Jordan v NYU Langone Health Sys.
2021 NY Slip Op 31859(U)
June 1, 2021
Supreme Court, Kings County
Docket Number: 508377/2016
Judge: Ellen M. Spodek
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At an IAS Term, Part 63 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 1st day of June 2021

P R E S E N T:

HON. ELLEN M. SPODEK, Justice

- -X

DONNA JORDAN, as Administratrix of the Estate of THOMAS J. JORDAN,

Plaintiff,

-against-

NYU LANGONE HEALTH SYSTEM and NYU LUTHERAN MEDICAL CENTER,

Defendants

- -X

DECISION AND ORDER

Index No. 508377/2016

Papers	**Numbered**
Notice of Motion/Cross Motion and Affidavit………………………..	1
Answering Affidavits……………………………………………..	2
Replying Affidavits	3
Exhibits – CV of plaintiff expert...	4

Defendants NYU LANGONE HEALTH SYSTEM and NYU LUTHERAN MEDICAL CENTER ("Lutheran") move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiff opposes the motion.

In May 2015, the decedent, an 87 year old man, began seeing urologist Dr. Giasullo due to blood in his urine. The decedent had previously been diagnosed with a floating bladder tumor in the late 1980s, which was benign, and frequent urinary tract infections. Dr. Giasullo diagnosed the decedent with an enlarged prostate.WHEN?? In June and July 2015, the frequency of the decedent's urination and blood in his urine did not improve despite taking antibiotics and urinary retention medications. The decedent

began to rapidly lose weight and Dr. Giasullo ordered an out-patient cystoscopy to be performed at Lutheran Hospital and sent the decedent for pre-operative testing.

On August 6, 2015, the decedent presented to Lutheran for a cystoscopy and transurethral resection of his prostate, which was performed by Dr. Giasullo. He found a friable bladder that was entirely filled with a tumor. A small area of the tumor was resected for pathological diagnosis, as Dr. Giasullo determined that a full resection of the tumor would not benefit the decedent at that time.

Postoperatively, the decedent developed gross hematuria and was admitted to Lutheran for continuous bladder irrigation. He remained bedbound on IV fluids and was totally incontinent with a Foley catheter still in place from the operation. Dr. Giasullo noted that his recommendation on further treatment of bladder cancer would await the pathology result from the partial resection. A chest CT was performed and showed a right lung nodule, suspicious for metastasis to the lungs. Also, on August 6, a skin and wound assessment was performed. The skin assessment was unremarkable, and the skin was noted as intact. The decedent was also assessed to be at a mild risk for development of pressure ulcers, due to his inability to turn and position himself independently after the surgery and his debilitated condition. SKINSAVERS interventions were initiated due to the decedent's risk. These interventions included assisted turning and positioning every 2 hours, mattresses and padding, and use of moisturizers and barrier cream as necessary.

Additional skin and wound assessments were performed by nurses on August 10, 12, 14, and 17th. At each of these assessments, the decedent's skin was noted to be intact. At the August 12th and August 14th assessments, it was noted that the decedent

was now able to turn and position himself independently, and briefly the SKINSAVERS orders including assisted turning and positioning were suspended. However, after a skin assessment on August 16th found that the decedent could no longer move in his bed independently, the assisted turning and positioning every two hours was resumed.

The decedent was also assessed for his nutritional status upon admission following Dr. Giasullo's procedure. The initial nutrition notes dated August 7, 2015 documented that the decedent had lost 20% of his body weight within the past year, including a recent loss of 10 pounds without trying to lose weight. The nutritionist noted visible loss of subcutaneous fat and muscle mass. Initial bloodwork indicated anemia and hyperglycemia. The decedent was assessed with moderate malnutrition due to chronic illness and determined to be a high nutritional risk. He was continued on his pre-existing puree diet with the goal to improve oral intake. Dietary supplementation was also ordered. The decedent's nutritional condition would be monitored with lab results, skin integrity, and weekly weight checks. On August 12th it was noted that the decedent showed poor oral food intake and was visually underweight. Dietary supplementation was continued, and total feeding assistance was ordered as of August 16th.

