At an IAS Term, Part 15 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 29th day of August 2023.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

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HYLTON HARRIS and WINSTON JONES AS EXECUTORS OF THE ESTATE OF JUNIOR JONES DECEASED, and VERA JONES,

Plaintiffs,

-against-

MONTEFIORE MEDICAL CENTER AND DR. MICHAEL J. VITTI,

Defendants.

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DECISION & ORDER

Index No. 520406/2016
Mo. Seq. 7

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.

Recitation, as required by CPLR §2219 [a], of the papers considered in the review:
NYSCEF #s: 123 – 124, 125 – 151, 152 – 153, 156, 157 – 158, 159, 161

Defendants MONTEFIORE MEDICAL CENTER ("MMC") and DR. MICHAEL J. VITTI, M.D. ("Dr. Vitti"), move pursuant to CPLR § 3212 for summary judgment in their favor, as well as dismissal of all derivative claims (Sequence #7).

This action arises from alleged acts of malpractice by Dr. Vitti for which HYLTON HARRIS and WINSTON JONES, executors of the estate of JUNIOR JONES ("Mr. Jones," deceased) and VERA JONES, plaintiffs, claim MMC is liable.

Plaintiffs also claimed wrongful death in their original action; however, plaintiffs indicate in their opposition papers that they will not pursue that claim, and therefore the wrongful death cause of action is dismissed without opposition.

Mr. Jones presented to MMC's Emergency Department (ED) on November 14, 2015, complaining of pain in his legs and drainage from an ulcer on his right leg. He rated his pain as an 8 out of 10. He reported no fever, chills, or vomiting at that visit, and the parties agree that his vital signs were within the normal range at that time. An x-ray was taken of his leg, and the ED attending noted that there was a soft tissue defect which was judged to be likely due to the patient's chronic venous stasis. The note continued that osteomyelitis was not ruled out, and that an MRI could be obtained if clinically warranted. A vascular surgery resident noted there was no sign of infection, dressed the wound, and determined that Mr. Jones should be seen in the wound clinic to be fitted with an Unna boot. He was directed to go to the East Tremont at 3219 Vascular Surgery clinic in two days' time, and was then discharged with Percocet and instructed to return to the Emergency Department if his symptoms worsened.

Mr. Jones claims he did go to the East Tremont wound clinic two days later – on November 16 – but for reasons that will be discussed more fully below, did not enter or receive treatment on that date. Mr. Jones did not present to the clinic again until December 17, 2015, and once there saw the defendant Dr. Vitti. By that time he was complaining of worsening pain, but the record shows he still denied fever, chills, or vomiting. Dr. Vitti noted that Mr. Jones had a history of ulcerative colitis and venous ulcerations dating back to 1985, as well as a history of ulcerations to his legs. His vital signs were noted as still being within the normal range. Dr. Vitti noted that the wound was "clean and granulating with no necrotic tissue or cellulitis" and that there was "no evidence of secondary infection." Dr. Vitti applied Unna boots to each of the patient's legs and instructed him to keep his legs elevated, dry, and to ambulate as tolerated. He also instructed Mr. Jones to obtain a venous duplex examination and then return to the clinic within a week, or to go to the Emergency Department if symptoms worsened.

Mr. Jones did not schedule or obtain this examination, and did not return to the clinic or the Emergency Department. He presented to Jacobi Medical Center several days later on December 23, 2015, complaining of increased pain, swelling, redness, and warmth in his right leg, and said that the wound had foul-smelling drainage. It was noted in the record that he said he had taken off a "cast" one week prior due to the pain, and that at the time he presented to Jacobi Medical Center he claimed the wound had a foul odor. His white blood cell count was found to be elevated, and he was given Clindamycin, Zosyn, and Vancomycin antibiotics. He underwent debridement of the leg, and an MRI on December 26 revealed that he did not have osteomyelitis or soft tissue collection. Between December 26 and 30, Mr. Jones developed a fever of 102.7º, underwent an additional debridement, and began to show signs of tissue necrosis on the right leg. On January 1, 2016, Mr. Jones underwent a below-knee amputation of his right leg, as well as additional debridement of his left leg. On January 4, a biopsy of Mr. Jones' left leg returned positive for pyoderma gangrenosum (PG), and he was treated with Prednisone. Thereafter he was transferred to rehabilitation facilities. Mr. Jones died more than three years later on April 7, 2019, of genitourinary cancer.

Plaintiff commenced this action on November 16, 2016, alleging that defendants failed to properly assess and treat Mr. Jones' leg injury, leading to his worsening condition and the eventual amputation of his right leg. Specifically, they allege that defendants failed to properly assess Mr. Jones' condition and medical history and implement proper testing or a medical plan to monitor his condition; failed to recognize signs of infection and explain the risks thereof to the patient; failed to refer him to an infectious disease specialist; failed to provide full and complete discharge instructions and discharged Mr. Jones without necessary equipment and planning; and

that defendants failed to comply with the Joint Commission on Accreditation of Healthcare Organizations guidelines.

