Estreich v Jewish Home Lifecare
2018 NY Slip Op 30586(U)
April 3, 2018
Supreme Court, New York County
Docket Number: 0450176/2016
Judge: George J. Silver

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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MARTA MICHELLE ESTREICH, as Administratrix of the Estate of CHARLOTTE MUCH, deceased, and MARTA MICHELLE ESTREICH, Individually,

Index 0450176/2016
Motion Seq. 001

DECISION & ORDER

Plaintiffs,

-against-

JEWISH HOME LIFECARE, NEW YORK-PRESBYTERIAN HOSPITAL, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION d/b/a COLER-GOLDWATER SPECIALTY HOSPITAL AND NURSING FACILITY and HENRY J. CARTER SPECIALTY HOSPITAL AND NURSING FACILITY

Defendants

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GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, plaintiff Marta Michelle Estreich ("plaintiff") alleges that defendants negligently allowed plaintiff's decedent Charlotte Much ("decedent") to develop pressure ulcers and failed to prevent the progression of those ulcers from December 20, 2008 through March 23, 2014. Defendant New York Presbyterian Hospital ("NYPH") moves, pursuant to CPLR §3212, for summary judgment by alleging that during decedent's one-month stay at the hospital in October 2013, NYPH personnel comported with good and accepted practice in treating the pressure ulcers, and properly followed NYPH protocols for the prevention and treatment of pressure ulcers. In the alternative, NYPH asks this court to dismiss plaintiff's cause of action based on wrongful death and preclude plaintiff from claiming conscious pain and suffering because she had no level of awareness during her NYPH admission. Defendant New York City Health and Hospitals Corporation ("NYCHHC") cross-moves for an order requesting the same relief as co-defendant NYPH regarding dismissal of plaintiff's claim of conscious pain and suffering because

decedent had no level of awareness during her NYPH admission or any time thereafter, including during her admission to NYCHHC facilities Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), and Henry J. Carter Specialty Hospital and Nursing Facility ("Henry J. Carter"). Plaintiff opposes the applications of both NYPH and NYCHHC.

Decedent was a long-time resident of defendant Jewish Home Life Care from 2008 to 2013. She eventually became bed-bound, non-verbal and dependent in all activities of daily living—including personal hygiene, dressing, functional mobility and self-feeding. Per nursing home reports, decedent was in a chronic vegetative state and was not generally alert or oriented to time, person or place, but could swallow and eat food that was fed to her. Decedent was transferred to Montefiore Hospital for a suspected stroke on September 27, 2012, and a brain MRI revealed that she had suffered an acute middle cerebral artery infarct (a small localized area of dead tissue resulting from failure of blood supply) and an old cerebellar infarct. She returned to the nursing home and remained in a vegetative state thereafter. Decedent continued in that state of health until approximately five days prior to her transfer to NYPH when it was noted that she could no longer swallow food when she was fed. On October 1, 2013, decedent was admitted to NYPH by ambulance from the nursing home for shortness of breath, with an oxygen saturation in the low 80s. The admitting diagnosis was pneumonia and respiratory failure. Decedent was subsequently intubated and deemed unresponsive to social work inquiries. In addition to multiple pressure ulcers and pneumonia, decedent's condition raised concern that she may have another stroke. A scan of decedent's head revealed a large left basal ganglia infarct.

On October 29, 2013, decedent was transferred from NYPH to NYCHHC facility Coler-Goldwater following treatment. The discharge diagnosis from NYPH was a cerebral vascular accident or stroke and atrial fibrillation. She was transferred with a ventilator, urinary catheter and

wound in place. Her initial neurological examination upon admission noted contracted limbs and minimal grimace to painful stimuli. Indeed, defendant was noted as being nonverbal and "not truly responsive." Decedent remained at Coler-Goldwater from October 29, 2013 until November 24, 2013, when she was transferred to Henry J. Carter following the closure of Coler-Goldwater. Upon arrival there, decedent was examined by a physician who noted on that decedent opened her eyes spontaneously but was non-communicative. A social worker documented on October 31, 2013 that decedent appeared to be unresponsive and showed no signs of being aware of her surroundings. Decedent was noted as being neither able to participate in a plan of care nor provide the social worker with any social history. A consultation performed that same day noted that decedent lay in bed with eyes open that could close to penlight but otherwise could not focus or track on a speaker. Decedent was further deemed as being non-communicative, non-responsive to questions, and unable to use alternative means of communication. The impression decedent left was that she was suffering from a brain injury, and the likelihood that she would make a significant neurological and cognitive recovery was deemed low. A subsequent neurological consultation on November 20, 2013 noted that decedent had no arousal to loud sounds, only mild arousal and grimace to sternal tactile stimulation on examination, and a general unresponsive mental state. The impression was that she was suffering from a persistent vegetative state due to multiple cerebral infarcts and her prognosis for meaningful recovery was deemed poor given her history.

