SUPREME COURT STATE OF NEW YORK
COUNTY OF BRONX TRIAL TERM - PART 15

PRESENT: Honorable Mary Ann Brigantti

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DESIREE THOMAS, as Administratrix of the Estate of SARAH THOMAS, and DESIREE THOMAS, Individually,

Plaintiff,

-against-

DECISION / ORDER
Index No. 21364/2014E

RONALD ST. LOUIS, M.D., et als.,

Defendants

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The following papers numbered 1 to 5 read on the below motion noticed on October 28, 2016 and duly submitted on the Part IA15 Motion calendar of **April 6, 2017**:

Papers Submitted	Numbered
Defendant's Notice of Motion, Exhibits	1,2
Pl.'s Opp., Exhibits	3,4
Defendant's Reply Aff.	5

Upon the forgoing papers, defendant Ronald St. Louis, M.D. ("Defendant") moves for summary judgment, dismissing the complaint of the plaintiff Desiree Thomas, as Administratrix of the Estate of Sarah Thomas ("Plaintiff"), entering judgment in Defendant's favor and deleting Defendant from the caption, pursuant to CPLR 3212. Plaintiff opposes the motion.

I. Background

This is a medical malpractice and wrongful death action commenced on behalf of decedent Sarah Thomas ("decedent"), who was a long time resident at defendant Beth Abraham Health Services ("Beth Abraham") nursing home beginning in the early 2000's up until the date of her death on December 20, 2013. Decedent had an extensive medical history including, among other things, hypertension, gallstone pancreatitis, GERD, diabetes, gout, acute renal failure, and morbid obesity. This action seeks damages due to Defendant's alleged medical malpractice in failing to prevent the development and subsequent deterioration of a sacral pressure ulcer, coccygeal pressure ulcer, right buttock pressure ulcer, and left buttock pressure ulcer during decedent's admission at Beth Abraham from June 1, 2012 through July 11, 2013, and from July 30, 2013 through December 20, 2013. Plaintiff's bill of particulars alleges that

Defendant, decedent's attending physician at Beth Abraham, deviated from good and accepted medical practice by, among other things: failing to perform proper risk assessment of decedent for development of pressure ulcers; failing to perform an adequate skin assessment; failing to employ the required vigilance and diligence necessary to prevent skin breakdown; failing to institute and follow the plan of care; allowing plaintiff's decedent to develop multitude pressure ulcers; failing to treat multiple pressure ulcers; failing to timely order and follow up on the implementation of a turning and positioning regimen; failing to order pressure relief devices; failing to evaluate nutritional needs; causing serious and irreversible complications from pressure ulcers; failing to order follow up consultations; and failing to timely order debridement procedures.

Defendant submits Plaintiff's medical records in support of his motion. In or around August 2011, while she was a Beth Abraham resident, it was noted that decedent had a pressure ulcer stage II to her left buttock. Dr. Sergei Kochlatyi performed wound evaluation and treatment. On August 31, 2011, a nursing wound care note indicated a stage III pressure ulcer on the sacrum measuring 1.8 x 0.8 x 0.3 cm. Another nursing note indicated that decedent refused to be repositioned in bed. Dr. Kochlatyi and his wound care team continued treatment. At this time, decedent's primary care physician was Dr. Amit Saxena. The doctor noted on July 6, 2012, there remained a stage III sacral pressure ulcer and decedent was referred to occupational therapy. On October 12, 2012, decedent was evaluated and treated with "bunny boots" to her bilateral feet while in bed and peri guard ointment to buttocks as a prophylaxis. A Care Plan Report indicated that decedent's skin was intact with treatment to bilateral buttocks ongoing for rash.

On December 28, 2012, Dr. Saxena noted a stage II decubitus ulcer in the sacral area and ordered treatment. On January 15, 2013, Dr. Kochlatyi noted a stage II ulcer to the left buttock - later measured at 1 x 0.8 x 0.3 cm. Later that month, Dr. Kochlatyi noted that decedent had "diminished peripheral pulses" under the "vascular" treatment note, and the ulcer was later measured at 1.4 x 1 x 0.3 cm. Defendant cites further treatment of this ulcer and medical notations indicating that decedent refused to be repositioned on several dates in March, April, May, June, and July 2013. Defendant further notes that weekly skin assessments were performed by staff and it was ordered that decedent be turned and positioned every two hours as a

