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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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DONALD HENDERSON,

Plaintiff,

-against-

NORTH SHORE UNIVERSITY HOSPITAL, RON ISRAELI, MD, GUSTAVE POGO, MD and RICK ESPOSITO, MD,

Defendants.

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Index No. 016520/05

Motion Dated: 7/20/07
8/20/07
Motion Submitted: 9/10/07
Motion Sequence: 001, 002

The following papers read on this motion:

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

This motion by defendant Gustave Pogo, M.D., and cross-motion by defendant Ron Israeli, M.D. for an Order pursuant to CPLR § 3212 granting them summary judgment dismissing the complaint against them or, in the alternative, an Order pursuant to CPLR § 3212 granting defendants Pogo, Israeli and North Shore University Hospital summary judgment dismissing plaintiff's claim for special damages, are determined as provided herein.

In this medical malpractice action, the plaintiff seeks to recover for the defendants' failure to timely diagnose and properly treat his decubitus ulcers. Defendants Dr. Pogo, plaintiff's cardiothoracic surgeon, and Dr. Israeli, plaintiff's plastic surgeon, seek summary judgment dismissing the complaint against them.

The pertinent facts are as follows:

The plaintiff presented to the Emergency Room of Huntington Hospital on May 19, 2003 with complaints of progressively increasing shortness of breath with minimal exertion, pain down the left arm and substernal chest pressure. He was admitted to the service of his cardiologist and a cardiac catheterization was performed, which revealed, among other things, three vessel coronary artery disease. Plaintiff's cardiologist recommended that the plaintiff undergo coronary artery bypass graft surgery to bypass the diseased coronary arteries. The cardiologist inserted an intra-aortic balloon pump until the surgery could be performed. The plaintiff was transferred from Huntington Hospital to North Shore University Hospital (hereinafter "NSUH") on May 22, 2003 and admitted to the NSUH's Department of Cardiothoracic Surgery. He was assigned to defendant Dr. Pogo. Dr. Pogo is board certified in Thoracic Surgery. Upon plaintiff's admission to NSUH, his skin was noted to be intact upon an assessment by the nursing staff. A Braden Scale score of 19 was assigned by the nursing staff. The Braden Scale assesses a patient's risk of developing a decubitus ulcer. Scores can range from 6 - 23. The lower the Braden score, the higher the risk of developing decubitus ulcers. A patient is likely to have a very low score immediately following surgery because the patient would be profoundly immobile and would have a diminished level of consciousness. If the total score is 17 or less, then the patient is considered to be at risk of developing a decubitus ulcer.

On May 23, 2003, Dr. Pogo performed the cardiac surgery on the plaintiff. Following the surgery, the plaintiff was sedated, intubated and put on a respirator. The plaintiff's skin was noted to be intact by NSUH's nursing staff but his Braden Scale score was ten. Because the plaintiff was considered to be at risk of developing a decubitus ulcer, the nursing staff placed him in a low air-loss bed that day where he remained until his discharge.

On May 24, 2003, the plaintiff experienced cardiac arrest. He was defibrillated and resuscitated. On May 25, 2003, the plaintiff again experienced cardiac arrest and was defibrillated and resuscitated. That day, NSUH's nursing staff placed the plaintiff on skin alert protocol. The skin alert protocol called for turning and positioning the plaintiff every two hours, padding bony prominences, elevating his heels at all times, and pulling sheets for lifting and moisturizing the skin. All of this was done to reduce the plaintiff's risk of developing a decubitus ulcer. The plaintiff's NSUH chart reflects that he remained on the skin alert protocol from May 25, 2003 until his discharge on June 16, 2003.

Plaintiff's NSUH chart reflects that on May 28, 2003, NSUH's nursing staff documented that there was a blister on his left buttocks and on May 29, 2003, the nursing staff documented Stage II decubitus ulcers on his left and right buttocks. Plaintiff's NSUH chart reflects that a nurse practitioner examined the plaintiff's decubitus ulcers and ordered

that PolyMem and Tegaderm be applied to them twice per day. Plaintiff's NSUH chart, in fact, reflects that pursuant to that order, the nursing staff applied PolyMem and Tegaderm dressings two times daily until June 4, 2003.

