

**Thomas v Klager**

2023 NY Slip Op 31324(U)

April 13, 2023

Supreme Court, New York County

Docket Number: Index No. 805485/2016

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY**

**PRESENT:** HON. JOHN J. KELLEY **PART** **56M**

*Justice*

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VENICE THOMAS, as Administratrix of the Estate of  
RUBEN THOMAS, Deceased, and VENICE THOMAS,  
Individually,

Plaintiff,

- v -

JOSEPH KLAGER, M.D., JEAN YVES-DASTAIN, M.D.,  
MING CHEONG, M.D., CARERITE CENTERS, LLC, doing  
business as THE RIVERSIDE PREMIER REHABILITATION  
& HEALING CENTER, and MOUNT SINAI HEALTH  
SYSTEM, INC., doing business as THE MOUNT SINAI  
HOSPITAL, also known as MOUNT SINAI WEST, formerly  
known as MOUNT SINAI ROOSEVELT,

Defendants.

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The following e-filed documents, listed by NYSCEF document number (Motion 007) 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 184, 185

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice, lack of informed consent, and wrongful death, internist Ming Cheung, M.D., sued incorrectly herein as Ming Cheong, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiff does not oppose the motion. The motion is granted.

The crux of the plaintiff's claims against Cheung is that, between December 25, 2014 and February 21, 2015, Cheung committed malpractice in the course of providing wound consultation services to the plaintiff's decedent by failing properly to diagnose, treat, and recommend appropriate testing for bed sores, pressure ulcers, skin lesions, and cellulitis. In support of his motion, Cheung submitted the pleadings, the plaintiff's bill of particulars as to him, the transcripts of the parties' depositions, relevant medical and hospital records, a statement of

material facts, an attorney's affirmation, and the expert affirmation of Lawrence Diamond, M.D., a physician who holds a certificate of added qualifications in geriatric medicine.

Dr. Diamond opined that Cheung did not depart from good and accepted medical practice in his treatment of the plaintiff's decedent, and that his conduct did not cause or contribute to any of the decedent's injuries.

Dr. Diamond explained that, on December 31, 2014 the decedent was admitted to the defendant Carerite Centers, LLC, doing business as The Riverside Premier Rehabilitation & Healing Center (Riverside), after his transfer from Harlem Hospital Center, and presented with a history of dementia, severe gait disorder, chronic atrial fibrillation, hypertension, chronic kidney disease, benign prostatic hyperplasia, degenerative joint disease, pre-diabetes, and urinary incontinence. At the time, the decedent was being followed at Riverside by the defendant internist and dermatologist Jean-Yves Dastain, M.D.

According to Dr. Diamond, upon the decedent's admission to Riverside, he already evinced a left buttock ulcer measuring 2.1 centimeters (cm) by 2.0 cm by 0.1 cm that was pink and irregular, as well as multiple hypopigmented skin on the right buttock, an unstageable right lateral malleolus pressure ulcer measuring 1.3 cm by 1.0 cm x 0.1 cm, with 100% yellow slough, and an unstageable left lateral malleolus pressure ulcer that measured 2.3 cm by 2.5 cm, with 100% yellow slough, and bilateral heel redness. The plan was to treat the decedent's pressure ulcers with a normal saline cleanse, followed by application of Collagenase and clean dressings. At that time, Kenneth Autencio was Riverside's wound care coordinator, and was responsible for supervising three treatment nurses. On January 5, 2015, Autencio prepared a care plan activity report for the decedent, at which time the decedent still had pressure ulcers on his right lateral malleolus, left lateral malleolus, and left buttock. That report stated that the nursing staff was required to turn and reposition the decedent every 90 minutes.

As Dr. Diamond explained it, Cheung was a wound care consultant who saw patients at Riverside one day per week. After being contacted by Autencio, Cheung saw the decedent for

the first time on January 7, 2015, assessed the decedent's pressure wounds, and noted that the decedent's risk factors for the development of pressure ulcers included decreased mobility, positional difficulty, dementia, malnutrition, and a history of pressure ulcers. On that date, the decedent evinced an unstageable pressure wound to his right lateral ankle that measured 1.0 cm by 0.8 cm by 0.0 cm, consisting of dry eschar, with no exudate, infection, or odor. Cheung determined that the wound was stable and had reasonable healing potential, and formulated plan to treat the wound and periwound by cleaning them with normal saline solution prior to applying dry protective dressing both daily and as needed, and then covering the wound secondarily with gauze and tape. According to Dr. Diamond, Cheung also recommended repositioning the decedent every two hours, per protocol, and to float the decedent's heels while he was in bed. In addition, the decedent presented with an unstageable pressure wound to the left lateral ankle that measured 1.4 cm by 1.0 cm by 0.2 cm, consisting of soft eschar with serosanguinous exudate, but no infection or odor. Cheung determined that the wound was stable and had reasonable healing potential, and recommended daily application of Collagenase, as well as repositioning every two hours, per protocol, and floating the decedent's heels while he was in bed. As of that date, the decedent also presented with a healed pressure ulcer to the left buttock, with respect to which Cheung recommended that it be observed and treated with skin care protection.

