

Schantz v Fish

2009 NY Slip Op 33040(U)

December 18, 2009

Supreme Court, New York County

Docket Number: 104720/06

Judge: Joan B. Carey

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

PRESENT: Honorable Joan B. Carey
Justice

PART 29

BRIAN SCHANTZ
Plaintiff,

INDEX NO. 104720/06
Motion Sequence No.: 2-3

-v-

IRVING FISH, M.D.,
Defendant.

The following papers, 1- 81, were read on this motion by plaintiff Brian Schantz for an order striking the answer of defendant, or precluding testimony at the time of trial, based upon spoliation of evidence in the form of medical records; and separate motion by defendant Irving Fish, M.D. for summary judgment dismissing the complaint.

Motion Number 2

Notice of Motion - Affidavits - Exhibits
Affirmation in Opposition - Affidavits - Exhibits
Replying Affirmation -
Sur-Reply

FILED
DEC 23 2009
NEW YORK
COUNTY CLERK'S OFFICE

<u>Papers Numbered</u>	
1-10	_____
11-22	_____
23-24	_____
25-33	_____

Motion Number 3

Notice of Motion - Affidavits - Exhibits
Affirmation in Opposition - Affidavits - Exhibits
Replying Affirmation -

<u>Papers Numbered</u>	
34-69	_____
70-79	_____
80-81	_____

Cross-Motion: Yes No

Plaintiff, Brian Schantz, commenced the instant medical malpractice action against defendant, Irving Fish, M.D., with the filing of a summons and complaint on or about April 6, 2006.¹ Plaintiff alleges that defendant was negligent in failing to properly diagnose his Chiari

¹ It is noted that prior to the commencement of the instant action an action was commenced in New Jersey against many individual physicians and medical treatment facilities alleging medical malpractice. Dr. Fish was named as a defendant in that action. However, that action was dismissed as against Dr. Fish for lack of personal jurisdiction.

It is also noted that the complaint named Children & Adolescent Comprehensive

I malformation.² According to plaintiff he had a Chiari I malformation when he treated with Dr. Fish for an approximately eight (8) month period from June of 2000 through January of 2001, and as a result of Dr. Fish's failure to diagnose this condition, his symptoms progressed to the point where surgical intervention was rendered ineffective. Plaintiff specifically alleges that Dr. Fish was negligent in, *inter alia*, failing to independently review an MRI film from November of 1999, which, according to plaintiff, reveals a Chiari I malformation; or ordering a repeat MRI, in light of plaintiff's worsening condition. Plaintiff contends that because of Dr. Fish's malpractice, plaintiff's Chiari I malformation was not diagnosed until November of 2003, when a repeat MRI was performed and read by Dr. Elliot Lerner, thereby reducing the effectiveness of surgical intervention. It is noted that the diagnosis of Chiari I malformation was agreed with by neurosurgeon, Dr. Rajnik Raab, and led to his performance of a sub-occipital craniectomy and C1 laminectomy for Chiari I malformation. According to plaintiff, this surgical intervention has not relieved his disabling symptoms, because the diagnosis of his condition and the performance of the surgery was delayed by defendant's malpractice

Discovery has been completed, a note of issue/certificate of readiness has been filed, and this action is now ready for trial. Plaintiff presently moves for an order striking the answer of defendant, or precluding testimony at the time of trial, based upon spoliation of evidence in the form of medical records. By separate motion defendant moves for summary judgment dismissing the complaint.

Plaintiff's Spoliation Motion

Plaintiff presently moves for an order striking the answer of defendant, or precluding testimony at the time of trial, based upon spoliation of evidence in the form of medical records. Plaintiff's counsel contends that when he received Dr. Fish's medical records pursuant to a discovery order of the Court, the chart, which was 29 pages, appeared to lack certain documents.³ Along with these records, plaintiff's counsel received two separate cover letters. Despite receiving a chart that contained 29 pages of records, one cover letter enclosed sought reimbursement for the copying of 37 pages, and the other cover letter sought reimbursement

Headache Medical Care (hereinafter "CACHMC") as a defendant. It appears that CACHMC was no longer operating at the time of the commencement of this action, and was never served with a summons and complaint.

