McNeill v New York City Health & Hosps. Corp.
2020 NY Slip Op 32281(U)
July 1, 2020
Supreme Court, New York County
Docket Number: 805488/2016
Judge: George J. Silver
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

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

----------X

JACKIE MCNEILL, Individually and as Administrator of the Estate of EMMANUEL THILLET, Deceased,

Plaintiff,

Index No. 805488/2016
Motion Seq. 002

-v-

DECISION & ORDER

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendant.

----------X

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

In this medical malpractice action, defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION ("defendant") moves for summary judgment. Plaintiff JACKIE MCNEILL ("plaintiff"), individually and as administrator of the estate of EMMANUEL THILLET ("decedent"), deceased, opposes the motion. For the reasons discussed below, the court denies the motion.

On May 23, 2016, decedent, then 19-years-old presented to Harlem Hospital with a chief complaint of a painful cough for the past two-to-three days. Decedent's vital signs were normal, and decedent denied any other complaints. Upon physical examination, decedent had some bilateral parasternal chest wall tenderness, normal breath sounds in all quadrants, and good air entry. Decedent's medical history included a recent acute upper respiratory infection.

In the emergency department ("ED"), decedent was given pain medication and cough suppressant. Decedent was diagnosed with an upper respiratory infection, and was discharged home with a prescription for ibuprofen and Robitussin, and instructions to drink plenty of fluids.

Decedent was also advised to follow up with his primary care physician or the Harlem medicine clinic in two-to-three days. Decedent was also given a follow-up appointment in one week.

The following day, May 24, 2016, decedent was brought to Harlem Hospital by ambulance. Decedent was coughing up blood, and had an elevated pulse and worsening oxygenation. There was a concern for a possible pulmonary embolism and pneumonia, and decedent was started on antibiotics and IV hydration. A blood test revealed that decedent had an elevated lactate and d-dimer, and that decedent's white blood cell count was normal with a left shift. An x-ray of decedent's chest revealed bilateral patchy airspace disease[1] with a small left pleural effusion.[2] A CT scan of decedent's chest ruled out a pulmonary embolism, but confirmed bilateral airspace disease most prominent at the lung base, and "suggest[ed] cavitation and/or bronchiectasis associated with the infiltrate in the left upper lobe." Decedent was diagnosed with likely bilateral necrotizing pneumonia,[3] and was admitted to the intensive care unit.

On May 25, 2016, decedent's condition deteriorated. Decedent experienced worsening breathing, and had a decreased white blood cell count. Decedent was subsequently intubated, and given vancomycin and linezolid in addition to ceftriaxone and azithromycin for antibiotic coverage. Decedent later progressed to multi-organ failure, and a left-sided chest tube was placed to evacuate fluid from decedent's lungs. Decedent was also started on vasopressors to maintain his blood pressure.

On May 27, a second chest tube was placed on decedent's right side. Later that day, decedent went into cardiopulmonary arrest for four minutes with successful resuscitation.

[1] Air space lung disease refers to air caught in the space between the outside of the lung and the inside of the chest cavity.
[2] A pleural effusion is an unusual amount of fluid around the lung.
[3] Necrotizing pneumonia refers to pneumonia characterized by the development of the necrosis within infected lung tissue.

However, decedent could not be sufficiently oxygenated despite interventions. On May 30, 2016, at approximately 5:45 p.m., decedent arrested for a second time, and could not be revived. At 6:25 p.m., decedent was pronounced dead. No autopsy was performed.

Plaintiff alleges that defendant improperly examined, diagnosed, treated, and discharged decedent on May 23, 2016. Plaintiff also asserts that had decedent been appropriately admitted to the hospital and treated on May 23, 2016, he would not have died of Methicillin-resistant Staphylococcus aureus ("MRSA") necrotizing community acquired pneumonia ("CAP") or MRSA pneumonia.

ARGUMENT

Based on the record before the court, defendant argues that summary judgment must be granted, because plaintiff cannot establish that defendant's medical treatment of decedent deviated from accepted standards of care or proximately caused decedent's alleged injuries and/or death.

Defendant argues that Harlem Hospital treated decedent in accordance with the standard of care on May 23, 2016 through May 30, 2016, and that Harlem Hospital did not proximately cause decedent's alleged injuries and/or death. In support of its motion, defendant annexes the affirmation of Bruce Farber, M.D. ("Dr. Farber"), a physician board-certified in internal medicine and infectious disease medicine.

