

Orlando v Daniyan

2025 NY Slip Op 35287(U)

June 1, 2025

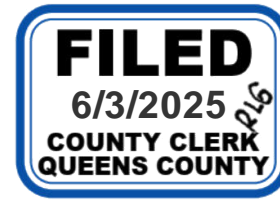
Supreme Court, Queens County

Docket Number: Index No. 720522/2020

Judge: Tracy Catapano-Fox

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This opinion is uncorrected and not selected for official publication.



Short Form Order

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

-----X
CAROL ORLANDO, as the Executrix of the Estate of
ANTHONY ORLANDO, and CAROL ORLANDO,
Individually,

Plaintiff,

Index No. 720522/2020

Part MDP
Motion Date: April 30, 2025

-against-

Calendar No. 22
Sequence No. 1

ANTHONY DANIYAN, M.D., TOBIAS M. HOHL,
M.D., JULIA RIZZO, R.N., MEMORIAL HOSPITAL
FOR CANCER AND ALLIED DISEASES and
MEMORIAL SLOAN KETTERING CANCER
CENTER,

Defendants.

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The following papers numbered EF-18 to EF-123 read on this motion by defendants ANTHONY DANIYAN, M.D., TOBIAS M. HOHL, M.D., JULIA RIZZO, R.N., MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES and MEMORIAL SLOAN KETTERING CANCER CENTER for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212.

Papers
Numbered

Notice of Motion, Affirmation, Exhibits.....EF18-EF96
Affirmation in Opposition, Exhibits.....EF98-EF120
Reply Affirmation, Exhibits.....EF121-EF123

Upon the foregoing papers, it is ordered that this motion is determined as follows:

Defendants Anthony Daniyan, M.D., Tobias M. Hohl, M.D., Julia Rizzo, R.N., Memorial Hospital for Cancer and Allied Diseases, and Memorial Sloan Kettering Cancer Center's motion for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212 is granted as to defendants Dr. Daniyan, Dr. Hohl, and RN Rizzo, and as to plaintiff's claims for lack of informed consent and negligent hiring. (*See generally DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2d Dept. 2017].) Defendants' motion is denied as to the medical malpractice and wrongful death

claims against institutional defendants Memorial Hospital for Cancer and Allied Diseases and Memorial Sloan Kettering Cancer Center, to the extent that they may be vicariously liable for the acts and/or omissions of their employees. (*See generally Fuessel v. Chin*, 179 A.D.3d 899 [2d Dept. 2020].)

Plaintiff commenced this action for medical malpractice, wrongful death, lack of informed consent, negligent hiring and loss of services arising out of pressure injuries plaintiff decedent Anthony Orlando sustained while in defendants' care. Plaintiff filed the Summons and Complaint on November 2, 2020 and issue was joined by defendants via the filing of their Verified Answers on January 28, 2021. It is noted decedent Anthony Orlando passed away on November 1, 2018 caused by cardiopulmonary arrest due to polymicrobial sepsis and CMML.

Defendants argue they are entitled to summary judgment and dismissal of plaintiff's Complaint, and present the pleadings, the parties' deposition testimony, decedent's medical records, and the expert affirmations of Roy J. Goldberg, MD, FACP, AGSF, CMD and Amir Steinberg, MD, FACP in support of their motion. Defendants argue they did not depart from accepted standards of care or proximately cause or contribute to decedent's injuries and death. Rather, defendants argue they rendered care and treatment that was appropriate and in accord with good and accepted medical and nursing practices. Defendants argue dismissal is warranted as to defendant Dr. Daniyan, because he did not become involved in decedent's care until two days before his death, at which point decedent already had a stage IV sacral pressure ulcer, sepsis, malnutrition, and a poor prognosis. They further argue Dr. Daniyan is an oncologist who was not responsible for treatment of decedent's pressure ulcers, and there are no alleged departures related to decedent's cancer treatment. They argue dismissal is warranted as to Dr. Hohl because as the attending physician he was not responsible for the treatment of decedent's pressure ulcers. Defendants argue RN Rizzo's involvement with decedent ended by 7:36am on the day of his admission, during which she performed an appropriate and timely evaluation and properly requested a wound care team consultation. As RN Rizzo provided care and treatment limited to decedent's date of admission, they argue she cannot be liable for decedent's injuries and death. Defendants further argue plaintiff cannot maintain a claim for lack of informed consent because decedent signed consent forms and was given lifesaving treatment that no reasonable person would deny. Defendants further argue plaintiff cannot maintain a cause of action for negligent hiring, because plaintiff cannot establish any employees of the institutional defendants departed from the standard of care. Defendants similarly argue that because all the direct claims should be dismissed, plaintiff cannot maintain a derivative claim for loss of services.

Defendants present the expert affirmation of Dr. Roy J. Goldberg in support of their motion. Dr. Goldberg affirmed to being a physician licensed in New York and board-certified in internal medicine with a certificate of advanced qualifications in geriatric medicine. Dr. Goldberg further affirmed to reviewing the pleadings, deposition testimony, and decedent's medical records

in rendering opinions. He affirmed to being fully familiar with the applicable standard of care based upon his training and experience providing care to individuals with pressure ulcers. Dr. Goldberg opined to a reasonable degree of medical certainty that defendants' care and treatment of decedent was at all times in full accordance with good and accepted standards of practice, and did not cause or contribute to decedent's injuries.