² Chiari I malformation is defined as a congenital abnormality of the posterior fossa (base of brain where the spinal column joins the skull) that causes a protrusion of the cerebellum through the bottom of the skull (foramen magnum) into the spinal canal, and results in a poor circulation of cerebrospinal fluid from the brain to the spinal cord. The symptoms of this condition include headaches, neck pain, dizziness, vision problems, balance problems and muscle weakness. Surgery to enlarge the opening of the posterior fossa of the skull is often recommended for patients. Such surgery may alleviate pressure on the neural elements and may result in an improvement of symptoms.

³ It is noted that plaintiff's counsel herein was provided a copy of Dr. Fish's treatment records of plaintiff from plaintiff's New Jersey counsel prior to the commencement of the New York action. The chart received from plaintiff's New Jersey counsel contained only 18 pages.

for the copying of 52 pages. Following the receipt of these records and the accompanying cover letters, plaintiff's counsel demanded a certified copy of Dr. Fish's chart. The certified copy of the chart was received and contained 37 pages. According to plaintiff's counsel there appeared to be unexplained gaps in what was certified to be a full chart, as plaintiff's mother had cancelled checks for visits to Dr. Fish that were not documented in this chart. In addition, at the deposition of Dr. Fish, he testified that the original chart, which he brought with him to the deposition, was not complete. Dr. Fish could not offer a reason as to why all of plaintiff's treatment records were not in the chart.

It appears that plaintiff first treated with Dr. Fish, at CACHMC, in June of 2000, and continued to treat with him until January of 2001. Plaintiff contends that, based upon a review of the billing records, as well as cancelled checks, he treated with Dr. Fish on June 8, 2000, July 6, 2000, July 31, 2000, August 24, 2000, October 19, 2000, December 14, 2000, and on or about January 23, 2001. Notwithstanding, plaintiff's chart only contains records relating to the June 8, 2000 and January 2001 visit. No records relating to the July 6, 2000, July 31, 2000, August 24, 2000, October 19, 2000 or December 14, 2000 visits were contained in the chart.

With respect to the June 8, 2000 visit, the chart includes a typewritten letter, dated June 14, 2000, from Kathleen Young, a nurse employed by CACHMC, to Dr. Judy Woo, a pediatric neurologist that referred plaintiff to Dr. Fish. This letter by Nurse Young, among other things, sets forth plaintiff's medical history with respect to his headaches, and states that following an examination by the staff of CACHMC, including Dr. Fish, it was determined that plaintiff had "chronic daily headaches transformed from migraine headache with rebound." This letter states that the treatment plan arrived at, in addition to recommending the establishment of a regular sleep pattern, the performance of exercise, and the keeping of a headache journal,⁴ included altering plaintiff's medication as follows: "Two week washout of headache medicines. Wean off Neurontin over 2-3 days. Celebrex 100mg, as a headache salvage only. Following the 2 week washout will start Zomig 2.5mg, repeat once in 2 hrs. prn, maximum 3 days/week. May consider Nortriptyline 10 mg. hs as a headache preventative." A follow up exam was to be conducted in one (1) month, and was, based upon the billing records/cancelled check, conducted on July 6, 2000. The aforementioned treatment plan is also set forth in a handwritten document entitled Patient Treatment Plan - according to Dr. Fish's deposition testimony, he completed the medication portion of this form and Nurse Young completed the remainder of the form. A patient data form, dated June 8, 2000, which contains plaintiff's address, phone number, information regarding his parents, as well as information regarding the referring physician and plaintiff's pediatrician, is also included in plaintiff's chart.

Plaintiff's chart contains two (2) letters to plaintiff's school, dated September 5, 2000; one written to the nurse and the other to the school guidance counselor. These letters, which are signed by Nurse Young, and initialed by Dr. Fish, are written to advise that plaintiff was suffering from chronic migraine headaches. A third letter, which appears to be handwritten by Dr. Fish, and dated December 14, 2000, is included in plaintiff's chart. This letter is written to "To Whom It May Concern," and advises that plaintiff was going to be receiving home tutoring to catch up on missed school work. A "Follow up Headache Questionnaire" relating to the

⁴ A headache journal for June of 2000 was included in the medical chart. It is noted that plaintiff had headaches of varying degrees of severity every day from June 8 through June 31.

symptoms of plaintiff's headaches, dated December 14, 2000, is also a part of the plaintiff's chart.⁵

