SHORT FORM ORDER

INDEX No. 09-8435
CAL. No. 11-02341MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 48 - SUFFOLK COUNTY

PRESENT:

Hon. HECTOR D. LaSALLE
Justice of the Supreme Court

MOTION DATE 4-4-12 (#007)
MOTION DATE 4-25-12 (#008, #009 & #010)
ADJ. DATE 9-18-12
Mot. Seq. # 007 - MG # 009 - XMG
008 - MD # 010 - XMD

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FLORENCE LENT and CHARLES LENT,

Plaintiffs,

-against-

GOOD SAMARITAN HOSPITAL MEDICAL CENTER, JOHN MATHEW, D.O., STEVEN SAMUELS, M.D., BERNARD NASH, M.D., SUFFOLK INTERNAL MEDICINE ASSOCIATES, P.C., S. PARIKH, M.D., and P. PARIKH, M.D.,

Defendants.

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Upon the following papers numbered 1 to 85 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (007) 1 - 18; 19-23; (008) 24-42; (009) 46-59; (010) 60-68 ; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 69-72 ; Replying Affidavits and supporting papers 43-45; 73-77; 78-85 ; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (007) by the defendant, Prakash Parikh, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint is granted and the complaint and any cross claims are dismissed as asserted against Prakash Parikh, M.D. and Suryakant Parikh, M.D. pursuant to plaintiffs' discontinuance of the action as to each; and it is further

ORDERED that motion (008) by the defendant, Steven Samuels, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint is denied; and it is further;

ORDERED that motion (009) by the defendants Bernard Nash, M.D. and Suffolk Internal Medicine Associates, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint is granted and the complaint and any cross claims asserted against them are dismissed pursuant to plaintiffs' discontinuance of the action as to each; and it is further

ORDERED that motion (010) by the defendants, John Mathew, D.O. and Good Samaritan Hospital, pursuant to CPLR 3212 for summary judgment dismissing the complaint is denied as untimely.

In this medical malpractice action, the plaintiffs, Florence Lent and Charles Lent, seek damages personally and derivatively, premised upon the alleged negligent departures from the good and accepted standards of medical care and treatment, and failure to provide informed consent, by the defendants during their care and treatment of Florence Lent while she was hospitalized at Good Samaritan Hospital from June 28, 2008 through July 27, 2008. It is alleged that the defendants failed to timely diagnose and treat Florence Lent for Babesiosis (Babesia protoza/parasite infection) and concurrent Lyme disease, causing her to undergo a prolonged course of treatment and a spleenectomy, to suffer pulmonary emboli and require mechanical ventilation, causing a worsening of her cardiac function, and causing her to require plasmapheresis.

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 (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***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 [2d Dept 1981]).

Motion (007)

In motion (007), the defendant, Prakash Parikh, M.D., seeks summary judgment dismissing the complaint. In the plaintiffs' opposing papers, counsel has affirmed that a Stipulation of Discontinuance has been

provided by the plaintiffs as to both defendant Suryakant Parikh, M.D. and Prakash Parikh, M.D. pursuant to CPLR 3217. None of the co-defendants have objected to such discontinuance and they have not submitted an expert affirmation in opposition.

Accordingly, motion (007) is granted and the complaint and any cross claims are dismissed as asserted against Prakash Parikh, M.D. and Suryakant Parikh, M.D.

Motion (009)

In motion (009), the defendants Bernard Nash, M.D. and Suffolk Internal Medicine Associates, P.C., seek summary judgment dismissing the complaint. The note of issue and certificate of readiness were filed in this action on November 17, 2011. Pursuant to CPLR 3212, the defendants should have filed the instant application by March 17, 2012, and did not do so until April 5, 2012. While it is determined that this motion (009) is untimely, in the plaintiffs' opposing papers, counsel has affirmed that a Stipulation of Discontinuance has been provided to Bernard Nash, M.D. and Suffolk Internal Medicine, P.C. None of the co-defendants have objected to said discontinuance and have not submitted an expert affirmation as against Bernard Nash, M.D. and Suffolk Internal Medicine, P.C.

