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

PRESENT: LOBIS Justice PART 6

CORNISH, DIMITRI

-v-

NINAN KOSHY, M.D. ET AL.

INDEX NO. 105679/09

MOTION DATE 7/28/11

MOTION SEQ. NO. 02

MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion to/for Summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1 - 9
Answering Affidavits — Exhibits	10 - 25
Replying Affidavits	26 - 27

Cross-Motion: ☐ Yes ☑ No

Upon the foregoing papers, it is ordered that this motion

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

FILED

OCT 05 2011

NEW YORK COUNTY CLERK'S OFFICE

Dated: 10/4/11

JOAN B. LOBIS J.S.C.

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

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

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

----------X

DIMITRI CORNISH a/k/a DEMIR WILLIAMS,

Plaintiffs

Index No. 105679/09

-against-

Decision and Order

NINAN KOSHY, M.D. and THE ST. LUKE'S-ROOSEVELT HOSPITAL CENTER,

Defendants.

----------X

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

Defendants Ninan Koshy, M.D., and The St. Luke's-Roosevelt Hospital Center (the "Hospital") move, by order to show cause, for an order pursuant to C.P.L.R. Rules 3212(b) and/or 3211(a)(7), granting them summary judgment and/or dismissing the case for failure to state a cause of action. Plaintiff Dimitri Cornish a/k/a Demir Williams opposes the motion.

This action sounding in medical malpractice and negligence arises out of plaintiff's admission to the Hospital from August 9, 2007 through September 7, 2007. He was hospitalized for a gunshot wound to his abdomen that severely damaged his internal organs and caused permanent paralysis from the waist down. On August 30, 2007, plaintiff was found with a Stage II pressure ulcer on his coccyx. Plaintiff alleges that defendants departed from the standard of care in failing to perform timely skin integrity examinations, failing to turn him in bed, and failing to provide a proper mattress, and that such departures caused the pressure ulcer and subsequent scarring and deformity. The ulcer has since healed.

Defendants now move for dismissal of the case, maintaining that there was no deviation from the standard of care and that their actions did not proximately cause plaintiff's injury.

On a motion for summary judgment, a defendant in a medical malpractice action bears the initial burden of demonstrating that there was either no departure from the standard of care, or that any such departure did not proximately cause the plaintiff's alleged injury or damage. King v. St. Barnabas Hosp., 87 A.D.3d 238, 2011 N.Y. Slip Op. 5641 (1st Dep't 2011). To satisfy that burden, the defendant must present expert medical opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Roques v. Nobel, 73 A.D.3d 204, 206 (1st Dep't 2010). Failure to meet that burden will result in denial of the motion, regardless of the sufficiency of plaintiff's papers in opposition. Cregan v. Sachs, 65 A.D.3d 101, 108 (1st Dep't 2009).

In support of defendants' motion for summary judgment, they present an affidavit from Susan Hirsch, M.D., who states that she is a physician board certified in internal medicine and licensed to practice medicine in the State of New York. She states that she reviewed the Hospital's records and plaintiff's subsequent medical records, as well as the pleadings, protocols, and deposition transcripts in this matter. At the time plaintiff was admitted, the Hospital had nursing protocols for treating pressure ulcers which Dr. Hirsch opines were appropriate for the assessment, prevention, and treatment of pressure ulcers, and which she states were followed by the Hospital's employees and physicians. Defendants' expert maintains that the Hospital staff took the standard assessment steps for wound care during plaintiff's entire admission. She avers that once the open wound on plaintiff's coccyx was noted on August 30, 2007, pressure prevention protocol was initiated and maintained, wound care was consulted, Xenaderm was applied, and plaintiff was put on an air mattress. Further, she opines that plaintiff's nutrition status was appropriately evaluated

and the importance of proper nutrition was emphasized to plaintiff. Dr. Hirsch points out that the wound is described as a Stage II ulcer in the medical records and that the ulcer remained at Stage II until plaintiff's discharge on September 7, 2007. She also points out that at one point in plaintiff's chart, it was noted that he "refused to be log rolled," which is a positioning technique for alleviating pressure. However, once the importance of log rolling and repositioning was explained to him, plaintiff agreed.

