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Short Form Order

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART XXXVI SUFFOLK COUNTY

PRESENT:
HON. PAUL J. BAISLEY, JR., J.S.C.

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DARELL MURRAY,

Plaintiff,

-against-

BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER, SHLOMO PIONTKOWSKI, M.D., RAVINDRA KOTA, M.D. and ST. CHARLES HOSPITAL,

Defendants.

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INDEX NO.: 4764/08
CALENDAR NO.: 201500842MM
MOTION DATE: 6/9/16
MOTION SEQ. NO.: 007 MG; 008 MG
009 MG

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Upon the following papers numbered 1 to 75 read on these motions for summary judgment : Notice of Motion/ Order to Show Cause and supporting papers 1-31; 37-52; 53-65 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 32-36 ; Replying Affidavits and supporting papers 66-69; 70-73; 74-75 ; Other___ ; (and after hearing counsel in support and opposed to the motion) it is,

ORDERED that the following motions are hereby consolidated for the purposes of this decision and order and determined as set forth herein: and it is further

ORDERED that the motion (motion sequence no. 007) of defendant Shlomo Piontkowski, M.D. for an order pursuant to CPLR R. 3212 granting summary judgment dismissing the complaint is granted; and it is further

ORDERED that the motion (motion sequence no. 008) of defendant St. Charles Hospital for summary judgment in its favor dismissing the complaint is granted; and it is further

ORDERED that the motion (motion sequence no. 009) of defendant Ravindra Kota, M.D. for summary judgment in his favor dismissing the complaint is granted.

Plaintiff commenced this action seeking damages for injuries he allegedly suffered due to defendants' medical malpractice in their treatment of him for a gunshot wound he suffered on August 17, 2005. The complaint alleges that the plaintiff was treated for the gunshot wound at Brookhaven Memorial Hospital; that he became a surgical patient of Dr. Shlomo Piontkowski and Dr. Ravindra Kota; and that bullet fragments, which were permitted to remain in his right leg, caused an infection and, ultimately, the loss of his leg. Plaintiff also alleges he received treatment

at St. Charles Hospital and that treatment did not conform to good and accepted medical practice. Issue has been joined, discovery is complete and a note of issue was filed on May 6, 2015.

Defendants Dr. Shlomo Piontkowski, St. Charles Hospital, and Dr. Ravindra Kota now move for summary judgment on the grounds that the care and treatment that plaintiff received conformed with good and accepted medical practice. In support of the motion defendants submit, *inter alia*, plaintiff's medical records, copies of the pleadings, plaintiff's verified bill of particulars, an affidavit of Dr. Randall Ehrlich, the affirmations of Dr. Rosemary Soave and Dr. Robert J. Ward, the deposition transcripts of the plaintiff, and the deposition transcripts of defendants. In opposition to these motions, the plaintiff submits, *inter alia*, his attorney's affirmation, and an affirmation of Dr. Michael R. Golding.

On August 7, 2005, at 5:45 a.m., plaintiff presented at Brookhaven Hospital with gunshot wounds to both of his legs. Plaintiff was initially seen by Dr. Ravindra Kota. At 6:10 a.m., Dr. Piontkowski, a board certified private orthopedic surgeon, was asked to consult. X-rays revealed, in relevant part, that plaintiff had comminuted fractures of the mid tibia and fibula diaphysis, and displacement of fracture fragments in his right leg. At 6:30 a.m., hospital progress notes indicate the presence of pedal pulses, indicating that there was no compartment syndrome. The progress notes indicate that at 8:00 a.m. plaintiff's right leg had a moderate to large amount of bleeding, at 8:10 a.m. the pedal pulses were barely palpable, and at 9:30 a.m. there were no pedal pulses. Dr. Piontkowski performed a fasciotomy at 10:20 a.m. on plaintiff's right leg. A fasciotomy is a surgical procedure where the fascia (a band or sheet of connective tissue, primarily collagen, beneath the skin that attaches, stabilizes, encloses, and separates muscles and other internal organs) is cut to relieve tension or pressure, commonly to treat the resulting loss of circulation to an area of tissue or muscle. Dr. Piontkowski testified that when plaintiff was taken into surgery he was suffering from compartment syndrome, and that prior to the surgery he informed plaintiff that he could lose his right leg because of infection, non-union or malunion. After performing the fasciotomy, Dr. Piontkowski performed an exploration of plaintiff's right tibia and fibula. Dr. Piontkowski testified he did not remove all the bullet fragments "because [he] felt that they were not removable without causing further damage to the circulation and to the nerve." He testified he applied an external fixator to the proximal fragment and to the distal fragment in order to stabilize plaintiff's right leg. Dr. Kota, who assisted during the surgery, testified his role was to hold retractors and cut the sutures. He testified he did not play any role during the fasciotomy, and that it was not his role to search for bullet fragments as he was not the primary surgeon.