Accordingly, motion (009) is granted and the complaint and any cross claims asserted against Bernard Nash, M.D. and Suffolk Internal Medicine, P.C. are dismissed pursuant to the plaintiffs' discontinuance of the action as asserted against them.

Motion (010)

In motion (010), the defendants, John Mathew, D.O. and Good Samaritan Hospital, seek summary judgment dismissing the complaint as asserted against them.

As set forth above, the note of issue and certificate of readiness were filed in this action on November 17, 2011. Pursuant to CPLR 3212, the defendants John Mathew, D.O. and Good Samaritan Hospital should have filed the instant application by March 17, 2012, and did not do so until April 19, 2012, thus rendering the motion (010) untimely (*see* CPLR 3212; ***Brill v City of New York***, 2 NY3d 648, 781 NYS2d 261 [2004]). The moving defendants have not offered a "good cause" explanation for not having served their motion within the requisite 120 days after the note of issue was filed, and instead, offer no explanation at all. This application is not identical to the motions (007), (008), and (009) as the defendants are different and provided care and treatment separate and apart from their co-defendants, precluding a determination on this application (***Teitelbaum v Crown Heights Association for the Betterment***, 84 AD3d 935, 922 NYS2d 544 [2d Dept 2011).

Accordingly, motion (010) by John Mathew, D.O. and Good Samaritan Hospital is denied as untimely.

Motion (008)

In motion (008), the defendant, Steven Samuels, M.D., seeks summary judgment dismissing the complaint. In support of the motion, Steven Samuels has submitted, inter alia, an attorney's affirmation; the affirmation of Steven Samuels, M.D. which fails to comport with CPLR 2106; copies of the summons and complaint, the answer of defendant Samuels, plaintiff's verified bill of particulars; the signed and certified transcript of the deposition of Prakash Parikh, M.D. dated October 20, 2010; the unsigned but certified transcripts of the deposition of Florence Lent dated September 16, 2010, and Charles Lent dated October 4, 2010, with proof of service pursuant to CPLR 3116; copies of the unsigned and uncertified transcripts of the deposition of Bernard Nash, M.D. with proof of service; a signed copy of the transcript of the deposition of non-party David Reich, M.D. dated August 17, 2011; signed and certified transcripts of the deposition of Steven Samuels, M.D. dated October 7, 2011and Prakash Parikh, M.D. dated October 20, 2011; certified medical records of the Parikh defendants; uncertified copy of the Good Samaritan Hospital medical records which are not in admissible form, but certified by a supplemental affirmation by Dr. Samuels, and also provided by defendant Prakash Parikh, M.D. in his moving papers; and the expert affirmation of Alan A. Pollack, M.D.

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[2d 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 plaintiff's 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]).

Alan A. Pollock, M.D., defendant Samuels' expert, has affirmed that he is licensed to practice medicine in New York State and is board certified in internal medicine and the sub-specialty of infectious diseases, and is further board certified by the National Board of Medical Examiners. He set forth his education and training and work experience, and the records, transcripts and materials which he reviewed. He opined with a reasonable degree of medical certainty that Steven Samuels, M.D. treated Florence Lent, a seventy one year old woman, appropriately and in accordance with the accepted standards of medical practice, and that there were no

departures from the standard of care by Dr. Samuels which caused or contributed to the injuries alleged by the plaintiff.