preventative measure and for wound healing/prophylaxis. However, these orders were not administered on several occasions in February, March, April, May, June, and July 2013 because decedent refused such treatment. On July 9, 2013, it was noted that decedent had a stage III left buttock decubitus ulcer at 4.0 x 4.3 cm with a depth of 0.2 cm. Dr. Kochlatyi recommended, among other things, urgent surgical evaluation. Decedent was then admitted to Montefiore Medical Center ("Montefiore") from July 11 to July 30, 2013 because of fever, leukocytosis, and altered mental status believed to be caused by infection of the sacral pressure ulcer. On July 12, 2013, it was noted that decedent had a pressure ulcer on the left buttock stage III 4 x 5 x 2 cm, and a left ischial stage IV pressure ulcer 4 x 4 x 2 cm with tunneling and undermining. She underwent a surgical procedure on July 17, 2013, involving a major sharp excisional debridement and irrigation hemostatis and packing of the left buttock wound. An attending infectious disease note on July 19, 2013 assessed decedent with, among other things, severe sepsis on top of chronic cellulitis/soft tissue infection of the sacral decubitus ulcer with development of gas gangrene, as well as leukocytosis, anemia, and elevated ESR (erthrocyte sedimentation rate), RF and CRP (C-Reactive protein) due to the chronic soft tissue infection and gangrene. The infectious disease physician recommended continued local area of the decubitus ulcer and continued medications.

Medical records indicate that doctors had a long meeting with decedent's daughter Paticea Thomas concerning decedent's worsening condition, poor oral intake, and chronic infection. On July 30, 2013, a social worker wrote that the daughter would make decisions on behalf of decedent when decedent was unable to do so. The hospital discharge summary noted that decedent had a host of prior medical complications during her prior stay at Beth Abraham's facility. Multiple discussions were had with Paticea Thomas concerning goals of decedent's care and possible hospice / "do not rescucitate" agreement, but no decision was made at that time.

Decedent returned to Beth Abraham on July 30, 2013 and Paticea became decedent's health care proxy. On that date, Defendant first began treating decedent as her attending physician. Defendant was aware of decedent's medical history and had discussions with Paticea regarding the need for a feeding tube, Paticea refused to have a feeding tube implemented. Upon her readmission, decedent had a stage IV left buttock pressure ulcer measuring 5 x 4 cm, and a second ulcer, intergluteal folds, at the sacrum at stage III, 3 x 3 cm. Defendant testified that he

implemented a plan in order to treat these ulcers including turning and positioning, getting her out of bed as tolerated, bunny boots, and hydrogel applications. On July 31, 2013, it was noted that decedent had (1) a left sacral stage IV ulcer measuring 7 x 6 x 3 cm; (2) a midline sacral decubitus ulcer stage III 2 x 2 x 0.8 cm, and (3) left and right lower buttock excoriations. Defendant on the same date further noted an inter-gluteal fold/sacral with stage III 3 x 3 cm bilateral buttock excoriation. While decedent's mental status had improved, it was not baseline. It was further noted that decedent's daughter declined a gastrostomy tube placement. Defendant thereafter ordered various treatment including weekly skin assessments/ evaluations. Decedent's health had been declining over the last two months as she had stopped eating and lost some 60 pounds, and her cognitive status had not improved.

In early August 2013 Defendant and his staff had discussions with decedent's daughter about possible hospice care, given decedent's poor prognosis. Hospice care then began on August 3, 2013, and it was noted that decedent was terminally ill with a life expectancy of six months or less if the illness ran its course. Decedent had been refusing to eat with a feeding tube and the family was seeking only comfort care at that point. Defendant testified that in early August he had an informal meeting with Paticea concerning hospice and the goals of care given decedent's refusals to treat. He noted that the goals of hospice admission were palliative comfort care. Treatment notes indicate that decedent was only consuming 20 - 50% of her meals while having difficulty swallowing, and she was refusing feeding tube placement and did not want to be dialyzed despite failing kidneys. Decedent underwent treatment for various conditions while in hospice care. Nursing notes indicate that decedent was refusing fluids and repeatedly saying "I want to die, leave me alone I just want to die. I don't want anything." On August 14, 2013, Paticea signed a do not resuscitate/intubate form designating comfort care as the main aim of medical treatment going forward.

