Williams v Tursi
2022 NY Slip Op 34351(U)
May 5, 2022
Supreme Court, Richmond County
Docket Number: Index No. 152581-2018
Judge: Judith N. McMahon

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND

x **IAS PART 6**

HAROLD WILLIAMS, as Administrator of the Estate of DELINA WILLIAMS, Deceased, and HAROLD WILLIAMS, Individually,

Plaintiff(s),

- against -

ORDER

Index Number: 152581-2018

WILLIAM TURSI, MD, EDWARD ARSURA, MD, RICHMOND UNIVERSITY MEDICAL CENTER, ALDO ARPAIA, MD, BARTHOLOMEW SAVINO, MD, VERRAZANO NURSING HOME, INC., KOCHUVILAPADITTATHIL RAJU, MD, SADAF KHAN, MD, and STATEN ISLAND UNIVERSITY HOSPITAL,

Hon. Justice Judith N. McMahon

Defendant(s).

x

Defendants Dr. William Tursi, Dr. Edward Arsura, and Richmond University Medical Center's motion, pursuant to CPLR § 3212, to dismiss this action in its entirety, with prejudice, and directing summary judgment in favor of Defendants Dr. William Tursi, Dr. Edward Arsura, and Richmond University Medical Center, is granted as detailed herein.

This medical malpractice action seeks damages for the alleged injuries of Plaintiff Decedent Delina Williams and is brought by Harold Williams (her brother), as the Administrator and Individually, which are claimed to have been caused by the alleged malpractice of Defendants during their care and treatment of Ms. Williams in connection with an admission to Defendant Richmond University Medical Center, from March 18, 2016 through March 31, 2016 and subsequent admissions to co-Defendants Verrazano Nursing Home, Inc., and Staten Island University Hospital.

Plaintiff alleges that Defendants, Dr. Tursi, Dr. Arsura and RUMC, failed to diagnose and treat a cerebral vascular accident (CVA); malnutrition; a C. difficile infection and pressure ulcers. Harold Williams also claims damages in a derivative cause of action.

This case stems from the March 2016 admission of Delina Williams. She was brought to RUMC by ambulance on March 18th, by her siblings. At that time, the record reflects that she had a lifelong history of psychiatric illness. Although she was 66 years old, she lived with her mother, who had recently experienced a stroke and was admitted to the hospital. Plaintiff testified, and the record demonstrates, that Ms. Williams' siblings went to check on her at home and that they found her with an altered mental status from her baseline, noncommunicative and doubted that she had eaten over several days. A workup for a possible cerebral vascular accident was immediately started. The history and physical obtained and performed at that time demonstrated that the patient had not been under the care of a doctor for many years. She had left sided weakness and could not communicate. Her labs were drawn and supported the physical examination, which revealed that she was malnourished on admission and dehydrated. A bedside speech and swallow examination was performed as part of the stroke work up and it was determined that she was at risk for aspiration (choking) and therefore recommendations for nutrition via a nasogastric tube were made.

Ms. Williams underwent radiology studies, which confirmed that she had an acute right sided CVA, which demonstrated as left sided weakness and the aphasia. Chest x-rays were also taken that time and supported a diagnosis of pneumonia. Antibiotics were started.

Ms. Williams was admitted to the medical floor for further work up. The records demonstrate that the attending physician who was covering the admissions that night is Defendant Dr. Tursi. Dr. Tursi evaluated the patient and then agreed with the work up and treatment plan and then signed the patient out to the attending for the floor, Defendant Dr. Arsura, who then followed the patient during the admission, along with the resident and nursing staff.

The record demonstrates that Dr. Tursi's involvement was limited to that first day of the presentation and had no further involvement. Ms. Williams was transferred to the telemetry unit on March 19, 2016. Upon transfer to the telemetry unit, several treatment protocols were started, including CVA, a skin risk assessment/Braden Scale, Morse Fall Scale, and nutrition. A sepsis protocol was started on March 22, 2016.

Throughout the RUMC admission, Ms. Williams was incontinent of bowel and bladder due to her CVA. A foley catheter was placed to control the bladder incontinence. Other than March 24, 2016, the patient did not show any signs of diarrhea. Ms. Williams was also evaluated for the possibility of pressure ulcers.

The first skin breakdown occurred on March 26, 2016, at which time the nursing staff appreciated an area on Ms. Williams's left buttocks which was assessed as a stage II skin injury. From that point on the flow sheets note that the injury was closed, clean and dry and there was no drainage/odor. The records reflect that the patient's skin injury was assessed, a treatment plan was put into place and the nurses followed its progression or lack thereof.