Dr. Pollack continued that the plaintiff alleges that the defendants caused injury to her, including severe life-threatening Babesiosis and Lyme disease, which resulted in hemorrhagic shock and splenic rupture, which required her to undergo a spleenectomy. Dr. Pollack stated that Florence Lent was admitted to Good Samaritan Hospital by Dr. Prakash Parikh on June 28, 2008, who noted that during an office visit, she complained of feeling tired for one to two weeks, felt flushed, and was sweating for two days. She had a temperature of 102.3. History revealed that she had fallen on April 4, 2008 and sustained injuries to her face and head, with a fracture of the nasal bone, and injury to the left leg below the knee. She lost a lot of blood and had not felt "not well" since that time. She was treated with Levaquin and improved. Upon examination by Dr. Parikh at his office, her skin showed no rash, and she had tachycardia with occasional premature beats. Various blood tests were ordered, including Lyme serology and a tuberculosis skin test. Dr. Parikh's impression was that of acute sinusitis, rapid atrial fibrillation and extensive ST-T changes due to myocardial ischemia. Levaquin for five days was ordered as was Tylenol as needed. She was sent to the emergency room at Good Samaritan and Dr. Parikh notified the cardiologist, Dr. Reich, to see the plaintiff. Dr. Pollack stated that the Lyme IgM results were reported as reactive, however, in the absence of a positive IgG, it was considered a false positive.

In the emergency room at Good Samaritan Hospital, the plaintiff was seen by John Mathew, D.O., who ordered laboratory studies, chest x-ray, Cardizem, a cardiology consult, and admission to the telemetry unit. She was admitted to the service of Dr. Prakash Parikh, who requested an infectious disease consult which was done by Dr. Samuels. Dr. Samuels noted her history, physical findings, laboratory, and radiology studies, assessed that she had a new onset of atrial fibrillation associated with fever, and that he wished to rule out an underlying bacterial or viral infection pending cultures. Antibiotics had been started by Dr. Reich. The following day, Dr. Samuels noted that the plaintiff's blood and urine cultures were negative, so he discontinued the antibiotics. Dr. Samuels did not see the plaintiff again until July 19, 2008, several days after the diagnosis of Babesiosis was made on July 15, 2008.

Dr. Pollack continued that on June 30, 2008, the plaintiff became hypotensive and complained of abdominal pain, for which she was seen on GI and Surgical consultation, as ordered by Dr. Parikh, and was transferred to ICU. A CT scan of the abdomen revealed a ruptured spleen, thus, a spleenectomy was performed by Dr. Francfort on June 30, 2008. The plaintiff was also followed by internal medicine by Dr. Lenefshy. Dr. Pollack stated that on July 13, 2008, Dr. Nash was asked to see the plaintiff for an infectious disease consult due to recurrent fever and leukocytosis. At that time, she had an open mid-abdominal wound which was draining seropurulent material from which cultures were obtained and for which Primaxin and Vancomycin were ordered. Significant abnormalities were noted in the CBC performed on July 15, 2008, which showed, inter alia, red blood cell parasites which were consistent with Babesia. She was found to have a high parasitemia level of 16%, so Dr. Lenefsky was notified and ordered Atovaquone and Azithromycin, and additional antibody testing for Lyme Wester Blot IgG/IgM, Erichiosis and Babesia. Additional repeat peripheral smears for Babesia and daily CBC's were also ordered. Lyme titers and Ehrlichia were subsequently negative. Through July 27, 2008, parasite levels were monitored and were noted to be continuously diminishing while the plaintiff was receiving

antibiotics. Dr. Pollack stated that Dr. Samuels saw the plaintiff on a daily basis between July 19 and July 27, 2008.