Defendant and staff continued treatment thereafter, with Dr. Kochlatyi providing weekly wound care as he did in decedent's admission prior to her hospitalization. On August 20, 2013, he noted a stage IV open wound to the muscle of the left medial buttocks/sacral area was 4 x 3.3 x cm, mostly covered with granulation tissue with significant undermining. The wound to the coccyx was 1 x 0.7 x 0.3 cm stage III. Decedent continued to refuse all oral intake including medications and I-V fluids. On September 17, 2013, a wound evaluation and treatment note

indicated a stage IV wound at 2.8 x 3.0 x 2.0 cm with significant undermining, with poor potential for healing. An abrasion over the right dorsal third toe had healed. Prior to that, Defendant's staff ordered a psychological consult and general surgery consult. Defendant continued treatment in September 2013, and he discussed decedent's poor prognosis with decedent's daughter. Decedent continued to refuse medications and had poor oral intake of nutrition. On October 7, 2013, the left buttock/sacrum wound was noted at stage IV and extended to the level of subcutaneous tissue, making it recalcitrant chronic stage IV. The wound to the right buttock was stage II, and another ulcer to the left buttock was 0.8 x 0.7 x 0.1 cm stage II. Later that month, Defendant noted that decedent had poor/erratic PO intake and wound care healing was severely compromised as a result. On October 27, 2013, Defendant noted a foul odor from the left buttock stage IV ulcer which was draining serosanguineous discharge. She was encouraged to consume Suplena and prostat for added nutrition, but her prognosis remained poor. Defendant and the wound care team continued to treat decedent.

In November 2013, Defendant noted that decedent continued to have poor PO intake and her daughter continued to decline gastronomy tube placement. Dr. Kochlatyi indicated a wound to the left buttock/sacrum a 3.3 x 2.5 x 1.5 cm extending to the muscle, stage IV with significant undermining, and a wound to the right buttock at 4.0 x 2.0 x 0.2. On December 11, 2013, Defendant saw decedent due to her poor PO intake and reports of nausea, vomiting, and diarrhea. She was started on an antibiotic. Defendant then discussed decedent's condition with Paticea, who indicated she wanted comfort care measures only at that time. Decedent continued to resue medications, although she was more adherent with medication when her daughters were present. Her overall prognosis remained very poor. The last wound evaluation/treatment by Dr. Kochlatyi was on December 17, 2013, where he noted left buttock/sacrum wound, stage IV, and right buttock wound. Defendant continued to treat decedent until December 20, 2013, when she passed away.

In support of his motion, Defendant provides an affirmation from Frederick A. Smith, M.D. Dr, Smith opines that, within a reasonable degree of medical certainty, the care Defendant provided during decedent's final admission at Beth Abraham was in accordance with the standard of care at such a facility. He opines that the development of pressure ulcers and the death of decedent were unavoidable and predictable in spite of good care she received during her

final admission. The ulcers were predictable due to (1) decedent's bedbound status, despite maximal measures to reduce pressure point loads; (2) her general inflammatory state, as noted by doctors during her admission at Montefiore in July 2013; (3) anorexia and malnutrition coupled with a hypercatabolic state; (4) type II diabetes mellitus, steroid use, poor food intake, catabolic protein-wasting and hyperalbuminemia which impeded healing of otherwise well cared for skin pressure ulcers, and (5) severe secondary pulmonary arterial hypertension which subsequently caused hypotension and hypoxia. Dr. Smith alleges that the progression of ulcers and death resulted from decedent's condition prior to her final admission to Beth Abraham, in conjunction with her own refusals to consume nutrition, take I-V fluids, be administered medications, treatment, and her refusal to be turned and positioned. He further explains that the goal of treatment during the final admission was comfort care in hospice. He states, "[w]ith this comes the understanding that patient is likely to die within a certain amount of time, which from a Medicare standpoint is six months, but could be extended to 2-3 month intervals if decline with death is still expected." Defendant made appropriate orders throughout admission to alleviate sores, prevent future sores. Decedent often refused nutrition, and her pre-existing conditions and other risk factors led to her eventual death.

Defendant argues that, in light of the foregoing, he is entitled to summary judgment as decedent's injuries and death were not proximately caused by any act or omission of Defendant.