Dr. Goldberg reviewed decedent's medical history and noted decedent was admitted to Memorial Sloan Kettering Cancer Center (hereinafter referred to as "MSKCC") on June 30, 2018 through its Urgent Care Center. Decedent was 78 years old and had been suffering from chronic myelomonocytic leukemia (hereinafter referred to as "CMML") for three years. Decedent presented to MSKCC for the management of cough, congestion, fever with chills, progressive right neck swelling and right-sided weakness due to history of stroke, and was timely assessed by RN Julia Rizzo upon admission. RN Rizzo noted a sacral skin tear, gave decedent a Braden scale score of 18, and initiated an appropriate care plan including moisturizing the skin, applying skin barrier ointments, avoiding diapers and blue pads, frequent linen changes, turning and repositioning every two hours, and patient/caregiver instructions on measures to prevent pressure injuries. Dr. Goldberg noted RN Rizzo had no further contact or involvement with decedent.

Dr. Goldberg noted decedent was also seen and assessed by the wound care team on his admission, and was found to have incontinence-associated dermatitis ("IAD"). He noted decedent received appropriate treatment, including cleaning with normal saline, patting dry, applying Triad, and a repositioning schedule was in place, as well as a fall prevention care plan. Dr. Goldberg noted on the day of admission, a sepsis alert was triggered and the rapid response team (hereinafter referred to as "RRT") called. Decedent underwent a neck CT-scan and surgery to drain an infected neck abscess, and he remained sedated postoperatively in the intensive care unit (hereinafter referred to as "ICU"). Decedent was transferred back to the leukemia service the same day where he continued to be followed by the wound care team. Dr. Goldberg noted decedent was incontinent of bowel and remained fully incontinent during the duration of admission, which further increased decedent's risk of developing pressure ulcers.

Upon transfer to the leukemia service, the wound care team noted a flapless superficial coccyx skin tear on July 5, 2018. On July 8, 2018, decedent's neck abscess infection returned, and had to be drained again. Dr. Goldberg noted on July 11th, the wound care team examined decedent and noted the coccyx area appeared to be healing and all interventions continued. Decedent developed several health issues including acute kidney injury, respiratory failure and septic shock, and was intubated and given steroids and blood transfusions. Wound care assessed decedent's skin tear on August 5, 2018 as a coccyx deep tissue injury, and additional interventions were implemented, including fluidized positioning device and heel protection. Dr. Goldberg noted by August 12, 2018, wound care noted decedent's pressure injury had grown, and treatment was modified to discontinue Triad, apply wound gel, and cover it with Biatain foam dressing. Decedent

refused the z-flo cushion but permitted offloading with pillows. By the following day, the coccyx pressure injury was deemed unstageable and treatment was again modified to include a Centrella max specialty bed, and Dr. Goldberg opined this was not unusual given decedent's overall significantly declining health.

Dr. Goldberg noted on August 18, 2018, the family reported decedent had increased pain with pressure injury at 6 out of 10. He noted decedent was on a Hillrom Centrella bed, and the option of a Clinatron bed was discussed, but the appropriate decision was made for decedent to remain on the Centrella bed. Dr. Goldberg noted decedent was transferred to the ICU on August 22nd for respiratory failure and septic shock, where he remained until September 2nd. Dr. Goldberg noted the wound was slowly improving as of August 22nd and pain to the sacral area improved slightly. He noted the family requested a Clinatron bed, but wound care believed it was contraindicated and decedent appropriately remained on the Centrella Max support surface. Dr. Goldberg noted as of September 2, 2018, decedent was transferred to the Specialized Advanced Care Unit and returned to the leukemia service on September 5th, with a poor prognosis and active issues including CMML with increasing white blood count, encephalopathy/delirium and sacral ulcer.

Dr. Goldberg noted decedent continued to have episodes of delirium and complained of 7 out of 10 sacral pain on September 21, 2018. He noted the family declined all pain medication except Tylenol and declined antipsychotics for his delirium. Dr. Goldberg noted decedent's sacral pressure was assessed but showed no evidence of sepsis or wound infection. Dr. Goldberg noted the Plastic and Reconstructive Surgical Team (hereinafter referred to as "PRS") was consulted because wound care found the ulcer had worsening necrotic tissue that did not respond to chemical debridement. He noted the plan was for mechanical debridement because there was no sign of sepsis and no acute need for operative debridement. Dr. Goldberg opined appropriate treatment changes were implemented, including Dakin's solution, and decedent was recommended for imaging to evaluate underlying collection and/or osteomyelitis of pelvis.

Dr. Goldberg noted on September 21, 2018, decedent was seen by supportive care, which noted his ongoing delirium and poorly controlled pain due to sacral decubitus ulcer was difficult to manage due to the family's reluctance to administer opioids. A bedside debridement was performed on September 26th and a Clinatron Rite-Hite air fluidized mattress was implemented two days later. Dr. Goldberg noted as of October 9, 2018, decedent was not a candidate for wound VAC placement due to persistent necrotic tissue surrounding the sacral ulcer. He also noted PR advised the wound required a flap for healing given its size and severity, but decedent was not a candidate because of his poor nutritional status and active malignancy indicating he was unlikely to heal. Dr. Goldberg noted the family requested no labs be drawn, declined a PEG tube and denied Hydroxyurea the day prior, despite decedent's white blood count greater than 40.