Dr. Piontkowski testified that after performing surgery on plaintiff he conferred with Dr. Prichep, a vascular surgeon. Dr. Prichep recommended an arteriogram. At 11:20 a.m., Dr. Kota ordered a right femoral arteriogram on plaintiff's right leg, which was performed by Dr. MacGyver. The results of the arteriogram showed good vessel flow and Dr. Piontkowski testified there was, therefore, no need for vascular intervention.

Dr. Piontkowski testified that he prescribed Ancef and Gentamicin as antibiotics. Plaintiff was admitted to the ICU with orders to examine the leg every hour. Hospital records indicate that plaintiff was informed that there "was a large probability that he would lose his right leg."

On August 8, 2005, plaintiff's care was transferred to Dr. Kota. On August 11, 2005, Dr. Piontkowski was away for vacation and Dr. Prichep covered for him. On August 12, 2005, plaintiff refused wound treatment, because "he had a right to." Hospital records document that Dr. Kota advised plaintiff that if infection set in he would lose the leg. Hospital records indicate that on August 15, 2005 plaintiff's wound had fresh bleeding with no foul exudate, and no signs or symptoms of infection were present on August 15, 2005. Plaintiff repeatedly refused physical therapy, and on August 17, 2005 indicated that he would only eat fruits and vegetables.

On August 22, 2005, Dr. Prichep performed a split-thickness skin graft to plaintiff's medial and lateral wounds on his right thigh with no noted complications. Hospital records indicate that plaintiff continued to smoke cigarettes during his hospital stay. On August 26, 2005, plaintiff was discharged and hospital records indicate that he refused a dressing change. Discharge instructions included daily dressing changes and to keep his right leg elevated.

On August 28, 2005, plaintiff received care from Brookhaven Hospital Home Health Agency. Records indicate no sign of infection. On August 29, 2005, plaintiff refused pin care of the external fixator device.

On August 31, 2005, plaintiff was admitted to Southside Hospital Emergency Department by ambulance, and records indicate that plaintiff reported that he fell off a chair. X-rays reveal a comminuted fracture of the mid-shaft of the right tibia and a segmental fracture of the mid-tallus formation. Plaintiff, who refused to allow a fuller assessment of his condition, was discharged against medical advice.

On September 1, 2005, plaintiff was readmitted to Brookhaven Memorial Hospital after reinjuring his leg by "banging the external fixator." Admission records indicate he had a temperature of 97.5, difficult to palpate distal pulses and a poor prognosis. Plaintiff reported pain in his right leg and was admitted. On September 2, 2005, records indicate no wound discharge or foul odor. Records indicate that on September 3, 2005 plaintiff walked 10 feet, but refused a new IV line.