Plaintiff opposes the motion. She initially argues that Defendant failed to meet his burden of proof and has only provided speculative remarks to the court regarding the treatment of decedent without any definitions of the standard of care that should have been afforded to her. Plaintiff also submits a redacted affirmation from her expert, who is a physician board certified in Internal Medicine, Geriatric Medicine, and a Diplomate of the national Board of Medical Examiners. S/he reviewed decedent's medical records and alleges that despite the fact that decedent's risk of developing a pressure ulcer was increasing during her years of Beth Abraham admission, she was not noted as a high risk for ulcers until October 7, 2013. Records from August 2012 indicate both the presence of stage III sacral pressure ulcers and no pressure ulcers whatsoever. Pressure ulcers were noted on December 28, 2012 and treatment was ordered. On January 3, 2013, it was noted that decedent's functional status required one person assist with personal hygiene and dressing and two staff assist for transfers, bathing, and toileting. On

January 10, 2013, a note indicated that decedent frequently complained of pain to her buttocks and a dietary progress note from the same date indicated a sacral area opening as "PU Stage 2" and that resident is at risk for fluid deficit. A note from January 12, 2013, indicated decedent had been free from UTI and pressure ulcers that quarter. Later January 2013 notes indicate the presence of pressure ulcers on a plan for proper nutrition and treatment. Further records in February 2013 reveal the existence of pressures and treatment in response, while other records note that decedent's skin was "intact" with no indiction of pressure ulcers. Progress notes commencing February 27, 2013, however, indicate left buttock pressure ulcer measuring 1.6 x 1.3 x 0.3 cm, and the use of pillows for positioning and alternating surface while decedent was in bed. This ulcer continued to be present in progress notes dated March 22, 26, and April 4, 2013. On April 19, 2013, progress notes indicate the existence of a stage II sacral pressure ulcer being treated with hydrogel. An April 21, 2013 progress note indicates that decedent's left buttock ulcer is at stage IV and worsening. On April 25, 2013, a palliative care consult took place with decedent's daughter Pat, who wanted to keep decedent alive by any and all medical means and full code remained in place. The left buttock ulcer was noted in later medical progress notes. On June 12, 2013, a nursing progress note indicates that the ulcer was at stage III and decedent was noncompliant with turning and positioning continuously. On June 29, 2013, a nursing progress behavior note indicates that decedent is verbally abusive and experiencing hallucinations. Under "MD Interventions, "N/A" is marked. A June 30, 2013 note indicates that buttock pressure ulcer is worsening, measuring 3.0 x 2.0 x 02 cm, and decedent was non-compliant. The ulcer continued to worsen and decedent was eventually referred to general surgery for debridement.

On July 11, 2013, decedent was transferred to Monefiore at the request of her daughter based on a change in condition/ altered mental status. Upon admission, a stage IV pressure ulcer measuring 4 x 5 x 2 cm with purulent discharge was documented. Decedent's albumin levels were documented upon admission as 2.5 g/dl. On July 30, 2013, decedent was transferred back to the care of Beth Abraham, wherein it was noted that decedent was totally dependent in bed mobility, transfers, dressing, toileting, and eating. Upon re-admission, the left buttock pressure ulcer was at stage IV with significant tunneling, undermining, and drainage. Her sacral ulcer was noted as a stage II. Debridement of that ulcer took place on July 17, 2013. The medical progress notes indicate that a left sacral pressure ulcer stage IV measuring 7.0 x 6.0 x 3.0 and midline

stage III sacral pressure ulcer measuring 2.0 x 2.0 x 0.8 cm. There was further notation from this date that collagenase is not to be used for the left buttock wound (Dakins only), and the would care team was to reevaluate.

On July 31, 2013, Defendant ordered decedent a renal diet and a dietary supplement which continued through the date of her death. Decedent was accepted to hospice on August 3, 2013. It was noted at the time that decedent was not eating or drinking and was being monitored. Blood test from August 9, 2013 indicated an abnormally low albumin level of 2.3 g/dl. Behavioral notes state that decedent is "wishing to die/refusing meds" and MD intervention is marked as "N/A" with nurse manager made aware. August 26, 2013 wound care evaluation notes indicate a stage III pressure ulcer at the coccyx measuring 0.8 x 0.5 x 0.2cm, and left buttock ulcer is indicated as a stage IV ulcer measuring 3.5 x 3.0 x 2.5 cm. On September 3, 2013, it was noted that the coccyx pressure ulcer had healed, and the stage IV left buttock ulcer is measured at 2.8 x 3.0 x 2.0 cm.