Dr. Goldberg noted decedent underwent another bedside debridement on October 12, 2018, as he continued not to be a surgical candidate due to his medical comorbidities. He noted decedent underwent bedside debridement and wound VAC placement on October 16th, which was discontinued overnight after bleeding was noted. Dr. Goldberg noted the next morning decedent's wound was described as Stage 4, with no odor, and coccyx pain of 6 out of 10. Dr. Goldberg noted the wound VAC was replaced on October 17th and decedent continued to be followed by wound care and PRS for the sacral wound, including turning and offloading every two hours and additional therapies. By October 23rd decedent was declining turning and repositioning and his family was declining pain medication. On October 26, 2018, an ethics consult was held on that date to address goals of care with a family that were noted to have "unrealistic expectations for [decedent] recovery". Dr. Goldberg noted defendant Dr. Anthony Daniyan saw decedent for the first time on October 30, 2018, and had an extensive conversation with decedent's family regarding his overall functional decline and critically ill status, during which the family expressed hope decedent would return to his normal functional status from one year prior. Dr. Goldberg noted on November 1, 2018, decedent was noted to be "actively dying" with poorly controlled dyspnea and sacral ulcer pain, but the family insisted he was not in pain and continued to refuse pain medication. He noted decedent passed away that evening from cardiopulmonary arrest due to polymicrobial sepsis and CMML.

Dr. Goldberg opined to a reasonable degree of medical certainty that defendants complied with the standard of care and did not depart from good and accepted practice. Dr. Goldberg also opined decedent's death was not caused by his sacral pressure ulcer or any infection related to it, but rather the pressure ulcer was a symptom of the chronic and terminal leukemia which caused his death. He opined decedent was admitted to MSKCC with CMML, a blood cancer that rendered him immunocompromised with impaired ability to maintain skin integrity and heal, due to the high abnormal white blood count and low platelet count.

Dr. Goldberg opined RN Rizzo timely assessed decedent and noted he had a sacral skin tear and was at risk for pressure ulcers. He opined RN Rizzo appropriately implemented care plans taking into account decedent's comorbidities and risk factors, and properly carried out the extensive interventions in place. Dr. Goldberg opined RN Rizzo implemented the care plan and applied barrier cream on June 30, 2018, and placed an order referring decedent to the wound care team, and had no further contact or involvement with decedent. He opined RN Rizzo acted entirely in accordance with the standard of care, and she was not negligent nor caused or contributed to decedent's injuries.

Dr. Goldberg opined defendants' documentation in the MSKCC chart was excellent and demonstrated all interventions were appropriately and timely placed. He opined decedent was regularly and consistently followed by the wound care team from his admission. Dr. Goldberg explained decedent had incontinence associated dermatitis upon admission which reduced his

mobility and sensory awareness, caused skin break down, increased the risk of developing pressure injuries, and caused inflammation and skin damage. Dr. Goldberg explained the dermatitis was mistaken for the skin tear, but opined the discrepancy in the wound's initial description had no impact on the plan of care or efficacy of treatment, as each would have resulted in the same outcome. Dr. Goldberg opined decedent was properly treated with creams, dressings, and a repositioning schedule and decedent's care plan was modified as needed based on the condition of his injury. Dr. Goldberg further reasoned decedent's treatment was balanced against his comorbidities and his inability to heal, as his treating physicians were trying to minimize the pain and suffering from certain procedures against their potential benefits.

Dr. Goldberg opined decedent did not require a special low air loss mattress at the time of admission, because he did not have a pressure injury then and his Braden scale indicated mild risk. He further opined there was no delay in placing an air mattress, as a fluid mobilized overlay was placed on August 5, 2018 before the sacral skin tear developed into a deep tissue injury. Dr. Goldberg opined appropriate treatment recommendations were properly carried out based upon the wound team's thorough and regular assessments, and when the assessments revealed changes to decedent's wounds, proper treatment changes were made. He further opined given decedent's overall declining health, it was unsurprising and not uncommon for decedent's deep tissue injury to become an unstageable pressure ulcer within one week, despite all reasonable interventions in place.

Dr. Goldberg opined decedent was consistently followed by the PRS service for treatment of the sacral pressure ulcer, in addition to the wound care team. Dr. Goldberg also opined it was not a departure by MSKCC to not staff a wound care physician, and noted the PSR team and plastic and general surgeons were wound care physicians fully equipped and qualified to treat pressure ulcers. He further opined there was no delay in providing wound VAC therapy, as decedent was not a candidate for wound VAC placement prior to October 16, 2018 due to persistent necrotic tissue surrounding the sacral ulcer.

Dr. Goldberg opined plaintiff's allegations regarding failure to appreciate decedent's pain are entirely unfounded and contradicted by the medical records. Dr. Goldberg reasoned the treatment team wanted to prevent spikes in pain crisis, which led to agitation, confusion and delirium, but decedent's family consistently refused pain medication and antipsychotics for his delirium, even when they were advised death was imminent. He noted the medical records show decedent refused care, including turning and repositioning, the use of a z-flo cushion and participation in physical therapy/occupational therapy, despite education. Dr. Goldberg opined the absence of the recommended treatment had no bearing on the development of decedent's pressure ulcer, infection or death, and decedent's outcome would have been the same due to his aggressive cancer.

