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SHORT FORM ORDER

INDEX No. 06-2223
CAL. No. 12-00577MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 47 - SUFFOLK COUNTY

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 8-16-12
ADJ. DATE 10-17-12
Mot. Seq. # 002 - MD

EDWARD J. MORRIS and THOMAS P. MORRIS as CO-EXECUTORS OF THE ESTATE OF THOMAS J. MORRIS AND LOIS J. MORRIS, Plaintiffs, - against - CHARLES J. BLEIFELD, M.D., and ST. CATHERINE OF SIENNA MEDICAL CENTER, Defendants.	JACOB D. FUCHSBERG, ESQ. *Attorney for Plaintiffs* 500 Fifth Avenue New York, New York 10110 BARTLETT, McDONOUGH & MONAGHAN, LLP Attorney for Defendants 170 Old Country Road Mineola, New York 11501

Upon the following papers numbered 1 to 33 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 23 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers __; Replying Affidavits and supporting papers 24-33 ; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by the defendants, Charles J. Bleifeld, M.D. and St. Catherine of Sienna Medical Center, pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against them is denied.

This action for medical malpractice is asserted on behalf of the decedent, Thomas J. Morris, with causes of action premised upon the alleged negligence by the defendants Charles J. Bleifeld, M.D. and St. Catherine of Sienna Medical Center (SCSMC), lack of informed consent, the decedent's conscious pain and suffering, and a derivative claim on behalf of Lois J. Morris. It is alleged that the plaintiffs' decedent sought care and treatment from the defendants on or about March 26, 2004, and subsequent thereto until April 23, 2004, for pain in his right knee secondary to osteoarthritis. The decedent was admitted to SCSMC on March 26, 2004 for medical, surgical, and orthopedic care and treatment involving knee replacement by Dr. Bleifeld. During that admission, it is alleged that the decedent developed stage IV pressure ulcers on his sacrum due to the defendants' negligent departures from the accepted standards in rendering care and treatment to him. It is further alleged that due to the sacral

decubitus, the decedent required a surgical flap procedure, and suffered, inter alia, prolonged limited mobility, pain, scarring, generalized weakness, and additional care and treatment.

The defendants seek dismissal of the complaint asserted against them on the bases that they did not depart from the accepted standards of care and treatment; that the decedent was obese with many factors contributing to the development of the sacral ulcers, placing him at increased risk for the development of pressure ulcers. The defendants assert that they did not proximately cause the decedent to develop pressure sores. Defendant Bleifeld further asserts that his role in caring for the decedent related to the knee replacement, and that the decedent's overall medical care was assumed by the patient's primary medical physician, non-party Andrew Radzik, M.D., who coordinated the decedent's care with various treating physicians.

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 eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2nd Dept 1981]).

In support of this application, the defendants have submitted, inter alia, an attorney's affirmation; the expert affidavit of Bruce Hirsch, M.D.; a copy of the summons and complaint, defendants' answer, plaintiffs' bills of particulars; the unsigned, certified transcripts of the examinations before trial of decedent Thomas J. Morris dated January 11, 2007, Lois J. Morris dated May 16, 2007, and the unsigned transcript of non-party Diane L. Reisert dated February 3, 2009, which transcript is not in admissible form pursuant to CPLR 3212 and is not accompanied by an affidavit pursuant to CPLR 3116 (see ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]), and are not considered on this motion; the signed transcript of Charles J. Bleifeld dated October 16, 2007, continued February 27, 2012; and the uncertified copies of the decedent's death certificate and hospital record which are not in admissible form to be considered as evidence on a motion for summary judgment (see ***Friends of Animals v Associated Fur Mfrs***., supra). Expert testimony is limited to facts in evidence. (*see* ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d

Dept 1984]). Additionally submitted under separate cover is an uncertified and unauthenticated copy of a document entitled "Pressure Ulcer Prevention Standard of Care" which is not in admissible form.