Decedent was successfully weaned off the ventilator on January 30, 2014. Upon completion of weaning protocol, she was transferred to the medical floor. Decedent's mental status was described as "vegetative state" and her general condition as "[l]ying in bed with closed eyes unaware of surrounding[s]." Neurologically, decedent showed no change and opened her eyes spontaneously. Throughout the course of her admission at Coler-Goldwater and Henry J.

Carter, decedent's mental status and communication ability were variously listed as "non-responsive" or "in vegetative state."

On March 23, 2014, decedent became hypotensive and diagnostic studies confirmed pneumonia and positive urine culture. Decedent was transferred to NYCHHC facility Harlem Hospital for further treatment. She remained there until her death on May 4, 2014.

ARGUMENTS

NYPH supports the instant motion with the affidavit of geriatrics expert Barbara Tommasulo, MD. ("Dr. Tommasulo"), who attests that there was no evidence of any malpractice on the part of NYPH personnel. To the extent that the plaintiff contends that decedent developed new pressure ulcers during her NYPH admission, Dr. Tommasulo opines that the ulcers were not preventable due to decedent's extensive co-morbidities. Dr. Tommasulo also opines that the treatment of decedent by NYPH personnel was not a substantial factor in causing decedent's death, and theorizes that the decedent did not suffer any "conscious pain and suffering" during the NYPH admission because she was in a persistent vegetative state without credible evidence that she had any cognitive awareness.

NYCHHC adopts NYPH's position that the decedent did not suffer any conscious pain and suffering during her admission. In addition to Dr. Tommasulo, NYCHHC annexes the affirmation of Jeffrey M. Levine, M.D. ("Dr. Levine"). Dr. Levine similarly opines in accordance with Dr. Tommasulo that decedent did not experience any level of conscious pain and suffering from the time of treatment at NYPH to her stay at the NYCHHC facilities. Dr. Levine further opines, to a reasonable degree of medical certainty, that as a result of multiple cerebral infarcts endured prior to her admission to NYPH, decedent lacked sufficient cognitive function to experience conscious awareness or pain during her admission to the subsequent NYCHHC facilities, including Coler-

Goldwater and Henry J. Carter. Notably, Dr. Levine highlights that there was no meaningful change in decedent's mental status following her September 2012 diagnosis of having suffered an acute middle cerebral infarct. In Dr. Levine's estimation, decedent's history of multiple strokes and related ailments left her in a chronic vegetative state with no hope of improvement or healing. Dr. Levine emphasizes that decedent remained in this vegetative state throughout her admission to both Coler-Goldwater and Henry J. Carter, and that she lacked conscious perception of environmental stimuli, including any perception of pain as the result of severe brain injury. Finally, Dr. Levine opines that the testimony of the decedent's daughter in which decedent's daughter claimed that her mother would deliberately blink in response to her presence and voice to communicate emotion and awareness of her presence is not medically plausible given decedent's severely diminished mental status upon admission to Coler-Goldwater.

In opposition, plaintiff contends that NYPH's application for dismissal should be denied since NYPH failed to properly assess and measure decedent's pressure ulcers. Plaintiff further avers that had NYPH properly evaluated decedent's ulcers, her plan of care could have been modified as necessary. Plaintiff further states that NYPH failed to adhere to a regular and adequate turning and positioning regimen, thus departing from the standards of care in the medical field and the hospital's internal protocols, which proximately caused and contributed to the deterioration and development of decedent's pressure ulcers in her sacrum and lower extremities.

Contrary to defendant NYPH's allegations, plaintiff argues that decedent's co-morbidities did not independently cause her pressure ulcers. Indeed, plaintiff highlights the fact that decedent's medical records note that her sacral ulcer was healing and the pressure ulcers on her heels and feet did not develop until her admission to NYPH.