The plaintiff's NSUH chart reflects that on June 4, 2003, the plaintiff complained of pain in the buttocks. He was examined by Stacy Roberts, R.N., a Certified Wound Ostomy and Continence Nurse, for a skin consultation. Nurse Roberts noted a Stage II decubitus ulcer on the left and right buttocks and noted that there was no drainage, odor or erythema from the wounds, which indicated that the decubitus ulcers were not infected. Nurse Roberts documented that she recommended that DuoDERM be applied to the decubitus ulcers to auto debride the necrotic tissue and accelerate granulation. Plaintiff's NSUH chart reflects that DuoDERM was applied to the sacral decubitus ulcers on this date and that Nurse Practitioner Randy Plotkin was aware of this.

The plaintiff's NSUH record reflects that the following day, June 5, 2003, the nursing staff again documented Stage II decubitus ulcers on plaintiff's left and right buttocks. That day, Physician Assistant Dennis Rykor ordered that PolyMem be discontinued and, per Nurse Roberts' recommendation, that DuoDERM be applied to the sacrum every three days or as needed. The plaintiff's NSUH chart reflects that the nursing staff changed the DuoDERM dressing on the plaintiff's decubitus ulcers on that day. The plaintiff's NSUH chart also reflects that on June 7, 2003, the nursing staff changed the DuoDERM dressing secondary to diarrhea and again documented Stage II decubitus ulcers on plaintiff's left and right buttocks.

The plaintiff's NSUH record reflects that a Plastic Surgery Consultation was performed by defendant Dr. Israeli, a board certified Plastic Surgeon, to evaluate the decubitus ulcers on June 8, 2003. Dr. Israeli documented a sacral pressure wound that extended to the bilateral buttocks with dry, adherent eschar and no evidence of infection or abscess. Dr. Israeli ordered that Collagenase and Polysporin powder dressings be applied to the decubitus ulcers twice a day. Collagenase is a debrider that cleans wounds of dead tissue. Polysporin is an antibiotic powder. Dr. Israeli noted that he would perform a surgical debridement of the decubitus ulcers within a week.

The plaintiff's NSUH chart reflects that pursuant to the order of Dr. Israeli, the nursing staff changed the Collagenase and Polysporin powder dressing twice a day until June 13, 2003. Plaintiff's NSUH chart reflects that on June 12, 2003, the nursing staff again documented Stage II decubitus ulcers on plaintiff's left and right buttocks and that on June 13, 2003, Dr. Israeli sharply debrided necrotic eschar, fat and muscles from the decubitus ulcers. That day, Dr. Israeli noted that plaintiff would require further surgical debridements. Following the surgery, Dr. Israeli ordered 1/4 strength Dakin's wet-to-dry dressings for the

left buttock and normal saline wet-to-dry dressings for the right buttock and that each dressing be changed twice daily. Plaintiff's NSUH chart reflects that pursuant to Dr. Israeli's order, the 1/4 strength Dakin's wet-to-dry dressings for the left buttock and normal saline wet-to-dry dressings for the right buttock were changed twice daily by the nursing staff until the plaintiff's discharge to St. Charles Hospital for Rehabilitation on June 16, 2003. On the day of the plaintiff's discharge, the nursing staff described the decubitus ulcer on the right buttock as Stage III and the decubitus ulcer on the left buttocks as Stage IV. The plaintiff was directed to follow up with a plastic surgeon for continued surgical debridements.

"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.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*, ***Thompson v. Orner***, 36 A.D.3d 791, 828 N.Y.S.2d 509 (2d Dept., 2007); ***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." (***Chance v. Felder***, 33 A.D.3d 645, 823 N.Y.S.2d 172 (2d Dept., 2006) *quoting* ***Williams v. Sahay***, 12 A.D.3d 366, 368,

783 N.Y.S.2d 664 (2d Dept., 2004), *citing* ***Alvarez v. Prospect Hosp., supra; Johnson v. Queens-Long Is. Med. Group, P.C.***, 23 A.D.3d 525, 526, 806 N.Y.S.2d 614 (2d Dept., 2005); ***Taylor v. Nyack Hosp., supra***; *see also*, ***Thompson v. Orner, supra***).