It is determined that even if the defendants' aforementioned exhibits were in admissible form to be considered as evidentiary submissions, and there was admissible testimony submitted establishing that such standard of care for pressure ulcer prevention was complied with, that the defendants have not established prima facie entitlement to summary judgment dismissing the complaint.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2nd Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiffs' injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

A hospital generally cannot be held liable, other than derivatively, for another's malpractice. Thus, where there is no vicarious liability, the plaintiff must establish that the hospital, through its own agents, was guilty of malpractice or other tort concurring in causing the harm (***Fiortino v Wenger,***, 19 NY2d 401, 280 NYS2d 373 [1967]; ***Belak-Redi v Bollengier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; ***Welch v Scheinfeld***, 21 AD3d 802, 801 NYS2d 277 [1st Dept 2005]). A hospital or other medical facility is liable for the negligence or malpractice of its employees (*see* ***Birdell Hill v St. Clare's Hospital,*** 67 NY2d 72, 499 NYS2d 904 [1986]).

Dr. Bleifeld testified to the extent that he is board certified in orthopedic surgery and was on staff at St. Catherine of Sienna Medical Center in 2004. He first saw the decedent for a painful, arthritic knee on January 23, 2004. On March 22, 2004, he ordered blood work as routine testing prior to the decedent's upcoming surgery for a total knee replacement. He stated that prior to surgery, he would have talked to the decedent about his obesity and serious medical problems, and advised him that he had a higher than usual complication rate as the surgery is technically more difficult and the implants can be harder to put in. Dr. Bleifeld stated that Mr. Morris had significant heart and kidney disease and that the stress from surgery can exacerbate the co-morbidities. He did not remember telling the decedent of any

possible alternative to the knee replacement surgery, as he believed he already had all the available treatment for his knee. Dr. Bleifeld testified that the benefit to the decedent having the total knee replacement was, that if it was successful, he would have a marked reduction in pain and an increase in function.

Dr. Bleifeld testified that pressure sores are not usually an inherent risk in a total knee replacement, so he did not discuss bed sores as a risk during his preoperative talk with the decedent. He continued that because of diabetes and other co-morbidities, difficulty with wound healing would be an inherent risk of the procedure. He testified that pressure sores are areas of breakdown that occur from long-term pressure or even short-term pressure. Development of pressure sores can be more likely when the patient has poor general health, prolonged immobility, vascular problems, poor nutrition, shearing force, hypoalbuminemia, renal problems, and vascular problems, causing poor blood supply to an area.

Dr. Bleifeld testified that on March 29, 2004, he performed a total knee replacement of the decedent's left knee at St. Catherine of Sienna Medical Center. Mr. Morris was discharged on April 16, 2004. Post-operatively, it was planned for the decedent to be out of bed with physical therapy and a continuous passive motion machine. Dr. Bleifeld testified that after performing the surgery, his responsibility involved monitoring the decedent's care during the hospital stay, specifically, for complications, and to make sure that his wound was without sign of infection, to make sure that he began physical therapy as soon as he could, and to check his general progress. He continued that due to the decedent's serious medical conditions, he relied upon the other physicians involved in Mr. Morris' care, especially Dr. Radzik who was familiar with Mr. Morris. When asked if the development of bed sores was a complication to monitor, he replied that in general, after knee replacement, bed sores are not seen because patients are ambulatory by the time one could develop. However, the decedent was not ambulatory for a variety of medical complications. Dr. Bleifeld stated that he was concerned with how the wound was healing, when he could get up, and when he could start moving. He added that Dr. Radzik was more or less coordinating the care the decedent was receiving. He did not immobilize the decedent's knee and started motion almost immediately. Dr. Bleifeld testified that other than physically examining the decedent's left lower extremity during the postoperative period, he did not remember examining any other parts of his body.

