Levine v New York-Presbyt. Hosp.
2018 NY Slip Op 30899(U)
May 8, 2018
Supreme Court, New York County
Docket Number: 805093/2015
Judge: George J. Silver

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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SEYMA O. LEVINE, As Administratrix of the Estate of BERNARD LEVINE,

Index № 805093/2015
Motion Seq. 002, 003

DECISION & ORDER

Plaintiff,

-against-

NEW YORK-PRESBYTERIAN HOSPITAL,

Defendant

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GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendant New York and Presbyterian Hospital ("defendant") moves for summary judgment pursuant to CPLR §3212. Defendant seeks dismissal of the complaint in this action with prejudice. Plaintiff Seyma O. Levine ("plaintiff"), as administrator for the estate of Bernard Levine ("decedent"), opposes the motion. For the reasons below, the court denies the motion.

Plaintiff alleges that defendant was negligent in rendering care and treatment to decedent, then an 84-year-old male, during his hospital admission from August 2, 2012 to September 28, 2012. It is claimed that defendant's negligence resulted in decedent sustaining a sacral pressure ulcer, upper right back pressure ulcer, right scapula pressure ulcer, left ankle pressure ulcer, clostridium difficile, sepsis, infection, dehydration, malnutrition, scarring, and pain and suffering.

In response to plaintiff's allegations, defendant contends that when decedent was transferred to its facility on July 30, 2012 – the admission at issue – he had decubitus ulcers on his sacrum and left heel, as well as reddened areas on both of his feet, heels, legs, and right hip. Therefore, defendant asserts that these areas of ulceration and skin breakdown occurred during decedent's time at home rather than during his hospital admission.

Defendant further contends that decedent's multiple comorbidities and acute illnesses put him at very high risk for additional complications, including death, during his hospitalization. While he was admitted in the intensive care unit ("ICU"), decedent was ventilator dependent and was treated for multiple infectious processes and required feeding through a percutaneous endoscopic gastroscopy ("PEG") tube. Defendant submits that these required treatments severely compromised decedent's condition and put him at high risk for further skin deterioration. Despite that reality, defendant argues that it maintained decedent's sacral ulcer close to the size it was upon his admission, and treated his other areas of skin breakdown.

Defendant presupposes that the other pressure ulcers alleged to have been caused by its negligence, including decedent's upper right back pressure ulcer, right scapula pressure ulcer, and left ankle pressure ulcer, were not sustained during this admission as there is no documentation of any pressure ulcers on decedent's upper right back, right scapula, or left ankle between August 2, 2012, through September 28, 2012. For similar reasons, defendant asserts that decedent's infections and scars, including clostridium difficile, are not tethered to its treatment since decedent was documented as having multiple pre-existing infections and scars at the time of his admission. Defendant further defends against allegations that its negligence caused decedent to suffer dehydration and malnutrition as unsupported by the record. Finally, defendant challenges the allegation that its negligence caused decedent pain and suffering since the medical records document aggressive treatment of decedent's underlying medical issues as well as care and medical therapies to address his pain and comfort level, including the appropriate administration of intravenous pain medication.

ARGUMENTS

Based on the record before the court, defendant argues that summary judgment must be granted, because plaintiff cannot establish that defendant's medical treatment deviated from accepted standards of care or that its treatment proximately caused decedent's alleged injuries.

In support of its motion, defendant annexes the expert affirmation of Vincent Marchello, MD ("Dr. Marchello"), to sustain the position that it rendered proper care and treatment to decedent during his hospital admission in accordance with standards of accepted medical practice. Dr. Marchello opines, within a reasonable degree of medical certainty, that defendant conformed to the appropriate standard of care at all relevant times in the care and treatment it rendered to decedent. Moreover, Dr. Machello states that any alleged departures that defendant may have taken from the standard of accepted medical practice for geriatric patients like decedent were not a proximate cause of the alleged injuries or damages claimed in this action. This, Dr. Machello opines, is borne out by the medical records, which document that decedent was admitted to the hospital as a critically ill patient with multiple comorbidities, and was treated well enough that he was able to be transitioned to a skilled nursing facility. Dr. Machello highlights that decedent was regularly examined by physicians as well as nursing staff during his admission, and that these examinations are recorded throughout his chart. Dr. Machello emphasizes that the records of decedent's admission chronicle examinations, assessments, evaluations and diagnostic tests that were performed by physicians of various specialties as well as nursing staff specialized in wound care. Critically, Dr. Machello notes that these assessments included evaluating plaintiff using the Braden Scale, a tool developed to assess a patient's risk of developing pressure ulcers. Dr. Marchello further notes various levels of care which were engaged to treat medical issues ranging from extensive bilateral pneumonia to decubitus ulcers, and believes all of defendant's treatment

provided to decedent was within the parameters of proper care. With respect to plaintiff's allegation that defendant failed to take a proper history of decedent upon his admission, Dr. Marchello avers that a proper history was obtained and documented in the medical records. This included reference to decedent's recent medical history, as well as a delineation of decedent's comorbidities prior to his admission.

Dr. Marchello further points out that, upon decedent's diagnosis of various infections, he was immediately started on antibiotics. His response to antibiotic treatment and the status of infectious processes was continually monitored throughout his admission, and Dr. Marchello believes the care provided to plaintiff related to the prevention and treatment of infections was appropriate. In addition, throughout the hospitalization, Dr. Marchello notes that nutrition consults were regularly held to monitor decedent's nutritional status. Contrary to plaintiff's allegations, Dr. Marchello further opines that decedent was adequately hydrated. Dr. Marchello similarly opines that plaintiff's allegations that decedent did not receive proper diagnostic testing are contradicted by the medical records, which are full of clinical assessments conducted by physicians of various specialties and specialized wound-care nurses.

