At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 25th day of April, 2008

P R E S E N T:

HON. MARSHA L. STEINHARDT,
Justice.

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JAMES LAWRENCE,
Plaintiff,

- against - Index No. 20759/06

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, KINGS COUNTY HOSPITAL, RONALD TORRES, M.D. AND PATRICIA O'NEILL, M.D.

Defendants.

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The following papers numbered 1 to 4 read on this motion:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-2
Opposing Affidavits (Affirmations)	3
Reply Affidavits (Affirmations)	4
Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers, defendants New York City Health and Hospitals Corporation (HHC) and Patricia O'Neill, M.D. (Dr. O'Neill) (collectively defendants) move for summary judgment, pursuant to CPLR 3212, dismissing plaintiff's complaint insofar as asserted against them.

In this medical malpractice action, plaintiff alleges that defendants deviated from accepted standards of medical care while he was being treated in the hospital for severe injuries he sustained in an automobile accident. Plaintiff alleges, among other things, that defendants improperly and negligently positioned and restrained his wrists, failed to monitor the effects of the restraints, negligently failed to perform physical therapy on him, and negligently caused his arms to become paralyzed and non-functional.

On December 29, 2004, plaintiff, then age 62, was driving his vehicle when it struck trees, a fence and landed in a courtyard, ejecting him from the driver's side window. Plaintiff sustained various injuries, including a hemorrhage of the head, a crushed left leg from his foot to hip, and multiple lacerations and abrasions. EMS brought plaintiff to Kings County Hospital emergency room, where plaintiff was described as alert, combative, and intoxicated. Plaintiff was intubated and x-rays and abdominal/pelvic ct-scans were performed. Plaintiff sustained fractures of the pelvis, left femur, and left tibia/fibula, and had internal bleeding.

According to Dr. O'Neill, plaintiff required significant treatment to save his life, having arrived at the hospital "confused, combative, bleeding extensively . . . [with] multiple abrasions and contusions . . . a bad pelvic fracture, a head injury, [and] an open fracture . . . of the femur." He was unstable in the emergency room and Dr. O'Neill did not know if he was going to survive. A CAT scan was taken to look at plaintiff's head injury and to identify his severe pelvic fracture, but he become progressively more unstable and hemorrhaging. At approximately 6:00 or 7:00 A.M. the next day, plaintiff was brought to

the angiography suite, where he underwent multiple massive transfusions, and was then transferred to the intensive care unit, where he was still unstable. Dr. O'Neill testified that over the next 24 to 48 hours, she and other medical personnel were able to stabilize plaintiff, but he remained in "extremely critical condition."

Dr. O'Neill made the first order for wrist restraints on December 30, 2004, at 5:30 A.M. Orders for wrist restraints were written daily, from December 30, 2004 until February 6, 2005, while plaintiff was still in the intensive care unit. With respect to the need to restrain plaintiff in the critical care unit, Dr. O'Neill testified that:

> "It was to protect himself, there is documentation throughout his chart that clearly explains that, in combination with his head injury and his sedation, the fact that he was very dependant on a ventilator, required an endotracheal tube for his ventilator and multiple IV lines for his support, that he repeatedly reached and tried to pull out his lines."

"Restraint flow-sheets" were completed daily from December 30, 2004 until February 7, 2005. The policy for restraining patients, set forth on the Restraint flow sheets, indicates: "Behavioral Observations q (every) 30 minutes; Release/Skin Integrity Circulation ROM/Positioned q 2 hours," meaning, according to the parties, that medical personnel were required to: 1) assess the patient's behavior every 30 minutes; 2) release the restraints every two hours; 3) assess the circulation and skin integrity to a patient's arms every two hours and 4) perform range of motion exercises every two hours. The flow sheets also documented the behavior precipitating restraint, for example "to prevent patient from pulling out therapies," and "to prevent self-extubation." Plaintiff's behavior was frequently documented as restless

and agitated. In this regard, defendants point to the hospital chart, indicating that on January 6, 2005, plaintiff was continuing to bite on the "FH;" on January 7, 2005, plaintiff was trying to remove the "ET tube;" on January 30, 2005, plaintiff was restless and agitated and was seen holding the chest tube in his left hand, which was restrained, and the chest tube dislodged; and on February 2, 2005, plaintiff was agitated, was restrained and attempting to get up and pull out therapies. Defendants also state that the flow sheets document that the nursing staff at the hospital checked wrist restraints for skin integrity, circulation and range of motion on regular intervals while plaintiff was restrained

On February 11, 2005, physical therapy documented 15 to 20 degree extension/flexion in the left elbow and 15 to 30 degree flexion/extension in the right elbow. On February 14, 2005, plaintiff was evaluated for physical therapy. Bedside therapy was recommended three to four times per week to prevent further contractures and muscle weakness bilaterally in the upper and lower extremities and began at that time.