"While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in the field . . . the witness nonetheless should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable." (***Postlethwaite v. United Health Servs. Hosps.***, 5 A.D.3d 892, 895, 773 N.Y.S.2d 480 (3d Dept., 2004); *see also*, ***LaMarque v. North Shore Univ. Hosp.***, 227 A.D.2d 594, 643 N.Y.S.2d 221 (2d Dept., 1996); ***Matter of Enu v. Sobol***, 171 A.D.2d 302, 576 N.Y.S.2d 378 (3d Dept., 1991); ***Joswick v. Lenox Hill Hosp.***, 161 A.D.2d 352, 355, 555 N.Y.S.2d 104 (1st Dept., 1990.)

In support of his motion for summary judgment, defendant Dr.Pogo has submitted an affidavit by Dr. James Lyons, a physician licensed to practice in the State of Connecticut who is board certified in Plastic Surgery. Dr. Lyons represents that he has diagnosed and treated patients with decubitus ulcers over the course of his career.

It is Dr. Lyon's opinion with a reasonable degree of medical certainty that at all times the medical care and treatment Dr. Pogo provided to the plaintiff comported with good and accepted medical practice. It is also his opinion with a reasonable degree of medical certainty that the medical care and treatment provided by Dr. Pogo was not and could not have been a proximate cause of the plaintiff's alleged injuries.

In his affidavit, Dr. Lyons states that a cardiothoracic surgeon such as Dr. Pogo is a surgical specialist who operates on the heart and great vessels. Dr. Lyons opines that in 2003 as well as today, a cardiothoracic surgeon such as Dr. Pogo does not have the requisite education, training or experience to determine the stage of a patient's decubitus ulcer or to monitor or treat a patient for a decubitus ulcer. Dr. Lyons further states that in 2003 as well as today, it was not the standard of care for a cardiothoracic surgeon to monitor or treat a patient for a decubitus ulcer. In fact, Dr. Lyons opines that in 2003 as well as today, it was the standard of care for a cardiothoracic surgeon to rely on other medical care providers working in the cardiac unit of the hospital to diagnose, supervise, direct, control, manage or treat a patient's skin condition post-operatively, including decubitus ulcers, which providers include physician assistants, nurse practitioners, nurses, certified wound ostomy and continence nurses, nutritionists and intensivists, who are physicians board certified in, at the very least, Internal Medicine and Critical Care Medicine

In conclusion, Dr. Lyons opines that from the time of the plaintiff's admission on May 22, 2003 until June 8, 2003, NSUH medical care providers other than Dr. Pogo were

managing plaintiff's care in the cardiac unit of NSUH for the prevention, diagnosis and treatment of decubitus ulcers and that this plan of management was in accordance with good and accepted medical practice.

In support of his motion for summary judgment, defendant Dr. Israeli has submitted his own affidavit. He points out that he was not called upon to examine the plaintiff until June 8, 2003. That day, he diagnosed the plaintiff with a "very large sacral pressure wound extending to bilateral buttocks with dry adherent eschar." Consistent with his diagnoses, he maintains that "[t]here was no evidence of infection or abscess." He explains that in ordering treatment of plaintiff's decubitus ulcer, he sought to soften the adherent eschar (dry devitalized skin) in preparation for debridement. He further explains that he did this in order to avoid a formal surgical procedure, which would have been more traumatic for the plaintiff who was recovering from major cardiac surgery as well as cardiac arrests. He explains that when he next examined plaintiff on June 13, 2003, the sacral wound had softened and he was able to perform a sharp debridement of necrotic eschar, fat and muscle tissue. He states that he left orders for plaintiff to be treated with dressings twice a day. Shortly thereafter, the plaintiff was discharged, with instructions to follow up with a plastic surgeon.

Drs. Pogo and Israeli have established their entitlement to summary judgment shifting the burden to plaintiff to establish the existence of a material issue of fact.

In opposition to Dr. Pogo's motion, the Plaintiff submitted the affirmation (entitled affidavit) of a physician licensed to practice medicine in the State of New York who is a Diplomate of the National Board of Medical Examiners and American Board of Internal Medicine, a Fellow of the American College of Chest Physicians, and professes to be experienced in Hospital Risk Management, Critical Care and the treatment of patients with pressure ulcers. He opined that Dr. Pogo, as the attending physician, was responsible for failing to encourage good communication with other practitioners and not collaberating with other treatment providers. He further opined that Dr. Pogo departed from accepted practice by failing to caution the staff not to use occlusive dressings such as DuoDerm and that the application of the DuoDerm dressings cause the worsening of the ulcer. The physician further opined that the increased white blood cell count (WBC) was due to the application of the DuoDerm dressing. He also opined that the failure to call for a plastic surgery consultation on June 4 or 5 was a departure from accepted practice.