Defendants now move for summary judgment, contending that their experts' testimony demonstrates that they could not have been the cause of Mr. Jones' injury, and that plaintiffs have not sufficiently rebutted their contention to create a triable issue of fact.

"'In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries [internal citations omitted].'" *Hutchinson v. New York City Health and Hosps. Corp.*, 172 AD3d 1037, 1039 [2d Dept. 2019] [citing *Stukas v. Streiter*, 83 AD3d 18, 23 [2d Dept. 2011]]. "Thus, in moving for summary judgment, a physician defendant must establish, prima facie, 'either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries.'" *Hutchinson*, 132 AD3d at 1039 [citing *Lesniak v. Stockholm Obstetrics & Gynecological Servs., P.C.,* 132 AD3d 959, 960 [2d Dept. 2015]]. "Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause [internal citations omitted]." *Navarro v. Ortiz*, 203 AD3d 834, 836 [2d Dept 2022]. "'When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution.'" *Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022] [citing *Russell v. Garafalo,* 189 A.D.3d 1100, 1102 [2d Dept. 2020] [internal citations omitted]]. "Any conflicts in the testimony merely raised an issue of fact for the fact-finder to resolve." *Palmiero v. Luchs*, 202 AD3d 989, 992 [2d Dept 2022] [citing *Lavi v. NYU Hosps. Ctr.,* 133 A.D.3d 830, 832 [2d Dept. 2015]]. However, "expert opinions that are conclusory, speculative, or unsupported by the

record are insufficient to raise a triable issue of fact [internal citations omitted].” *Wagner v. Parker*, 172 AD3d 954, 966 [2d Dept. 2019].

As to the experts’ opinions, case law is clear that “mere conclusions, expressions of hope or unsubstantiated allegations are insufficient” to raise a triable issue of fact to defeat a motion for summary judgment on the issue of liability. *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562 [1980]. “General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat summary judgment.” *Salvia v. St. Catherine of Sienna Med. Ctr.,* 84 A.D.3d 1053, 1054 [2d Dept. 2011] [citing *Heller v. Weinberg*, 77 AD3d 622, 623 [2d Dept. 2010]].

As a preliminary matter, defendants contend that plaintiffs’ expert is not qualified to opine on this case; the identity of plaintiffs’ expert has been disclosed to the court, and the court finds that this expert is qualified to opine as to the standards of care in the fields of vascular surgery and general surgery. Defendants submit the affirmations of three experts – Dr. Asa Viccellio, M.D. (Internal and Emergency Medicine); Dr. Bruce Farber, M.D. (Internal Medicine and Infectious Disease); and Dr. George Todd, M.D. (Surgery and Vascular Surgery) – in support of their motion.

As to any claims regarding Mr. Jones’ treatment during his November 14, 2015 visit to MMC’s ED, defendant’s experts opine, and plaintiffs’ expert agrees, that the course of treatment during the visit was proper. The parties’ experts further agree that there was no sign of infection to Mr. Jones’ leg on that date, and therefore no need to admit him to the hospital; furthermore, they agree that instructions for Mr. Jones to return in two days’ time for follow up was a proper course of treatment. The court therefore need not address this visit further; any claims as to the treatment of Mr. Jones November 14, 2015 are dismissed.

Furthermore, defendants' experts contend that any claims that defendants violated the Joint Commission on Accreditation of Healthcare Organizations guidelines lack specificity as to which guidelines have been violated, and that such allegations are without merit as they opine that defendants complied with these guidelines. As this contention is never addressed in plaintiffs' expert affirmation, it, too, is therefore dismissed without opposition.

Plaintiffs' expert's opinion, then, covers the period beginning after Mr. Jones visited MMC on November 14, 2015, when the patient was advised to return for follow up. Plaintiffs' expert's opinion is that Mr. Jones returned as instructed two days later on November 16, but was turned away due to the inability to pay, which they opine was a departure from the standard of care. Defendants deny this interaction and claim that it was not the regular practice of their clinic to deny a patient treatment. Defendants' experts also opine that this would not have been done, and that there is no record of the interaction occurring. Furthermore, plaintiffs are unable to point to any evidence in the record to support the claim that Mr. Jones presented himself to defendants' clinic on November 16, 2015 and was turned away. Mr. Jones' own deposition testimony is equivocal on this point and does not directly state that he was told he could not be treated unless he paid in full. Thus, these submissions do not establish facts opposing a prima facie case as to this date and plaintiffs' expert's opinions are merely speculation with regard to this allegation, and will not be considered. Therefore, summary judgement is granted relative to the November 16, 2015 date and these claims are also dismissed.