Dr. Hirsch explains that pressure ulcers are generally caused by unrelieved pressure to a specific bodily surface. She states that some factors that affect the development and healing of pressure ulcers are nutrition, mobility, incontinence, and positioning. Dr. Hirsch opines that even with appropriate wound and nutritional care, patients can still develop pressure ulcers or have difficulty healing pressure ulcers. Further, ulcers can worsen due to co-morbidities, such as acute illness or traumatic injury. Thus, she opines, the development, non-healing, or progression of ulcers does not, in and of itself, necessarily indicate a deviation of medical care. Dr. Hirsch sets forth that plaintiff had a very complicated gunshot wound with extensive shrapnel, an abscess, paralysis, and traumatic injury to the kidney and colon. She also states that he was uncooperative with wound care. She opines that it was not malpractice, but the aforementioned risk factors and plaintiff's significant injuries, that led to the development of the pressure ulcer. Dr. Hirsch opines that despite the acute nature of plaintiff's injuries, the Hospital was able to achieve a level of healing of his pressure ulcers well within the standard of medical care.

In opposition to defendants' motion, plaintiff first argues that defendants' summary judgment motion was made over sixty (60) days after the note of issue was filed, in violation of the Part Rules for Part 6 and the parties' preliminary conference order. The note of issue was filed on April 12, 2011. The affidavit of service reflects that the motion was served on Tuesday, June 14, 2011. Plaintiff concedes that since that the sixtieth day from the filing of note of issue was on a weekend, the deadline to serve the summary judgment motion was Monday, June 13, 2011. The court will consider the motion on its merits without requiring defendants to show good cause for the lateness, given that defendants' attorney's firm filed their order to show cause and paid the motion fee on Friday, June 10, 2011, and that, due to a scheduled vacation day, the court was unavailable to sign orders on Monday, June 13.

In reaching the merits of the motion, however, the court finds that defendants failed to eliminate all material issues of fact that there were no departures or that the departures did not proximately cause plaintiff's pressure ulcer. Dr. Hirsch concedes that positioning is a factor in causing pressure ulcers. She opines that once the sore was discovered, defendants initiated and maintained pressure prevention protocol. However, except in conclusory terms, Dr. Hirsch fails to address whether defendants were maintaining proper pressure prevention protocol prior to the discovery of the pressure ulcer on August 30, 2007. While defendants portray plaintiff as noncompliant with the log rolling protocols in place, there is only one reference in the Hospital's chart that indicates that plaintiff was refusing log rolling, and in that instance, it appears that he changed his mind and agreed to be log rolled after he was explained the importance of the practice. Further, while defendants portray plaintiff as uncooperative with wound care, there is nothing

identified in the records indicating this. The court reviewed plaintiff's Hospital chart as submitted with the initial motion papers[1] and finds that issues of fact remain unresolved as to whether defendants were, indeed, following the log rolling protocols every two hours and performing regular skin examinations with each shift, since there are scant references in the chart to these practices prior to August 30, 2007.

Furthermore, although defendants argue that plaintiff has failed to state a cause of action under C.P.L.R. Rule 3211(a)(7), it appears that defendants are solely arguing this issue in the context of their motion under Rule 3212. Accordingly, it is hereby

ORDERED that the motion is denied in its entirety; and it is further

ORDERED that the parties shall appear for a previously scheduled pre-trial conference on October 11, 2011, at 9:30 a.m.

Dated: October 4, 2011

ENTER:

JOAN B. LOBIS, J.S.C.

[1] Defendants annex a separate, computerized medical record in their reply papers. It is unclear why this exhibit was not submitted in support of their initial papers. This exhibit, submitted for the first time with reply papers, "cannot be considered [by the court] for the purpose of establishing [defendants'] prima facie entitlement to judgment as a matter of law." Rosenzweig v. Friedland, 84 A.D.3d 921, 925 (2d Dep't 2011) (citation omitted).