On September 3, 2005, plaintiff was transferred to St. Charles Hospital. Plaintiff's admission records from September 3, 2005 indicate active bleeding from the wound site with edema and tenderness of the right lower extremity. Pulses were intact to his right lower extremity with good capillary refill, his foot was warm and there were no noted neurological defects. On September 4, 2005, plaintiff refused to get out of bed. On September 5, 2005, plaintiff's medical records indicate that he was bleeding below the second lateral pin insertion on his right leg. On September 6, 2005, St. Charles Hospital records indicate that the graft had taken on plaintiff's right side at 90% and there were no signs of infection. On September 9 and September 11, 2005, no drainage was noted at plaintiff's wound site.

Dr. Piontkowski's notes from September 9, 2005 indicate that plaintiff called and indicated that he had been going to different hospitals to attempt to remove the fixation device. Dr. Piontkowski recommended additional time for bone healing and antibiotics. On September 15, 2005, Dr. Piontkowski examined plaintiff and his notes indicate a clean wound, that the skin

graft had taken, a 2+ dorsali pedis pulse and a numb feeling over plaintiff's foot with minimal motion of his right toes. On September 16, 2005, records indicate plaintiff continued to smoke. On September 17, 2005, plaintiff refused therapy and left the hospital floor to smoke.

On September 22, 2005, a CT scan revealed a soft hematoma within the mid-region of plaintiff's right lower leg. Records also indicate that plaintiff had a low-grade fever and had removed the dressing from his leg. On September 23, 2005, Dr. Piontkowski noted seeing no signs of healing, good pulse and swelling over plaintiff's right leg. He again advised plaintiff to continue with antibiotics and rehabilitation at St. Charles Hospital. On October 1, 2005, plaintiff refused blood work. Despite experiencing chest pain, he also refused oxygen and refused to stay in his room, missing a radiology visit. On October 3, 2005, X-ray reports reveal a mild osseous healing seen about the tibial fracture fragments and no osseous healing about the fibular fracture fragments. On October 6, 2005, plaintiff cancelled an appointment at the Hospital for Special Surgery with orthopedic surgeon, Dr. Dean Lorich. On October 8, 2005, plaintiff again left the hospital to smoke. On October 9, 2005, plaintiff initially refused to have his dressing changed and also went outside to smoke. On October 12, 2005, plaintiff's right leg was again bleeding and radiology records indicate that plaintiff refused an angiogram. Despite a stat order of orthopedic surgeon Dr. Arnold, plaintiff also refused an arteriogram. On October 15, 2005, plaintiff refused a dressing change. On October 16, 2005, records reveal plaintiff was found removing the dressing himself. On October 17, 2005, against advice, plaintiff left the hospital floor to smoke. Records also reveal that plaintiff was touching the wounds on his leg and was advised that he could spread infection. On October 18, 2005, plaintiff continued to smoke and refused an arteriogram, despite warnings. Hospital records from October 19, 2005 reveal plaintiff continued to pick at his wounds. On October 20, 2005, a vascular note indicates no evidence of infection or compartment syndrome. On October 21, 2005, plaintiff refused a CT scan and refused an IV.

On October 27, 2005, plaintiff presented at Dr. Piontkowski's office with a large hematoma. Plaintiff was advised by a covering physician that Dr. Piontkowski was ill, but to go to St. Charles Emergency Room to have the hematoma drained and was prescribed an antibiotic. St. Charles Hospital records on the same day indicate moderately bloody drainage with a foul smell. St. Charles Hospital records from October 29, 2005 state plaintiff was picking at an open area of his right lower extremity. According to the hospital records, the next day plaintiff was found "pressing the lateral aspect of his lower right extremity expressing blood clots from same."

Hospital records reveal plaintiff continued to pick and pull at his wounds. He continued to smoke, was found without bandages, and refused follow-up appointments with Dr. Piontkowski. On November 2, 2005, records reveal plaintiff was found putting his fingers in his wound and sticking a Q-tip in it. When told to stop plaintiff responded, "I hope the wound gets infected." On November 4, 2005, the wound was debrided and the hematoma evacuated. Plaintiff agreed to amputation and continued to smoke. On November 22, 2005, plaintiff had pus draining from his staples. Plaintiff refused to return to Dr. Piontkowski and was referred to Dr. Legouri. He was diagnosed with chronic osteomyelitis and prescribed IV antibiotics. On November 25, 2005, plaintiff refused to see an orthopedic surgeon at Brookhaven Hospital and stated he would rather see Dr. Legouri. On November 28, 2005, a CT scan revealed osteopenia (low bone density). Plaintiff refused pain medication, threatened a nurse, threw X-rays and refused physical therapy.