On October 8, 2013, a nursing weekly ulcer/wound flow sheet indicated that decedent had a left buttock ulcer measuring 0.8 x 0.7 x 0.1 cm and a right buttock ulcer measuring 4.0 x 1.7 x 0.1 cm. This record indicated a total of four pressure ulcers on decedent's body: (1) stage IV left buttock/ sacral ulcer; (2) stage II right buttock pressure ulcer; (3) stage II left buttock ulcer; (4) an abrasion over right dorsal third toe. The etology of each of the ulcers was "pressure." Defendant ordered a supplemental nutrition in the form of prostat on October 11, 2013. Blood tests continued to show abnormally low albumin levels.

On November 6, 2013, a note indicates that the left buttock pressure ulcer was healed. Another note indicates that the left posterior/sacrum buttock pressure ulcer is stage IV measuring 2.8 x 2.4 x 1.5 with current treatment as calcium alginate OD PRN. A nursing progress note also indicates medial buttock pressure ulcer is at stage III measuring 4.0 x2.0 x 0.2 cm. On November 10, 2013, it was noted that decedent's left buttock was oozing blood, and Defendant ordered that decedent be "log rolled and not pull during repositioning." A Nursing Braden Scale Assessment on November 11, 2013, indicated a total Braden Score of 12 or "high risk" for decedent.

Further records from November 2013 indicate the presence of the stage IV left buttock ulcer, and a right buttock stage III pressure ulcer. A pain evaluation assessment indicated no

history of pain management for chronic conditions, despite prior pain management orders and decedent's generalized pain over the years. On November 27, 2013, Defendant authored a medical note indicating that decedent was vomiting after drinking fluids and was refusing meals and supplements. The note also states that decedent's daughter was not interested in placement of a feeding tube, and decedent was in hospice care with a goal of palliative/comfort care, and had a poor overall prognosis. A 2-hour turning and positioning chart is implemented from December 1, 2013 through December 19, 2013. A report of wound evaluation treatment note dated December 17, 2013 indicates a left buttock/ sacral pressure ulcer at stage IV measuring 2.7 x 2.3 x 1.3 cm, and a right buttock pressure ulcer at 3.7 x 1.6 x 0.2 cm, stage III. Decedent expired on December 20, 2013. The expert notes that a Narcotic Inventory and Count record for decedent indicates that Morphine Sulphate was provided to decedent from December 22, 2013 through January 7, 2014, after decedent's death. Another record indicated an unknown 90 ml dosage of morphine was provided to decedent starting December 18, 2013 through January 7, 2016.

Plaintiff's expert opines that Defendant deviated from good and accepted medical practice, and that deviation resulted in decedent's development and deterioration of multiple pressure ulcers. S/he first alleges that decedent was not properly nourished nor hydrated while under Defendant's care, and considering decedent's abnormally low Albumin levels, Defendant should have ordered additional consults and/or tests. The expert also alleges that it was unrelieved pressure, and not decedent's declining medical condition and extensive co-morbidities, that caused decedent's pressure ulcers. S/he contends that Defendant was on notice of decedent's medical history and fully aware of what was needed for proper care and treatment, including proactive and preventative care, to avoid the development of pressure ulcers. S/he states that Beth Abraham deviated from good and accepted practice by failing to monitor and address the various issues, and this deviation from good and accepted practice was a proximate cause of the development and subsequent deterioration of decedent's pressure ulcers. The expert notes that decedent was capable of healing from pressure ulcers, and her various co-morbidities did not cause the ulcers. Further, in light of decedent's morbid obesity, it was a departure from the standard of care for Defendant to only attempt a two-hour turning and positioning regiment. S/he states that for a patient such as decedent, Defendant should have ordered more frequent

turning and repositioning. Furthermore, Defendant failed to take into consideration the decedent's postural alignment, distribution of weight, balance, and stability. S/he also states that there should have been a written repositioning schedule such as the one implemented only in the month of December 2013. Finally, the expert notes that Defendant's expert attempts to blame decedent herself for the development of the pressure ulcers, citing her refusal to eat, reposition, or take medication. However, decedent lacked the ability to properly car for herself and decedent was dependent upon Defendant/movant to provide her with proper care. There is no record hat Defendant ever notified decedent's family to advise that he would be unable to provide proper care. Further, there is no record of Defendant recommending to decedent's family that they look into other physicians for proper treatment. The expert opines to a reasonable degree of medical certainty that Defendant had an obligation to investigate into any issues that were interfering with their ability to properly and appropriately treat Decedent and care for her conditions, and the failure to do so was a proximate cause of Decedent's injuries. S/he concludes that if Defenant genuinely felt that nothing could be done to properly and appropriately care for decedent, he should have investigated what was occurring that was causing such a drastic change in decedent. There is no record of any such investigation.

