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

PRESENT: LOBIS Justice

PART 6

WEISS, MINDY

-v-

THE NEW YORK PRESBYTERIAN HOSPITAL IN THE CITY OF N.Y., ET AL.

INDEX NO. 112007/07

MOTION DATE 7/17/12

MOTION SEQ. NO. 04

MOTION CAL. NO. ____

The following papers, numbered 1 to 21 were read on this motion to/for (summary judgment).

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-19
Answering Affidavits — Exhibits	SEE MS 005 X-MOT 17-25
Replying Affidavits	20-21

Cross-Motion: [X] Yes [ ] No

Upon the foregoing papers, it is ordered that this motion

FILED
OCT 18 2012
COUNTY CLERK'S OFFICE
NEW YORK

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION & ORDER

Dated: 10/12/12

JOAN B. LOBIS J.S.C.

Check one: [ ] FINAL DISPOSITION [X] NON-FINAL DISPOSITION

Check if appropriate: [ ] DO NOT POST [ ] REFERENCE

[ ] SUBMIT ORDER/ JUDG. [ ] SETTLE ORDER/ JUDG.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 6

----------x

MINDY WEISS, as Mother and Natural Guardian of MICHAEL WEISS,

Plaintiff,

Index No. 112007/2007

-against-

Decision and Order

THE PRESBYTERIAN HOSPITAL IN THE CITY OF NEW YORK d/b/a NEW YORK PRESBYTERIAN HOSPITAL-NEW YORK WEILL CORNELL CENTER, THE JAMAICA HOSPITAL MEDICAL CENTER DIAGNOSTIC and TREATMENT CORPORATION, Individually and d/b/a JAMAICA HOSPITAL MEDICAL CENTER, JAMAICA HOSPITAL MEDICAL CENTER, SAINT MARY'S HEALTHCARE SYSTEM FOR CHILDREN, INC., Individually and d/b/a SAINT MARY'S HOSPITAL FOR CHILDREN, SAINT MARY'S HOSPITAL FOR CHILDREN, LONG ISLAND JEWISH MEDICAL CENTER, Individually and d/b/a SCHNEIDER CHILDREN'S HOSPITAL, and SCHNEIDER CHILDREN'S HOSPITAL,

Defendants.

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JOAN B. LOBIS, J.S.C.:

Motion sequence numbers 004 and 005, brought on by order to show cause, are consolidated for disposition. In this negligence/medical malpractice action, defendants Jamaica Hospital Medical Center ("JHMC") (motion seq. no. 004) and The New York and Presbyterian Hospital, s/h/a The Presbyterian Hospital in the City of New York d/b/a New York Presbyterian Hospital-New York Weill Cornell Center ("NYPH") (motion seq. no. 005) move for an order granting them summary judgment dismissing plaintiff Mindy Weiss' complaint. Weiss, who is suing on behalf of her son, Michael Weiss, opposes the motions and cross-moves for leave to serve a late

certificate of merit and notice of medical malpractice action.

On October 1, 2006, Michael, a 15-year-old pedestrian, was struck by a speeding car and sustained a broken femur, a lacerated spleen, and severe head and brain injuries. He was taken, unconscious, by ambulance to JHMC, where he was intubated, his femur was stabilized, and a ventriculostomy, whereby a hole was drilled into his head and drains were placed into the ventricle to remove fluid externally to relieve intracranial pressure ("ICP"), was performed. That evening, he was transferred to NYPH's pediatric intensive care unit, which was better equipped to address his injuries. Michael was followed there by pediatric critical care intensivists, as well as by neurosurgery, trauma, and other teams. On the evening of his arrival, the neurosurgery team noted Michael's ICP's to be between 30-40 mmHg, normal allegedly being between 5-10 mmHg. An ICP of more than 20 mmHg can, according to NYPH's expert pediatric critical care physician, Margaret Satchell, results in brain damage or death. In an attempt to reduce Michael's ICP and prevent any further brain damage, Michael was put into a chemically induced coma, was administered various medication to sedate him and induce medical paralysis, his bed's head was raised, and he was provided with a cooling blanket to induce hypothermia.

On October 2, Michael underwent a procedure, during which his bowel was explored because there was a concern, which was ultimately unfounded, that his bowel was perforated. Also on that day, the external ventricular drains placed at JHMC were extended, and a Licox monitor was inserted to assess the oxygenation of Michael's brain tissue. Michael's ICP remained high that date and the next, and, on October 4 and 5, he experienced ICP spikes of over 20 mmHg.