On November 29 and November 30, 2005, plaintiff refused physical therapy and Bacitracin, and on November 30, 2005 and December 1, 2005 he refused pin care and a dressing change.

On December 5, 2005, plaintiff saw Dr. Piontkowski. Notes indicate that plaintiff had a chronic infection being taken care of by the infectious disease service at St. Charles Hospital. Dr. Piontkowski recommended the pins be removed. A CAT scan and X-rays revealed almost no healing, and amputation was discussed. On December 12, 2005, plaintiff was transferred to Stony Brook Hospital. Stony Brook Hospital records reveal plaintiff was "noncompliant multiple times with his treatment regimen. He had refused treatment on multiple occasions, had refused both medications and treatment, as well as exams by physicians on multiple occasions." On December 31, 2005, the pins were removed, and osteomyelitis was noted. On January 24, 2006, the external fixator device was dismantled and a revised fixator attempted Ilizarov lengthening. That procedure failed, and on April 7, 2006, plaintiff's right leg was amputated below the knee. The post-operative diagnosis was chronic right tibial non-union with infection.

To make a *prima facie* showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant must establish through medical records and competent expert affidavits that it did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that it was not the proximate cause of plaintiff's injuries (*see Castro v New York City Health & Hosps. Corp.*, 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2010]; *Deutsch v Chaglassian*, 71 AD3d 718, 896 NYS2d 431 [2d Dept 2010]; *Plato v Guneratne*, 54 AD3d 741, 863 NYS2d 726 [2d Dept 2008]; *Jones v Ricciardelli*, 40 AD3d 935, 836 NYS2d 879 [2d Dept 2007]; *Mendez v City of New York*, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). To satisfy this burden, the defendant must present expert opinion testimony that is supported by facts in the record and addresses the essential allegations in the bill of particulars (*see Roques v Noble*, 73 AD3d 204, 899 NYS2d 193 [1st Dept 2010]; *Ward v Engel*, 33 AD3d 790, 822 NYS2d 608 [2d Dept 2006]). Conclusory statements that do not address the allegations in the pleadings are insufficient to establish entitlement to summary judgment (*see Garbowski v Hudson Val. Hosp. Ctr.*, 85 AD3d 724, 924 NYS2d [2d Dept 2011]). A physician owes a duty of reasonable care to his or her patients and will generally be insulated from liability where there is evidence that he or she conformed to the acceptable standard of care and practice (*see Spensieri v Lasky*, 94 NY2d 231, 701 NYS2d 689 [1999]; *Barrett v Hudson Valley Cardiovascular Assoc., P.C.*, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]; *Geffner v North Shore Univ. Hosp.*, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]).

Failure to demonstrate a *prima facie* case requires denial of the summary judgment motion, regardless of the sufficiency of the opposing papers (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 5088 NYS2d 923 [1986]). Once the defendant makes a *prima facie* showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of triable issues of fact which require a trial of the action (*see Alvarez v Prospect Hosp.*, *supra*; *Kelley v Kingsbrook Jewish Med. Ctr.*, 100 AD3d 600, 953 NYS2d 276 [2d Dept 2012]; *Fiorentino v TEC Holdings, LLC*, 78 AD3d 911 NYS2d 146 [2d Dept 2010]). In a medical malpractice action, a plaintiff opposing a motion for summary judgment need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's *prima facie* showing (*see Bhim v Dourmashkin*, 123 AD3d

862, 999 NYS2d 471 [2d Dept 2014]; *Hayden v Gordon*, 91 AD3d 819, 937 NYS2d 299 [2d Dept 2012]; *Stukas v Streiter*, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; *Schichman v Yasmer*, 74 AD3d 1316, 904 NYS2d 218 [2d Dept 2010]).