During the course of the admission to RUMC, Ms. Williams was supported for the acute CVA. Given the unknown timing of the stroke, there was no specific treatment for the stroke other than supportive. Evaluations and care continued, including antibiotics and it was determined that the patient could not return home. Discussions occurred about supporting her nutrition and a further bedside swallow evaluation was performed after the one done in the emergency room. Although Ms. Williams did not pass this evaluation, it was determined that her swallow function may recover in time and so recommendations were made to repeat the swallow evaluation in two weeks. Given that, and the need for additional nutritional support, but due to the patient's persistent tachycardia, placement of a PEG tube for nutrition was delayed. Arrangements were then made to have Ms. Williams transferred to a skill nursing facility for further care. On March 31, 2016, Ms. Williams was transferred to Verrazano Nursing Home. At the time of her discharge she was noted as still having the same stage two skin injury on her left buttocks.

Subsequent treatment records from the co-Defendants demonstrate that Ms. Williams's skin injury worsened to a Stage 3 during the course of her admission to Verrazano Nursing Home; during her admission to SIUH this skin injury improved to a Stage 1.

On August 3, 2016, Ms. Williams expired. No autopsy was performed.

The only remaining Defendants in the case now move for summary judgment to dismiss Plaintiff's case as against them.

"The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted standard of care and evidence that the deviation or departure was a proximate cause of injury or damage. In order to establish prima facie entitlement to judgment as a matter of law, a defendant in a medical malpractice action must negate either of these two elements." *Arocho v. Kruger*, 110 A.D.3d 749, 973 N.Y.S.2d 252 (N.Y.A.D. 2nd Dept 2013); *see also Castro v. New York City Health & Hosps. Corp.*, 74 A.D.3d 1005, 903 N.Y.S.2d 152 (N.Y.A.D. 2nd Dept. 2010). "To prevail on a motion for summary judgment in a medical malpractice action, the defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or that any departure was not a proximate cause of the patient's injuries." *Kelly v. Rosca*, 164 A.D.3d 888, 83 N.Y.S.3d 317 (N.Y.A.D. 2nd Dept. 2018).

Defendants established a prima facie entitlement to judgment by showing there was no departure from good and accepted medical practice via the Affirmation of Dr. Norris Fox. *See Stukas v. Streiter*, 83 A.D.3d 18, (N.Y.A.D. 2nd Dept. 2011); *See also Joyner-Pack v. Sykes*, 54 A.D.3d 727, (N.Y.A.D. 2nd Dept. 2008).

In support of Defendants' motion, Dr. Fox opined that, "The plan of treatment for the CVA included supportive and restorative care and treatment. The patient was fully and timely evaluated for her acute stroke, given the unknown timing of the stroke, or the clear cause, there was no specific treatment that could be offered. Rather, the standard of care was to provide supportive care for the patient, which the record demonstrates was done. The patient was properly evaluated by speech therapy, occupational therapy, and physical therapy. She was given nutritional support and periodic radiology studies to determine the evolution of the CVA. The record demonstrates that the CVA was timely diagnosed, the patient was properly assessed, and the proper treatment and care was rendered."

Dr. Fox also opined that, "defendants also did not deviate from the standard of care for the diagnosis and treatment of a C. difficile infection. According to the record, the patient did not present to RUMC with C. difficile signs or symptoms. and at no time did she demonstrate or develop such an infection during her admission. C. Difficile may present with frequent, loose mucus filled and watery diarrhea. The patient did not experience that at the time of her

admission. There is one time during the admission, on March 24, 2016, when it is noted that she had a loose brown stool, which is not consistent with a C. difficile infection, but is a normal and expected reaction to the Jevity tube feeding."

Dr. Fox further opined that, "From the moment the patient was admitted, the record demonstrates that the staff at RUMC fully appreciated the potential for the patient to be nutritionally compromised. A speech and swallow consult was called in the ED and an evaluation was performed. The record demonstrates that serial nutritional assessments were done, which is in accord with the proper standard of care."

Dr. Fox concluded that, "The record demonstrates that the nursing staff fully and completely assessed the plaintiff's skin condition throughout the duration of her admission; the proper and appropriate techniques were employed to prevent skin breakdown including turn and reposition protocols, off-loading, pressure reducing surfaces, barrier treatments and protectants. These interventions are clearly documented in the record, which supports that all necessary and proper steps were taken to prevent skin breakdown."

"Once this showing has been made, a plaintiff, in opposition, need only demonstrate the existence of a triable issue of fact as to those elements on which the defendant met the prima facie burden." *Reid v. Soults*, 138 A.D.3d 1087, 31 N.Y.S.3d 527 (N.Y.A.D. 2nd Dept. 2016); *See also Zuckerman v. City of New York*, 49 N.Y.2d 557, 404 N.E.2d 718 (1980).