With respect to plaintiff's January visit of January 23, 2001, the chart includes a typewritten note prepared by Dr. Fish, as well as a typewritten note prepared by Nurse Young. The note prepared by Dr. Fish sets forth that plaintiff reports that his "headaches are the same," setting forth that they occur seven (7) days a week and last from several hours to all day, varying in severity. This note further sets forth that due to plaintiff's headaches he is getting home tutoring, as opposed to attending school. It also states that plaintiff did little else "but listen to music do a little homework and lie in bed." Dr. Fish's impression was "chronic daily headache - which are disabling [plaintiff] and his family." In this note Dr. Fish recommends "Counseling to teach [plaintiff] and his family how to live despite the pain. Fioricet q 4h prn - max 3 times weekly. Nortriptyline 25 mg hys as a preventive." The note prepared by Nurse Young adds that, at that time, plaintiff was totally disabled by his headaches and was homebound. According to these records, plaintiff was to return to Dr. Fish in two (2) months. However, it appears that plaintiff ceased his treatment with Dr. Fish following the visit of January 23, 2001.

Plaintiff presently moves for an order striking the answer of defendant, or precluding testimony at the time of trial, based upon spoliation of these medical records. Plaintiff argues that without such records he is prejudiced because such records are crucial to demonstrate that plaintiff had escalating complaints and Chiari symptoms during the period in which he treated with Dr. Fish. Plaintiff also argues that although the evidence herein relating to the spoliation of these medical records indicates that these records were intentionally destroyed, the sanctions sought, *i.e.*, striking the answer of defendant, or precluding testimony at the time of trial, are appropriate even where the destruction of evidence was done negligently, and even if the evidence was destroyed before the spoliator was a party to any legal action.

In opposition to plaintiff's spoliation motion, defendant, Dr. Fish, first argues that the instant motion should be denied because there was no willful or contumacious conduct, or any evidence of bad faith on the part of Dr. Fish, with respect to plaintiff's missing medical records. Dr. Fish points out that the records at issue have been missing from the patient's chart as early as March 27, 2001, approximately two months after he last saw plaintiff, as evidenced by the fact that such records were not part of the "complete record" that he forwarded to plaintiff's family practitioner, at that time. He also points that the office computers at CACHMC, on which the office notes are initially typed by Dr. Fish, were donated to a school sometime in 2003 when the facility was closed, and at that time all information on the computers was deleted. Based upon the foregoing, Dr. Fish argues that the physical records were missing in early 2001, and the computerized records were deleted in 2003, prior to the time that Dr. Fish had any indication that there was any potential litigation in connection with his treatment of plaintiff. Therefore, according to Dr. Fish, he could not have intentionally destroyed any evidence, because at the time of the destruction of plaintiff's medical records he was not on notice that there might be future litigation.

⁵ It is noted that plaintiff alleges that this headache questionnaire was altered by Dr. Fish to indicate that plaintiff was not experiencing headaches in the back of his head at that time, which is a symptom of a Chiari I malformation. However, this allegation against Dr. Fish is not supported by any evidence submitted in conjunction with the instant motion.

Notwithstanding such argument by Dr. Fish, as the First Department held in Herrera v. Matlin, 303 AD2d 198 [1st Dept. 2003], where a physician's failure to properly maintain medical records deprives a plaintiff of any means of establishing a prima facie case, it is no less prejudicial to that plaintiff merely because the loss of the medical records was inadvertent, and the striking of defendant's answer is still warranted. See Herrera v. Matlin, supra, citing Kirkland v New York City Hous. Auth., 236 AD2d 170 [1st Dept. 1997]; Squitleri v City of New York, 248 AD2d 201 [1st Dept. 1998]; Silvestri v General Motors Corp., 271 F3d 583, 593 [4th Cir. (Md.) 2001]); see also Gray v. Jaeger, 17 AD3d 286 [1st Dept. 2005][spoliation sanction warranted even though loss of medical records was not contumacious.] Therefore, the key factor in determining whether spoliation sanctions are warranted is whether the loss of the records at issue deprives plaintiff of any means of establishing a prima facie case.