Moreover, Dr. Marchello explains that the medical records indicate that decedent's ulcers were a pre-existing medical condition, and not proximately caused by the treatment administered by defendant. Finally, Dr. Marchello opines that plaintiff's allegations that defendant failed to order and implement proper pressure relieving devices and equipment, including but not limited to a special mattress, are contradicted by the medical records, which show that defendant employed proper padding and positioning for decedent, as well as the use of a mattress designed for pressure redistribution.

In opposition, plaintiff annexes the expert affirmation of Christine Stahl, M.D. ("Dr. Stahl") who affirms that she is highly familiar with the standard of care for the prevention and treatment of pressure ulcers in a geriatric patient.[1] Dr. Stahl opines that once decedent was scored using the Braden Scale, defendant should have implemented and followed its own protocols designed to prevent and treat pressure ulcers. Based on Dr. Shahl's review of the record, she concludes that defendant did not follow those protocols. In Dr. Stahl's assessment, the standard of care for a patient like decedent was to turn him every two hours to prevent pressure on his skin. Dr. Stahl notes that the record is devoid of any indication that defendant followed that procedure. Plaintiff and decedent's daughter have also submitted affidavits stating that hospital staff repeatedly failed to turn and reposition decedent. According to plaintiff, the failure to turn decedent every two hours constituted negligence, and led to the further breakdown of his skin and the development of new pressure ulcers. Dr. Stahl further opines that decedent's sacral wound increased in size based on defendant's ineffective cleaning and management of the amount of moisture decedent was receiving. Dr. Stahl further notes that if defendant had done a proper skin assessment, decedent's pressure ulcers could have been treated before they abscessed. The abscessing of decedent's wounds, Dr. Stahl opines, was a contributing factor to his death. Finally, Dr. Stahl notes that had defendant sought a surgical consult for decedent's sacral wound within ten days of his admission, his wound may not have expanded in the way that it did. Consequently, plaintiff submits that judgment in defendant's favor is inappropriate as there are material issues of fact that require resolution at trial.

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[1] Plaintiff initially did not annex Dr. Stahl's affirmation to the opposition papers, and moved by separate motion (Seq. 003), for an extension of time to file an initial expert affirmation, and subsequently an amended expert affirmation. That application has been granted. Consequently, Dr. Stahl's affirmation, in amended form, shall be considered as part of the court's determination of the instant motion.

In reply, defendant challenges the credentials of plaintiff's expert, Dr. Stahl, arguing that her assertions are conclusory in nature and unsupported by the medical records.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a defendant must demonstrate that it did not depart from accepted standards of practice or that, even if it did, it did not proximately cause the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id.* *quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once defendant makes a prima facie showing, the burden shifts to the plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, a plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendant set forth a prima facie case in favor of dismissal, as evidenced by the submission of decedent's medical records, and Dr. Marchello's expert affidavit, each of which attests to defendant's appropriate care and treatment of decedent's pressure ulcers, and provides support for the contention that nothing defendant did or did not do proximately caused injury to decedent. Dr. Marchello's affidavit is detailed and predicated upon ample evidence in the record. As defendant has made prima facie showing, the burden shifts to plaintiff.

To defeat summary judgment, plaintiff highlights several issues of fact that this court finds cannot be resolved as a matter of law. Plaintiff properly contends that issues of fact are raised by the notion that the record is devoid of reference to defendant turning decedent over every two hours as required by defendant's own protocol. Separate from the absence of evidence within the medical records regarding decedent being turned every two hours, decedent's daughter's affidavit affirmatively states that during her visits she observed hospital staff neglect decedent and fail to reposition him. Plaintiff further contends that defendant's failure to adhere to its protocols proximately caused injury to decedent, thus raising a triable issue of fact that cannot be resolved as a matter of law.

Plaintiff's expert affidavit of Dr. Stahl also raises triable issues of fact. To be sure, Dr. Stahl opines that defendant did not adhere to the appropriate standard of care regarding the prevention and treatment of pressure ulcers in a geriatric patient, and notes that defendant's actions led to a further breakdown of decedent's skin and the development of new pressure ulcers. Dr. Stahl further opines that decedent's sacral wound increased in size based on defendant's ineffective cleaning and management of the amount of moisture decedent was receiving. Dr. Stahl also states, within a reasonable degree of medical certainty, that had defendant done a proper skin assessment, decedent's pressure ulcers could have been treated before they abscessed, which ultimately was a

contributing factor to his death. Finally, Dr. Stahl notes that had defendant sought a surgical consult for decedent's sacral would within ten days of his admission, his wound may not have expanded in the way that it did. Because defendant did not adequately address these issues, Dr. Stahl states, defendant was negligent and, in addition, proximately caused plaintiff's injuries.

Defendant's challenge to Dr. Stahl's expertise has no merit, as Dr. Stahl established that she has the necessary experience to qualify as an expert (*see Walsh v. Brown*, 72 AD3d 806, 806 [2nd Dept. 2010]). Her alleged lack of knowledge as to the appropriate standard of care for the prevention and treatment of pressure ulcers merely raises a credibility issue defendant can advance at trial.

Accordingly, based on the foregoing, it is hereby ORDERED that defendant's motion for summary judgment is DENIED; and it is further

ORDERED that the parties are directed to appear for a pre-trial conference on Tuesday June 26, 2018 at 9:30 AM at 111 Centre Street, Room 1227, New York, NY 10013.

This constitutes the decision and order of the court.

May 8, 2018

HON. GEORGE J. SILVER