By August 11, 2015, Dr. Giasullo determined that the decedent had stage IV bladder cancer that was metastatic to his lung, with a pathology report of invasive papillary urothelial carcinoma. Hematology Oncology was consulted and recommended palliative radiation therapy due to the decedent's poor baseline state and advanced age. Palliative medicine consulted with the decedent's family, including the plaintiff, on August 12th regarding discharge planning to home hospice or facility placement and the end of life process. Additionally, radiation oncology confirmed the recommendation for outpatient

palliative radiation therapy, and Dr. Giasullo advised that the decedent had less than 6 months to live. The plaintiff initially wanted the decedent discharged to home with a home health aide, but became dissatisfied with the responsiveness of VNS, and on August 14th requested that Lutheran transfer the decedent to hospice facility Calvary Hospital instead. After Calvary advised the plaintiff that the decedent did not meet the financial criteria for admittance, Lutheran arranged for a referral to MJHS Hospice and Palliative Care. DNR paperwork was started by plaintiff on August 15. However, on August 17, the decedent's family changed their mind again and insisted that the decedent remain hospitalized at Lutheran for comfort care including pain control, and to stop exploring the option for out-patient radiation therapy. The decedent's primary care physician, Dr. Eugene Gibilaro, agreed to accept the decedent under the medical service, and the decedent was transferred within Lutheran to a bed in the medical unit with a plan for palliative care on the evening of August 17th.

Following the decedent's inter-hospital transfer, a Skin and Wound Assessment was performed at 11:00 pm on August 17th by Nurse Christopher Widgren. Nurse Widgren recorded that the decedent's skin was intact. He assessed the skin again on August 18th with a progress note at 3:58 am, showing that the decedent's skin was within normal limits, warm, dry and intact.

Several hours later on August 18, 2015, a progress note at 11:20 am reported the presence of pressure ulcers. A Skin and Wound Assessment note described a 3 cm x 3 cm stage II ulcer on the left buttock, a 2 cm x 0.5 cm deep tissue injury (”DTI”) on the spine, and a 10 cm x 12 cm DTI on the sacrum. The left buttock ulcer was red and with

excoriated edges, odor and serous drainage, and the DTIs appeared purple with intact edges and no drainage or odor.

On August 15th at 2:09 pm Nurse Practitioner Emmanuel authored a Wound Ostomy Consult Note. He described the decedent as bedbound with poor mobility, appearing cachectic with temporal wasting and sunken eyes. Upon examination of the wounds, NP Emmanuel noted that the sacrum DTI was irregularly shaped measuring 11 cm long by 12 cm wide with a base that was 95% purple; and 5% pink and open. The edges were diffused and irregular and with blanchable erythema. A small amount of serosanguineous exudate without odor was also noted. The thoracic spine DTI measured 4 cm x 0.8 cm and was deep purple in color, without exudate, odor or open area. NP Emmanuel recommended the SKINSAVERS bundle, a therapeutic support surface, ongoing nutritional needs, assessments and interventions; and Optifoam adhesive to the sacrum and thoracic spine ulcers twice a week. The decedent's updated condition was discussed with the plaintiff on August 18th, and she again declined palliative radiation treatment for her father and expressed her desire to take the decedent home.

On August 19, 2015, Dr. Gibilaro noted that the decedent had aggressive bladder cancer with failure to thrive and was a poor candidate for any treatment. It was also noted that the decedent refused physical therapy due to pain level. After a repeat discussion with the decedent's daughter, the plan was to pursue only comfort measures. Do not resuscitate, do not intubate, no further blood draws, and full evaluation for hospice placement was also noted.