As set forth above, plaintiff argues that without such records he is prejudiced because these records are crucial to demonstrate that plaintiff had escalating complaints and Chiari symptoms during the period in which he treated with Dr. Fish.⁶ In opposition, Dr. Fish argues that at trial plaintiff will adequately be able to demonstrate that his complaints and symptoms worsened during the period of time in which he treated with Dr. Fish. Dr. Fish also points out that although a portion of plaintiff's medical records are missing, records of plaintiff's visits to Dr. Fish on June 8, 2000 and in January 2001 have been provided to plaintiff. According to Dr. Fish, plaintiff has failed to demonstrate that with these records alone he would not be able to demonstrate that his symptoms worsened over the course of his treatment with Dr. Fish. Dr. Fish further argues that he himself testified at his deposition that plaintiff's headaches worsened while plaintiff treated with him, and, thus, plaintiff has the means to establish that his symptoms worsened while he treated with Dr. Fish.

Although it appears that plaintiff, through his own testimony, and the testimony of his mother and Dr. Fish, as well as the limited medical records that do exist, would be able to prove to a jury that his condition worsened while he treated with Dr. Fish, he is still deprived of an opportunity in proving a prima facie case of medical malpractice. The relevant issue herein is whether plaintiff began to exhibit worsening symptoms that would indicate to a physician that a patient may be suffering from a Chiari I malformation. Plaintiff cannot adequately prove his case by simply demonstrating that his overall condition was deteriorating, and, therefore, Dr. Fish was required by the standard of care to independently review the MRI film from November of 1999, or order a repeat MRI. Plaintiff will suffer great prejudice from not being able to demonstrate to the jury, through the use of his medical records, his specific complaints during this period, as well as the treatment plan formulated by Dr. Fish in response to such complaints. These records become rather important considering that Dr. Fish has no independent recollection of plaintiff. Furthermore, although plaintiff and his mother can offer testimony at the time of trial relating to plaintiff's condition at that time, this Court does not feel that the testimony of lay people relating to one's medical condition has the same weight as that which is contained in a medical record.

⁶ As discussed more fully below, plaintiff alleges that Dr. Fish departed from good and accepted medical practice in failing to personally review an MRI study of November 9, 1999, or ordering a repeat MRI study in light of plaintiff's worsening condition. Plaintiff contends that in light of his condition, it was improper to simply rely on the MRI report of the neuroradiologist indicating that it was a normal study that showed no evidence of a Chiari I malformation.

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It is important to note that while Dr. Fish argues that the loss of plaintiff's medical records has not deprived him with a means of proving his case, Dr. Fish also argues in connection with his summary judgment motion, which is addressed fully below, that plaintiff's expert opinion is insufficient as it is not based upon a review of the records of Dr. Fish. This argument is not only outrageous in light of the fact that Dr. Fish did not have any records which provided any insight as to what he did to treat plaintiff over the course of an eight (8) month period between June of 2000, through January of 2001, but it highlights the prejudice to plaintiff in being unable to have available to him the medical records setting forth what treatment he was provided by Dr. Fish, and what symptoms he presented with during the course of this treatment. The lack of documentary evidence in the form of medical records to support plaintiff's claims against Dr. Fish is clearly detrimental to the strength of his case. It is further noted that subsequent to the full submission of the instant motion, a conference was held with the parties, at which time the parties were advised that although the spoliation of these medical records does not warrant the striking of Dr. Fish's answer, fundamental fairness required the Court to fashion some sort of sanction against Dr. Fish. Following that conference, counsel for Dr. Fish wrote to the Court seeking that the sanction to be imposed to be the sanction suggested by plaintiff in his motion papers as an alternate form of relief, which was to preclude defendant from offering evidence at the time of trial regarding any non-compliance or comparative fault on plaintiff's part. As there has been no evidence presented in connection with this motion or the summary judgment motion of defendant, which is presently before this Court, that plaintiff was non-compliant or in any way contributed to his injuries, this suggested sanction appears to be of no consequence whatsoever. Therefore, defendant's request to be sanctioned in the form of being precluded from offering evidence at the time of trial regarding non-compliance or comparative fault on plaintiff's part is denied.