Each of the moving parties have established their *prima facie* entitlement to summary judgment. Dr. Piontkowski's expert, Dr. Randall V. Ehrlich, a board certified orthopedic surgeon, avers that Dr. Piontkowski did not depart from accepted standards of medical practice. He avers that Dr. Piontkowski explained the risks and benefits of the surgery to plaintiff, and that the medical treatment of plaintiff's right leg was properly and appropriately rendered within accepted standards of medical practice. Dr. Ehrlich opines that the fasciotomy was timely and appropriately performed. Significantly, Dr. Ehrlich opines that it was within accepted and standard medical practice to leave bullet fragments within plaintiff's right leg due to the substantial risk of creating more soft tissue and vascular damage. He avers "[i]t is not within the standard of care to remove small bullet fragments in a situation like the plaintiff's, as doing so creates more trauma. Due to significant vascular damage to plaintiff's right leg, the fact that Dr. Piontkowski left small bullet fragments in plaintiff's lower right extremity was not a departure from good and accepted surgical practice." He further opines that it has been demonstrated that retained high energy bullet fragments are not the nidus for infection in gunshot injuries. High rates of infection, he opines, are due to bone being exposed to bacteria in a high grade open fracture. Dr. Ehrlich concludes that all of the care and treatment rendered by Dr. Piontkowski to plaintiff was properly and promptly performed.

Dr. Kota's expert, Dr. Robert J. Ward, a board certified surgeon, opines that the care and treatment rendered by Dr. Kota to plaintiff was, at all times, within good and accepted standards of practice. In that no vascular injury to plaintiff was found, Dr. Ward opines that Dr. Kota's care of plaintiff ended. Dr. Ward opines it was not the duty of Dr. Kota to determine if surgery was appropriate, to identify or look for bullet fragments, or play any role in the surgery other than holding retractors and cutting sutures.

St. Charles Hospital's expert, Dr. Rosemary Soave, who is board certified in internal medicine and infectious disease, opines that "the fact that bullet fragments remained in plaintiff's right leg following surgery greatly increased the possibility that an infection could develop." Dr. Soave concludes that the personnel at St. Charles did not commit any departures from accepted medical practice with the treatment rendered to plaintiff.

In opposition to all three motions, plaintiff offers the expert opinion of Dr. Michael R. Golding, a board certified thoracic and cardiovascular surgeon. Dr. Golding opines that it was the duty of Dr. Piontkowski and Dr. Kota to "thoroughly debride and remove all necrotic tissue and bullet fragments" from plaintiff's leg. He opines that Dr. Kota had an obligation to identify the existence of bullet fragments, and "[t]his was not done." Dr. Golding opines "[w]hat is apparent from the Brookhaven and St. Charles records is that bullet fragments were left in the patient a resultant infection ensued." Dr. Golding does not opine that the bullet fragments caused the infection in plaintiff's leg. Dr. Golding does not discuss causes of the infection, plaintiff's non-cooperation with hospital and nursing staff, plaintiff's affirmative acts of wanting to cause infection, and ultimately causing that infection, his continued smoking against medical advice and

his discharge from Southside Hospital against medical advice. St. Charles Hospital points out that Dr. Golding testified on May 6, 2008, in an unrelated case, that the last time he performed surgery was on December 3, 1986, and that he has not demonstrated that he was familiar with the standard of care in effect in 2005, that he has any expertise about the standards of nursing care and how infections should be properly treated.

Plaintiff has failed to raise a triable issue of fact with regard to his claim against Dr. Kota. Dr. Kota testified that:

> Sometimes the bullets are incorporated very close to major structures and if it involves doing a lot more dissection causing damage to other structures, it's safer not to do it at that time. You deal with – you're dealing with an acute situation, so you deal with the problem and stabilize the patient.