An interim note documented that the decedent was re-evaluated by the palliative care team and started on a Fentanyl patch the day prior. A further note stated that pain

was not well controlled, and the decedent was started on Morphine 5mg loading dose. Infectious disease attending Dr. Margaret Kuhn-Basti noted at 11:59 am that antibiotics were being discontinued to provide for comfort care. At this time, Dr. Kuhn-Basti noted that the decedent was awake, he was cachectic with bitemporal muscle wasting and was confused. She further noted that he had a stage II sacral hemorrhagic lesion that was without necrosis of malodor.

A skin assessment was performed on August 20th and revealed that the three ulcers remained unchanged. It was further noted that wound care was consulted, and that the MD was aware of skin breakdown. A further nutritional assessment on August 20th noted the decedent was lethargic, cachectic, and not eating orally. It was recommended that decedent be evaluated for non-oral intake.

On August 20th, a case management note showed that a DNR/DNI was signed by the family and the decision was made by the plaintiff for transfer to Calvary Hospital for hospice care. By August 21st, the decedent was not financially cleared for Calvary Hospital and the family was offered the option of home Hospice Care. On August 21st, the decedent was discharged from the physical therapy program at the hospital as the family refused to continue any more PT services. At 8:00 pm on August 21st, Nurse Ionie E. Skyers-Gilchrist noted that the decedent was being transferred to 5 East. Dr. Gibilaro saw the decedent that day and noted that he was transferred to a private room on IV morphine for comfort care measures and that he expected breathing to become agonal in 24-48 hours.

A skin and wound assessment performed on August 21st documented a sacral

DTI of partial thickness measuring 13 x 16 cm that was red and purple with excoriated edges, open surrounding tissue and serosanguineous drainage. The SKINSAVERS bundle was applied to the area in addition to foam and barrier bream. Also documented was a partial thickness thoracic DTI measuring 1.5 cm x 6 cm with intact edges and no drainage. The SKINSAVERS bundle was applied along with foam.

Skin and wound assessments performed on August 24th and August 27th documented that sacral and thoracic DTI's remained unchanged. At 1:22 pm on August 25th, Dr. Gibilaro noted that the decedent's breathing was very poor and he did not expect "much more time." He further noted that he spoke with the patient's family by phone. On August 25th, resident Erika Maria Reategui Schwartz noted that she spoke with the decedent's son and that the family now refused hospice care at home. She further noted that palliative care had been re-consulted and the original Morphine drip of 2.5 mg an hour from August 19th was increased to 4 mg per hour also, also with Ativan.

On August 26th, Dr. Gibilaro noted that the decedent's breathing continued to be poor and that he spoke with the decedent's daughter at the bedside and made clear that his time would likely be very soon. At 7:21 am on August 27th, Nurse Kitty Lau noted that the decedent was found unresponsive, pulseless and with no respiration. At 7:35 am, the decedent was pronounced dead from cardiopulmonary arrest with a secondary cause of death noted as high grade bladder carcinoma.

Defendants submit the affidavit of Dr. Jeffrey M. Levine, a board-certified doctor of Internal Medicine and Geriatric Medicine with a certification as a Wound Care Specialist Physician. Dr. Levine opined that the defendants did not depart from the standard of care in the treatment and care rendered to the decedent. He opined that the defendants