On February 17, 2005, plaintiff was restless and pulling out therapies. According to defendants, on that same day, plaintiff was evaluated by occupational therapy.[1] The therapist noted severe contractures of the elbow joints and shoulders. Occupational therapy commenced at that time and continued, along with physical therapy, until plaintiff's discharge to a rehabilitation center on April 13, 2005.

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[1]This note could not be located in the record but plaintiff does not dispute its existence or its content.

On April 5, 2005, one week prior to discharge, therapy documented a 15 degree lag in extension/20 degrees flexion of the left elbow and a 10 degree lag in extension/forty degree flexion in the right elbow. Despite two months of intensive therapy, after the wrist restraints were removed, plaintiff's upper extremity contractures persisted.

On July 12, 2005, bilateral elbow x-rays performed at the Kings County Hospital outpatient clinic revealed a diagnosis of heterotopic ossification.[2]

On August 19, 2005, surgery for the right elbow contracture release and excision of heterotopic calcification was performed at Kings County Hospital. On October 28, 2005, surgery for left elbow contracture release and excision of heterotopic calcification was performed.

Plaintiff commenced the instant action for medical malpractice and lack of informed consent in July, 2006. Issue was joined in August, 2006. Discovery is now complete. Plaintiff filed a note of issue on November 17, 2006. Defendants' motion is now before the court.

Arguments

In support of their motion, defendants argue that they are entitled to summary judgment dismissing the complaint based upon the affidavits of their expert physicians,

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[2]Heterotopic is defined as "[r]elating to heterotopia" (Stedman's Medical Dictionary 886 [28th Ed 2006]). Heterotopia is defined as "[i]n neurology, displacement of gray meter, typically into the deep cerebral white matter" (*id.*). Ossification is defined as "[t]he formation of bone" (*id.* at 1387).

which demonstrate that there was no departure from accepted standards of practice and that defendants did not cause plaintiff's injuries.

Defendants submit the summons and complaint, the bill of particulars, plaintiff's hospital chart, the deposition testimony of plaintiff and Dr. O'Neill, and the affirmations of their experts, Dr. Spiros G. Frangos, licensed to practice medicine in New York and Board Certified in Surgery with an additional certification in Surgical Critical Care, and Dr. James Dickson, licensed to practice in New York State and board certified in Orthopedic Surgery.

Upon a review of plaintiff's hospital chart, the verified bills of particulars as to defendants, the deposition testimony of plaintiff and Dr. O'Neill, Dr. Frangos summarized plaintiff's care upon arrival at the emergency room, noting that his alcohol level was 298 mg per dL, which is greater than three times the legal limit for intoxication; that plaintiff was described as combative in the emergency room; that he was immediately intubated and placed on a ventilator; and that he sustained various fractures, as well as an acute right subdural hematoma and subarachnoid hemorrhage. According to Dr. Frangos, the ventilatory support, defendants' response to the clinical and radiographic findings, and the transfusions of blood plaintiff received were consistent with good and accepted medical practice and saved plaintiff's life, and were not the cause of the injuries to plaintiff's elbows.

Dr. Frangos further affirms that "[w]rist restraints are routinely used for intensive unit patients . . . [who] are often at increased risk of injuring themselves by pulling out therapies such as IV lines, endotracheal tubes, central lines and chest tubes." He also states that

"[w]rist restraints allow for some range of motion and enable a degree of flexion and extension of the wrists and elbows and pronation and supination of the arms," as evidenced by "the fact that on January 30, 2005 plaintiff was seen holding the dislodged chest tube tubing [sic] with his restrained left hand." Citing the dates defendants noted above when plaintiff was placed in wrist restraints, Dr. Frangos opines, with a reasonable degree of medical certainty, that their use was appropriate and consistent with good and accepted medical practice. He also notes that there are 38 orders for wrist restraints in the chart, which [was] consistent with the time period during which plaintiff was in restraints (December 30, 2004 - February 6, 2005); that "the orders indicate that the need for wrist restraints was constantly reassessed and that defendants continued to consider plaintiff at a high risk for injuries without restraints;" that there is sufficient documentation that the nursing staff consistently checked the wrist restraints, according to hospital protocol; that there was no evidence that plaintiff's wrist restraints ever caused circulatory impairment, were improperly positioned, or that plaintiff developed any pressure sores in the wrist area; and that the wrists restraints were a necessary and vital part of plaintiff's management.

Dr. Dickson, having reviewed the same medical and litigation records as Dr. Frangos,[3] asserts that "[i]t is well known and . . . accepted in critical care medicine that intubated patients require upper extremity restraints . . . because patients generally become combative and invariably pull out their endotracheal tube, IVs, foley catheters, and rectal tubes;" that

[3]Dr. Dickson affirms that he also reviewed the medical records of a Dr. Ronald Chase, but these records do not appear to be in the record.

"[i]n order to provide adequate therapy, upper extremity restraints are absolutely necessary;" and "that wrist restraints were used on plaintiff because he was frequently described as restless and agitated in the intensive care unit and was considered at risk of self-injury."

Like Dr. Frangos, Dr. Dickson also states that there is sufficient documentation that the nursing staff continuously monitored the wrist restraints according to hospital protocol; that there was no evidence that plaintiff's wrist restraints ever caused circulatory impairment, were improperly positioned, or that plaintiff developed any pressure sores in the wrist area; and that the wrists restraints were a necessary and vital part of plaintiff's management.

Dr. Dickson also asserts that the February 27, 2005 "bilateral elbow x-rays revealed extensive hypertrophic new bone formation over the distal humerus bilaterally most prominently posteriorly," but that "plaintiff's elbow contractures were not the result of stiffness/tightness associated with atrophy from lack of use . . . [r]ather, the soft tissue around the elbow joints turned into bone." Dr. Dickson adds that "[a]lthough soft tissue contractures developed in many joints both in the upper and lower extremities, heterotopic ossification was only found in the elbows."

Dr. Dickson further states that despite intense physical therapy received after the removal of wrist restraints, the elbow contractures persisted. In this regard, he notes that on February 11, 2005, the therapy department documented 15 to 20 degree extension/flexion in the left elbow and 15 to 30 degree extension/flexion in the right elbow, but that on April 5,

2005, there was a 15 degree lag in extension/20 degree flexion in the left elbow, and a 10 degree lag in extension/flexion in the right elbow.

Dr. Dickson states that heterotopic ossification is a medical condition which involves the gradual formation of bone in the soft tissue around major joints; that the normal soft tissue of the joint turns into bone; that it is a rare condition which is most frequently seen with musculoskeletal trauma, spinal cord injury, or central nervous system injury; that there is no medical evidence which suggests that heterotopic ossification has any relation to immobilization or restraint; and that physical therapy is not usually an effective treatment of heterotopic ossification and was not effective on plaintiff.

Further, Dr. Dickson notes that plaintiff was diagnosed with a C1-C2 subluxation at the time of admission but no surgery could be performed because of plaintiff's general medical condition, and that stabilization surgery was performed on March 28, 2005. He states that the relationship between spinal injury and heterotopic ossification is well established, and that here, as a result of plaintiff's spinal cord injury, he was diagnosed with spastic quadraparesis[4] in the hospital ambulatory care clinic on June 16, 2006.

As such, Dr. Dickson opines, with a reasonable degree of medical certainty, that plaintiff developed heterotopic ossification as a result of musculoskeletal trauma and spinal cord injury sustained during the automobile accident; that heterotopic ossification was not

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[4]Spastic is defined as "[r]elating to spasm or spasticity" (Stedman's Medical Dictionary 1796 [28th Ed 2006]). Quadraparesis is a synonym for tetraparesis (*id.* at 1616). Tetrparesis is defined as "[w]eakness of all four extremities" (*id.* at 1968).

and could not be caused by wrists restraints; and that there was no departure from good and accepted medical practice by the orthopedic service at Kings County Hospital, nor was anything done or not done by the orthopedic services at the hospital which was related to the injuries for which plaintiff seeks recompense.

In opposition to defendants' motion, plaintiff argues that defendants have failed to make a prima facie showing that they did not depart from accepted standards of medical care or that such departures did not proximately cause his injuries. In this regard, plaintiff relies upon the redacted affirmation of his own expert, who is licensed to practice in New York State and is board certified in Emergency and Internal Medicine. Upon review of the medical and litigation records in this case, the expert cites the dates plaintiff was restrained for "many hours",[5] and asserts that the hospital failed to follow its own protocol and the standard of care with respect to wrist restraints by failing to: 1) assess plaintiff every thirty minutes to ensure that the restraints were no longer necessary 2) release the restraints; 3) assess circulation and skin integrity to plaintiff's arms; 4) perform range of motion exercises; and 5) monitor plaintiff's response to the restraints. He states that these interventions were meant to ensure, among other things, that any restrained patient did not develop complications including, limitation in mobility and contractures. He also asserts that plaintiff had a full range of motion on both his arms prior to his admission; "that it is no coincidence

[5]The expert cites the following dates: December 31, 2004, January 2, 4, 7, 9, 10, 11, 13, 14, 16, 17, 26, February 2 and 4, 2005.

that [plaintiff] developed severe bilateral elbow contractures during this admission;" and that failure to perform these interventions was a departure from accepted medical standards.

The expert further opines that the above departures constituted a substantial factor in causing plaintiff's injuries, and that the finding that plaintiff developed heterotopic ossification (HO) at his elbow joints does not affect this opinion. Specifically, he asserts that it is widely accepted that gentle and active passive range of motion substantially limits the risk of HO and that the failure to position and move plaintiff's arms for several hours during the day was a substantial factor in the development of his HO "to the degree and nature that it could cause such severe upper extremity dysfunction."

The expert also states that even with HO, plaintiff's severe bilateral elbow contractures were avoidable had his arms not been improperly restrained as noted above. He asserts that "[c]ontractures occur when tendons/muscles harden and become 'fixed' or less elastic as a result of disuse;" that in plaintiff's case, the contractures were a separate and distinct injury from HO; and that the failure to reposition plaintiff's arms for several hours a day on the days he was restrained was a substantial factor in causing his contractures and loss of range of motion in both arms.

In reply, defendants argue that plaintiff's expert failed to address defendants' experts' contentions that there is sufficient documentation that the nursing staff continuously monitored the wrist restraints; that there is no evidence that the restraints caused circulatory impairment or were improperly positioned; that plaintiff received physical and occupational

therapy, yet the elbow contractures persisted; that HO is a rare condition most frequently seen with musculoskeletal trauma, spinal cord injury or central nervous system injury; that there is no medical evidence which suggests that heterotopic ossification has any relation to immobilization or restraint; and that the relation between spinal injury and heterotopic ossification is well established.

Defendants also argue that plaintiff's expert does not specify how or why the restraint protocol was not followed and that there is documentation in the nurses' progress notes that the restraints were monitored.

Analysis

"The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted standards of medical practice, and (2) evidence that such a departure was a proximate cause of the plaintiff's injury" (*Keevan v Rifkin*, 41 AD3d 661, 662 [2007]; *DiGiaro v Agrawal*, 41 AD3d 764,767 [2007]). "'On a motion for summary judgment in a medical malpractice action, a defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice, or that the plaintiff was not injured thereby" (*Germaine v Yu*, __ AD3d __, 2008 NY Slip Op 2551, *2 [2008], quoting *Shahid v New York City Health & Hosps. Corp.*, 47 AD3d 800, 801 [2008]). Defendant must make this showing through medical records and competent expert affidavits (*Jones v Ricciardelli*, 40 AD3d 935, 935 [2007]). Once the defendant has made a prima facie showing, the burden shifts to the plaintiff to raise a triable issue of fact *(Shahid*, 47 AD3d

at 801; *DiGiaro,* 41 AD3d at 764). "'In opposition, a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury'" (*Keevan,* 41 AD3d at 662, quoting *Thompson v Orner*, 36 AD3d 791, 792 [2007]). "General allegations of medical . . . malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical . . . malpractice, are insufficient to defeat defendant physician's . . . summary judgment motion" (*Starr v Rogers*, 44 AD3d 646, 648 [2007], quoting *Alvarez v Prospect Hosp.*, 68 NY2d 320, 325 [1986]; *see also Keevan,* 41 AD3d at 662 ["General allegations that are conclusory and unsupported are insufficient to defeat summary judgment"]). On the other hand, "'[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury'" (*Bengston v Wang*, 41 AD3d 625, 626 [2007], quoting *Feinberg v Feit,* 23 AD3d 517, 519 [2005]; *see also Graham v Mitchell*, 37 AD3d 408, 409 [2007]).

Defendants have made a prima facie showing entitling them to summary judgment with respect to their claim that the wrist restraints used on plaintiff did not cause plaintiff to contract heterotopic ossification. In this regard, both of defendants' experts testified, and the record reveals, that the use of the wrist restraints on plaintiff was necessary because he was frequently described as restless and was considered at risk for self injury. In addition, noting that heterotopic ossification is a rare condition which is most frequently seen with

musculoskeletal trauma, spinal cord injury or central nervous system injury; that plaintiff had sustained spinal cord injury as a result of his accident; and that the relationship between spinal cord injury and heterotopic ossification was well established, Dr. Dickson opined that plaintiff developed heterotopic ossification as a result of musculosekletal trauma and spinal cord injury sustained during the automobile accident, and that it was not and could not be caused by wrist restraints.

Defendants, however, have failed to make a prima facie showing that the wrist restraints did not cause plaintiff's elbow contractures. In this regard, Dr. Dickson opined that plaintiff's elbow contractures were not caused by stiffness/tightness associated with atrophy from lack of use, asserting that there was no evidence that the restraints caused circulatory impairment, were improperly positioned, or that plaintiff developed pressure sores in the upper extremities. He also asserted that "[t]here is sufficient documentation that the nursing staff continuously monitored the wrist restraints, according to hospital protocol." However, Dr. Dickson does not identify the documentation in the record to which he refers. While defendants refer to the Restraint flow sheets to support their position that the "nursing staff of [the hospital] checked the wrist restraints for skin integrity, circulation and range of motion on regular intervals while plaintiff was restrained," and the record reveals that the majority of these flow sheets monitored plaintiff in accordance with hospital protocol, portions of several of these flow sheets are not fully completed.[6] On some of these sheets,

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[6]See dates: January 9, 10, 11, 13, 14, 16, 17, 18 , 19, 21, 23, 24, 29, 31; February 1, 2, 5

there are intervals of several hours where the categories for assessing release, skin integrity, circulation, ROM (range of motion), and position are not checked off. Further, merely because the wrists restraints did not cause circulatory problems or pressure sores does not mean that they did not cause plaintiff's contractures. Thus, defendants' own papers raise an issue of fact as to whether the proper protocols with respect to wrist restraints were consistently followed, and if not, whether the failure to do so was a proximate cause of plaintiff's contractures.

In any event, plaintiff has raised a question of fact as to whether his heterotopic ossification and contractures resulted from defendants' negligent use of wrist restraints on him, which precludes the court from granting defendants' motion for summary judgment. With respect to plaintiff's heterotopic ossification, plaintiff's expert asserted that during some of the days plaintiff was restrained, he was not properly monitored according to hospital protocol. The expert also opined that "[i]t is widely accepted that gentle and active passive range of motion substantially limits the risk of HO," and that failure to reposition plaintiff's arms for "many hours during the days" (which the expert identified) "was a substantial factor in plaintiff's development of [plaintiff's] HO to the degree and nature that it could cause such severe upper extremity dysfunction."

As to plaintiff's contractures, plaintiff's expert opined that they were "avoidable had [plaintiff's] arms not been improperly restrained;" that "[c]ontractures occur when tendons/muscles harden and became 'fixed' or less elastic as a result of disuse;" and that

"the fact that [plaintiff's] arms were not repositioned and moved for "many hours during the days" (which the expert identified) "was a substantial factor in causing his contractures and loss of range of motion."

Thus, plaintiff has raised a question of fact as to whether defendants' use of restraints on plaintiff was negligent and whether this alleged negligence was a proximate cause of plaintiff's heterotopic ossification and/or elbow contractures. As such, defendants' argument that plaintiff did not rebut their showing that there was sufficient documentation that plaintiff was continuously monitored, and that there is no evidence which suggests that heterotopic ossification has any relation to immobilization or restraint, is without merit. Further, while defendants argue that plaintiff's expert did not rebut their expert's contention that heterotopic ossification is a rare condition and most frequently seen with, among other things, spinal cord injury, plaintiff's expert raised an issue of fact as to whether the failure to properly monitor the wrist restraints caused plaintiff's elbow contractures and heterotopic ossification. In addition, contrary to defendants' claims, plaintiff's expert specified how the restraint protocol was not followed.

That branch of defendants' motion for summary judgment as to plaintiff's cause of action for lack of informed consent is granted. Defendants have made a prima facie showing, through their expert affirmations, that a reasonably prudent person would have undergone all of the procedures plaintiff underwent if informed of the risks and benefits of the procedures. Plaintiff has failed to address this cause of action in his opposition.

Finally, in light of the factual issues raised, the court declines to search the record and grant plaintiff partial summary judgment.

In sum, that branch of defendants' motion for summary judgment as to plaintiff's cause of action for lack of informed consent is granted, and the remainder of defendants' motion is denied.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.