Dr. Piontkowski also testified that he was aware of bullet fragments in plaintiff's leg but did not remove them "[b]ecause [he] felt that they were not removable without causing further damage to the circulation and to the nerve." Given this testimony, Dr. Ward's opinion, and Dr. Ehrlich's opinion, plaintiff has failed to raise a triable issue of fact as to Dr. Kota. Plaintiff's expert's speculation that Dr. Kota should have seen bullet fragments is belied by Dr. Piontkowski's testimony that bullet fragments were seen, but not removed due to damage the removal might cause. Accordingly, Dr. Kota's motion is granted and the complaint as asserted against him is dismissed.

Plaintiff has also failed to raise a triable issue of fact as to St. Charles Hospital. As a thoracic and cardiovascular surgeon, Dr. Golding is not qualified to opine as to the hospital's infectious disease care. Where a physician opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered (*see Romano v Stanley*, 90 NY2d 444, 451–452, 661 NYS2d 589 [1997]; *Nangano v Mount Sinai Hosp.*, 305 AD2d 473, 759 NYS2d 538 [2d Dept 2003]). Moreover, Dr. Golding does not opine what nursing treatment should have been rendered that was not, and contrary to his opinion, the record establishes that plaintiff was treated by infectious disease specialists at St. Charles Hospital on numerous occasions during the period from September 16 through December 9, 2005. Dr. Golding does not opine what specific antibiotics plaintiff should have received and does not comment on plaintiff's refusal to receive IV antibiotics. Accordingly, St. Charles Hospital's motion is granted and the complaint as asserted against it is dismissed.

Plaintiff has raised an issue of fact with regard to Dr. Piontkowski's initial surgery and whether bullet fragments could have been safely removed at that time. Plaintiff's expert opines that "[i]n reviewing the post-operative imaging studies it was clear and apparent that these bullet fragments were located within the patient when they could have been appropriately removed if identified without causing any major structural damage." While Dr. Piontkowski points out that Dr. Golding is not board certified in orthopedic surgery and has not performed surgery since December 3, 1986, it appears that as a retired surgeon that is board certified by the "American Board of Surgery" he has set forth his requisite skill, training, knowledge and experience to render

his opinion as reliable (*see Behar v Coren*, 21 AD3d 1045, 803 NYS2d 629 [2d Dept 2005] *lv denied* 6 NY3d 705, 812 NYS2d 34 [2006]).

Plaintiff, however, has not established that the alleged failure to remove bullet fragments from his right leg was the proximate cause of his infection and ultimate amputation of his right leg. Dr. Ehrlich opines that it has been demonstrated that retained high energy bullet fragments are not the nidus for infection in gunshot injuries. Based upon his training and experience, he opines that once bone is exposed to bacteria in a high grade open fracture there is a high rate of infection. Plaintiff, he avers, had increased risk for infection, including a comminuted, compound, open fracture of his right leg, and the introduction of the bullet into his leg, and his own non-cooperative conduct, including smoking and efforts at trying to infect the wound increased that risk. While Dr. Golding opines that Dr. Piontkowski's failure to remove bullet fragments "allowed for the tissue to become inflamed and eventually became infected at a level that the patient lost his leg" and that Dr. Piontkowski "led the patient down the path of infection," he does not opine that the failure to remove the bullet fragments caused plaintiff's infection. Moreover, because Dr. Golding is not an infectious disease specialist, his opinion lacks probative value because there is no evidence that he has expertise in infectious disease medicine (*Behar v Coren*, 21 AD3d 1045, 803 NYS2d 629 [2d Dept 2005] *lv denied* 6 NY3d 705, 812 NYS2d 34 [2006]). Accordingly, the motion by Dr. Piontkowski to dismiss the complaint as asserted against him is granted.

Dated: February 16, 2017

HON. PAUL J. BAISLEY, JR.

J.S.C.