Although the Court does not feel that the spoliation of plaintiff's medical records completely deprives plaintiff of any and all means of establishing a prima facie case, plaintiff is, as discussed above, undoubtedly prejudiced by the unavailability of these records. Therefore, although the spoliation of these medical records does not warrant the striking of Dr. Fish's answer, the jury will be given a negative inference charge at the time of trial. See PJI 1:77.1, General Instructions - Evidence - Failure To Produce Documents. The jury charge, fashioned from PJI 1:77.1 to fit the circumstances of this action, is as follows:

If you find that defendant, either intentionally or through negligence, destroyed, deleted, or otherwise lost, a significant portion of plaintiff's medical records, and that no reasonable explanation for such destruction, deletion, or loss of these records has been offered, you may, although you are not required to, infer that the destruction, deletion, or loss, had a fraudulent purpose and that if produced, the medical records would have been against defendant's interest. Moreover, such destruction, deletion, or loss of these records casts doubt upon defendant's position and may be considered against his case as such. If you find that the destruction, deletion, or loss of these records, was without a reasonable explanation, that does not, however, in and of itself, mean that the plaintiff is entitled to win. You may give the fact of such destruction, deletion, or loss the weight you think proper under the circumstances; you may consider it decisive with respect to plaintiff's claim, you may ignore it altogether, or you may give it the weight between these extremes you determine appropriate.

Lastly, it is noted that Dr. Fish also argued in connection with this motion that he takes the position, and will defend this case at the time of trial, arguing that plaintiff does not, and never did, suffer from a Chiari I malformation, and, thus, liability hinges solely on whether the plaintiff can prove that he did in fact suffer from a Chiari I malformation at the time he treated with Dr. Fish. Notwithstanding this argument, even if plaintiff has the ability to prove that he suffered from a Chiari I malformation at that time, he must also be able to demonstrate that a deviation from the standard of care by Dr. Fish was the proximate cause of injury to plaintiff. To do so, as previously discussed, plaintiff must demonstrate that his Chiari I symptoms progressed during the time he treated with Dr. Fish, and nothing was done by Dr. Fish during this period to address the progression of plaintiff's symptomology.

Defendant's Motion For Summary Judgment

By separate motion defendant moves for summary judgment, dismissing the complaint. "[T]he remedy of summary judgment is a drastic one, which should not be granted when there is any doubt as to the existence of a triable issue or where the issue is even arguable, since it serves to deprive a party of his day in court." Byrnes v. Scott, 175 AD2d 786 [1st Dept. 1991], quoting Gibson v. Am. Export, 125 AD2d 65 [1st Dept. 1987]. Initially, "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 demonstrate the absence of any material issues of fact." Alvarez v. Prospect Hospital, 68 NY2d 320 [1986]; see also Winegrad v. New York Univ. Med. Center, 64 NY2d 851 [1985]; Zuckerman v. City of New York, 49 NY2d 557 [1980]. A failure by the movant in demonstrating, *prima facie*, its entitlement to judgment as a matter of law requires the denial of summary judgment, regardless of the sufficiency of the opposing papers. See Alvarez v. Prospect, *supra*; Winegrad v. New York Univ. Med. Center, *supra*. Where a *prima facie* showing of entitlement to judgment as a matter of law has been properly demonstrated, the burden then shifts to the party opposing the motion to produce evidence that establishes the existence of material issues of fact which require a trial in the action. See Alvarez v. Prospect, *supra*; Zuckerman v. City of New York, *supra*.

Defendant presently moves for summary judgment dismissing the complaint, as asserted against him, pursuant to CPLR §3212. Dr. Fish argues that plaintiff does not suffer from a Chiari I malformation, and contends that he correctly diagnosed plaintiff with chronic daily headaches transformed from migraine headaches with rebound. Dr. Fish further contends that once this diagnosis was made, he correctly managed plaintiff's care and treatment. In support of his motion, Dr. Fish relies upon, *inter alia*, the expert affidavit of a physician, who is board certified in neurological surgery and pediatric neurological surgery. According to this expert, Dr. Fish correctly diagnosed plaintiff with chronic daily headaches transformed from migraine headaches with rebound. The expert sets forth in this affidavit that based upon an MRI study performed on November 9, 1999, approximately seven months prior to plaintiff's initial visit to Dr. Fish, and the comprehensive neurological evaluation that was performed by Dr. Fish, as well as a review of treatment records of the referring pediatric neurologist, Dr. Judy Woo, Dr. Fish acted appropriately in arriving at this diagnosis. The affidavit further sets forth that plaintiff did not manifest any clinical symptoms suggestive of a Chiari I malformation while under the care of Dr. Fish. The expert states that Dr. Fish's initial treatment plan, which consisted of adjusting plaintiff's medication, and having plaintiff fill out a headache diary was appropriate. Defendant's expert also states that the further adjustment of plaintiff's medications, as his symptoms grew in duration and intensity, was appropriate. In this expert's opinion, no further testing, including

a repeat MRI, was warranted at anytime while plaintiff was treating with Dr. Fish, as plaintiff did not develop any focal neurological deficits or symptoms during this period.