An initial nutrition assessment of October 4 indicated that Michael was at risk for malnutrition, and another such note of October 6, indicated that he had inadequate intake. The nutritionist recommended, on October 4, that, when medically feasible, and if Michael's gastrointestinal tract were working, enteral[1] feedings be commenced, but, if that tract were not working, total parenteral[2] nutrition ("TPN") be considered. A radiology report that day revealed the presence of a feeding tube. As of October 4 and 5, the pediatric critical care attending found Michael to be well nourished. On October 6, Michael underwent an open reduction of his femoral shaft, and, several hours later, experienced ICP spikes. An orthopedic surgical note of that date indicated that the patient was to have physical therapy when he was medically fit. According to a nursing update, at 5:00 P.M. that day, feeds with Pediasure were started, but, at some point, the nasoduodenal tube ("ND") was found to be clogged. Michael experienced some ICP spikes in the low 20s during the day on October 7, but, in the evening, he started having consistently elevated ICP readings in the high 20s and up to 38 mmHg. At 1:00 that afternoon, Michael was turned on his side, and, according to the pediatric resident note of 2:00 P.M., Pediasure feeds were to continue.

On October 8, the spikes continued, reaching as high as 41 mmHg, so a hemicraniectomy, to remove part of Michael's skull and relieve pressure, was performed. The next day, a nurse indicated that Michael was tolerating the ordered diet and had "gained weight since [his] admission." NYPH chart, vol. 6, 110. The nutrition note of that date recites that "attempts for enteral feeding access unsuccessful" and that TPN was being considered. NYPH chart, vol. 6, 114.

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[1] Via that gastrointestinal tract. Stedman's Electronic Medical Dictionary, 4th ed.

[2] By means, other than through the gastrointestinal tract, such as intravenously or by injection. Id.

On October 9, Michael's ICP reached 20 mmHg once. The next day, NYPH started to wean Michael from sedation. On October 11, Michael's ICP reached 22 mmHg once, at 1:00 P.M. A half hour later, a course of physical therapy was commenced, the first session lasting for 75 minutes. At about 7:30 that evening, the pediatric critical care attending noted that the ICP values had become satisfactory, and that part of the plan was to adjust the ND, consider starting feeds from it, and to commence TPN, while establishing access to the ND. Michael was started on Pediasure that day.

On October 12, due to bloody returns in the ND, such feeds were stopped, and TPN feeds were to be, and in fact were, started the next day. Michael began a course of occupational therapy on October 12 and had a 75-minute occupational/physical therapy session. In order to test the degree of cerebral recovery, the ventriculostomy's drain was clamped that day, so that fluid could no longer drain, but was still able to measure ICP. That night, at 7:00, Michael's ICP spiked to 24 mmHg, and, then, after a diaper change, at around 9:00 P.M., Michael's ICP spiked again. As of October 13, the ICP was no longer spiking.

Early on the morning of October 14, a stage II sacral decubitus ulcer (also known as a pressure ulcer or a bedsore), measuring approximately 2 cm in diameter, was discovered. It was treated with various creams and skin coverings. Also, starting at 10:00 that evening, the hospital chart's Treatment Flowsheet's Activity/Positioning section reveals that Michael was turned twice to his right side. Prior to those entries, all of the flowsheets' entries were either blank or showed that Michael had been in a supine (on his back) position, with the exception of the one entry of October 7. Following October 14, the flowsheets showed intermittent turning to the right and left sides, but Michael was mainly kept in a supine position, and there were many blanks in the

Activity/Positioning sections. NYPH chart's Shift Assessment Plans of Care reveal that interdisciplinary teams discussed the plans of care and that such plans, on October 5, 6, 7, 8, 9, 12, 14, 15, 16, 19, 20, 22, 23, 24, 25, 26, 27, 29, and 30, included turning Michael every two hours, and that plans of various other days included maintaining his skin's integrity.

The ventriculostomy drain was removed on October 15. That day, the administration of Pedialyte was initiated, but feeds were then withheld due to a history of bloody NGT (evidently nasogastric tube) output. A stage I left heel pressure ulcer, measuring about 1" x 3/4" was discovered on October 16. That day, ND feeds of Pediasure resumed. The pediatric critical care attending's notes of October 17 and 18 characterized the patient as well developed and nourished, but a nutritional assessment note of October 17 indicated that Michael's nutritional intake was inadequate. On October 19, Michael was extubated, but remained in a stupor-like state. On October 21, Michael had respiratory problems, which led NYPH to suspend ND feedings until October 23, on which day, a gastroenterology consult was requested for PEG tube placement, a procedure in which holes are punched into the stomach and abdominal wall and a feeding tube, which extends from the exterior of the abdominal wall into the stomach, is inserted. The pediatric gastroenterologist saw Michael the next day and was to discuss the PEG tube placement with the attending physician. According to Weiss, around the third week of Michael's admission, the NYPH staff tried to administer nutrition through a nasogastric tube several times, but had a problem with a kinking tube, and believed that PEG tube placement would be needed. On October 26, it was decided that a PEG tube would be placed.