Dr. Goldberg also opined the development from dermatitis to a pressure ulcer was unavoidable given decedent's multiple intertwined comorbidities including incontinence, immobility, and malnutrition. Dr. Goldberg reasoned decedent's CMML was a contributing factor because leukemia often results in immobility, debilitation, and impaired functioning. Dr. Goldberg further opined decedent's increasing white blood cell count from the CMML impaired his wound healing and made him more susceptible to chronic infections. Dr. Goldberg also opined plaintiff's claims pertaining to sepsis and infection are entirely unfounded. He opined none of defendant's acts or omissions were a proximate cause of decedent's infection and sepsis, as decedent was on a sepsis alert upon admission and developed repeated chronic infections because of the CMML. Dr. Goldberg further reasoned decedent was prescribed medication to combat the infections, but they were unavoidable due to his comorbidities and weakened immune system as a result of suffering from a chronic and terminal illness.

Dr. Goldberg opined Dr. Daniyan did not depart from the applicable standard of care nor did his treatment cause decedent's injuries and death. He opined Dr. Daniyan did not render care or treatment related to decedent's pressure ulcer and sepsis, as he is an oncologist who did not become involved until two days before decedent passed away, and there are no claims related to decedent's leukemia care. Dr. Goldberg opined Dr. Daniyan was not liable for decedent's pain and suffering, as he had numerous discussions with decedent's family urging them to allow the recommended pain management, which they declined. Dr. Goldberg opined Dr. Hohl did not depart from the applicable standard of care nor did his treatment cause decedent's injuries or death. He opined that as the attending physician, Dr. Hohl was neither consulted for decedent's pressure ulcer, nor should he have been, because it was the responsibility of the wound care team. Dr. Goldberg further opined that to the extent the individually named defendants were involved, they did not depart from the applicable standards of care or cause decedent's injuries and death.

Dr. Goldberg also opined plaintiff's claim for lack of informed consent is entirely without merit, as decedent signed consent forms for several treatments and received life-saving medical care that no reasonable person would deny. Dr. Goldberg opined decedent's injuries and death were not caused by defendants, as the cause of death was cardiopulmonary arrest due to polymicrobial sepsis and CMML. He opined decedent's pressure injury was unavoidable despite defendants' actions or inactions and his death was ultimately caused by the aggressive cancer.

Defendants also present the expert affirmation of Dr. Amir Steinberg in support of their motion. Dr. Steinberg affirmed to being a physician licensed in New York and board-certified in internal medicine, medical oncology, and hematology. Dr. Steinberg further affirmed to reviewing the pleadings, deposition testimony, and decedent's medical records in rendering his opinions. Dr. Steinberg opined to a reasonable degree of medical certainty that no act or omission by defendants proximately caused decedent's injuries. He opined nothing defendants did or did not do caused or contributed to the development or deterioration of decedent's sacral wound, infection or death,

which he opined was clinically unavoidable due to decedent's underlying conditions and prognosis. Dr. Steinberg noted CMML is among the most aggressive chronic leukemias and is universally fatal absent a stem cell transplant. He further noted the average life expectancy for a patient with CMML is approximately thirty months, which decedent had exceeded by the time of admission to defendants' hospital.

Dr. Steinberg noted decedent presented upon admission with a sacral skin impairment which RN Rizzo documented as a sacral skin tear and later, the wound team noted as incontinence-associated dermatitis (IAD). He opined the discrepancy in description is immaterial as defendants' care plan and interventions were appropriate for either condition. Dr. Steinberg noted decedent's multiple comorbidities related to CMML, and opined despite the implementation of appropriate and proper treatments and interventions based on timely assessments, the development and deterioration of decedent's sacral wound was clinically unavoidable and merely a symptom of decedent's chronic and terminal illness, and not the cause of it.

Dr. Steinberg opined RN Rizzo cannot be liable for decedent's injuries and death, as her care and treatment was limited to June 30, 2018, the day decedent was admitted, and she acted entirely in accordance with the standard of care. He opined the wound team closely followed decedent's sacral skin impairment, and they ordered numerous interventions and made appropriate treatment changes based on their near-daily assessments. Dr. Steinberg opined in addition to decedent's already impaired wound healing due to decedent's CMML, the long standing medications needed for CMML treatment further impeded his wound healing abilities. He further opined nothing defendants did or did not do caused or contributed to decedent's infections, including urinary tract infection and sepsis. Dr. Steinberg opined decedent's infections were a result of his terminal condition and immunocompromised status, and were additionally timely identified, thoroughly assessed, and properly treated. He opined the sacral wound was not infected during decedent's admission and showed no evidence of sepsis or wound infection.

Dr. Steinberg opined plaintiff's claims against Dr. Hohl regarding failure to appreciate sepsis are without merit. He opined Dr. Hohl did not observe decedent, but only discussed decedent's condition with the fellow who saw decedent on November 1, 2018, the date of his death. Dr. Steinberg opined decedent had already been treated for sepsis and infection which Dr. Hohl agreed should continue, and he had no responsibility for decedent's pressure ulcer care. Dr. Steinberg further opined plaintiff's claims that defendants failed to appreciate plaintiff's pain are without merit, as the record demonstrates the numerous attempts defendants made to convince plaintiff and family to provide pain management to decedent, but they declined. He further opined that the absence of the recommended pain treatment had no bearing on the development of decedent's infection or pressure ulcer, which would not have healed, and his outcome and prognosis would have been the same given the nature of his disease.