Additionally, plaintiff annexes the expert affirmation of Dr. Johnson-Arbor, who opines that plaintiff's decedent's medical history did not render the deterioration of decedent's ulcers clinically unavoidable, and that NYPH caused and contributed to the progression of decedent's pressure ulcers and permitted the development of new pressure ulcers, which ultimately became infected and contributed to her death. Dr. Johnson-Arbor further opines that despite her impaired mental condition, decedent demonstrated that she had at least some level of awareness to be able to perceive conscious pain and suffering following her stroke on September 27, 2012 and at the time of her admission to Harlem Hospital Center. Dr. Johnson-Arbor contends that the medical records reveal that decedent responded and withdrew from pain and/or painful stimuli, responded to verbal and tactile stimuli, grimaced, moaned, yawned, and/or blinked when prompted. Dr. Johnson-Arbor also mentions that decedent was receiving medications, such as Fentanyl, Methadone, and Morphine, to manage her pain. Therefore, plaintiff argues that there is sufficient evidence for a jury to determine that plaintiff's decedent had a level of awareness to entitle plaintiff to an award for pain and suffering. As such, plaintiff contends that defendants NYPH and NYCHHC have no basis to assert that decedent did not suffer any conscious pain and suffering during her admission at defendants' facilities.

In reply, NYPH and NYCHHC argue that Dr. Johnson-Arbor's affirmation is replete with mischaracterizations about Drs. Tommasulo and Levine's opinions as contained in their expert affirmations as well as the relevant deposition testimony and medical records. Additionally, NYPH and NYCHHC contend that Dr. Johnson-Arbor's affirmation makes conclusory and speculative statements that are unsupported by the medical records, and fails to raise triable issues of fact.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a defendant must demonstrate that it did not depart from accepted standards of practice or that, even if it did, it was not the proximate cause of the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g., Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once 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 material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, a plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept. 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

However, the First Department noted in *Oestreich v. Present, et al.*, 50 AD3d 522 (1st Dept. 2008), that where a plaintiff's expert opinion is based on erroneous facts, such an opinion does not raise a triable issue of fact. This principle has been noted in several cases (see *Ramirez v. Columbia-Presbyterian Medical Center*, 16 AD3d 238 [1st Dept. 2005][plaintiff's expert affirmation was flawed by its misstatements of the evidence and its unsupported assertions]; *Wong v. Goldbaum*, 23 AD3d 277 [1st Dept. 2005][expert's opinion has no probative force where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation]; *Coronel v. New York City Health and Hospitals Corporation*, 47 AD3d 456 [1st Dept. 2008][plaintiffs failed to raise a triable issue of fact as their expert's affirmation set forth general conclusions, misstatements of evidence and unsupported assertions, which were insufficient to demonstrate that defendants failed to comport with accepted medical practice, or that any such failure was the proximate cause of plaintiffs injuries]).

Here, defendant NYPH set forth a prima facie case in favor of dismissal, thus shifting the burden of proof to plaintiff. In particular, Dr. Tommasulo, who is experienced in the field of geriatrics, states that to the extent that decedent developed new pressure ulcers during the NYPH admission, the ulcers were not preventable due to the decedent's extensive co-morbidities. Similarly, Dr. Tommasulo opines that the knee abrasions documented in the NYPH records were not preventable due to decedent's lower extremity contracture which caused her legs to be led in a flexion pattern. Dr. Tommasulo also opines within a reasonable degree of medical certainty that the decedent's right heel ulcer was not preventable, and that once identified, NYPH personnel properly treated the ulcer as it remained free and clear of infection. Dr. Tommasulo further opines that NYPH staff took all the reasonable and necessary steps in order to prevent the development of new pressure ulcers and to treat and prevent infection of the existing ulcers decedent already

had upon presentation to NYPH on October 1, 2013. NYPH also highlights the fact that Dr. Tommasulo's conclusions were based on a review of NYPH protocols that NYPH staff properly and appropriately adhered to throughout decedent's admission and treatment. Dr. Tommasulo also provides a basis for the dismissal of plaintiff's wrongful death claims by positing that NYPH properly treated decedent's infection with, amongst other things, antibiotics. Dr. Tommosulo further opines that the infection dissipated enough to permit decedent to be transferred from the ICU to the stepdown unit. Upon discharge from NYPH, Dr. Tommosulo also states that there was no evidence that any of decedent's skin ulcers had signs or symptoms of infection, as all wounds remained clean and dry.