An October 26 note indicates that the stage II ulcer was healing. A nursing ulceration

note of October 28 indicates that there was a sacral ulcer with overall dimensions of 5 ½ x 7 ½ cm, which was stage I on the edges and stage II in the center. A nursing shift assessment note of October 29 recites that the heel ulcer was 3 x 3 cm and blackened. The PEG tube was placed on October 27. A critical care attending note of October 28 recites that Michael was receiving Pedialyte and was to be transitioned to Pediasure, which, according to the pediatric resident note of October 29, was started that day, via the PEG tube. On October 31, an update note indicates that the sacral ulcer had a small amount of bleeding. On October 31, Michael was believed to be sufficiently stabilized for transfer back to JHMC.

Over the course of his stay at NYPH, Michael lost about 20 pounds. According to Weiss, she expressed her concern about Michael's weight loss to the staff, and at least one physician, a Dr. Greenwald, a neurosurgeon, allegedly told her that, when one is brain injured, the brain grabs calories from the body, a phenomenon which he denominated a "coma diet." Weiss ebt, at 477- 81. Dr. Greenwald allegedly did not tell Weiss that Michael's lack of being fed was due to his high ICP, but merely explained that the staff was not as concerned with his nutrition as it was with getting his ICP under control and stabilizing him. Id. at 181-82. On October 31, 2006, NYPH transferred Michael to JHMC's acute rehabilitation facility. On the day of Michael's arrival at JHMC, a skin assessment was performed there. A note of that assessment indicates that Michael had a 3 ½ x 2 cm heel ulcer and a 5 x 3 cm stage II sacral ulcer, for which various treatment was rendered. As a result of a nutritional consult of November 1, Michael was placed on a 1920-calorie diet, which was administered through the PEG tube.

On November 24, 2006, Michael was transferred to former defendant, Long Island

Jewish Hospital ("LIJ"), to address kidney stones. Several days later, Michael was transferred to former defendant St. Mary's Hospital, and received treatment there, as well as at subsequent medical institutions. According to Weiss, among some of the treatment rendered to Michael, after his November 30, 2006 release from LIJ, was the placement of a piece of bone in his skull to cover the hole left by the hemicraniectomy, at least one debridement of the sacral ulcer, and a procedure to incise it. Weiss testified that, at one point, after Michael's release from movants' hospitals, she was able to see the bone through the sacral ulcer and that Michael developed osteomyelitis of that bone, which infection was treated and resolved. She further testified that she believed that the sacral ulcer, finally healed in late 2007, i.e., close to a year after it was discovered, and that its presence, after Michael's release from the defendant hospitals, impeded his physical therapy because of a concern that aggressive therapy would cause tearing and shearing of the open wound.

Weiss commenced one action against JHMC and others and another action against NYPH, which actions were ultimately consolidated. Weiss' pleadings principally allege that the defendants' malpractice/negligence caused the formation of pressure ulcers, and that, after they formed, defendants failed to properly treat them to promote their healing, and failed to avoid the formation of additional bedsores. Weiss maintains that the defendants failed to provide appropriate nutritional support to avoid skin breakdown, adequately turn and position Michael, provide pressure reducing devices, and render treatment to promote healing and prevent the development of "multiple" bedsores. JHMC Bill of Particulars, ¶ 3; NYPH Supplemental Bill of Particulars, ¶ 5. As to NYPH, the pleadings add that the alleged failures violated Public Health Law § 2801-d, 10 N.Y.C.R.R. 415.12 (c) (2) and 42 C.F.R. 483.25 (c).

NYPH now moves for an order granting it summary judgment dismissing the complaint and any cross claims. JHMC moves for an order granting it summary judgment dismissing the complaint. Weiss opposes the motions and cross-moves for an order permitting her to file a late notice of a medical malpractice action and a late certificate of merit.