In opposition to Dr. Israeli's motion, the plaintiff has submitted an affirmation by a physician licensed to practice medicine in the State of New York who is a Diplomate of the National Board of Medical Examiners and American Board of Internal Medicine, a Fellow of the American College of Chest Physicians, and professes to be experienced in Hospital Risk Management, Critical Care and the treatment of patients with pressure ulcers. In

criticizing the care rendered by Dr. Israeli, plaintiff's expert states that on June 5, 2003, a finding of blood "serosanguinous" drainage from the sacral decubitii is noted on plaintiff's NSUH chart as well as a differential diagnosis of the plaintiff's elevated white blood cell count as including "infected pressure ulcer." On June 4, 2003, plaintiff's NSUH chart notes a "layer of brown fibrin exudate" over the sacral pressure ulcers, which "suggests that the ulcers were becoming complicated by the involvement of deeper layers of tissue." In fact, plaintiff's expert notes that plaintiff's white blood cell count was elevated for several days prior to Dr. Israeli's examination of plaintiff. All of this, plaintiff's expert opines, indicated that the plaintiff's sacral pressure ulcers were increasing in depth and size as well as that they were infected. Accordingly, he opines that sharp surgical debridement with biopsies was called for as early as June 4, 2003. Thus, plaintiff's expert further opines that Dr. Israeli's failure to perform sharp debridement on June 8, 2003 constituted medical malpractice.

Plaintiff's expert further states that in order for the Collagenase prescribed by Dr. Israeli to be effective, the ulcerations should have been resected with scalpel and scissors, which would also have enabled Dr. Israeli to properly inspect the base of the sacral wounds. He notes that Dr. Israeli admitted at his examination-before-trial that he did not evaluate the base of the plaintiff's ulcers on June 8, 2003, and that the sacral wounds may have been infected. Plaintiff's expert further explains that staging of pressure sores like plaintiff's enables doctors to determine the appropriate treatment. He opines that Dr. Israeli's failure to stage the plaintiff's pressure ulcer on June 8, 2003 was inappropriate.

In conclusion, plaintiff's expert opines that Dr. Israeli's examination of the plaintiff on June 8, 2003 was substandard. He explains Dr. Israeli's "failure to perform mechanical removal of the eschar with a sharp dissection and tissue biopsy with cultures on 6/8/03 was a substantial factor in causing the bacterial infestation in the ulceration to worsen with further progression and deeper penetration of tissue destruction." He further states "[t]he eschar needed urgent removal in order to allow proper care to the tissues underneath and in the base of the ulcer crater. [Dr. Israeli's] substandard care caused deeper penetration of the ulceration beneath the skin into fat and muscle, which were increasingly becoming devitalized and infected . . . Delaying the patient's surgery in order to soften the eschar was inappropriate in this particular case and caused an unnecessary delay of 5 additional days before Dr. Israeli's scissors removed the eschar when he surgically debrided the patient's pressure sores 6/13/03. The delay of [five] 5 additional days caused infection in the pressure ulcers to worsen. . .. " As for damages, plaintiff's expert states that Dr. Israeli's shortcomings "caused and permitted the sacral pressure ulcers to increase in size, depth and severity." In addition, he opines that Dr. Israeli's substandard care caused the patient to experience pain, deformity and disability thus causing the patient to require extensive medical care and rehabilitation.

The plaintiff was in need of surgical debridement when Dr. Israeli first evaluated him.

Thus, Dr. Israeli cannot be held responsible for that. And, as for the five-day delay in the procedure, which was indisputably attributable to Dr. Israeli, there is no evidence that any damages resulted. (See, ***Yasin v. Manhattan Eye, Ear & Throat Hosp.***, 254 A.D.2d 281, 678 N.Y.S.2d 112 (2d Dept., 1998); ***Koeppel v. Park***, 228 A.D.2d 288, 644 N.Y.S.2d 210 [1st Dept., 1996]).

