her continued hospitalization on June 4, 2003, as that could have been the result of "many alternative physiological mechanisms" and all other indicia indicated that her discharge was appropriate; namely, all cultures had been negative; she had been afebrile for five days; she had been cleared for discharge by the Infectious Disease Consultant; she herself reported "feeling much better" and wanted to go home; only clear fluid was draining from her abdomen; and, only serous fluid without odor was coming from her wound with granulation (a sign of healing) at the exit site. Moreover, she was discharged on oral antibiotics and scheduled for and in fact went to out-patient hemodialysis three times a week on June 6th, 9th, 11th and 13th at the hospital's renal/dialysis center, where she was closely monitored. He notes that in fact, the decedent's Progress Notes Report from her hemodialysis center on June 13, 2003 indicate that Dr. Latcha checked the abdomen site where the catheter had been removed and found "no signs/symptoms of infection." This, defendants' lawyer contends, establishes that the Home Care nurses did not neglect to treat the decedent properly as her wound had healed.

As for the decedent's June 13th visit to the emergency room, defendants' lawyer states that she presented complaining of "sharp chest pain" when she belched as well as back pain, not abdominal pain. She remained afebrile, thus indicating no infection. And, consistent with the decedent's complaints, a chest x-ray and EKG were immediately performed and

showed changes from three weeks earlier. Regarding their alleged failure to act on the decedent's blood count results, counsel notes that decedent checked herself out, against medical advice. As for her discharge on June 13, 2003, the defendants' attorney opines that there is nothing unusual or sinister about the fact that the decedent's husband consented to her treatment but she signed her discharge form and plan. As for the blood work, defendants' attorney notes that in addition to her elevated white blood count, the decedent had other chemical values revealing other complications, i.e., elevated Troponin, which was consistent with an acute MI and indicated cardiac muscle damage.

Finally, defendants' attorney asserts that the decedent's medical records indicate that she did not die as a result of peritonitis. He states that it is incontrovertible that her blood cultures of June 16, 2003 showed no growth after five days of culturing and she never had a fever during her final admission. Defendants' attorney opines that the decedent died of cardiogenic shock as a direct result of a diseased/calcified and globally dysfunctional heart.

The defendants' attorney lacks standing to opine on the propriety of the decedent's discharge on June 4, 2003 despite an elevated white blood count; the care provided to the decedent on June 13, 2003 and her discharge; and, the cause of her death: An expert's opinion is required. In any event, issues of fact would exist. Furthermore, the defendants have not established that there clearly was no relationship between decedent's peritonitis, her heart failure and her demise.

In sum, the plaintiffs have raised a number of questions as to whether defendants' care and treatment of the decedent were consistent with good and accepted medical standards, including, *inter alia*, the propriety of her discharge on June 4, 2003; the care provided by the North Shore Home Care nurses; her discharge on June 13, 2003; and, the cause of her death.

Issues of fact preclude summary judgment. Defendants' motion is denied.

The foregoing constitutes the Order of this Court.

Dated: September 19, 2007
Mineola, N.Y.

Karen V. Murphy
J. S. C.