Dr. Pollack opined that Dr. Samuel's treatment of the plaintiff conformed in all respects with the accepted medical practice without deviation from accepted practice. When requested to provide a consultation, he did so timely and properly obtained a medical history. He reviewed the results of the various tests and noted that there was no report of any Babesia organisms in the red blood cell differential reported by the technician. Dr. Pollack set forth that it would be scientifically impossible to make a diagnosis of Babesiosis in the presence of negative peripheral smears. He continued to set forth the care and treatment provided by Dr. Pollack and opined that the same was reasonable and appropriate and within the standard of care. Dr. Pollack stated that there was no delay in diagnosing the Babesiosis by Dr. Samuels and that his impression that the plaintiff probably had a viral infection was supported by the history and findings, and the results of the manual differentials performed by the technicians on June 28, July 5, July 12, and July 15, 2008, as indicated by the findings identified. Prior to July 15, 2008, there was no evidence of Babesiosis in the testing, and when it did present, Dr. Parikh was notified. Dr. Pollack opined that it would have been impossible to diagnose Babesia infection prior to July 15, 2008, and that the diagnosis of probable viral infection was appropriate and supported by the plaintiff's clinical presentation.

Dr. Pollack continued that infectious disease was not consulted again until July 13, 2008, when the plaintiff again developed recurrent fever and leukocytosis, and was seen by Dr. Nash. Dr. Pollack opined that there was no reason to suspect Babesiosis or other parasitic disease during the time that Dr. Samuels cared for the plaintiff based upon her medical history, spontaneous improvement in her clinical condition, and the results of her laboratory tests, including negative blood and urine culture and negative peripheral smears. Dr. Pollack also opined that the plaintiff did not have Lyme disease, and that Dr. Samuels did not fail to diagnose and treat the plaintiff for Lyme disease. The Lyme serology obtained on June 28, 2008 in Dr. Parikh's office showed a result of 0.37 which was negative according to the reference range. Only one out of ten bands were reported as positive or reactive, and did not confirm a diagnosis of Lyme disease as a positive IgG result is based upon the presence of at least five out of ten separate positive Western Blot bands, which the plaintiff did not have. Repeat testing was conducted on July 16, 2008 for Lyme disease, and was completely negative, confirming that the plaintiff did not have Lyme disease. Dr. Pollack continued that when the plaintiff was diagnosed with Babesiosis, she was properly treated with Atovaquone and Azithromycin. Parasite levels were monitored daily, and by July 26, 2008, the Babesia infection was eradicated, as indicated by a level of 0%, decreased from 16% on July 15, 2008, at the time the diagnosis was made.

In opposing this application, the plaintiffs have submitted the affirmations from their two expert physicians.

Plaintiffs' pathology expert set forth that he is licensed to practice medicine in New York and is board certified in both anatomic clinical pathology and forensic pathology. He set forth the materials and records reviewed and opined within a reasonable degree of medical certainty that the care rendered by the defendant Good Samaritan Hospital Medical Center failed to conform to the standards utilized in the diagnostic evaluation

of peripheral blood smears known generally as manual differential, and that this failure was directly responsible for a delay in the diagnosis of Babesiosis. In turn, this delay allowed the parasitic disease to progress to a point where the patient needlessly suffered a rupture of her spleen, requiring a spleenectomy. He continued that when John Mathew, D.O. examined the plaintiff in the emergency room of Good Samaritan Hospital on June 28, 2008, he made a finding that there was no palpable organomegaly, and that this finding is in dispute as the ultrasound examination the following day revealed an enlarged spleen. Plaintiff's pathology expert opined that examination of the spleen is not easy to perform, and the absence of a finding of an enlarged spleen on physical examination further contributed to the failure to consider a tick borne disease like Babesiosis which causes splenic enlargement and rupture when left untreated.

Plaintiffs' pathology expert further stated that in a CBC with manual differential blood test, the characteristics of the size and quality of individual blood cells and estimated quantities of different blood lines are directly visualized by a physician or laboratory technologist trained to see abnormalities that would not be picked up by a machine. He continued that there was a failure to recognize the presence of Babesiosis and that this failure was a direct result of an inadequate evaluation of the peripheral blood smear. He added that although it is true that the main purpose of the manual differential count is to categorize white cells by the blood line from which they are derived, a stained smear is examined in order to determine the percentage of each type of leukocyte present and assess the erythrocyte and platelet morphology.