Defendant has submitted a reply affirmation, and Defendant's contentions therein will be addressed *infra* if necessary.

II. Standard of Review

To be entitled to the "drastic" remedy of summary judgment, the moving party "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 from the case." (*Winegrad v. New York University Medical Center*, 64 N.Y.2d 851 [1985]; *Sillman v. Twentieth Century-Fox Film Corp.*, 3 N.Y.2d 395 [1957]). The failure to make such prima facie showing requires denial of the motion, regardless of the sufficiency of any opposing papers. (*Id.*, see also *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]). Facts must be viewed in the light most favorable to the non-moving party (*Sosa v. 46th Street Development LLC.*, 101 A.D.3d 490 [1st Dept. 2012]). Once a movant meets his initial burden, the burden shifts to the opponent, who must then produce sufficient evidence, also in admissible form, to establish the existence of a triable issue

of fact (*Zuckerman v. City of New York*, 49 N.Y.2d 557 [1980]). When deciding a summary judgment motion the role of the Court is to make determinations as to the existence of bonafide issues of fact and not to delve into or resolve issues of credibility (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499 [2012]). If the trial judge is unsure whether a triable issue of fact exists, or can reasonably conclude that fact is arguable, the motion must be denied. (*Bush v. Saint Claire's Hospital*, 82 N.Y.2d 738 [1993]).

III. Applicable Law and Analysis

"The required elements of proof in a medical malpractice action are a deviation or departure from good and accepted standards of medical practice, and evidence that such departure was a proximate cause of the injury" (*Elias v. Bash*, 54 A.D.3d 354, 357 [1st Dept. 2008], *lv. den.*, 11 N.Y.3d 711 [2008]). In order to establish entitlement to summary judgment, a defendant must "'rebut[] with factual proof plaintiff's claim of malpractice'" (*Pullman v. Silverman*, 28 N.Y.3d 1060, 1062 [2016], quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 325 [1986]). "'[B]are conclusory assertions ... with no factual relationship to the alleged injury' are insufficient to 'establish that the cause of action has no merit so as to entitle defendant[] to summary judgment'" (*id.*, quoting *Winegrad v. New York Univ. Medical Center*, 64 N.Y.2d 851,853 1985]).

In this case, Defendant established a prima facie entitlement to summary judgment via medical records, deposition testimony, and the affirmation of their expert Dr. Smith, a board certified internal medicine physician who had previously held qualifications in Geriatric Medicine and was board certified in Acute Geriatric and Palliative Care Medicine. Dr. Smith reviewed the relevant medical records and opined that, under the totality of the circumstances, decedent's development of pressure sores and death were unavoidable and predictable. He asserts that these injuries were predictable due to 1) decedent's bedbound status, contributing to non-healing ulcers despite maximal measures to reduce pressure point loads; 2) decedent's general inflammatory state, as indicated by extremely high eryhrocyte sedimentation rate of 130 and C-reactive protein of 33.2 while admitted at Montefiore, before re-admission to Beth Abraham; 3) decedent's anorexia and malnutrition coupled with a hypercatabolic state (excessive breakdown of a specific substance or body tissue in general, leading to weight loss and wasting),

4) type III diabetes mellitus, steroid use, poor food intake, catabolic protein-wasting and hyperalbuminemia which impeded healing of otherwise well cared for skin pressure ulcers; 5) severe secondary pulmonary arterial hypertension which subsequently caused hypotension and hypoxia. Furthermore, it is not disputed that Defendant did not begin treating decedent until July 30, 2013. Dr. Smith alleges that the progression of ulcers and subsequent death resulted from decedent's pre-existing condition, "in conjunction with [decedent's] refusal during the final admission to Beth Abraham to 1) take PO foods and fluids regularly, 2) take I-V fluids, 3) be administered medications; 4) be administered treatment; 5) be turned and positioned. Expert further notes that the goal of treatment during the final admission was comfort care in hospice. He concludes that Defendant made appropriate orders throughout the admission to best alleviate any active pressure sores and to prevent future sores including orders for turning and positioning, use of an air mattress, and bunny boots, regular skin assessments as well as treatment from wound care specialist Dr. Kochlayti. Dr. Smith concludes that Defendant and his staff's treatment was within the standard of care. Decedent's pre-existing conditions, along with other risk factors such as her own refusal to consume nutrition, led to this outcome.