The party moving for summary judgment bears the initial burden of prima facie establishing its entitlement to the requested relief by eliminating all material allegations raised by the pleadings. Alvarez v. Prospect Hosp., 68 N.Y.2d 320 (1986); Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851 (1985); Kuri v. Bhattacharya, 44 A.D.3d 718 (2d Dep't 2007). The failure to meet that burden mandates the denial of the application, "regardless of the sufficiency of the opposing papers." Winegrad, 64 N.Y.2d at 853. However, where the movant demonstrates its prima facie entitlement to summary judgment, the burden shifts to the other side to raise a material triable issue of fact warranting the motion's denial. Alvarez, 68 N.Y.2d at 324. Further, "the remedy of summary judgment is a drastic one, which should not be granted where there is any doubt as to the existence of a triable issue or where the issue is even arguable, since it serves to deprive a party of his day in court [internal citations omitted]." Gibson v. Am. Export Isbrandtsen Lines, 125 A.D.2d 65, 74 (1st Dep't 1987). In a malpractice action, the defendant, to meet its prima facie burden, must establish that it did not depart from accepted standards of practice, or that, even if it did, it did not proximately cause the patient's injuries. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010).

The branch of NYPH's motion, which seeks an order dismissing all claims based on violations of Public Health Law § 2801-d, is granted, without opposition, and all such claims are

dismissed, since Weiss does not dispute that such provision is inapplicable to hospitals. See Matter of Town of Massena v. Whalen, 72 A.D.2d 838, 839 (3d Dep't 1979) (under Public Health Law, "hospital is separate and distinct from a residential health care facility," which does not include hospitals); Cunningham v. Newman, 2009 NY Slip Op 33072(U), *5 (Sup. Ct. N.Y. County 2009), aff'd 81 A.D.3d 440 (1st Dep't 2011). Similarly 10 NY.C.R.R. 415.12 (c) is inapplicable to hospitals, since it falls under Part 415, which relates to minimum standards for nursing homes. 42 C.F.R. 483.25 (c) is also inapplicable because Michael's care was rendered in a hospital, and the foregoing provision pertains to the quality of care that must be rendered in nursing facilities. Accordingly, the branch of NYPH's motion, which seeks an order granting it summary judgment dismissing all claims based on violations of 10 N.Y.C.R.R. 415.12 (c) and 42 C.F.R. 483.25 (c), is granted, without opposition, and all such claims are dismissed.

The balance of NYPH's motion is supported mainly by its chart, Satchell's affirmation, and by the deposition transcript of Basma Albuliwi, a nurse who rendered care to Michael at NYPH on some night shifts. The essence of Satchell's position is that it would have been inappropriate to turn Michael until the sacral ulcer was discovered on October 14, because to turn him before then, when his ICP was unstable and spiking, and when movement, incurred by turning Michael, could have triggered more spiking, would have risked further brain injury. As to Michael's care rendered after the sacral ulcer was discovered, Satchell claims, for example, that it was appropriate, that the nurses' notes detail that Michael was turned every two hours, such as was allegedly done on October 19 and 20. To support the assertion that Michael was turned every two hours on those days, defense counsel references two plans of care for a shift on each of those days,

which indicate that the patient was to be turned every two hours. Satchell claims that, once Michael's ICP had improved, his sacral ulcer was properly treated. Additionally, Satchell claims that the ventricular tubing and monitor prevented turning Michael, as did the fact that he had a soft spot in his skull, as a result of the hemicraniectomy.

Satchell also claims (aff., ¶ 17) that it was "typical[]" to "withhold feeding a patient affected by neurological trauma to prevent hypoglycemic exacerbation of the brain injury," and to control the patient's sodium level to promote brain healing, and that it was, therefore, proper, during the first two weeks of Michael's hospitalization, to "withhold and minimize" his feeds. Further, Satchell claims that causation is speculative, because "some patients" get pressure ulcers, even if they are frequently turned, and that "[t]his is especially so" for critically ill patients who have been administered vasoconstricting drugs, such as Michael. Satchell aff., ¶ 27.

Weiss opposes the motion, relying on NYPH's chart and the affirmation of her expert internist, Joseph Namey, D.O. Namey disputes that appropriate care was rendered at NYPH, and asserts that, simply because turning had the potential to affect Michael's pressure, and the providing of nutrition had the potential to cause hypoglycemia, were not reasons to neglect the maintenance of Michael's skin and nutritional needs. Namey maintains that turning is required for patients who lack the ability to turn themselves to help them reperfuse ischemic skin by alleviating pressure from vulnerable areas. He observes that turning is not limited to large shifts of body weight, and can include partial turns or minimal movements. Namey notes that there were times when Michael's ICP was within normal limits, and that he should have been turned, but was not. He further claims that

Michael was bathed and received physical and occupational therapy, which all involved movement, and that this undermines Satchell's position that Michael could not have been turned until October 14. Namey urges that, if Michael were not permitted to have been turned, there would have been a doctor's order to that effect, and that not only was there no such order, but the hospital identified the need for turning Michael every two hours as early as October 5, as reflected in the chart. Yet, Namey observes, NYPH failed to turn Michael, except for on one occasion on October 7, before the sacral ulcer was discovered and the ICP was stabilized, and that, even after that time, NYPH failed to regularly turn him. Namey opines that the failure to properly turn Michael resulted in avoidable skin compromise, which required prolonged treatment for about 10 months. In reply, NYPH urges, among other things, that Namey lacks the qualifications to offer an opinion, since he is not licensed in New York, is not a pediatrician, and allegedly never worked with patients in an intensive care unit who were treated for neurological trauma.