Dr. Steinberg opined plaintiff's claims against Dr. Daniyan are without merit because, as an oncologist, Dr. Daniyan would not have been consulted on the management of decedent's pressure ulcer or infection. He also opined Dr. Daniyan did not become involved in decedent's care until two days before decedent's death, and had no prior role in decedent's treatment. Dr. Steinberg opined Dr. Daniyan's treatment of decedent, whose injuries preexisted his limited involvement in decedent's care, was entirely in accordance with acceptable standards of medical care, and nothing Dr. Daniyan did or did not do proximately caused decedent's injuries and death. He opined plaintiff's claim of lack of informed consent should be dismissed as decedent signed multiple consent forms for defendants' care and treatment, including incision and drainage procedures, dialysis, sacral pressure ulcer debridement and wound VAC placement. Based upon the foregoing, defendants argue they are entitled to summary judgment and dismissal of plaintiff's Complaint.

Plaintiff opposed the motion and argued defendants failed to establish a prima facie entitlement to summary judgment. Plaintiff argued defendants' motion is untimely because per the Preliminary Conference Order, motions for summary judgment must be made within sixty days of the filing of the Note of Issue. Plaintiff also argued defendants' experts failed to lay a proper foundation and failed to address all of defendants' departures, including whether decedent's wound was timely and properly debrided and whether a surgical debridement should have been done. Plaintiff also argued defendants' experts ignored the medical records and parties' deposition testimony, which demonstrate that despite the care plan, decedent was not turned and repositioned every two hours. Plaintiff further argued her experts' opinions demonstrate departures from good and accepted medical practice and confirm a causal relationship between the departures and decedent's injuries and death. Plaintiff further argued Carol Orlando's derivative claims for loss of services and loss of consortium should not be dismissed in light of her testimony concerning decedent's contribution to the home before his admission to MSKCC and death.

Plaintiff presented the affirmation of a physician licensed in New York and board-certified in general surgery in opposition to defendants' motion. The expert affirmed to be fully familiar with the standard of care in 2018 as it relates to the prevention, diagnosis and treatment of bedsores. Plaintiff's expert affirmed to reviewing the motion papers, deposition testimony, and decedent's medical records in rendering opinions. Plaintiff's expert opined bedsores are a "never event" in medicine that never occur absent negligence and an indicia of patient abuse and neglect. Plaintiff's expert further opined to a reasonable degree of medical certainty that there were several deviations in the standard of care by defendants that were substantial factors in decedent's pressure injury and death. Plaintiff's expert opined decedent did not have the pressure ulcer upon admission, even though he had been diagnosed with CMML three years prior and was incontinent of urine. The expert opined decedent was at a high risk for developing a pressure ulcer, but a proper care plan was not put in place or executed. Plaintiff's expert opined the standard of care for a high-risk patient required prophylactic measures including turning and repositioning decedent every two

hours and utilizing a low air loss mattress. Plaintiff's expert also opined the standard of care required a surgical debridement by August 18, 2018 at the latest when the wound was covered with necrotic tissue. The expert opined the standard of care is to perform debridements for necrotic wounds, and failure to remove necrotic tissue caused the wound to worsen, become more difficult to manage, and substantially increased decedent's risk of infection.

Plaintiff's expert opined defendants' failure to surgically debride decedent's wound until September 26, 2018 was a deviation in the standard of care and caused the wound to worsen. The expert opined the standard of care required defendants to apply a wound VAC after the September 2018 debridement. Plaintiff's expert opined wound VACs promote healing, remove excess moisture and debris, and prevent further tissue death, and defendants deviated from the standard of care in failing to place a wound VAC after the September debridement, which was a substantial contributing factor to decedent's worsening pressure injury, sepsis and death.

Plaintiff's expert opined decedent developed a pressure injury at defendant hospital because defendants deviated from the standard of care by failing to take prophylactic measures. The expert opined pressure injuries are readily preventable if measures are appropriately carried out even in patients with comorbidities such as CMML. Plaintiff's expert further opined defendants should have moved decedent frequently, kept him out of bed as much as possible, cleaned wounds, turned decedent every two hours and provided an offloading air mattress. Plaintiff's expert opined defendants failed to ensure decedent was turned every two hours, as the standard of care required to prevent excess pressure to the skin that causes pressure ulcers to develop. The expert opined the nursing intervention flowsheets confirm decedent was turned on average one-to-two times per day, which is grossly inadequate and a deviation from the standard of care. Plaintiff's expert opined that even if a patient does not want to be moved every two hours, the standard of care requires a physician to speak with the patient about turning and assist with the physical act to ensure the patient is moved.

Plaintiff's expert disagreed with Dr. Goldberg's opinion that defendants' staff acted appropriately to prevent pressure ulcers by turning and repositioning decedent, and opined defendants deviated from the standard of care in failing to turn and reposition him every two hours. The expert further opined this deviation was a substantial contributing factor to decedent's skin integrity interruptions and decedent's pressure injury developed as a result of defendants' neglect. Plaintiff's expert opined defendants' failure to provide decedent with a low air loss specialty mattress was a deviation from the standard of care and proximate cause of his injuries. The expert opined Nurse Rizzo's failure to take steps to order decedent a low air loss mattress was a deviation from the standard of care and a substantial contributing factor to decedent's development of a pressure injury. Plaintiff's expert disagreed with Dr. Goldberg's opinion that a low air mattress was not necessary upon admission because decedent did not have a pressure ulcer at that point. Plaintiff's expert reasoned decedent was admitted with a Braden score of 18 which classified him

as high-risk for skin injury and warranted a specialty mattress to prevent a pressure injury, not to react to an existing one. The expert opined had decedent been timely provided with a low air loss mattress, decedent would not have developed a pressure injury, and had decedent been provided with a low air loss mattress between August 6, 2018 and September 29, 2018, decedent's pressure injury would have healed and he would not have died from polymicrobial sepsis. Plaintiff's expert also disagreed with Dr. Goldberg's opinion that the Hillrom Centrella Max bed was sufficient when it was implemented, and opined it is a foam mattress that is insufficient to properly offload and prevent pressure injuries.