Contrary to Plaintiff's contentions, Dr. Smith's opinion is not conclusory or speculative, as it is supported by the medical records demonstrating the existence of decedent's ongoing chronic conditions that existed before her final July 30, 2013 admission to Beth Abraham (*see Negron v. St. Barnabas Nursing Home*, 105 A.D.3d 501 [1st Dept. 2013]). The records further support Dr. Smith's opinion that Defendant implemented a proper treatment plan, including nutrition plan, skin assessment, regular wound care, and took adequate pressure sore alleviation measures, however decedent's chronic condition and other factors such as her own refusal to consume nutrition led to her injuries and eventual death.

The burden therefore shifted to Plaintiff to raise a triable issue of fact. In order to do so, a medical malpractice plaintiff "must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice'" (*Frye v. Montefiore*, 70 A.D.3d 15, 24 [1st Dept. 2009], quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320). Usually, the opinion of a qualified expert that the plaintiff's injuries were the result of a departure from relevant industry or medical

standards is sufficient to preclude entry of summary judgment in favor of a defendant (*id*). "Where the expert's 'ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment'" (*id.* at 24, quoting *Diaz v. New York Downtown Hosp.*, 99 N.Y.2d 542 [2002]). Furthermore, "[a]n expert opinion that is contradicted by the record cannot defeat summary judgment" *Bartolacci-Meir v. Sassoon*, 149 A.D.3d 567, 572-73 [1st Dept. 2017]).

Plaintiff's medical expert alleges that "decedent was not properly nourished nor hydrated while under Defendant's care. During that time, her visceral protein stores, as reflected in her Albumin levels, and on the Abnormal Lab Reports dated August 9 - October 25, 2013, were as low as 2.2g/dl, which is outside normal range. [Defendant's] failure to order additional consults and order additional tests was a departure from the accepted standards of care." This opinion is without probative value, as it fails to state what specific consults or tests should have been ordered, and how those consults or tests would have resulted in a better outcome (*see Joseph ex rel Griffin v. City of New York*, 74 A.D.3d 440 [1st Dept. 2010]). The expert also fails to address the fact that decedent's daughter had refused the implementation of a PEG tube before decedent came under Defendant's care, and that decedent was consistently refusing nourishment and had poor overall oral intake. Furthermore, the expert does not claim that the diet that Defendant ordered for decedent was improper.

Plaintiff's medical expert also alleges that decedent's pressure ulcers could have been avoided with proper medical and nursing care. S/he asserts that decedent's skin breakdown was caused by unrelieved pressure, rather than her declining medical condition and extensive co-morbidities. S/he asserts "in light of decedent's morbid obesity, a condition which defendant was on notice of from the date of her admission in 2003, it was a departure in the standard of care as it existed in 2012 and 2013 for Beth Abraham Health Services to only attempt a two-hour turning and positioning regiment. The appropriate pressure ulcer prevention procedure to turn and reposition a patient *at least every two hours* and more frequently if, as in the case of decedent, a two-hour turning regiment proves insufficient." The expert claims that the failure to order additional turning and reposition was a deviated from good and accepted medical practice, and was "the proximate cause of the development and deterioration of decedent's pressure

ulcers" (Pl. Expert Aff. At Par. 78). The expert then states in the next paragraph that it would have been good and accepted practice to re-position decedent more often than every two hours, and consideration should have been given to decedent's postural alignment, distribution of weight, balance, and stability, and finally there should have been a written repositioning schedule such as the one implemented only in the month of December. S/he concludes that the "failure to ensure that decedent was re-positioned more often than every two hours and the lack of consideration given to postural alignment was a deviation from good and accepted medical practice, and a proximate cause of decedent's development of pressure ulcers and subsequent surgical intervention to the same" (Pl. Expert Aff. At Par. 79).