Dr. Bleifeld testified that the decedent was out of bed on March 31, 2004 and tolerating it well. His neurovascular status was noted to be normal. It was noted in the chart that there was a stage two ulcer on the decedent's sacrum. About a week after surgery, he believed he had a conversation with the nurses at the hospital who advised him that the decedent's skin was starting to break down, and that it was difficult to turn him. He did not recall his response. He did not have a custom and practice with regard to skin breakdown after a knee replacement. On post-operative day four, he noted some ischemic changes at the skin edges at the operative site, which changes he felt were due to the decedent's overall poor vascular supply to multiple areas related to his diabetes, poor kidney function, and obesity. Dr. Bleifeld testified that the nursing staff at the hospital is responsible for monitoring bed sores as it is a nursing care issue. He stated that bed sores were not his area of expertise and he wrote no orders concerning the care and treatment of the decubitus which had developed. He continued that the other care givers, doctors and nurses, were more accustomed to having patients who developed bed sores due to prolonged bed rest. He stated that in a general sense, he had a responsibility to monitor the

complications of surgery, but that there are people in the hospital who are much better equipped to monitor and care for the complications as they occur. He had no specific recollection of any other physicians addressing the bed sores. He made no recommendation as to how to treat the bed sores. He was not familiar with the staging of bed sores and did not recall learning the stage of the decedent's bed sores. Dr. Bleifeld testified that there were no physicians who were part of the team involved in the treatment of pressure sores at St. Catherine of Sienna Medical Center. When Dr. Bleifeld checked the decedent's assessment form dated March 22, 2004, it was noted that the decedent was not considered to be at risk for pressure ulcers as his score was 19.

Defendants' expert, Bruce Hirsch, M.D. avers that he is a physician licensed to practice medicine in New York and is board certified in internal medicine, geriatric medicine, and infectious diseases. He set forth his training, but has not set forth his work experience to qualify as an expert, and no copy of his curriculum vitae has been provided. He opined with a reasonable degree of medical certainty that the care and treatment rendered to the decedent during his March 29, 2004 to April 23, 2004 admission to SCSMC was at all times appropriate and conformed to the standards of care, that neither Dr. Bleifeld nor the nursing staff at defendant hospital deviated from the standards of care in the treatment rendered to the decedent during his admission. Dr. Hirsch stated that the basis for his opinions was a review of the various bills of particulars and the deposition transcripts of the decedent, his wife, and nurse Diane Reisert, R.N.; however, all the aforementioned transcripts have not been submitted in admissible form.

Dr. Hirsch opined in his conclusory and unsupported opinion that the decedent was a high risk patient given his medical history of chronic renal insufficiency, polycystic kidney disease, atherosclerotic heart disease, type II diabetes for 25 years, hypertension and hyperlipidemia, as well as obesity. These risks, he stated, were recognized by defendant Bleifeld, the primary care physician Dr. Andrew Radzik, the cardiologist Dr. Shapell, and the nephrologist Dr. Ilamathi, all of whom cleared the decedent for surgery. He continued that the decedent was properly assessed pre-operatively by Dr. Bleifeld and the hospital's nursing staff, although he does not indicate the assessment which was done and the results of such assessment. Dr. Hirsch opined that in consenting to having his knee replaced, the decedent also accepted the various risks of the procedure, including a heart attack, renal failure, congestive heart failure, skin breakdown, and decubitus ulcers; however, Dr. Hirsch does not support this conclusion that these are the risks of such procedure and that the decedent was apprised of the same. It is noted, however, that Dr. Hirsch's opinion that skin breakdown and decubitus ulcer is an accepted risk of the procedure raises a factual issue with Dr. Beifled's testimony that bed sores are generally not seen because patients are ambulatory by the time they would develop. Dr. Hirsch does not set forth the standard of care for prevention or treatment of bed sores when a patient is not immediately ambulatory.