NYPH's motion for an order granting it summary judgment dismissing the balance of Weiss' complaint is denied, since, aside from the fact that NYPH incorrectly asserted that this action only involves a sacral ulcer, and, therefore, failed to address the heel ulcer and the propriety of the treatment it rendered for it, there are issues at least as to whether NYPH failed to appropriately turn Michael to avoid the development of the sacral and heel ulcers, and as to whether such alleged continuing failure impeded the healing of the ulcers and caused, at minimum, the sacral ulcer to enlarge/worsen.

As to the threshold issue of Namey's competency to offer any opinion in this case,

an individual is qualified to offer an expert opinion if that individual is "possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the information imparted or the opinion rendered is reliable [internal quotation marks and citations omitted]." O'Boy v. Motor Coach Indus., Inc., 39 A.D.3d 512, 513-14 (2d Dep't 2007). An expert may be qualified based upon "[l]ong observation, actual experience and/or study. No precise rule has been formulated and applied as to the exact manner in which such skill and experience must be acquired." Steinbuch v. Stern, 2 A.D.3d 709, 710 (2d Dep't 2003) (internal quotation marks and citations omitted).

While Namey's affidavit is somewhat tenuous, for purposes of NYPH's summary judgment application, "where there is no opportunity to fully explore the scope of [his] expertise," I find it adequate. DaRonco v. White Plains Hosp. Ctr., 215 A.D.2d 339, 340 (1st Dep't 1995); cf. Limmer v. Rosenfeld, 92 A.D.3d 609 (1st Dep't 2012) (physician not required to be a specialist in a particular field; once physician purports to have requisite knowledge, issue of expert's qualifications to offer opinion must await trial). In particular, Namey, who is licensed in Florida, claims to be familiar with the standards of acute care nationally, and defense counsel does not assert that the standards in New York are different than they are in Florida, or, for that matter, nationally. In addition, while Namey's resume does not reveal that he ever worked exclusively in an ICU, defense counsel does not purport to have any personal knowledge when she opines, in her reply papers, that Namey never worked with patients in an intensive care unit who were treated for neurological trauma. Clearly, Namey has had no opportunity to respond to that allegation, and, as an internist, a clinical associate professor of internal medicine, and the director of hospital medicine

and the internal medicine residency program at a Florida hospital, he has likely seen acutely ill patients in an ICU setting, including those who have sustained neurological injury. Further, he has been the director of several skilled nursing and rehabilitation facilities, and may well have been involved in the treatment of neurologically impaired patients there. Even Satchell does not purport to be an expert in neurology, and defense counsel does not claim that the testimony of a neurologist is required. Also, it does not appear that the issues raised in this case, including the prevention, development, and treatment of pressure ulcers, the effects of blood sugar and sodium on ICP, and the effects of movement on ICP, are limited to pediatric cases. Thus, under the circumstances, the issue of Namey's qualifications should be left for trial. In any event, the bulk of NYPH's arguments in support of its motion is undercut by its own records, rather than by Namey's affirmation.

Satchell's claim that Michael could not be turned, because he had ventricular drains and the monitor in his head, is without merit, since the chart reveals that he was turned on October 7 when those items were present. Similarly, that Michael had a piece of his skull missing and, thus, allegedly could not be turned, is unavailing, since he had a piece of his skull missing until he had surgery to implant a piece of bone, which surgery was performed long after he left NYPH. Despite this fact, NYPH's records indicate that, after the hemicraniectomy, Michael was turned on occasion.