Defendant's expert further opines that plaintiff did not have a Chiari I malformation at any time, including while he was under the care of Dr. Fish. The expert explains that "Chiari I malformations can only initially be definitively diagnosed radiographically on MRI studies." The expert reviewed the MRI study of November 9, 1999, which was taken prior to Dr. Fish's care of plaintiff, and two studies taken subsequent to the termination of Dr. Fish's care, and concludes that these were all normal studies that showed no evidence of a Chiari I malformation. Moreover, the expert's review of a cine CSF flow study performed subsequent to plaintiff's treatment with Dr. Fish showed normal spinal fluid flow anteriorly to the brainstem, further evidence that plaintiff did not have a Chiari I malformation. According to this expert, the subsequent diagnosis, made by Dr. Rajnik Raab, of a Chiari I malformation was incorrect, and the neurological intervention that plaintiff eventually underwent only made his condition worse. The expert adds that there is no organic etiology or basis to explain plaintiff's continued current complaints and states that these current complaints are suggestive of a psychiatric/somatoform disorder. In addition to the aforementioned expert affidavit, defendant has submitted the medical report of a board certified neuropsychologist. The neuropsychologist concludes, in this report, that plaintiff suffers from Munchausen's Syndrome and Munchausen's Syndrome by Proxy, and is manufacturing and/or exaggerating his complaints.

In opposition to defendant's summary judgment motion plaintiff argues that despite defendant's contention to the contrary, he did suffer from a Chiari I malformation, and defendant's failure to diagnose this condition was a departure from good and accepted medical practice. Plaintiff relies upon, *inter alia*, the medical reports of his expert physician who is board certified in neurology and psychology, as well as an affidavit by the expert swearing to the truth of these reports. Plaintiff's expert physician opined that plaintiff suffered from a Chiari malformation and that there was a delay of over eight years in diagnosing this condition. The expert further opines that such delay was the proximate cause of "his suffering protracted and disabling headaches, now refractory to all treatment, recurrent vertigo with vomiting, and the progressive gait and limb ataxia, as well as decline in his intellectual function and other cognitive skills." According to this expert, there was a deviation from the appropriate standard of care on the part of the initial neurologist, family physician, pediatric neurologist and hospital personnel in obtaining the proper diagnostic studies necessary to correctly diagnose plaintiff's condition. The expert states that MRI scans, including the 1999 MRI taken prior to the time Dr. Fish treated plaintiff, were misread, and contributed to the failed diagnosis. The expert states that had the correct diagnosis been timely, plaintiff could have undergone decompression surgery earlier, and such earlier surgery "would have significantly reduced the risk of Brian suffering protracted neurological disability."

Plaintiff's neurology and psychology expert concludes in his report that:

"[a]t this time I would state that within a reasonable degree of medical certainty that Brian Schantz suffers residual protracted headaches, vestibular disturbance, gait and limb ataxia, significant residual cognitive neurological impairments affecting his memory, intelligence attention-concentration capability, reading capability, learning capacity, and mental processing speed - attributable to an eight-year delay in establishing the proper neurological diagnosis in his case - i.e., Arnold-Chiari malformation. Next I would state within a reasonable degree of medical certainty that

failure in establishing the proper diagnosis in his case over these eight years' duration from age ten to age eighteen was the proximate cause in his suffering protracted and disabling headaches, vertigo with vomiting, progressive gait and limb ataxia, decline in his intellectual functioning, personality deterioration and withdrawn behavior - even following multiple attempts at corrective decompression surgical procedures performed in the past three years. Next I would state within a reasonable degree of medical certainty that it was the combined negligence of neurologists, family physicians, pediatric neurologists, and hospital personnel in obtaining proper diagnostic studies and in making the appropriate diagnosis in this case as well as the negligence of radiologists who did not accurately report the Arnold-Chiari-I malformation in MRI scans performed in 1999 and 2002 that were responsible for this delay in diagnosis and was the proximate cause of Brian Schantz suffering his current residual neurological, neuropsychological, and psychiatric disability. Finally I would state within a reasonable degree of medical certainty that because Brian Schantz has suffered the disability as described above even following decompression surgical procedures performed over the past three years - that these will remain as permanent residual neurological, neuropsychological, and psychiatric disabilities in the future."