Dr. Hirsch continued that the nursing staff took proper measures to prevent skin breakdown and the development of decubitus ulcers, and when he developed the same, that the condition was recognized and various modalities were employed to treat the ulcer once it developed. However, Dr. Hirsch does not set forth the standard of care or hospital protocol which was followed. He stated that the hospital record indicated that the plaintiff was either uncooperative or unable to assist in his care, contributing to his development of pressure sores. However, in view of this inability to cooperate, he does not set forth what measures were taken to prevent and treat the skin breakdown. There are factual issues raised with Nurse Diane Reisert's testimony to the extent that turning and positioning would be specific nursing care

with regard to a stage two sacral ulcer, noticed on March 31, 2004, but she worked the night shift, and stated that there are not a lot of people around, and if anything were ordered, it would be done on days. Additionally, wound care was done during the day. Thus, whether or not decubitus care was provided by nursing during the night shift is at issue.

Dr. Hirsch opined that as it turned out, the decedent survived his admission, despite the various complications following the knee replacement procedure during that admission, and was able to live another five years until he died on March 1, 2009. He continued that the development of the sacral decubitus pressure ulcer was unfortunate but not uncommon. Given his clinical condition and his medical history upon admission to the hospital, the development of the decubitus ulcer was not preventable or avoidable, he added, without submitting a basis to support this opinion. Additionally, Dr. Hirsch does not opine that the plaintiff was apprised of this condition given his medical history. Dr. Hirsch added that it is his further opinion that there is no action or alleged failure by Dr. Bleifeld or the hospital's medical and/or nursing staff that was a substantial factor, or otherwise, the proximate cause of the plaintiffs' decedent's sacral decubitus ulcer.

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions as such credibility issues can only be resolved by a jury (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]; *see also* ***Shields v Baktidy***, 11 AD3d 671, 783 NYS2d 652 [2d Dept 2004]; ***Barbuto v Winthrop Univ. Hosp.***, 305 AD2d 623, 624, 760 NYS2d 199 [2d Dept 2003]; ***Halkias v Otolaryngology-Facial Plastic Surgery Assoc.***, 282 AD2d 650, 724 NYS2d 432 [2d Dept 2001]). Here, it is concluded that even if the defendants had established their prima facie entitlement to summary judgment, the plaintiffs have submitted a conflicting medical expert opinion raising factual issues, precluding summary judgment from being granted.

The plaintiffs' expert has set forth that he is a physician licensed to practice medicine in New York State and has further set forth his education and work experience. He set forth the records and materials which he reviewed and opined within a reasonable degree of medical certainty that the defendant Dr. Bleifeld did not provide informed consent regarding the risk of developing a decubitus ulcer which is a deviation from the accepted standards of medical care. He continued that the plaintiff did not accept the risk of a decubitus ulcer. The plaintiffs' expert further opined that Dr. Bleifeld and the hospital staff at St. Catherine departed from good and accepted practice by failing to assess Mr. Morris's risk for developing a decubitus ulcer and reassess that risk both intra-operatively and post-operatively; by failing to develop and implement a strategy of specific prevention measures including, but not limited to, closely and vigilantly monitoring Mr. Morris for skin changes and abnormalities post-operatively, and paying close attention to the areas of bony prominences where subdermal injuries may arise; and failing to assess, monitor and treat Mr. Morris' decubitus ulcer after it was discovered on March 31, 2004, until it was first assessed and treated on April 2, 2004. The plaintiffs' expert further opined that, at the very least, Dr. Bleifeld, as Mr. Morris' admitting physician, was obligated to follow and monitor his patient's deteriorating sacral skin condition.

The plaintiffs' expert set forth that Mr. Morris' past medical history, significant for chronic renal insufficiency, type II diabetes mellitus, hyperlipidemia, hypertension, and obesity, posed as risk factors for developing decubitus ulcers. This therefore required a plan for preventive care, given his need for