The plaintiffs' pathology expert stated that in this case, when the manual differential was performed, there was a failure to identify the abnormalities of the red cells. After the June 28, 2008 laboratory studies, there were additional opportunities to identify the abnormal red cells on July 5, 2008 and on July 12, 2008, when manual differential courts were again performed, and the abnormalities of the red cells were again overlooked. Plaintiffs' pathology expert opined that the reason these manual differential examinations failed to identify the presence of Babesiosis inclusions was that the smears were improperly read. However, he continued that the diagnosis of Babesiosis is made when serology tests confirm the presence of the parasite, or when direct visualization of the organism is seen on peripheral smear as the organisms are directly visible as soon as they are present in sufficient quantity to be seen within the cytoplasm of the red cells. The parasite is readily visible prior to the patient becoming symptomatic and will be identified if it is looked for. By the time the disease causes splenic enlargement, the parasites are plentiful and will be identified readily if the red cells are observed under a microscope.

Plaintiffs' pathology expert continued that on July 15, 2008, for the first time intracellular parasites were seen on manual differential, consistent with Babesia species, and that there is no reason to believe that these parasites were only first visible on this date because the parasite had already been present in sufficient quantities to cause symptoms and to lead to splenic rupture when affected red blood cells were sequestered in the spleen. Based upon the plaintiff's symptoms of fever, fatigue, and generalized malaise, and enlarged spleen, it is his opinion that the parasites were present and visible on earlier peripheral blood smears, and that a negligent failure to look for them on the slides by an employee technician, or whoever was responsible for evaluating the slides, was directly responsible for the delay in recognizing this parasitic disease, and that this delay was a departure from the standards of care, causing a worse prognosis and continued suffering.

Plaintiffs' have submitted the affirmation of another physician who is licensed to practice medicine in New York, who is board certified in internal medicine (internist) and infectious diseases, and who set forth the

records and materials reviewed upon which he based his opinions. Plaintiffs' expert internist opined within a reasonable degree of medical certainty that Dr. Samuels departed from the standard of care in providing treatment to the plaintiff which was responsible for the delay in the diagnosis of Babesiosis, permitting the disease to progress to a point where the plaintiff was forced to suffer a rupture of her spleen, prolonged mechanical ventilation, the need for lifelong anti-coagulation, plasmapheresis and development of chronic pulmonary emboli. Plaintiffs' internist continued that Dr. Samuels performed a history and physical examination that failed to identify the patient's likelihood of exposure to tick-born disease; failed to document whether or not there was any evidence of splenic enlargement; and failed to consider the aspects of her presentation that would favor a diagnosis of tick-borne parasites, such as Lyme disease and Babesiosis. Thus, he stated, the diseases were not considered and were permitted to progress.

Plaintiffs' internist opined that Dr. Samuels evaluated the laboratory and radiological tests which were completed, and relied upon the laboratory technician's evaluation of the manual differential. He stated that while such reliance is generally a reasonable course of action, if his initial evaluation had considered the possibility of parasitic infection, then his training as an infectious disease specialist would have required that he be extra vigilant for the possibility of the overlooked diseases, and he should have independently evaluated the peripheral smear. He continued that Dr. Samuel's reliance upon the laboratory technician's evaluation was not reasonable, and his failure to review the peripheral smear slide himself was a departure from the standard of care. Had he done so, the Babesiosis inclusions would have been immediately identified. Plaintiffs' internist further stated that had there been any suspicion of parasitic disease, then serology testing for parasitic organisms would have been performed, and the failure to consider parasitic diseases led to the omission of this diagnostic test, which was a departure from the standard of care. He continued that Dr. Samuels was called as a consultant to evaluate the plaintiff for any and all infectious organisms, and that failure to do so was a further departure from the standard of care.