adhered to the standard of care in the prevention and treatment of the decedent's skin breakdown during the admission at Lutheran from August 6, 2015 to August 27, 2015. Moreover, he opines that the decedent's development of skin breakdown, pressure ulcers, and/or inability to heal, despite multiple interventions provided by Lutheran was unavoidable and secondary to his severe, terminal stage IV bladder cancer with likely metastases to his lungs, associated debility related to advanced cancer, inability to ambulate, and being bedbound. These conditions reduced the blood flow to his skin, causing the skin tissue to be poorly oxygenated and failing to deliver the necessary nutrients to maintain his skin integrity. Dr. Levine states that the standard of care for skin evaluation in institutional settings is for a body audit to be performed upon admission or readmission, with reevaluation of the skin for individuals at risk for skin breakdown or pressure ulcers to be completed at least weekly. The progress notes in this case contain daily skin assessments with updated Braden scores, which Dr. Levine states are a clinical tool used to predict individualized risk of pressure ulcers based on clinical observation. Dr. Levine affirms that the decedent was appropriately identified as a mild or moderate risk for pressure ulcers throughout his admission prior to the development of skin breakdown on August 18th Dr. Levine affirms that the daily skin progress notes and bidiurnal Skin and Wound Assessments are each above the frequency required by the accepted standard of care. He opines that the allegations that the defendants failed to document pressure risk assessment scores or failed to perform a head-to-toe assessment of plaintiff's skin condition are completely meritless.

Dr. Levine opines that to a reasonable degree of medical certainty, the defendants implemented appropriate and timely plans of care to maintain the decedent's skin

integrity. He states that prevention of skin breakdown and pressure ulcers is focused on relieving pressure at bony prominences and maintaining proper hydration and nutrition to promote proper oxygenation and delivery of nutrients to the skin. He affirms that the SKINSAVERS bundle of procedures were applied based on decedent's risk of developing pressure ulcers and that this combined with the orders to be turned and administered every two hours were within the standard of care.

Dr. Levine states that the defendants did not depart from the standard of care in managing the decedent's nutritional and hydration needs, as they were properly monitored and assessed. He affirms that just because the nutritional and hydration interventions could not reverse his pre-existing malnourishment and poor intake levels is not evidence of any departure from the accepted standard of care, but rather, was a clear consequence of underlying advanced cancer and a pre-existing trajectory of decline.

Defendant's expert opines that the defendants did not depart from the standard of care in preventing the pressure ulcers. Dr. Levine opines that the ulcers that the decedent developed during his admission were unavoidable, not caused from any failure on the part of the defendants and developed secondary to complications from the severe advanced cancer, significant co-morbidities, and chronic immobility of the decedent. Dr. Levine affirms that the decedent developed terminal ulcers, also called skin failure, as a result of consequences of advanced cancer including weakness, poor nutrition, and cancer cachexia. He states that cancer cachexia is where tumors create cachexins, a hormonal polypeptide which causes a wasting syndrome. Dr. Levine affirms that the decedent was cachectic.

As for the alleged failure to document and treat the decedent's perianal, spinal, and ischial DTIs, Dr. Levine opines that the defendants comported with the accepted standard of care. He states that in patients suffering from skin breakdown, pressure relieving measures must be implemented including, but not limited to, turning and repositioning at least every two hours, use of pressure relieving devices, use of dressings or skin protectants, and measures to ensure adequate nutrition and hydration status, which were all done in this case.

Dr. Levine states that plaintiff's allegation that the defendants failed to detect the DTIs "before they reached stage IV" is meritless and unsupported by the records as the decedent never developed any stage IV ulcers during his admission; the spinal and ischial wounds were classified as DTIs and the left buttock ulcer was stage II.

Defendants' expert affirms that there is no merit to plaintiff's allegations that the defendants failed to appreciate the significance of the decedent's episodes of decreased hemoglobin or leukocytosis. Dr. Levine states that the records show decedent's blood chemistry was tested daily throughout the admission.

Dr. Levine's opinion is that defendants were within a reasonable degree of medical certainty and did not deviate from the standard of care in failing to timely transfer decedent to hospice. He states that it is clear from the records that the decedent was timely and properly referred to hospice care by the defendants, but the family decision making and choice of one facility that would not accept the decedent caused the delay. Dr. Levine affirms that the standard of care does not require that a terminal patient be transferred to a hospice facility. He states that when a patient is terminal and life expectancy is no longer than 6 months, comfort care is instituted and medical professionals must exercise

their judgment to attempt to manage the symptoms of a terminal disease in a patient so that the patient is able to live an alert, pain-free life during their last days. Dr. Levine states that the defendants provided the appropriate counseling to the decedent's family and the comfort care treatment ultimately provided were within the standard of care.

Plaintiff opposed the motion and submitted the affidavit of Dr. Richard Bassin. He states that he has "extensive experience, for many years, in the care of patients including prophylactic procedures to safeguard patients from skin ulcerations" and that he "treats patients with severe comorbidities and those who were terminally ill and elderly". He states that if the defendants had adhered to the proper standard of care with adherence to the ordered protocol to safeguard against decubitus ulcers, the decedent would not have suffered from his stage IV decubitus ulcers until his death on August 27. He affirms that the only explanation for the development of the ulcers was the failure by the defendants to adhere to the standard of care. He opines that the decubitus ulcers would have been prevented if the defendants had not failed to adhere to the standard of care.

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. *Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v Streiter*, 83 AD3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Brinkley v. Nassau Health Care Corp.*, supra; *Fritz v. Burman*, 107

A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. City of New York*, 99 AD3d 673, 675 (2d Dept. 2012); *Bezerman v. Bailine*, 95 AD3d 1153, 1154 (2d Dept. 2012); *Stukas v. Streiter*, at 24. A plaintiff succeeds in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused plaintiff's injury. *Contreras v Adeyemi*, 102 AD3d 720, 721 (2d Dept. 2013); *Gillespie v New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Semel v Guzman*, 84 AD3d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas*, at 24.

After oral argument and a review of the papers, the Court finds that the defendants have sustained their burden of showing that they did not depart from good and accepted medical standards of care. The burden then shifted to plaintiff to provide evidence to the Court that the defendants did in fact deviate from the accepted standards of medical care, raising a triable issue of fact. The Court finds that plaintiff has not sustained her burden. Plaintiff failed to lay a proper foundation for the Court to consider Dr. Bassin's affirmation. "Physicians offering opinions in medical, dental, podiatric, chiropractic, or other specialty malpractice actions must establish their credentials in order for their expert opinions to be considered by the court." Bongiovanni v. Cavagnuolo, 138 AD 3d 12, 18 (2d Dept. 2016). "Thus, when a physician offers an expert opinion outside of his or her specialization, a foundation must be laid tending to support the reliability of the opinion tendered." Id. The plaintiff did not provide any foundation to allow Dr. Bassin to opine on the circumstances of this case. His CV, which the Court reviewed, does not show that he treats skin wounds or is qualified to discuss the treatment of skin wounds. The affirmation only states that

he has "extensive experience…in the care of patients including prophylactic procedures to safeguard patients from skin ulcerations. Patients under my care have included those with severe comorbidities and those who were terminally ill and elderly. I am fully aware of the present standards of care for physicians and nurses." Such statements are insufficient to lay a proper foundation to allow him to opine on any issues in this case.

Plaintiff attempted to rectify the problems with their expert's affirmation by submitting another affirmation after the Court had already marked the papers fully submitted. Plaintiff was only given permission to submit the expert's CV, not a new affirmation. This second affirmation was rejected and not considered by the Court.

Dr. Bassin's CV does not help lay a proper foundation to allow the affirmation to be considered. There is no mention in the CV that Dr. Bassin treats skin wounds or has any other familiarity with the standards of care for skin wounds. It simply shows a doctor who has general surgery experience and extensive teaching experience. That is not a proper foundation for this doctor to opine on a case involving skin wounds, and therefore his affirmation is not considered a reliable expert opinion. Without an expert's opinion, plaintiff has failed to sustain her burden to show that there is a question of fact that the defendants departed from good and accepted medical practice in the treatment of the decedent. As plaintiff has failed to sustain her burden, defendants' motion for summary judgment must be granted. The complaint against the defendants is dismissed.

This constitutes the decision and order of the Court.

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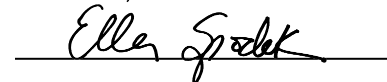

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