With respect to plaintiff's claims of conscious pain and suffering, Dr. Tommasulo opines that decedent did not have any cognitive awareness during the NYPH admission from October 1, 2013 through October 29, 2013, and that decedent was continually documented as being in a "chronic vegetative state," as unresponsive, and/or "without mental status" throughout the NYPH admission. NYCHHC similarly debunks plaintiff's claims of conscious pain and suffering through Dr. Levine, who further opines, to a reasonable degree of medical certainty, that as a result of multiple cerebral infarcts endured prior to her admission to NYPH, decedent lacked sufficient cognitive function to experience conscious awareness or pain during her admission to the subsequent NYCHHC facilities, including Coler-Goldwater and Henry J. Carter.

In opposition, Dr. Johnson-Arbor's expert affirmation raises triable issues of fact as to whether NYPH staff conformed to the appropriate standard of care (medical malpractice) and contributed to decedent's death (wrongful death) (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, *supra*). Based on a review of the relevant records, Dr. Johnson-Arbor opines that plaintiff's decedent's medical history did not render the deterioration of decedent's ulcers clinically

unavoidable, and that NYPH caused and contributed to the progression of decedent's pressure ulcers and permitted the development of new pressure ulcers, which ultimately became infected and contributed to her death. Dr. Johnson-Arbor further opines that decedent's death could have been avoided or at least minimized with proper care and treatment by NYPH. For instance, Dr. Johnson-Arbor notes that NYPH does not deny that decedent's pressure ulcers increased in size and that new ulcers developed while decedent was a patient at its facility. Thus, Dr. Johnson-Arbor opines that although the pressure ulcers were not noted to be infected at the time of decedent's admission to NYPH, NYPH was responsible for the progression and development of decedent's ulcers during her approximately one-month admission to the extent that these contributed to her demise. Dr. Johnson-Arbor also opines, based on her review of the medical records, that decedent expired as a result of a cardiac arrest due to severe septic shock, which was proximately caused at least in part by the decubitus ulcers that NYPH improperly treated. Because NYPH did not adequately address factors such as this, Dr. Johnson-Arbor states, an issue of fact exists with respect to whether NYPH was the proximate cause of decedent's death. Consequently, issues of fact exist with respect to whether NYPH staff conformed to the appropriate standard of care (medical malpractice) and contributed to decedent's death (wrongful death).

However, plaintiff has failed to raise credible issues of fact with respect to plaintiff's decedent's claim of conscious pain and suffering. Indeed, Dr. Johnson-Arbor's conclusion that decedent's cognitive "deficits were not an impairment for her to perceive at least some level of conscious pain" is speculative, conclusory, and contradicted by ample records that expressly document that decedent was unresponsive at both NYPH and NYCHHC facilities (*see Ramirez v. Columbia-Presbyterian Medical Center*, 16 AD3d 238, *supra*; *Wong v. Goldbaum*, 23 AD3d 277, *supra*). Even Dr. Johnson-Arbor's references to decedent grimacing do not support the allegation

that decedent suffered conscious pain and suffering. Dr. Tommasulo opines that while grimacing is considered a colloquial indicator of pain, it is not a conscious perception, because grimaces occur reflexively through the subcortical pathways in the thalamus and limbic system. Plaintiff presents no credible evidence to discredit this claim and cannot opine to any degree of medical certainty that decedent had any level of conscious pain or perception. Finally, Dr. Johnson-Arbor provides no evidence in the medical records that the use of opioid medication was specifically used for pain management and any opinion as such is presumptive as to the intended use of this medication, which can also be used to synchronize breathing with mechanical ventilation.

Accordingly, it is hereby

ORDERED that defendant NYPH's motion for summary judgment is denied as to defendant NYPH's application to dismiss plaintiff's complaint in its entirety; and it further

ORDERED that and defendant NYPH's motion for summary judgment is denied as to defendant NYPH's application, in the alternative, to dismiss plaintiff's cause of action based on wrongful death; and it is further

ORDERED that defendants NYPH and NYCHHC's applications for the dismissal of plaintiff's claim of conscious pain and suffering as to both NYPH and NYCHHC, is granted; and it is further

ORDERED that the parties are directed to appear for a conference on April 17, 2018 to facilitate further discovery.

This constitutes the decision and order of the court

April 4, 2018

George J. Silver

GEORGE J. SILVER