In response to plaintiffs' Bill of Particulars, Defendant's expert, Dr. Todd, opines that defendants' treatment of Mr. Jones was at all times proper and within the standard of care. He opines that, according to the record, when Mr. Jones presented to Dr. Vitti's clinic on December 17, 2015, his symptoms were not consistent with an infectious process, and that, as reflected in

the record, Dr. Vitti did in fact inquire about Mr. Jones' medical history and the condition at issue. As of that visit, he opines, the record shows that Mr. Jones' wounds were "clean and granulating with no necrotic tissue or cellulitis" and that there was "no evidence of secondary infection." Specifically, Dr. Todd opines that where the record shows the patient did not report fever or chills – nor did he have pus, purulent drainage, or edema or redness coming from his wounds – that infection is not indicated. Rather, he opines that the evidence in the record supports Dr. Vitti's conclusion that the patient was suffering from venous stasis disease. He opines that, based on this lack of indicated infection, there was no need to culture the wounds – as doing so would not have returned useful results for informing additional treatment – and that there was therefore no need to refer Mr. Jones to the ED. Furthermore, Dr. Todd opines that defendants' treatment of Mr. Jones could not have been a cause of his injuries because he did not yet have clinical indications of PG at the time he presented to Dr. Vitti on December 17. He opines that PG can present similarly to venous stasis disease, but that given the patient's long history with the latter, it was reasonable to conclude that his symptoms were a product of venous stasis disease.

Drs. Todd and Farber each also opine that Dr. Vitti's discharge of the patient with Unna boots and instructions to return within a week for additional imaging and follow-up were within the standard of care, and that Unna boots are a routine method of treating and healing ulcers that stem from venous stasis disease. Dr. Todd opines that to ultrasound the affected area is an appropriate evaluation method, and that Mr. Jones' noncompliance with instructions to schedule the ultrasound robbed Dr. Vitti of any opportunity to diagnose PG in the patient. He also opines that a diagnosis of PG would have necessitated high-dose steroids, rather than antibiotics, as treatment.

Plaintiffs' expert in response fails to address many of the points of the opposing experts. In particular, plaintiffs' expert fails to respond to defendants' experts' reasoning for why additional testing and treatment were not clinically warranted as of the December 17 visit. They opine that Mr. Jones "clearly" had an infection when he presented to Dr. Vitti's clinic on December 17, and that Dr. Vitti should have admitted Mr. Jones to the hospital, cultured and elevated his wound, given him antibiotics, imaged his leg using a CT scan or MRI, and that these actions would have had a 90% chance of saving Mr. Jones' right leg. They opine, without citing evidence in the record, that this infection is what necessitated the amputation, rather than the PG evidenced in the Jacobi Medical Center record.

But plaintiffs' expert does not explain the particular symptoms that led them to believe that Mr. Jones had an infection as of the December 17 visit, nor how such an infection led to the deterioration of the patient's leg by the time of his December 23 visit to Jacobi Medical Center. They also list symptoms from the December 17 visit that are not present in the medical record and present them as evidence of infection. They further fail to respond to the defendants' experts' opinion – which cites to the record – that Mr. Jones was, in fact, told to elevate his leg when he was given Unna boots. Rather, they claim that to discharge a patient such as Mr. Jones with Unna boots was a departure from the standard of care. Significantly, they also do not address Dr. Todd's opinion that the proper treatment for PG is high-dose steroids, not antibiotics.

Plaintiffs' expert also does not address imaging from Jacobi showing that Mr. Jones did not have osteomyelitis; defendants opine that such imaging demonstrates that osteomyelitis was not present, and therefore testing for it would have been unnecessary on December 17. Plaintiffs' expert, rather, opines simply that such testing should have been carried out, but does not explain what such testing would have accomplished in terms of treating Mr. Jones.

In reviewing plaintiffs' expert's testimony, it is clear that they either do not address the points of the opposing experts or offer conclusory remarks regarding the defendants' responsibility for Mr. Jones' injuries. Defendants' experts lay out clear reasoning that references evidence in the record tending to show that Dr. Vitti and MMC acted in accordance with the standard of care when dealing with Mr. Jones and could not have been a proximate cause of his injuries. In listing the care, treatments, and tests defendants should have performed during Mr. Jones's December 17 visit, plaintiffs' expert repeatedly fails to provide "competent evidence" in the record to ground their allegations. See *Salvia v. St. Catherine of Sienna Med. Ctr.,* 84 A.D.3d 1053, 1054 [2d Dept. 2011] [citing *Heller v. Weinberg*, 77 AD3d 622, 623 [2d Dept. 2010]]. Such reasoning falls short of the standard necessary to rebut a motion for summary judgment.

Accordingly, defendants have established *prima facie* that they are entitled to summary judgment and that no triable issues of fact exist; plaintiffs in response have offered merely conclusory statements of defendants' responsibility and have been unable to refute defendants' specific contentions using evidence in the record. Summary judgement is therefore GRANTED as to defendants MMC and Dr. Michael J. Vitti. As derivative claims depend on the main claim to survive, those claims are necessarily dismissed. *See Wijesinghe v. Buena Vida Corp*., 210 A.D.3d 824, 826 [2d Dept. 2022].

Defendants' motion for summary judgment pursuant to CPLR § 3212 is GRANTED (Sequence #7). The entire action is dismissed, and the Clerk is directed to enter judgement.

This constitutes the decision and order of the court.

ENTER.

Hon. Consuelo Mallafre Melendez
J.S.C.

This Decision was drafted with the assistance of intern, Isaac Burke, Brooklyn Law School.