Satchell's claim that Michael could not have been turned before his ICP was stabilized, is also without merit, because Satchell and NYPH's counsel failed to address, in its initial and reply papers, that Michael was turned on October 7, when his ICP was unstable, and the multiple interdisciplinary team plans of October 5, 6, 7, 8, 9, and 12, that Michael was to be turned every two

hours, which plans were formulated, notwithstanding that Michael had been experiencing elevated ICP levels and spikes during that period. Even if Michael could or should not have been turned before October 14, NYPH failed to demonstrate that Michael was, thereafter, turned every two hours, despite the fact that, once again, there were multiple plans for him to be turned every two hours. The illustrative examples, upon which NYPH relies to show that Michael was turned every two hours on October 19 and 20, are merely references to pages in the chart showing the plans that Michael be turned every two hours, and do not specifically indicate that Michael was turned every two hours. Moreover, the chart's treatment flowsheets, which document the actual turning activity, fail to support NYPH's claim that Michael was regularly turned every two hours on those dates, or, for that matter, on or after October 14. See NYPH chart, vol. 3, 612-39.

Albuliwi, upon whom NYPH relies, testified that she did not make a determination as to whether to turn Michael based on his ICP, but inconsistently testified that, when Michael had spikes of 33, 35, and as high as 40 mmHg, he would not be turned. *See* Albuliwi ebt, at 39-41, 85. However, I note that Albuliwi's October 6, 8:00 P.M. shift note plan recites that the patient was to be turned every two hours, yet her vital sign flowsheet ICP entry for that same exact time reveals that Michael's ICP was 33 mmHg. Similarly, Michael's ICP was spiking to 35 mmHg at 8:00 P.M. on October 7, but, again, Albuliwi's note of the plan for that time was to turn Michael every two hours, notwithstanding the spikes. Albuliwi further declined to indicate whether Michael was turned by her, during her shifts between October 5 and 8, but, then, on prompting by defense counsel, seemed to change her answer. Id. at 85. For her shifts after October 15, Albuliwi first claimed that she could not recall whether she turned Michael every two hours, but later claimed that, to the best of her

recollection, she did, if she was allowed to and could turn him. Albuliwi ebt, at 82, 85. I further note that the deposition transcript, provided by codefendant JHMC, of another nurse, Shelly Khan, who treated Michael at NYPH, between October 20 and 22, reveals that she testified that she could not recall how often she had turned Michael, that there was no turning schedule, that she was not instructed to turn Michael every two hours, and that, during her shift, she did not recall him being turned every two hours. Additionally, while Michael received physical therapy, starting on October 11, the treatment flowsheets of that day until 10:00 P.M. on October 14 are either blank or show Michael in a supine position. All of this suggests that NYPH's increased documentation of turning activity, starting late on October 14, may have been due to the discovery of the sacral ulcer, rather than to a stabilization of Michael's ICP.

Satchell's claim that causation is speculative, because "some patients," especially those who are critically ill and are on vasoconstrictors, get pressure ulcers, even when turned, is inadequate to meet NYPH's prima facie burden of establishing a lack of causation, since Satchell fails to indicate the percentage of such patients who develop pressure ulcers when appropriately turned and does not go so far as to state that it is more likely than not that Michael would have had pressure ulcers, even if proper care had been rendered.

Additionally, Satchell's claim that feedings, during the first two weeks of admission, were withheld to avoid raising Michael's spiking ICP, is questionable, since Satchell does not discuss the specifics of Michael's feeding during that time, including that he was feed Pediasure on October 6, and that a note of October 7 indicated that he was to continue with such feedings, even

though his ICP was spiking on those days. Also, the nutrition note of October 8 seems to indicate that NYPH was having difficulty administering ND feeds, rather than it had made a decision not to feed Michael because it was concerned about increasing his ICP. Moreover, NYPH has not provided an affidavit from any physician who actually treated Michael stating that feeds were withheld to avoid raising Michael's ICP. Finally, as to NYPH, for reasons to be explained in connection with Weiss' cross motion, NYPH's claim that this action must be dismissed because Weiss failed to file a certificate of merit, pursuant to C.P.L.R. § 3012-a, is without merit.

As to JHMC's motion, its expert internist, Gisele Wolf-Klein, M.D., maintained that there was nothing in JHMC's records suggesting that the care it rendered caused or exacerbated the sacral or heel ulcers and that, in fact, JHMC took "all necessary measures ... to prevent a worsening of the skin breakdown." Wolf-Klein aff., ¶ 7; see, also, id., ¶ 16. She also claimed that these measures included placing Michael on an "appropriate diet," which was administered through a PEG tube (Wolf-Klein aff., ¶¶ 19, 21); placing boots on his feet; providing him with an air mattress; applying creams to his ulcers; elevating his feet; and turning him every two hours. According to Wolf-Klein, "[d]ue to th[is] superior care," the heel and sacral ulcers stayed the same throughout Michael's second admission to JHMC. Id., ¶ 26. Then, Wolf-Klein took the inconsistent position that, nothing which JHMC did or did not do, caused or worsened Michael's pressure ulcers, because Michael's "lack of mobility, diminished appetite, and resulting poor nutrition" rendered skin breakdown "unavoidable." Id., ¶¶ 30, 33, 38. She further urged that the ulcers were due to Michael's having been hit by a car, rather than to JHMC's care and treatment. Apparently in an effort to show a lack of any damages, Wolf-Klein added that there is no evidence that the bed sores'

presence interfered with any physical therapy sessions.