Accordingly, the burden shifts to 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., supra.* In a medical malpractice action, this requires that a plaintiff "submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant['s]... summary judgment motion." *Id.*

"A plaintiff's expert opinion must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." *Dallas-Stephenson v. Waisman*, 39 A.D.3d 303, 833 N.Y.S.2d 89 (N.Y.A.D. 1st Dept. 2007).

It should be noted that at in the Opposition papers and at oral argument on the motion, conducted via Microsoft Teams, Plaintiff stated that any claims related to informed consent or wrongful death were withdrawn. Additionally, Plaintiff did not oppose the summary judgment motion of Dr. Tursi, so those portions of Defendants' motion are granted without opposition.

Plaintiff submitted an Affirmation from Dr. Larisa Shpitalnik in Opposition to the remainder of Defendants' motion.

Dr. Shpitalnik opined "that [the] failure of RUMC and its physician to take appropriate precautions against skin breakdown, given Delina's particular medical condition, was a proximate cause of her pressure ulcers, skin wounds, infections, eschar, and prolonged pain and suffering."

Dr. Shpitalnik further opined, "that [the] decision of RUMC and its physician [to] use a Naso-Gastric tube in a patient with poor mouth hygiene and psychiatric conditions, and who failed the swallow test, was a proximate cause of chronic malnutrition which contributed to her pressure ulcers, skin wounds, infection, eschar, and prolonged pain and suffering."

Dr. Shpitalnik also opined, "that the decision of RUMC and its physician to not place a gastric feeding tube, but continue with an NG tube was a proximate cause of Delina's aspiration pneumonia, which lead to severe infection and eventually sepsis."

Dr. Shpitalnik concluded, "that the failure of RUMC and its physician to immediately order antibiotics when there was ample evidence of infection prolonged the course of Delina's infection and sepsis, which in turn required even more antibiotics be administered over a longer period of time. It is my professional opinion, within a reasonable degree of medical certainty that due to the prolonged use of antibiotics and extended hospitalizations, Delina developed C. Diff. Once suspected, specific antibiotics such as Vancomycin must be started immediately. There is no reason to wait for a confirmed diagnosis as delay in administering antibiotics will only prolong the disease."

"In opposition, the Plaintiff failed to raise a triable issue of fact by the submission of [their] expert's affidavit[s] since expert opinions which are speculative, conclusory, and unsubstantiated are insufficient to defeat a motion for summary judgment." *Martirosyan v. Antreasyan*, 153 A.D.3d 616, 57 N.Y.S.3d 404 (N.Y.A.D. 2nd Dept. 2017).

Plaintiff's Expert's affirmation is speculative and conclusory as it fails to set forth an explanation of the reasoning and does not rely on specifically cited evidence in the record. *See Tsitrin v. New York Community Hospital*, 154 A.D.3d 994, 62 N.Y.S.3d 506 (N.Y.A.D. 2nd Dept. 2017).

The opinions of Plaintiff's Expert are conclusory as they are contradicted by the medical records in this case, or Dr. Shpitalnik refers to occurrences in the medical record that happened after Plaintiff Decedent left RUMC without regard for the timeline. Dr. Shpitalnik's Affirmation states only that she read Plaintiff Decedent's medical records and nothing else. Plaintiff's Expert does not address Dr. Fox's opinions in any way, nor even indicate that she read Dr. Fox's Affirmation. Dr. Shpitalnik fails to delineate specific support in the record as the basis for her opinions.

"In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record." *Kim v. N. Shore Long Island Jewish Health Sys., Inc.*, 202 A.D.3d 653, 655, 162 N.Y.S.3d 132, 135 (N.Y.A.D. 2nd Dept. 2022).

ORDERED that any allegations related to wrongful death have been withdrawn by Plaintiff; and it is further

ORDERED that any allegations related to informed consent have been withdrawn by Plaintiff; and it is further

ORDERED that Defendants' motion, pursuant to CPLR § 3212, to dismiss this action in its entirety, with prejudice, and directing summary judgment in favor of Defendant Dr. William Tursi is granted unopposed; and it is further

ORDERED that the remainder of Defendants' motion, pursuant to CPLR § 3212, to dismiss this action in its entirety, with prejudice, and directing summary judgment in favor of Defendants Dr. Edward Arsura and Richmond University Medical Center is granted; and it is further

ORDERED that Plaintiff's Summons and Verified Complaint in this matter are dismissed with prejudice; and it is further

ORDERED that any and all other requested relief is denied; and it is further

ORDERED that the Clerk of the Court shall enter judgment accordingly.

THIS IS THE DECISION AND ORDER OF THE COURT.

Dated: 5/5/2022

So Ordered.

ENTER:

J.S.C

Hon. Judith N. McMahon
J.S.C.