Plaintiff's expert essentially maintains that further investigation of plaintiff's pressure ulcers by Dr. Israeli on June 8, 2003 would have enabled him to stage the decubitus ulcer and enhanced his ability to effectively treat it as the results would have prompted immediate surgical debridement and avoided infection. However, there is in fact no evidence that the treatment would have been any different had the pressure sores been staged on June 8, 2003. Contrary to plaintiff's expert's conclusions, there is no conclusive evidence that the plaintiff's decubitus ulcers were ever infected. Dr. Israeli acknowledged that the pressure sores **might** have been infected on June 8, 2003 and that he prescribed Dakin on the 13th of June because he observed evidence of colonization **or** infection when he did the debridement –"not necessarily infection." This does not establish the presence of infection. Indeed, an examination done in the course of plaintiff's follow-up on June 17, 2003 revealed "no evidence of infection or abscess." As for the plaintiff's white blood cell count, plaintiff reported having experienced gout a week before his admission and he experienced burning when urinating after the Foley catheter was removed and his urinalysis was abnormal. Similarly unsupported by the record is the plaintiff's expert's conclusion that the pressure sores increased in size and depth.

An expert may not make conclusions based on facts not in evidence or which directly contradict the evidence. (See, ***Holbrook v. United Hosp. Med. Ctr., supra***; *see also*, ***Kaplan v. Hamilton Med. Assoc.***, 262 A.D.2d 609, 610, 692 N.Y.S.2d 674 [2d Dept., 1999]). The opinion of a qualified expert that a plaintiff's injuries caused by a deviation from relevant industry standards has no probative force when the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation. (See, ***Wong v. Goldbaum***, 23 A.D.3d 277, 805 N.Y.S.2d 47 (1st Dept., 2005) *citing* ***Diaz v. New York Downtown Hosp.***, 99 N.Y.2d 542, 544, 784 N.E.2d 68, 754 N.Y.S.2d 195 [2002]). Plaintiff's expert has ignored the not rebutted Dr. Lyon's opinion that Dr. Pogo was a cardiothoracic surgeon and that others were properly treating the plaintiff for his skin condition, an area outside of Dr. Pogo's expertise; and did not address the contentions regarding the overall health of the patient and in particular the gout and UTI and how his condition impacted on the care of the plaintiff. (See, ***Kaplan v. Hamilton Medical Associates, P.C.***, 262 A.D. 2d 609, 692 N.Y.S.2d 674 (2d Dept., 1999); ***Fhima v. Maimondides Med. Ctr.,*** 269 A.D.2d 559, 703 N.Y.S. 2d 743 (2d Dept., 2000); ***Wong v. Goldbaum,*** 23 A.D. 2d 277, 805 N.Y.S. 2d 47 [1st Dept., 2005]). Plaintiff's expert also failed to establish that he possessed the requisite background and knowledge to render a reliable opinion. Furthermore, the plaintiff's expert has completely

disregarded plaintiff's overall status and how that affected Dr. Israeli's treatment of him. That is, the plaintiff was recovering from heart surgery and two cardiac arrests, which was properly taken into account by Dr. Israeli in formulating his treatment plan for plaintiff. Plaintiff's expert's failure to take this into account is also fatal to his opinion. (***Kaplan v. Hamilton Med. Assoc., supra***; see also, ***Fhima v. Maimonides Med. Ctr.***, 269 A.D.2d 559, 703 N.Y.S.2d 743 [2d Dept., 2000]). The plaintiff has failed to raise an issue of fact concerning Dr. Pogo and Dr. Israeli's treatment. Drs. Pogo and Israeli's motions for summary judgment are granted.

Defendants' motions to dismiss plaintiff's claim for special damages are granted. When called upon to document economic loss, all plaintiff has produced are Medicare statements, which document the amounts paid by Medicare to plaintiff's providers. However, these statements are not bills and plaintiff has failed to establish any economic loss by him. Furthermore, there is nothing to support plaintiff's bald assertion that these funds were paid by Medicare for "occurrence related treatment." The amounts paid to NSUH and St. Charles Hospital were certainly related at least in part to plaintiff's cardiac condition.

The foregoing constitutes the Decision and Order of this Court. Submit Judgment on notice.

Dated: December 17, 2007
Mineola, N.Y.

Karen V. Murphy
J. S. C.