JHMC's motion for an order granting it summary judgment dismissing Weiss' complaint is denied, since there are issues at least as to whether its employees adequately turned Michael, and whether JHMC, therefore, failed to promote the healing of the ulcers, and caused the formation of the elbow ulcer and the worsening of the sacral ulcer. Specifically, Wolf-Klein's assertion, that Michael was turned every two hours while at JHMC, is not supported by the hospital chart, an omission which Namey notes. The hospital chart's "TBI & REHAB FLOW SHEET AND NURSING ASSESSMENT" pages, which are broken down by date and by eight-hour shift, contain a preprinted section for turning the patient every two hours. A check mark would be placed under a shift to show that the patient had been turned every two hours. On November 2, 2006, only the first shift contains a check. The other two shifts contain, an unexplained entry, "w/c." On November 11, none of the shifts is checked. On November 12, neither the first nor last shift is checked, but the middle shift states "OOB," presumably out of bed. On November 15, only two of the three shifts contain a check mark. The same is true with respect to November 22. None of the shifts is checked for November 23, and on November 24, the date when Michael was transferred from JHMC at 2:00 P.M., the shift that starts at 7:00 A.M. and ends at 3:00 P.M. is not checked.

JHMC's counsel's claim, that Weiss testified, at some unspecified page of her deposition, that Michael had been turned "every 15 to 20 minutes for every day he was in [sic]

hospital"[3] (Cote aff., ¶ 61), is unavailing, since Weiss testified that she did not stay at JHMC 24 hours a day. Moreover, any such testimony would clearly constitute hyperbole, since, even JHMC's expert only alleges that Michael was turned every two hours.

Wolf-Klein's claim, that the ulcers remained unchanged during Michael's stay, is also not supported by the record. Initially, it must be noted that Wolf-Klein did not, in her initial moving affirmation, address the fact that, on November 14, several days after the absence, on November 11 and 12, of any turning notations in the chart, a new ulcer, measuring 2 x 1 cm, was discovered on Michael's right elbow. Further, at 8:45 P.M. on November 14, the nurse on duty indicated in her nursing assessment, that the sacral ulcer appeared to be necrotic and that the doctor was aware of that fact. Additionally, while the sacral ulcer was yellowish white in color and measured 5 x 3 cm on admission to JHMC, on November 14, it was red. Moreover, on the day of Michael's discharge to LIJ, the LIJ chart's skin risk assessment, aside from noting the presence of the elbow and heel ulcers, listed the sacral ulcer as measuring 10 x 10 cm and at stage III, and the pediatric surgery consult note of the same day listed the sacral ulcer as having a necrotic center and as being at stage II-III.

Wolf-Klein's claim, that causation is lacking because of Michael's lack of mobility and diminished appetite, is unavailing. Aside from Wolf-Klein's internally inconsistent positions, that its superior care caused the ulcers to remain unchanged and that nothing it did or failed to do would have mattered, Namey maintains that it is precisely when a patient cannot turn (offload)

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[3] A search of the word "every" using Weiss' deposition's three word indices, failed to unearth such quote.

independently that offloading is required to help "re-perfuse ischemic skin" and prevent its deterioration. Namey aff. as to JHMC, ¶ 7. Namey further asserts, in effect, that the failure to turn Michael every two hours caused the development of "avoidable skin compromise and ... [the] deterioration [of] existing skin compromise." Id., ¶¶ 7, 12. I further note, on the issue of immobility that, although Michael was not ambulatory, his sacral ulcer eventually healed, as reflected in Weiss' deposition testimony and in the affirmation of a Dr. Moshe Yadoo, upon which JHMC relies on their motion.

Also, Wolf-Klein's claim of Michael's diminished appetite, was bald and conclusory, and made without reference to any particular facts in the JHMC chart, or to the fact Wolf-Klein claimed that JHMC had placed Michael on an appropriate diet, which was administered through a PEG tube, i.e., through his abdomen, rather than through his mouth. In any event, recognizing that Michael was at great risk for developing pressure ulcers, Namey disputes that the skin breakdown was unavoidable. Wolf-Klein's attempt, in her reply affirmation, to distance herself from her prior assertion, that JHMC appropriately turned Michael every two hours, by asserting, for the first time, that his condition did not permit such turning, is unavailing. Dannasch v. Bifulco, 184 A.D.2d 415, 417 (1st Dep't 1992) (purpose of reply papers is to address opposing arguments, not to seek relief based on new grounds or arguments).