Plaintiff also submitted the report of a neuropsychologist, who, contrary to the conclusions of defendant's neuropsychologist, found "unequivocal objective evidence of ongoing neurobehavioral and neuropsychiatric dysfunction that is the direct result of his neurological condition." In the opinion of the neuropsychologist, plaintiff's condition is permanent in nature.

In addition to these reports, the plaintiff submits the deposition testimony of several experts that were retained and gave testimony in connection with plaintiff's New Jersey action. According to the testimony of Dr. Daniel Adler, a board certified pediatric neurologist who testified for a defendant in the New Jersey action, the MRI performed in 2003 showed a Chiari I malformation.⁷ Plaintiff also relies on the testimony Dr. Jeffrey Wilsoff, another defense expert in the New Jersey action, who was board certified in neurological surgery and pediatric neurosurgery. According to Dr. Wilsoff, if an MRI had been ordered in January 2001 (which was during the period of time plaintiff treated with Dr. Fish) it would have revealed a Chiari I malformation. Neurosurgeon, Dr. Blumenkopf, retained by plaintiff in the New Jersey action, testified at his deposition that the 1999 MRI showed Chiari malformation. Similarly, plaintiff's expert neuroradiologist in the New Jersey action, Dr. Michael Deck, testified that plaintiff's MRIs of 1999 and 2003 clearly demonstrate the existence of Chiari malformation. Furthermore, the MRI of November of 2003, was performed and read by Dr. Elliot Lerner, who diagnosed plaintiff as having a Chiari I malformation. This diagnosis was agreed with by neurosurgeon, Dr. Rajnik Raab, and led to his performance of the surgery, i.e., sub-occipital craniectomy and C1 laminectomy for Chiari I malformation.

⁷ It appears that several of the defendants in the New Jersey action did not defend the case, as the defendant herein chooses to do, by arguing that plaintiff never suffered from Chiari I. These defendants conceded that plaintiff suffered from Chiari I, but argued that plaintiff's condition was asymptomatic, and not the cause of his headaches.

Based upon the conflicting evidence submitted, this Court finds that issues of fact and credibility exist in connection with whether Dr. Fish, one of plaintiff's pediatric neurologists, failed to properly diagnose a Chiari I malformation in plaintiff, and whether such failure proximately caused injury to plaintiff. Such issues cannot be resolved on this motion for summary judgment (see Bradley v. Soundview Healthcenter, 4 AD3d 194 [1st Dept. 2004]; Morris v Lenox Hill Hosp., 232 AD2d 184 [1996]). Accordingly, Dr. Fish's motion for summary judgment is denied.

As discussed above, in connection with plaintiff's spoliation motion, defendant argues in his reply that the report of plaintiff's neurology and psychology expert failed to point to any evidence contained in the records of Dr. Fish that he departed from the standard of care with respect to his treatment of plaintiff. Again, this argument is outrageous in light of the fact that Dr. Fish did not have any records which provided any insight as to what he did to treat plaintiff over the course of an eight month period between June of 2000, through January of 2001.

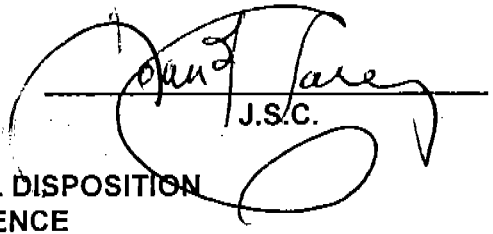
Based on the foregoing, it is hereby

ORDERED that the motion by plaintiff Brian Schantz for an order striking the answer of defendant, or precluding testimony at the time of trial, based upon spoliation of evidence in the form of medical records is granted only to the extent that the negative inference charge set forth in full above will be given to the jury at the time of trial; and it is further

ORDERED that the motion by defendant Irving Fish, M.D., for summary judgment dismissing the complaint is denied; and it is further

ORDERED that counsel for all parties are to appear before the court on March 8, 2010, at 9:30am, at 60 Centre Street, room 228, Part 29, for jury selection.

Dated: 12/18/2009


J.S.C.

Check one: FINAL DISPOSITION NON- FINAL DISPOSITION
Check if appropriate: DO NOT POST REFERENCE

FILED

DEC 23 2009

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