Plaintiff's expert also disagreed with defendants' experts' argument that decedent's wound was clinically unavoidable and a symptom of his terminal illness. The expert opined decedent's pressure injury was caused by defendants' failure to turn and reposition him in bed, and failure to provide decedent with a specialty mattress. Plaintiff's expert opined CMML did not increase decedent's risk for developing a pressure injury, noting decedent had CMML for over three years prior to admission and was stable, able to eat solid food, and mobile. Plaintiff's expert opined decedent's worsening condition due to the pressure ulcer caused extreme pain which led to his limited function, mobility, and oral intake. Plaintiff's expert further reasoned decedent's neck wound that was surgically treated twice early in his admission healed, and if his CMML affected his ability to heal, it would have impacted his ability to heal the neck wound.

Plaintiff's expert further opined it was a deviation from the standard of care for PRS not to perform a surgical debridement immediately after the initial evaluation on September 21, 2018, knowing that enzymatic debridement was not working for more than one month before the consult. The expert opined it was a departure from the standard of care to recommend mechanical debridement on September 21, 2018, as mechanical debridement is not as exact as surgical debridement and contraindicated with a patient who has fragile skin and poor perfusion. The expert disagreed with PRS assessment that decedent was not a candidate for surgical debridement, which is not invasive and can be performed at a patient's bedside. Plaintiff's expert opined failure to surgically debride decedent between August 18, 2018 and September 26, 2018 was a deviation in the standard of care that was a substantial factor to the worsening of decedent's pressure injury that caused infection, sepsis and death. Plaintiff's expert also disagreed with Dr. Goldberg's opinion that PRS was constantly following up and reasoned PRS should have been consulted a month earlier, no later than August 18, 2018. Plaintiff's expert disagreed with Dr. Goldberg's opinion that the pressure injury did not cause decedent's death, and opined the pressure injury caused a septic infection which ultimately caused decedent's death.

Plaintiff also presented the expert affirmation of a physician licensed in New York and board-certified in internal medicine with sub-certifications in hematology and oncology. The expert affirmed to be fully familiar with the standard of care in 2018 as it relates to the prevention, diagnosis, and treatment of pressure ulcers in cancer patients. Plaintiff's expert affirmed to

reviewing the motion papers, deposition testimony, and decedent's medical records in rendering opinions in this case. Plaintiff's expert opined to a reasonable degree of medical certainty that defendants' deviations from the standard of care caused decedent's pressure injury to develop and worsen, and resulted in decedent's premature death caused by polymicrobial sepsis. The expert acknowledged decedent's CMML contributed to his risk of developing a pressure ulcer, but opined it did not render it a foregone conclusion and could be prevented in patients with CMML the same way it is prevented in other patients. Plaintiff's expert opined the standard of care required defendant hospital staff to frequently turn and reposition decedent and provide a specialty air mattress. The expert opined defendants failed to perform these prophylactic measures and caused decedent to develop a pressure injury.

Plaintiff's expert disagreed with Dr. Steinberg's opinion that decedent's pressure injuries were clinically unavoidable, and opined defendants' failure to properly treat decedent's pressure injury caused the wound to worsen. The expert further opined had decedent been properly and timely turned and repositioned, provided a low flow air mattress, surgically debrided and provided with a wound VAC after his September 26, 2018 debridement, decedent's pressure injury would have been successfully treated and healed without causing infection, sepsis and death. Plaintiff's expert opined throughout decedent's admission, his wound was contaminated by urine and sepsis due to decedent's incontinence, and the pressure injury became infected, causing polymicrobial sepsis and death.

Plaintiff's expert opined defendants deviated from the standard of care in failing to timely surgically debride decedent's pressure injury. The expert opined the standard of care required surgical debridement to remove necrotic tissue and promote healing, and failure to remove necrotic tissue from a wound causes it to worsen and increases the risk of infection. Plaintiff's expert opined the failure to surgically debride decedent's wound between, at the latest, August 18, 2018 and September 25, 2018 was a deviation in the standard of care and a substantial contributing factor to decedent's worsening wound, infection and death. The expert further opined defendants deviated from the standard of care in failing to utilize a wound VAC after the surgical debridement, which caused further tissue damage and increased decedent's risk of infection, and was a substantially contributing factor to decedent's worsening wound, pain and suffering, sepsis and death. Plaintiff's expert further opined decedent's polymicrobial sepsis was caused by his pressure injury and disagreed with Dr. Steinberg's opinion that decedent's CMML prevented healing. The expert further opined decedent's polymicrobial sepsis was not caused by an infection in his gut, as decedent's intraabdominal complained had resolved by the time the polymicrobial infection was detected. Based upon the foregoing, plaintiff argued defendants' motion should be denied.