bed rest post-surgically. Mr. Morris did not have any decubitus ulcer or skin lesion at the time of admission. He was sixty nine years of age with a history of osteoarthritis of his left knee. He stated that there was no plan in place or not followed to provide skin care to the decedent to prevent decubitus ulcer. Subsequently he developed a decubitus ulcer, and while in the defendants' care, the wound worsened to a stage IV ulcer that required several debridement surgeries, and an extensive flap surgical procedure and hospital care that continued for months, followed by lengthy rehabilitation. The failure to implement a plan of turning and re-positioning, off-loading, and skin care, departed from good and accepted medical and hospital nursing practice, which was the proximate cause of Mr. Morris' injury. No such plan was implemented until April 2, 2004, four days post-operatively, and two days after a sacral ulcer had been noted and allowed to fester without treatment. The plaintiffs' expert continued that there is nothing in the record or in the testimony of any of the witnesses to indicate that monitoring or preventive measures were implemented post-operatively before the stage II decubitus ulcer to the sacrum was first observed, or even after that for two days. Nor is there any evidence of any consultation regarding the assessment, monitoring, or treatment plan of the decubitus ulcer during that two-day interval following the bed sore being noted.

The plaintiffs' expert continued that assessment for the risk of developing a decubitus ulcer, and a plan for prevention, should have been established upon Mr. Morris' admission to St. Catherine and was not done until April 2, 2004, four days post-operatively. Such assessment and plan was also mandated by St. Catherine's own policies and protocols for pressure ulcer prevention-and the standard of care, which requires that a patient who is confined to bed be turned every two hours, and protective lubricants be used to decrease shearing friction. There was no plan established nor interventions implemented following Mr. Morris' need for bed rest following his myocardial infarction. The plaintiffs' expert continued that there should have been a plan which included orders to closely and vigilantly monitor the skin for changes and abnormalities. He should have been placed on a repositioning schedule, pressure-reducing surfaces utilized, and unnecessary skin shear avoided. There should have been wound cleansing, woundvac, draining the fluids (from the blisters), managing the infection, wound dressing, placement on a pressure relieving device, and use of positioning devices. The plaintiffs' expert disagrees with the statement of defendants' expert Dr. Hirsch, that Mr. Morris was administered appropriate skin care throughout the admission as there was a two-day window post-operatively where no preventive care was given. The plaintiffs' expert further stated that Dr. Hirsch is directly contradicted by the defendants' own medical records and by the testimony of Dr. Bleifeld who acknowledged that Mr. Morris' decubitus ulcer was not assessed, monitored, or otherwise treated for a period of more than two days after the ulcer was first observed. Nor was there even a consultation regarding the assessment, monitoring, or plan of treatment during that interval.

The plaintiffs' expert continued that as a proximate cause of this negligent care and medical malpractice by the defendants, Mr. Morris lost a substantial opportunity to treat the wound when it was small and nascent, thereby to arrest the worsening of the ulcer and to promptly and naturally bring about its healing. Mr. Morris' ulcer worsened to a stage IV that then required several debridement surgeries and an extensive flap surgical procedure. He continued that Mr. Morris was transferred to St. Charles Hospital on April 23, 2004, for, among other treatment, several extensive surgical procedures in an attempt to treat the then stage IV sacral decubitus ulcer which was noted to be necrotic down to the bone. On April 28, 2004, Mr. Morris underwent an operation to debride necrotic subcutaneous tissue by the

sacral decubitus. Addition debridement procedures were done on May 2, 2004 and May 11, 2004 (notably without anesthesia). On May 14, 2004, an additional surgical procedure was performed to excise a sacral decubitus ulcer with osteotomy and a gluteus maximus flap repair. The decedent suffered scarring from the condition and permanent loss of muscle and bone.

The plaintiffs' expert further disagrees with Dr. Hirsch's statement that Dr. Beifeld followed the patient from an orthopedic standpoint, Dr. Hirsch fails to state that Dr. Bleifeld appropriately followed or otherwise administered care to Mr. Morris concerning his sacral decubitus ulcer.

Based upon the foregoing, the plaintiffs' expert has raised factual issues which preclude summary judgment, even if the defendants' evidentiary submissions had established prima facie entitlement to summary judgment dismissing the complaint.

Dated: Dec. 3, 2012

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**

HON. JERRY GARGUILO