JHMC's counsel's claim, that causation is lacking because Michael was allegedly comatose and could not have experienced any pain, is without merit, since JHMC fails to offer any expert opinion that Michael could not feel pain. Moreover, the JHMC chart shows that, although

Michael was in a somewhat vegetative state, during this hospitalization, he was awake and often alert, and was responsive to some stimuli, including tactile stimuli. A November 3, 2006 orthopedic consultant's report, contained in the JHMC record, indicates that, on examination, Michael "responds to pain." I also note that, even before Michael was transferred to JHMC, Michael was capable of experiencing pain. See, e.g., NYPH discharge note, NYPH chart, vol. 6, 404 (Michael "[a]wake to tactile stimuli").

That Weiss' expert physician, in another action commenced by her against the driver and/or owners of the car that struck Michael, opined that Michael's injuries included a sacral ulcer, fails to constitute an admission that such ulcer, its exacerbation, or its lack of healing was not due to JHMC's negligence/malpractice. Further, Wolf-Klein's assertion, that there is no evidence that the pressure ulcers inhibited Michael's physical therapy, is unavailing, since such assertion was conclusory and made without any evidentiary support. In light of the foregoing, JHMC's motion is denied.

Weiss' cross motion, which seeks leave to file a late certificate of merit and notice of medical malpractice, and deeming the certificate of merit and notice of medical malpractice action, appended respectively to her cross motion as exhibits "A" and "B," as served and filed nunc pro tunc, is, in the exercise of my discretion, granted to the extent that, within 30 days of service of a copy of this order with notice of entry, plaintiff is directed to serve and file an executed certificate of merit and, within that same 30-day period, is directed to file an appropriate executed notice of medical malpractice action, with the requisite documents attached. The copies appended to Weiss'

motion are not executed, and the boxes, under item 7 of the notice of medical malpractice action, have not been checked, nor have the requisite items, set forth under item 7, been attached. Defendants have not demonstrated any prejudice or willfulness on the part of the law firm representing plaintiff when it overlooked its obligation to timely file these documents, i.e., in committing law office failure, and, despite the passage of many years, defendants do not assert that they ever moved earlier to compel plaintiff to file these documents, or that they even requested them from plaintiff. See, generally, Tewari v. Tsoutsouras, 75 N.Y.2d 1, 11-13 (1989). Further, no showing of merit is needed to excuse a failure to timely serve a notice of medical malpractice action. Id. at 12. Defense counsels' reliance on case law (see, e.g., Santangelo v. Raskin, 137 A.D.2d 74 [2d Dep't 1988]), which treated a failure to timely serve a certificate of merit as a default requiring a showing of merit in order to avoid dismissal, is misguided, since that case law was abrogated about 20 years ago. See Bowles v. State of New York, 208 A.D.2d 440, 443-44 (1st Dep't 1994); Kolb v. Strogh, 158 A.D.2d 15 (2d Dep't 1990). Accordingly, it is hereby

ORDERED that Jamaica Hospital Medical Center's motion (seq. no. 004) for an order granting it summary judgment dismissing Mindy Weiss' complaint is denied; and it is further

ORDERED that The New York and Presbyterian Hospital, s/h/a The Presbyterian Hospital in the City of New York d/b/a New York Presbyterian Hospital-New York Weill Cornell Center's motion (seq. no 005) for an order granting it summary judgment dismissing Mindy Weiss' complaint and any cross claims is granted solely to the extent that all claims and any cross claims based on violations of Public Health Law § 2801-d and 10 N.Y.C.R.R. 415.12 (c) and 42 C.F.R.

483.25 (c) are dismissed, but is otherwise denied; and it is further

ORDERED that Mindy Weiss' cross motion for leave to file a late notice of medical malpractice action and to serve and file a late certificate of merit is granted to the extent that, within 30 days of service of a copy of this order with notice of entry, plaintiff is directed to serve and file an executed certificate of merit and, within that same 30-day period, is directed to file an appropriate, executed notice of medical malpractice action, with the requisite documents attached; and it is further

ORDERED that the parties shall appear for a pretrial conference on Tuesday, November 13, 2012, at 9:30 a.m.

Dated: October 12, 2012

ENTER:

JOAN B. LOBIS, J.S.C.