Plaintiffs' internist stated that Dr. Samuels saw the plaintiff on June 28, 2008 and June 29, 2008, then did not return to participate in her care until July 19, 2008, and thus departed from the standard of care when he failed to continue to follow the plaintiff even though no clear reason for the continued symptoms had been identified. He continued that when the ultrasound of the abdomen was performed on June 29, 2008, the spleen was noted to be enlarged, but this was not considered by Dr. Samuels. The spleen then ruptured and required removal, however, this did not trigger additional scrutiny. When additional manual differentials were performed, they too were not accompanied by a specialist's review of the peripheral slide smears. It is plaintiffs' expert opinion that the absence of more frequent visits by Dr. Samuels, as a consultant, was a departure from the standard of care, as it destroyed any chance of an earlier diagnosis.

Based upon the foregoing factual issues, it is determined that summary judgment is precluded as to Dr. Samuels. It is noted that neither the experts for Dr. Samuels, nor the experts for the plaintiffs, have set forth that they reviewed the peripheral smear slides concerning which they have offered differing opinions. Thus, without such review, it is not known if the initial peripheral smear slides were incorrectly interpreted by the laboratory technician, and whether the experts' respective opinions are meritorious. While the experts opine as to the presence of parasites which are able to be viewed on manual differential, neither expert has offered an opinion as to the presence or absence of such organisms on the slides prior to their detection.

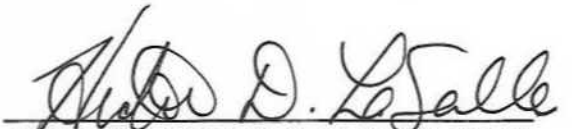
Plaintiffs' internist further stated that there is a basic disagreement regarding the meaning of the manual differential examinations by the laboratory technician between the defendant expert and himself. He further stated that while the defendant's expert believes that the absence of any report of any parasite means that none was present, it is his opinion that the absence of any documentation of the presence of the Babesiosis organism means only that the laboratory technician failed to look for it or was inadequately trained to recognize it. Here, such factual issues preclude the granting of summary judgment, as it cannot be determined from the experts' opinions and the evidentiary submissions whether such parasites were present, or could have been identified, and thus the disease diagnosed, and treatment initiated. It is determined that both the plaintiffs' and defendant Samuels's experts' opinions are conclusory and unsupported based upon their having failed to examine the subject slides prior to rendering an opinion.

In Dr. Samuels' reply, Dr. Pollack sets forth that Dr. Mathew in the emergency room, and Dr. Samuels in the hospital, both examined the plaintiff's abdomen and neither found the spleen to be enlarged. He stated that the spleen lies under the diaphragm and in order to feel the tip of the spleen on clinical abdominal examination, the spleen has to be at least two to two and one-half times its normal size. There was no disparity between their findings upon physical examination documenting no organomegaly and the subsequent finding of enlargement of the spleen on ultrasound. The absence of splenic enlargement upon abdominal examination did not, he stated, in any way contribute to a failure to consider Babesiosis, as the spleen must be extremely large to be felt on abdominal examination, and the absence of enlargement does not favor the diagnosis of Babesiosis or tick borne parasites. Dr. Pollack further stated that there is no proof that Dr. Samuels would have found the parasites in red blood cells if he reviewed the slides, and plaintiffs' expert opinion in that regard is mere speculation. He continued that physicians treating patients routinely rely upon the technicians to interpret blood tests and other cytology and pathology studies, and that this is the standard of care and the protocol in all hospitals in the area. Dr. Pollack further stated that peripheral blood smears on manual differentials performed early in the disease process of Babesiosis are usually negative and repeat smears are required to detect the presence of parasites. Thus, the experts disagree on these issues as well, further precluding summary judgment.

Accordingly, motion (008) by defendant Steven Samuels, M.D., for summary judgment dismissing the complaint as asserted against him, is denied.

The foregoing constitutes the Order of this Court.

Dated: October 25, 2012
Central Islip, NY



HON. HECTOR D. LASALLE, J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION