Cummings v Brooklyn Hosp. Ctr.
2014 NY Slip Op 33848(U)
August 12, 2014
Supreme Court, Kings County
Docket Number: 904/09
Judge: Laura Lee Jacobson
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At an IAS Term, Part 21 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 27th day of June, 2014.

PRESENT:

HON. LAURA LEE JACOBSON,
Justice.

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ROSA CUMMINGS, AS ADMINISTRATOR OF THE ESTATE OF MERDIS WASHINGTON, AND ROSA CUMMINGS, INDIVIDUALLY,

Plaintiff,

- against -

Index No. 904/09

THE BROOKLYN HOSPITAL CENTER AND LENOX HILL HOSPITAL,

Defendants.

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The following papers numbered 1 to 14 read herein:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-3; 4-6
Opposing Affidavits (Affirmations)	7-8; 9-10
Reply Affidavits (Affirmations)	11-12;13
______ Affidavit (Affirmation)	
Other Papers Supplemental Affirmation	14

Upon the foregoing papers, defendant Lenox Hill Hospital (Lenox Hill) moves, pursuant to CPLR 3212, for an order granting summary judgment dismissing plaintiff's

summons and verified complaint, and defendant the Brooklyn Hospital Center (Brooklyn Hospital) moves for the same relief.

BACKGROUND AND CONTENTIONS

The instant motion practice arises out of separate lawsuits commenced by plaintiff to recover damages stemming from alleged acts of negligence. Specifically, plaintiff alleges that both named defendants were negligent with regard to the care rendered to decedent Merdis Washington (Washington) in failing to prevent the development and deterioration of two pressure sores–specifically, a stage-IV sacral skin ulcer and an anterior left-thigh skin ulcer. The allegations as against Brooklyn Hospital pertain to six separate admissions that occurred between September 24, 2006 and February 8, 2008, and as against Lenox Hill based upon admissions of October 8, 2006 to October 14, 2006, and of November 5, 2006 to November 18, 2006. A second cause of action in each complaint alleges loss of services on behalf of plaintiff Rosa Cummings, the daughter of the decedent. Although plaintiff's Verified Bills of Particulars indicate that Washington died on February 10, 2008, and alleges death as an injury, neither Verified Complaint alleges a cause of action for wrongful death. Moreover, while negligence is alleged, specific departures are not set forth.

The instant action was commenced by the filing of summons and verified complaints as against Brooklyn Hospital on or about January 20, 2009, and as against Lenox Hill on or about November 5, 2009. Following the respective joinder of issue in each case, by order of Justice Gloria Dabiri dated March 23, 2010, the two matters were consolidated under the above index number.

The factual history of this matter commences in the period between August 13, 2004 to August 25, 2004, during which time, decedent was admitted to Brooklyn Hospital for severe decompensated congestive heart failure, obesity, cellulitis of the lower extremities, weeping skin ulcers of the legs and severe rheumatoid arthritis. In addition, according to Brooklyn Hospital and the affirmation of its expert, Dr. Jeffrey M. Levine, Brooklyn Hospital's records show that prior to her next admission on September 26, 2006, she suffered from coronary artery disease, chronic afibrillation, bilateral leg cellulitis, hypertension, renal failure, severe bradycardia necessitating the placement of a pacemaker, repeat episodes of pneumonia, and stroke leading to quadreparesis and diabetes. Her medical history further included osteoarthritis, severe osteoporosis, syslipidemia, asthma, radiculopathy of her cervical and lumbar spines with a prior history of cervical cord compression, a prior history of gastrointestinal bleeding, and a prior history of poor medication compliance. According to the record, she had been bedbound since approximately the year 2000, was incontinent of bowel and bladder, and was totally dependent for all activities of daily living, including being turned in bed and being spoon-fed her meals.

During her admission to Brooklyn Hospital in the time period between September 24, 2006 and October 8, 2006, in addition to other co-morbidities, decedent was diagnosed with terminal congestive heart failure. In addition, on October 1, 2006, it was documented that Ms. Washington had a right buttock, stage III decubitus ulcer measuring 0.75 centimeter long x 0.5 centimeter wide x 0.00 centimeter deep. By October 6, 2006, it was documented that

she had three buttock decubiti, including a stage III and a stage II ulcer on her right buttock, and a stage II ulcer on her left buttock. On October 6th, 2006, Dr. Shaikh, Ms. Washington's primary care physician, documented that the decedent had urosepsis, impending septic shock, terminal congestive heart failure, generalized (10/10) pain, and a poor prognosis. Because of Dr. Shaikh's concerns regarding medicational non-compliance and failure to return to Brooklyn Hospital for medical follow-up treatment, Brooklyn Hospital's social worker attempted to schedule a family conference to discuss the potential of nursing home placement, and the doctors at Brooklyn Hospital, including Dr. Shaikh, recommended that she be admitted to hospice.

However, decedent's family, initially supportive of transferring Ms. Washington to a hospice, later refused to accept this advice, expressing a desire for "aggressive management." Consequently, on October 8, 2006, she was transferred to Lenox Hill, as she needed an evaluation to determine if her permanent pacemaker could be upgraded to an implantable cardioverter defibrillator (ICD) device–an invasive procedure which Dr. Shaikh informed the family was high-risk and would involve general anesthesia which could be life-threatening. On the date of the transfer, it was noted that her right buttock ulcer was oozing blood-stained drainage.

Upon her arrival at Lenox Hill, decedent was reportedly too lethargic to provide her history, which was provided from other sources. She had a fever of 101.6 degrees, an elevated white blood cell count, and hematuria. Cultures were taken of her blood and sacral decubitus ulcer, both revealing MRSA. Ms. Washington was diagnosed with bacteremia, an

infected sacral decubitus ulcer, and a suspected lower-lobe pneumonia. Further, it was documented that her stage III, right buttock/sacral decubitus was oozing serosanguineous fluid.

When seen by an infectious disease consultant at Lenox Hill, it was determined that Ms. Washington was too medically unstable to undergo the ICD insertion and would require a 4-6 week course of IV antibiotics. According to Lenox Hill, during her six-day admission, documentation shows that multiple skin protective measures were administered, including that she was placed on a pressure relief air mattress, was frequently turned and positioned, received timely and appropriate twice-a-day decubitus ulcer dressing changes (i.e., cleansed with normal saline and solosite gel, and a sterile gauze dressing applied), and received timely and appropriate IV antibiotics to treat her MRSA-infected decubitus. On October 13, 2006, Ms. Washington's sacral ulcer was noted as a stage III ulcer, with three stage II ulcers under this area.

On October 14, 2006, Ms. Washington, now septic, was transferred back to Brooklyn Hospital to complete the course of antibiotics, and remained there until November 5, 2006. At this point, she was also being treated for pneumonia and the infected sacral decubitis. The Brooklyn Hospital readmission documentation notes that she had a stage IV sacral decubitus, now 2 centimeters deep, with tunneling of 1 centimeter. Although in severe pain, she had adverse effects to the pain medication which was being administered, but her family reportedly refused to allow her to be given Morphine or consent to a transfer to hospice. Brooklyn Hospital alleges that Ms. Washington received a series of wound consults and

treatments, as well as extensive care rendered in response to her terminal condition.

Ms. Washington was then transferred back to Lenox Hill to be re-evaluated for an ICD device insertion. On admission, it was documented that the stage IV sacral ulcer measured 5.5 centimeters long by 5.5 centimeters wide by 2 centimeters deep. Upon re-evaluation by the electrophysiologist consultant, it was determined that she was too medically unstable to undergo an ICD procedure, and she was continually treated with IV antibiotics. According to Lenox Hill, during this 13-day stay, there was documentation showing that multiple skin protective measures were employed including frequent turning, placement on a pressure-relief mattress, timely decubitus ulcer dressing changes as described, and receipt of timely and appropriate IV antibiotics. On November 16, 2006, her Stage IV sacral decubitus measured 6 centimeters by 9 centimeters by 2.5 centimeters deep. She was transferred back to Brooklyn Hospital on November 18, 2006 to undergo antibiotic and decubitus treatments.

Treatments at Brooklyn Hospital are alleged to have continued for the admission of the period between November 18, 2006 and December 6, 2006. As noted on admission, she was at that time suffering from a Stage IV sacral ulcer, as well as from MRSA bacteremia secondary thereto, a urinary infection, severe anemia, terminal congestive heart failure, and acute renal failure. Although she reportedly expressed a wish to be allowed to die, her family pressed for further treatment, and in deference thereto, Brooklyn Hospital performed further procedures, including a sacral debridement on December 6, 2006. Her family permitted her to be discharged to a nursing home on December 6, 2006.

On April 18, 2007, Ms. Washington was transferred back to Brooklyn Hospital upon developing a fever, possibly due to an infected pacemaker. She was admitted with multiple pre-existing skin ulcers, including a sacral stage IV, which, per the physician's notes, showed improvement while she remained a patient. A PEG feeding tube was inserted into her abdomen, as she was unable to swallow. She was discharged back to the nursing home, with the authorization of her family.

Ms. Washington's final admission at Brooklyn Hospital took place on February 8, 2008 as a result of a malfunction of the feed tube and which required replacement. On her second day, she suffered cardiac arrest but because there was no DNR on file, the doctors revived her. Ten minutes later, she coded again but could not be revived. An autopsy, the performance of which was insisted upon by the family, found that Ms. Washington, age 72.5 years, died of natural causes, hypertensive and atherosclerotic cardivascular disease.

Brooklyn Hospital's Contentions

On its motion, Brooklyn Hospital contends that as the gravamen of the plaintiff's complaint involves the diagnosis and specialized medical treatment of decubiti, the causes of action, in reality, sound in medical malpractice and for that reason, a medical expert's opinion is required. Accordingly, it provides the expert affirmation of Jeffrey Levine, M.D. in support of its motion. It further contends that the fact that a wound occurred does not, without more, create a presumption that the physician was negligent, and that in order to establish liability, plaintiff must present proof in evidentiary form that Brooklyn Hospital departed from the standard of care and that such departure was the proximate cause of

decedent's allege injuries–to wit, skin ulcers. Based upon Dr. Levine's affirmation, Brooklyn Hospital contends that it has made a prima facie showing that it did not depart from good and accepted medical practice.

Dr. Levine's Affirmation

Dr. Levine states that he is a physician duly licenced to practice medicine in the State of New York, and is Board Certified in both internal medicine and geriatric medicine, and is a wound care specialist. He further states that he is familiar with the standards for the prevention and treatment of skin ulcers, and that after reviewing the pleadings and deposition transcripts and Ms. Washington's extensive medical records from both Brooklyn Hospital and Lenox Hill, concludes that within a reasonable degree of medical certainty, there were no departures from good and accepted medical practice by Brooklyn Hospital.

He first addresses the "injuries" alleged and disputes the factual basis for some of them, specifically finding that records from November 12, 2006 show a negative finding for sacral steomyelitis by the attending physician. He further assails as nonsensical, plaintiff's allegation, as injuries, the multiple diagnoses for which decedent was admitted to Brooklyn Hospital. In addition, he notes that plaintiff has alleged the development of only two specific pressure sores as caused by the negligence of Brooklyn Hospital for time specific periods only–specifically, that since plaintiff begins with the admission of 9/24/06, lists six subsequent admissions, and ends with decedent's death on the second day of an admission that began on February 8, 2008, plaintiff bypasses any discussion of her prior extensive, significant and contributory health history, including prior admissions to Brooklyn Hospital.

Dr. Levine alleges that there is thus no discussion of decedent's pre-existing skin ulcers resulting from hypoperfusion, venous stasis disease, cardiac disease, longstanding non-compliance with follow-up appointments and taking prescribed medications, decedent's development of diabetes mellitus (which promotes the development and retards the healing of skin ulcers) and her rheumatoid arthritis which required the administration of steroids which cause the thinning of the skin and blunting of the immune system, and a diagnosis of spinal cord disease which causes similar risk for development of skin ulcers.

Further contributory pathologies noted by Dr. Levine include: parapalegia resulting from "syrinx" of the spinal cord[1] and multiple vertebral discs bulging into the spinal canal; and poor nutritional status resulting from poor oral intake resulting from her underlying illnesses, particularly congestive heart failure. He states that all such cumulative illness and comorbidity leads to unavoidable pressure ulcers when patients take a turn for the worse and death is impending, and is known to experts in the field as "Skin Changes at Life's End," or SCALE. He notes that long before the admission of 9/24/06, decedent had suffered cyclical pressure ulceration to the sacrum, having the effect of weakening the skin and increasing the recurrence of skin damage even if all preventive measures are taken, which is what occurred in this case.

Other allegations of plaintiff challenged by Dr. Levine as spurious include: (1) a left-anterior thigh pressure ulcer, as not mentioned in the Brooklyn Hospital record or in the

[1]"Syrinx" is defined as cyst caused by obstruction of spinal fluid that can expand and cause permanent irreversible spinal cord damage.

autopsy study, and which, in any event, is an unlikely location for a pressure ulcer as it is not over a bony prominence; (2) failure to supervise for injury and infection, as decedent was not shown to have suffered any physical traumatic injury and all infections were followed by infectious disease specialists; and (3) although "death" is alleged as an injury, the report of the autopsy, undertaken at the insistence of the family, reflected a determination that the patient's death was as a result of her long-standing atherosclerotic heart disease, and entirely unrelated to skin ulcers. Dr. Levine emphasizes that the ulcers were unavoidable due to her severe underlying conditions, that the skin is an organ that is subject to failure, and that frequent turning in a situation such as this will not prevent decubiti, and in his affirmation, he focuses on each admission, beginning on 8/13/04, noting decedent's progressive deterioration and the presence of pre-existing skin ulcers. He thus finds, upon his review of the patient's history, that she suffered from chronic skin ulcers, particularly in the legs and sacrum, that she entered Brooklyn Hospital with a strong history of such wounds, that they were a direct consequence of her own co-morbidities and risk factors, as noted, and that her progressive deterioration was a direct result of her underlying pre-existing diseases and did not implicate negligence by care-givers.

Lenox Hill's Motion

In support of its motion for summary judgment, Lenox Hill provides, and bases its contention that it acted in accordance with the standard of good and accepted medical practice on, the affirmation of Dr. Barbara Katzeff, an internist and geriatrician, who opines within a reasonable degree of medical certainty that Lenox Hill did not depart from the

standard with regard to the care it rendered to Ms. Washington. Referring to her extensive medical history prior to her arrival at Lenox Hill on October 8, 2006, Dr. Katzeff notes that the results of cultures taken of her blood and the sacral decubitus ulcer revealed infection with MRSA, and that the record reveals oozing from the wound, and that the infectious disease consultant immediately began treating her with IV antibiotics.

Dr. Katzeff, who states that she has reviewed the entire record involving decedent's condition and care, as well as the pleadings and deposition testimony herein, asserts that there is documentation showing that during her first (six day) admission in Lenox Hill, she was placed on a pressure relief air mattress, was frequently turned and positioned, and received timely and appropriate dressing changes twice a day. Further, during her second (13 day) admission to Lenox Hill, from November 5 to November 18, 2006, she was treated with IV antibiotics for her urinary tract infection and likely still-infected stage IV sacral decubitis. Again, she finds documentation that appropriate protective and treatment measures were taken in response to decedent's sacral decubitis. She opines that Ms. Washington did not develop any decubitis ulcers while she was in Lenox Hill. Rather, she opines that the medically unstable and critically ill patient, who had a poor prognosis, was initially transferred on October 8, 2006 to Lenox Hill with buttock/sacral decubiti. She further opines that Lenox Hill acted in accordance with good and accepted medical practice in treating her wounds, and that in her expert opinion, the decedent's multiple pre-existing medical condition and her then severely compromised, medically unstable, critically and terminally-ill condition, made it excessively difficult to improve and/or heal her decubiti, even with the

most vigilant, timely and appropriate skin care preventive and treatment measures provided by Lenox Hill's staff.

Plaintiff's Opposition

In opposition to Brooklyn Hospital's motion, plaintiff, in opposition, disputes a number of claims raised therein by providing the redacted affirmation of her expert.

Plaintiff's expert states that he or she holds Board Certification in Internal Medicine and Emergency Medicine; claims thorough familiarity with the standards for the prevention and treatment of decubitus ulcers and skin ulcers; and states that he or she has reviewed decedent's medical records for both defendant hospitals, as well as non-party Green Park Nursing Home, and all pleadings and deposition transcripts. Based thereon, he or she opines within a reasonable degree of medical certainty that the care and treatment of decedent was not in accordance with good and accepted medical practice and that Brooklyn Hospital's staff deviated from the standard.

Addressing Dr. Levine's discussion of decedent's hospital admissions prior to 2006, the expert states that there is a failure to note that while the records for 2005 and 2006 reveal that she had a documented stage II sacral pressure ulcer, which had healed as of January 2006, he fails to note that records for the April 2006 admission reveal that the skin was intact with no skin breakdowns. The expert further challenges Dr. Levine's assertion that decedent's diabetes was a causative or contributing factor of the ulcers, claiming that "it is a well-known medical fact" that diabetes in and of itself does not cause decubitis ulcers, and that "patients who develop pressure ulcers do, with the proper medical and nursing treatment,

that resolution of the pressure ulcers" [sic]. With regard to Dr. Levine's assertions that the ulcers were the unavoidable result of several noted co-morbidities, the expert states that Dr. Levine ignores the fact that there is no showing, based upon the entire time frame, that decedent was facing impending death. On similar grounds, he or she challenges the assertions regarding the role played by "terminal" congestive heart failure, diagnosed at the time of her admission on September 24, 2006, noting that she lived for an additional one year and five months.

After summarizing the contents of voluminous medical records, the expert opines within a reasonable degree of medical certainty that the sacral decubitus ulcer developed at Brooklyn Hospital during the admission of September 24, 2006 due to the deviations from good and accepted medical practice of its medical personnel. Stating that it is a well-known fact that there are risk factors involved with patients such as Ms. Washington, and that friction, immobility, inactivity and nutritional deficits play a role in her care, the expert asserts that such risk factors were not identified in her case, and alleges that nothing was done by Brooklyn Hospital with regard to her immobility. Among the various modalities of treatment alleged by the expert to be necessary is that the head of the bed should have been at or below 30 degrees. It is opined that the deviations cited were a proximate cause of the development of pressure ulcers on the sacrum, buttock and thigh, and that had the proper methods and measures been undertaken, the pressure ulcers would not have occurred. Elsewhere in the affirmation, the expert opines that the turning and positioning noted in the records was inconsistent and therefore "questionably insufficient" throughout the decedent's

stays and as such was a departure and a "substantial factor contributing to the plaintiff's decedent's Stage 4 pressure sores, infection, pain, suffering and death."

The expert asserts that the records do not show that any wound care rounds took place during the admissions, and that their absence was a departure and a substantial causative factor. He or she challenges Dr. Levine's assertion that certain underlying conditions may make certain patients more susceptible to developing pressure ulcers as unsupported. Rather, he or she concludes within a reasonable degree of medical certainty that decedent's medical history did not render the deterioration of a pressure sore clinically unavoidable.

Similarly, plaintiff's expert finds deviations from good and accepted medical practice on the part of Lenox Hill in failing to identify certain risk factors, such as the patient's right-side paraplegia and her immobility, that called for intervention, that she should have been re-positioned every two hours or more, that her postural alignment, balance and stability should have been considered, and the head of the bed should have been at or below 30 degrees. The expert further finds that it is not clear from the record that decedent's nutritional needs were properly monitored or addressed during her admissions to Lenox Hill. He or she opines that decedent's history did not render the deterioration of a pressure sore clinically unavoidable, and that Lenox Hill's deviations from good and accepted medical practice led to the deterioration of the sacral decubitis ulcer and subsequent bacteremia from the infected sacral decubitus ulcer.

Defendants' Replies

In reply, Brooklyn Hospital asserts that as a matter of law, plaintiff's expert lacks the

qualifications to render opinions on the subject of skin ulcers, and provides a second affirmation of Dr. Levine, wherein he challenges the opinions rendered by her expert as conclusory and speculative and based upon mischaracterizations and misrepresentations, as well as on the ground that he or she fails to address his notation that while decedent had indeed suffered ulceration to the sacrum long before the 9/24/06 admission, and that her wounds were documented to occur and then heal, the resultant skin damage made recurrence of ulceration more likely. He assails the expert for confusing two separate wound issues, namely, non-healing ulcers, for which there may be many systemic reasons, and unavoidable ulcers, which are wounds which develop when all preventive interventions are put into place. Among several other challenges to plaintiff's expert, Dr. Levine notes that (1) while the expert questions any diagnosis of terminal condition (congestive heart failure) made over a year before her death, he or she ignores the facts that she was accepted into a hospice program immediately upon her September 24, 2006 admission which, by definition, accepts patients with a prognosis of six months or less to live, and she was kept artificially alive by the insertion of a feed tube, at the family's behest; (2) the expert's opinions regarding diabetes are a gross oversimplification of the role the disease plays in causing and/or contributing to the formation of skin ulcers; (3) his or her opinion that the patient's head should have been tipped at a 30 degree angle lacks efficacy, as such would have resulted in suffocation; (4) his or her insistence that pressure ulcers always heal with proper medical and nursing treatment is in direct contravention with the most recent consensus of the National Pressure Advisory Panel that no single interventional strategy reduces pressure ulcer

incidents to zero; and (5) the physician advocates nonexistent standards of care, fails to identify when the deviations took place, and refuses to address the existence of decedent's preexisting chronic illnesses.

In its reply, Lenox Hill notes that plaintiff did not submit, as an exhibit, a certain position statement published by the Wound Ostomy and Continence Nurses Society (WOCNS), a peer-accepted society that refutes the assumption that all pressure ulcers are avoidable. It further points out that decedent was admitted to Lenox Hill with preexisting pressure ulcers, and that as pointed out by Dr. Katzeff in her affirmation, given her severely compromised medical condition, the small amount of deterioration of her pressure ulcers was unavoidable and not due to any malpractice. Finally, based on Dr. Katzleff's factual findings upon her review of the medical record, Lenox Hill disputes plaintiff's assertions that it did not render treatment for pressure ulcers that deviated from good and accepted medical practice.

DISCUSSION

The burden on a motion for summary judgment rests initially upon the moving party to come forward with sufficient proof in admissible form to enable a court to determine that it is entitled to judgment as a matter of law. If this burden cannot be met, the court must deny the relief sought (CPLR 3212; *Zuckerman v City of New York*, 49 NY2d 557 [1980]). However, once a moving party has made a prima facie showing of its entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the

action" (*Garnham & Han Real Estate Brokers v Oppenheimer*, 148 AD2d 493 [1989]; *see also Zuckerman,* 49 NY2d at 562). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat the motion (*Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966 [1988]).

The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (*see Holbrook v United Hosp. Med. Ctr.*, 248 AD2d 358, 359 [1998]). Although for a plaintiff to prevail on a medical malpractice claim, "(e)xpert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause" (*Nichols v Stamer*, 49 AD3d 832, 833 [2008], quoting *Lyons v McCauley*, 252 AD2d 516, 517 [1998]), "[o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant...has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Chance v Felder*, 33 AD3d 645, 645 [2006] [internal quotation marks and citations omitted]; *see Hernandez-Vega v Zwanger-Pesiri Radiology Group*, 39 AD3d 710, 711 [2007]). In opposition, a plaintiff must submit material or evidentiary facts to rebut the defendant's *prima facie* showing that he or she was not negligent in treating the plaintiff (*Langan v St. Vincent's Hosp. of New York,* 64 AD3d 632, 633 [2009]). Moreover, it is well-settled that unless such evidence is found to be speculative or conclusory (*see Callistro v Bebbington,* 94 AD3d 1208 [2012]), "[s]ummary judgment may not be awarded in a medical malpractice action where the parties adduce conflicting opinions of medical experts. When

experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution" (*Shields v Baktidy,* 11 AD3d 671, 672 [2004] [citations omitted]; *see also Feinberg v Feit,* 23 AD3d 517, 519 [2005]; *Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 [2003]). However, it is equally well-settled that "[g]eneral, conclusory allegations of medical malpractice, based on speculation or unsupported by competent evidence, are insufficient to meet plaintiff's burden and defeat summary judgment" (*Chase v Cayuga Med. Ctr. at Ithaca*, 2 AD3d 990, 990–991 [2003]).

As a threshold matter, the court rejects Brooklyn Hospital's challenge to plaintiff's expert's affirmation based upon his or her purported lack of qualifications. As is the case here, "[o]nce a medical expert establishes his or her knowledge of the relevant standards of care, he or she need not be a specialist in the particular area at issue to offer an opinion. Any lack of skill or expertise goes to the weight of his or her opinion as evidence, not its admissibility" (*Texter v Middletown Dialysis Center, Inc.*, 22 AD3d 831[2005]).

Based upon Dr. Levine's and Dr. Katzeff's expert affirmations which contain non-conclusory opinions supported by reference to the record, both Brooklyn Hospital and Lenox Hill have established, *prima facie*, their entitlement to judgment as a matter of law by demonstrating that there were no departures from good and accepted medical practice, or that any departure as might be found to exist was not a proximate cause of the decedent's injuries and death (*see Barnett v Fashakin,* 85 AD3d 832 834 [2011]; *Stukas v Streiter,* 83 AD3d 18, 20-21 [2011]), thus shifting the burden to plaintiff to raise an issue of fact. Such issue of fact has been raised based upon the conflicting opinions, as set forth above in detail, as presented

by a qualified expert. In view of the aforementioned clear mandate that "[c]onflicting expert opinions may not be resolved on a motion for summary judgment" (*Pittman v Rickard,* 295 AD2d 1003, 1004 [2002]), the issue of whether either or both defendant hospitals were negligent at the time of decedent's admissions, as well as the issue of whether such negligence proximately caused her injuries, is properly left for the trier of fact (*see generally Brown v State of New York*, 192 AD2d 936, 937-938 [1993], *lv denied* 82 NY2d 654 [1993]). Accordingly, the court denies both defendants' motions for summary judgment.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.

HON. LAURA JACOBSON

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