Pursuant to CPLR §3212, a motion for summary judgment "shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party." (*Smith v. City of*

New York, 210 A.D.3d 53, 68 [2d Dept. 2022].) The proponent of a summary judgment motion 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. (*Morejon v. New York City Tr. Auth.*, 216 A.D.3d 134, 136 [2d Dept. 2023].) If there is any doubt as to the existence of a triable issue of fact, the motion must be denied. (*Id.*) The failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposition papers. (*Winegrad v. N.Y. Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 [1985]; *see also Antonyuk v. Brightwater Towers Condo Homeowners' Assn., Inc.*, 147 A.D.3d 711, 712 [2d Dept. 2017].) In determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party, and all reasonable inferences must be resolved in favor of the nonmoving party. (*Matter of New York City Asbestos Litig.*, 33 N.Y.3d 20, 25 [2019].) Additionally, the court's function in determining a motion for summary judgment is not to resolve issues of fact or determine matters of credibility, but merely to determine whether such issues exist. (*Reyes v. S. Nicolio & Sons Realty Corp.*, 212 A.D.3d 851, 852-853 [2d Dept. 2023].) Once the moving party has demonstrated a prima facie entitlement to summary judgment, the burden then shifts to the non-moving party to demonstrate the existence of material issues of fact. (*See generally Coscia v. Mosca*, 203 A.D.3d 695 [2d Dept. 2022].)

In moving for summary judgment in a medical malpractice action, the defendant must establish a prima facie case that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby, and the plaintiff in opposition must submit evidentiary facts or materials to demonstrate the existence of a triable issue of fact. (*Stukas v. Streiter*, 83 A.D.3d 18, 24 [2d Dept. 2011].) In presenting opposition to raise a triable issue of fact, the plaintiff is required to provide an affidavit of merit by a medical expert, and the failure to submit an affidavit by a medical expert competent to attest to the meritorious nature of the plaintiff's claims requires dismissal of the Complaint. (*Id.* at 28.) Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. (*Buch v. Tenner*, 204 A.D.3d 635, 638 [2d Dept. 2022].) In general, a hospital may be vicariously liable for the negligence or malpractice of its employees acting with the scope of employment under the doctrine of *respondeat superior*. (*See Valerio v. Liberty Behavioral Mgt. Corp.*, 188 A.D.3d 948 [2d Dept. 2020].)

To establish a cause of action to recover damages based upon lack of informed consent, a plaintiff must prove “(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury.” (*Gilmore v. Mihail*, 174 A.D.3d 686, 688 [2d Dept. 2019].)

Defendants established a prima facie entitlement to summary judgment, as they demonstrated through the production of the documentary evidence and expert affirmations that they did not depart from accepted standards of care or proximately cause decedent's injuries and death. Defendants demonstrated through Dr. Goldberg and Dr. Steinberg's affirmations that decedent was suffering from CMML, a chronic and aggressive terminal illness, upon his admission to MSKCC and his pressure injury was unavoidable due to his litany of intertwined comorbidities. Defendants further demonstrated through their experts' affirmations, medical records, and deposition testimony that the CMML treatment lowered decedent's white blood cell count which made it difficult to fight off infection and created a breeding ground for infection. Defendants further demonstrated due to decedent's comorbidities, decedent had limited mobility, incontinence, and poor nutrition, which also contributed to his skin breakdown and inability to heal. Defendants demonstrated through their experts' opinions that decedent was not a candidate for surgical debridement, wound VAC, or a PEG tube, based upon his worsening illness and low likelihood of recovery and healing. Defendants further demonstrated decedent's pressure injury was unavoidable and did not cause his death, but instead was caused by a septic infection. Defendants also demonstrated through the deposition testimony and medical records that despite the advice of physicians, decedent's family consistently refused pain medications and antipsychotics to manage his pain and episodes of delirium.

Defendants further established through the above evidence that RN Rizzo did not depart from accepted standards of care or proximately cause decedent's injuries and death. They established RN Rizzo properly evaluated decedent during admission, prepared an appropriate care plan, treated his skin breakdown with creams and dressings, and appropriately called for a wound consult. They further demonstrated RN Rizzo's care and treatment of decedent was limited to that date, and she was not involved in his care past the morning of his admission. Defendants further demonstrated Dr. Hohl, as the attending physician, did not manage and was not required to manage decedent's wound care, and did not depart from accepted standards of care nor proximately cause decedent's injuries. Defendants further demonstrated Dr. Daniyan did not depart from accepted standards of care, as he was an oncologist with no involvement in decedent's wound care treatment and did not see decedent until two days before his death. Defendants also demonstrated decedent gave written informed consent to several procedures and received lifesaving medical care that no reasonable person would deny. Defendants further demonstrated the institutional defendants did not negligently hire, supervise, or retain their employees. Finally, defendants demonstrated if plaintiffs cannot maintain their direct claims, plaintiff Carol Orlando cannot maintain derivative claims for loss of services and loss of consortium. Plaintiff's argument that defendants' motion should be denied as untimely is without merit. Based upon the foregoing, defendants established a prima facie entitlement to summary judgment and dismissal of plaintiff's Complaint.

Plaintiff failed to raise a triable issue of material fact with respect to defendants Dr.