First, the expert fails to differentiate between (1) the treatment administered by Defendant and (2) the treatment decedent received at Beth Abraham before Defendant became her attending physician. Indeed, there is no record of Defendant ever performing any surgical procedure on decedent after becoming her attending physician on July 30, 2013. In any event, the expert's opinion that Defendant should have turned and positioned the decedent "more frequently" than every two hours is overly non-specific and unsupported by any medical or evidentiary foundation. While a medical opinion regarding deviation need not be based upon medical literature, studies, or professional group rules, and may be based upon personal knowledge acquired through professional experience (*see Mitrovic v. Silverman*, 104 A.D.3d 430, 431 [1st Dept. 2013]), the opinion cannot be speculative (*id* at 431), and the expert must sufficiently identify and define the applicable standard of care (*see Snyder v. Simon*, 49 A.D.3d 954, 956 [3rd Dept. 2008]). Here, the expert fails to state specifically how often a patient such as decedent should have been turned and positioned. The expert's conclusory assertion that she should have been turned and positioned "more frequently" than every two hours is simply too general to sufficiently set forth the applicable standard of care (*see Vogt v. Herstik*, 128 A.D.3d 602, 603 [1st Dept. 2015]; *Bartolacci-Meir v. Sassoon*, 149 A.D.3d 567, 572-73 [1st Dept. 2017]). Moreover, the expert fails to explain how the more frequent turning and positioning would have prevented the formation/deterioration of pressure ulcers here, in light of decedent's pre-existing co-morbidities including her generally high inflammatory state and poor nutrition/medication intake (*see Negron v. St. Barnabas Nursing Home*, 105 A.D.3d at 501).

Plaintiff's expert's assertion that Defendant gave no consideration to decedent's postural

alignment, distribution of weight, balance, and stability is unsupported by the record. As noted in Defendant's expert affirmation and the medical records, the Defendant ordered procedures to offload pressure points including heels with heel protectors, a special mattress, turning and positioning every two hours, and she was ordered out of bed as tolerated. A nursing flow sheet added that use of an air mattress and foam wedges for repositioning every two hours (Dr. Smith Aff. At Par. 14). Plaintiff's expert does not point to any medical record or other evidence indicating that Defendant failed to take into account decedent's postural alignment. The expert adds that "[t]here should have been a written repositioning schedule" during the entire duration of decedent's treatment, but s/he fails to assert that this Defendant was responsible for ordering such a written schedule.

Finally, Plaintiff's expert states that Defendant improperly blames decedent's own actions for the development of her pressure ulcers, as decedent was dependent upon Defendant to provide her with proper care and treatment of her underlying conditions, and she relied upon Defendant to provide her with said care. S/he alleges that there is no record of Defendant ever notifying any member of decedent's family that they would be unable to provide proper care, and there is no record of Defendant recommending to her family that they look into other physicians who would provide the care that he could not provide. S/he alleges that Defendant had an obligation to investigate into any issues that were interfering with his ability to properly and appropriately treat Decedent and care for her conditions, and the failure to do so was the proximate cause of Decedent's injuries. S/he concludes that if Defendant genuinely felt that nothing could be done to appropriately care for decedent, he should have investigated what was occurring that was causing such drastic change in decedent, and there is no record of such an investigation. The foregoing contentions are too general and unsupported by the medical record, and thus fail to raise an issue of fact. First, the expert fails to address the fact that at the time Defendant became decedent's attending physician, the goal of treatment was only comfort care and hospice care. The expert also fails to state what specific measures or investigation Defendant should have undertaken to properly care for decedent. Indeed, the record reflects that in addition to treatment from Defendant himself, the decedent was regularly seen for skin assessments from a wound care specialist, and Defendant had ordered a psychological consult. Furthermore, the expert fails to address the multiple instances where Defendant spoke with

decedent's daughter about ongoing care and treatment, apprised her of decedent's poor prognosis, and explained that decedent had poor PO intake and refused to cooperate with treatment, and discussed the placement of a feeding tube. The expert's failure to take into account any of the foregoing renders his/her opinion speculative and unsupported by a proper evidentiary basis, therefore s/he fails to raise an issue of fact as to whether Defendant deviated from good and accepted practice (*see Frye v. Montefiore*, 70 A.D.3d 15, 24, quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320).

IV. Conclusion

Accordingly, it is hereby,

ORDERED, that defendant Ronald St. Louis, M.D.'s motion for summary judgment is granted, and it is further,

ORDERED, that Plaintiff's complaint against defendant Ronald St. Louis, M.D., is dismissed with prejudice.

This constitutes the Decision and Order of this Court.

Dated: 9/18, 2017

Mary Ann Brigantti

Hon. Mary Ann Brigantti, J.S.C.