Cheung next saw the decedent on January 14, 2015, by which time the unstageable pressure wound to his right lateral ankle had slightly decreased in length, and slightly increased in width and depth, with approximately the same overall size as was observed on the prior visit. The wound then consisted of 80% soft eschar and 20% pink granulation with serous exudate, but no infection or odor, upon which Cheung determined that the wound was stable and had reasonable healing potential. He changed the treatment protocol for this wound from dry protective dressing daily, or as needed, to Collagenase both daily, and as needed. He

continued to recommend repositioning the decedent and floating the decedent's heels while he was in bed. The size of the wound to the left lateral ankle had increased slightly, and consisted of 90% slough and 10% pink granulation, with serosanguinous exudate, but no infection or odor. Cheung determined that the wound continued to be stable and had reasonable healing potential, and continued to recommend application of Collagenase on a daily basis and as needed, along with repositioning and floating the decedent's heels. On that same date, Cheung recommended a venous doppler study of the decedent's bilateral lower extremities to rule out peripheral vascular disease. On January 20, 2015, Dastain performed the recommended study, which was negative for evidence of deep vein thrombosis.

Also on January 20, 2015, a wound care nurse notified Registered Nurse Myrna Evangelista that the decedent had developed a fluid-filled closed blister on his left heel, measuring 1.8 cm by 2 cm. Evangelists notified staff to off-load the decedent's heels when he was in bed and to turn and reposition him every two hours. On January 21, 2015, Cheung saw the decedent for the third time, and noted that the size of the wound to his right lateral ankle had slightly decreased, and then consisted of 100% soft eschar and 0% pink granulation, with serous exudate, and no infection or odor, while the pressure wound to the left lateral ankle was slightly larger in length and slightly smaller in depth than on the previous visit, and by then consisted of 90% yellow slough and 10% pink granulation, with serosanguinous exudate and no infection, but that an odor was present. Cheung modified the treatment protocol for this wound to a wash with a 25% solution of Dakin's sodium hypochlorite antiseptic and thereafter the application of Collagenase both on a daily basis and as needed, along with continued repositioning and floating of the decedent's heels. That same date, Cheung noted the presence of the left-heel ulcer, and recommended repositioning and treatment with dry protective dressings both on a daily based and as needed. He again recommended an arterial doppler test to rule out peripheral vascular disease of the bilateral lower extremities, as well as an X-ray of the decedent's left foot to rule out osteomyelitis.

As Dr. Diamond summarized it, on January 24, 2015, the arterial doppler of the decedent's bilateral lower extremities was performed, and revealed peripheral vascular disease with diffuse atherosclerotic plaquing. He stated that elevated peak systolic velocity was seen in the right posterior tibial artery, suggesting stenosis of greater than 50%, while stenosis under 50% was suspected as extending from the common femoral arteries through the popliteal arteries, and otherwise bilaterally. X-rays of the decedent's left foot that were taken on the same date revealed no acute fracture or dislocation. Although osteoarthritis and osteoporosis were present, there was no radiographic evidence of osteomyelitis.

Cheung next saw the decedent on January 28, 2015, at which time the size of the wound to his right lateral ankle had increased slightly, and consisted of 80% yellow slough and 20% pink granulation, with serous exudate, but no infection or odor. The treatment plan remained unchanged. The left lateral ankle wound had increased in size, and consisted of 60% soft eschar and 40% pink granulation, with serosanguinous exudate, and no infection, but an odor remained present. The treatment plan for that wound remained the same as well. Cheung opined that the left lateral ankle wound worsened due to the decedent's arterial insufficiency and age but that, in the absence of gangrene or an active infection, surgery was not indicated. The blister wound on the decedent's left heel remained, and the treatment protocol was changed to the application of a Xeroform dressing both on a daily basis, and as needed, along with frequent repositioning and floating of the heel.

On January 28, 2015, Cheung recommended a vascular surgery consultation. Dastain agreed, and arranged for John Lantis, M.D., to examine the decedent on February 10, 2015. Before Dr. Lantis could examine the decedent, however, the decedent was transferred to Riverside's long-term care unit due to his development of a fever and other physical deterioration. Upon the decedent's transfer to that unit, Riverside personnel noted not only the two ankle wounds and the one left heel wound that were then being treated, but also the presence of an excoriation to the left and right buttocks. They further recorded that his sacrum

was red and non-blanchable. Cheung saw the decedent for the fifth and last time on February 4, 2015. At that examination, Cheung noted that the wounds that previously had been diagnosed and treated remained virtually unchanged, and recommended continuation of the existing treatment protocols. Later that day, the decedent was transferred from Riverside to St. Luke's/Mount Sinai Roosevelt. On February 6, 2015, the decedent underwent an above-the-knee amputation at that hospital, after which he continued to decline. On February 16, 2015, the decedent was admitted to hospice care at MJHS Hospice and Palliative Care, with a diagnosis of Alzheimer's Disease, sepsis secondary to osteomyelitis and pneumonia, unstageable right ankle pressure ulcer, stage II sacral ulcer, hypertension, atrial fibrillation, and benign prostatic hypertrophy. The decedent died on February 21, 2015.