Daniyan and Dr. Hohl, as plaintiff failed to sufficiently rebut those portions of defendants' motion with competent, admissible evidence. (*See Keun Young Kim v. Lenox Hill Hosp.*, 156 A.D.3d 774, 775 [2d Dept. 2017][holding that in opposing a motion for summary judgment, a plaintiff must demonstrate the existence of a triable issue of fact as to the elements on which the defendant has met his or her initial burden].) As plaintiff's experts presented no opinions with regard to specific acts or omissions of defendants Dr. Daniyan and Dr. Hohl, there are no triable issues of fact in dispute.

Plaintiff also failed to raise a triable issue of material fact with respect to RN Rizzo. Plaintiff's experts opined RN Rizzo departed from accepted standards of care by failing to order a low air mattress, but failed to demonstrate the standard of care required the admitting nurse to order a low air mattress upon admission rather than the wound care team. Plaintiff's experts also failed to demonstrate RN Rizzo not ordering a low air mattress immediately upon decedent's admission caused or contributed to decedent's injuries, as their claims with regard to RN Rizzo are conclusory and vague. Additionally, this departure was not claimed in the Bills of Particulars and cannot be raised for the first time in opposition to summary judgment. (*See Bacalan v. St. Vincents Catholic Med. Ctrs. Of N.Y.*, 179 A.D.3d 989, 992 [2d Dept. 2020][“A plaintiff cannot, for the first time in opposition to a motion for summary judgment, raise a new or materially different theory of recovery against a party from those pleaded in the complaint and the bill of particulars.”].) Moreover, RN Rizzo provided no further treatment to decedent beyond the morning of his admission, and therefore did not cause or contribute to decedent's injuries and death. As plaintiff's experts failed to sufficiently rebut defendants' prima facie case with respect to RN Rizzo, there are no triable issues of fact.

Plaintiff also failed to raise triable issues of material fact with respect to the claims for lack of informed consent and negligent hiring and supervision, as plaintiff failed to sufficiently rebut those portions of defendants' motion. (*Id.*) As plaintiff's experts presented no opinions regarding those claims, there are no triable issues of fact in dispute.

However, plaintiff raised triable issues of fact with respect to whether the institutional defendants' employees departed from accepted standards of care by not turning and repositioning decedent at least every two hours, not performing a timely surgical debridement, and postponing the wound VAC, and whether these departures proximately caused or contributed to decedent's injuries and death. Plaintiff's experts sufficiently addressed and refuted defendants' experts opinions, and opined it is the hospital staff's duty to ensure the patient is turned and repositioned an appropriate amount of times. Plaintiff further demonstrated through the expert opinions, medical records, and photographs that decedent's pressure injury worsened during admission at the hospital and was serious enough to warrant more turning and repositioning to keep pressure off the skin. Plaintiff's experts opined the standard of care required timely surgical debridement and earlier performance of the wound VAC to treat decedent's skin wound, and the failure to do

so proximately caused decedent's injuries and death. Plaintiff also raised issues of fact whether decedent's pressure injury was unavoidable given decedent's comorbidities, as plaintiff's experts explained how pressure injuries are a "never event" and would not have occurred, or would have been greatly mitigated, if decedent was turned and repositioned every two hours, the surgical debridement was performed, and a wound VAC was done earlier. Plaintiff's expert further raised issues of fact as to whether defendants' departures proximately caused decedent's pressure injury to develop, worsen and cause his pain and suffering, infection and death. The experts opined CMMC treatment does not prevent all patients from suffering pressure ulcers and infection, and raised issues of fact whether defendants' staff should have more aggressively cared for and treated decedent's pressure ulcer, including performing surgical debridement earlier in admission. As plaintiff's experts sufficiently rebutted those portions of defendants' experts' opinions, they raised triable issues of material facts in dispute. (*See Mehtvin v. Ravi*, 180 A.D.3d 661, 664 [2d Dept. 2020][summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, as issues of credibility are properly left to a jury for its resolution].) Plaintiff also raised triable issues of fact with respect to the claims for loss of services, as there is sufficient deposition testimony to support Carol Orlando's derivative claims.

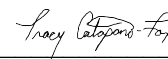
Accordingly, defendants Anthony Daniyan, M.D., Tobias M. Hohl, M.D., Julia Rizzo, R.N., Memorial Hospital for Cancer and Allied Diseases, and Memorial Sloan Kettering Cancer Center's motion for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212 is granted as to defendants Dr. Daniyan, Dr. Hohl, and RN Rizzo, and as to plaintiffs' claims for lack of informed consent and negligent hiring. Defendants' motion is denied as to the medical malpractice and wrongful death claims against institutional defendants Memorial Hospital for Cancer and Allied Diseases and Memorial Sloan Kettering Cancer Center, to the extent that they may be vicariously liable for the acts and/or omissions of their employees and staff's actions and omissions. It is hereby

ORDERED that plaintiff's Complaint is dismissed as to defendants ANTHONY DANIYAN, M.D., TOBIAS HOHL, M.D., and JULIA RIZZO, R.N., and it is further

ORDERED that plaintiff's claims for lack of informed consent and negligent hiring are dismissed, and it is further

ORDERED that the parties shall appear for a pretrial conference on Wednesday, May 28, 2025 at 9:30 am in Courtroom 48. This constitutes the decision and Order of the Court.

Dated: June 1, 2025



Hon. Tracy Catapano-Fox, J.S.C.