Dr. Diamond noted that Cheung's role in the decedent's treatment was in his capacity as a wound-care consultant, obligating him to evaluate and recommend treatment of existing wounds and optimize prevention strategies. According to Dr. Diamond, the actual implementation of such strategies was the obligation of Riverside's nursing staff and the institution itself, a conclusion supported by Autencio's deposition testimony. Dr. Diamond further explained that the overall management of the decedent's care rested with Dastain, and that Cheung could only make recommendations. In this regard, he concluded that the responsibility for accepting or rejecting Cheung's treatment recommendations rested with the decedent's medical team. Dr. Diamond asserted that "[a] review of the chart makes clear that CHEUNG did not enter any orders; instead, Dr. Dastain issued the orders, which were often entered by the wound care coordinator, Mr. Autencio."

Dr. Diamond opined that, at the first examination, Cheung performed an appropriate physical examination to evaluate the decedent's pressure ulcers, and recommended a treatment plan that was reasonable, and based on the patient's clinical picture. He averred that Cheung's conduct was well within the standard of care. Dr. Diamond further concluded that, at each subsequent visit, Cheung properly recognized the decedent's medical history, conducted

an appropriate examination, made appropriate diagnoses and observations, made the proper recommendations for the treatment of each of the wounds, made the appropriate adjustments to the treatment protocol based on the decedent's progress of lack thereof, made the proper recommendations for further testing, and made appropriate and timely recommendations for examination and treatment by specialists, including a consultation with a vascular surgeon after the decedent had been diagnosed with peripheral vascular disease. As Dr. Diamond explained,

“[t]he oxygen and nutrients that new blood carries to the wound are key to successful healing. A wound that is not getting enough blood could take at least twice as long to heal, if it heals at all. This was determined to be the reason that the decedent's wounds were not healing. It is also a sign that had mechanical debridement been performed, the wounds from same would have had a very low likelihood of healing.

“As a result, CHEUNG appropriately recommended a vascular surgery consult to evaluate the decedent's non-healing pressure ulcers that were complicated by peripheral vascular disease. A vascular surgeon could evaluate the decedent and propose available surgical interventions to increase blood flow to the decedent's lower extremities, which would help the decedent's wound healing ability. As an internal medicine/wound care consultant, it would be inappropriate for CHEUNG to recommend specific vascular surgical interventions as same would be outside the scope of his practice.”

It is well settled that the movant on a summary judgment motion “must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case” (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see CPLR* 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, “[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility” (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact

(see *Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

“The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even ‘arguable’” (*De Paris v Women’s Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; see *Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

“To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury” (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (see *McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; see generally *Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record,

addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (see *Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (see *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (see *Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; see *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to

preclude an award of summary judgment in a defendant’s favor (see *Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

Dr. Diamond’s affirmation established, prima facie, that Cheung did not depart from good and accepted medical practice in his capacity as a wound care consultant, either in his examinations of the decedent, his diagnoses of the nature of the decedent’s wounds, or his recommendations of a treatment protocol, further testing, and additional consultations in connection with each of the decedent’s wounds. It also was sufficient to establish that his conduct did not cause or contribute to the decedent’s injuries. Inasmuch as the plaintiff elected not to oppose Cheung’s motion, she has failed to raise a triable issue of fact, and Cheung’s motion must be granted.

Accordingly, it is

ORDERED that the motion is granted, the defendant Ming Cheong, M.D., is awarded summary judgment dismissing the complaint insofar as asserted against him, and the complaint is dismissed insofar as asserted against the defendant Ming Cheong, M.D.; and it is further,

ORDERED that, upon the court’s own motion, the action is severed against the defendant Ming Cheong, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint against the defendant Ming Cheong, M.D.; and it is further,

ORDERED that the remaining parties to the action shall appear for a pretrial conference on May 23, 2023, at 10:00 a.m.

This constitutes the Decision and Order of the court.

4/13/2023  
DATE

  
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JOHN J. KELLEY, J.S.C.

CHECK ONE:

CASE DISPOSED

NON-FINAL DISPOSITION

GRANTED

DENIED

GRANTED IN PART

OTHER

APPLICATION:

SETTLE ORDER

SUBMIT ORDER

CHECK IF APPROPRIATE:

INCLUDES TRANSFER/REASSIGN

FIDUCIARY APPOINTMENT

REFERENCE