In Dr. Farber's opinion, defendant appropriately treated decedent in the ED on May 23, 2016. Dr. Farber contends that defendant properly diagnosed decedent with an upper respiratory infection, prescribed decedent with pain medication and cough suppressant, and instructed decedent to follow with his primary care physician. Dr. Farber also asserts that there was no indication to perform a chest x-ray or labs on May 23, 2016 since decedent's vitals were normal, and decedent's lungs were clear with no shortness of breath or respiratory distress. In that regard,

Dr. Farber notes that the fact that decedent had a productive cough[4] versus a non-productive cough was irrelevant to decedent's diagnosis and treatment. Dr. Farber further posits that defendant properly discharged decedent on May 23, 2016 based on decedent's history of a prior upper respiratory infection, painful cough for the past two-to-three days, normal vital signs, unremarkable physical exam, ability to speak normally, and positive response to pain medication and cough suppressants.

Dr. Farber also opines that defendant timely and appropriately treated decedent on May 24, 2016 through May 30, 2016. Dr. Farber notes that defendant properly diagnosed decedent with pneumonia on May 24, 2016, and started decedent on antibiotics within hours of his presentation at the ED. Dr. Farber also points out that defendant timely intubated decedent when decedent developed respiratory insufficiency, and properly started decedent on antibiotic therapy—first, with ceftriaxone and azithromycin, and later with vancomycin and linezolid.

Dr. Farber also opines that decedent's MRSA pneumonia and empyema[5] caused decedent's condition to suddenly and aggressively deteriorate within 24 hours from his discharge on May 23, 2016. According to Dr. Farber, MRSA pneumonia typically occurs after another viral infection, usually influenza, resolves. Dr. Farber explains that the prior infection depresses the host's immune system, thus making the host susceptible to a superimposed bacterial infection. Dr. Farber further elaborates that due to the rarity of MRSA pneumonia, particularly in a healthy 19-year-old male, the standard of care requires initial treatment with ceftriaxone and azithromycin, and a change in antibiotics only after the host's condition worsens and/or the initial antibiotics are shown to be ineffective. In that regard, Dr. Farber highlights that the organism that infected decedent was

[4] A productive cough is a cough where mucus is produced, and is either coughed up into mouth or can be heard in the airways.
[5] An empyema is a condition in which pus collects in the pleural space, the area between the lungs and the inner surface of the chest wall.

resistant to ceftriaxone and azithromycin, the frontline antibiotics for CAP. Moreover, Dr. Farber maintains that although the organism was susceptible to vancomycin and linezolid, decedent's disease process was so aggressive that even with timely and appropriate antibiotic therapy, the disease overwhelmed decedent's immune system as evidenced by decedent's development of respiratory insufficiency, sepsis, neutropenia,[6] multi-organ failure, and death.

Additionally, Dr. Farber opines that nothing defendant did, or failed to do on May 23, 2016 caused or contributed to the "virulence of the underlying infection" or decedent's death. Dr. Farber posits that even if decedent had been suffering from pneumonia on May 23, 2016, and had been diagnosed with CAP on May 23, 2016, the standard of care required antibiotic treatment with ceftriaxone and azithromycin. However, Dr. Farber points out that this treatment would have been ineffective since the organism that infected decedent was resistant to ceftriaxone and azithromycin. Moreover, Dr. Farber concludes that decedent died from a multi-drug resistant, necrotizing CAP which could not have been diagnosed on May 23, 2016 since blood cultures would not have been indicated. Dr. Farber further submits that even if blood cultures were obtained, they would not have been positive for MRSA. Similarly, Dr. Farber maintains that pleural fluid and sputum cultures[7] could not have been obtained, and would not have come back for at least 48 hours.

In opposition, plaintiff argues that defendant's motion should be denied since defendant relies on uncertified medical records. Plaintiff also asserts that Dr. Farber failed to explain why it was proper for defendant not to order labs or a chest x-ray in light of decedent's pleuritic chest pain, or why the nature of decedent's cough (productive versus non-productive) was irrelevant to decedent's diagnosis. Similarly, plaintiff posits that Dr. Farber failed to address the inconsistency

[6] Neutropenia is a blood condition characterized by low levels of neutrophils, which are white blood cells that protect the body from infections.
[7] A sputum culture is a laboratory test that looks for germs that cause infection. Sputum is the material that comes up from air passages when one coughs deeply.

in decedent's medical records with respect to decedent's assigned emergency severity index ("ESI"), as a change in status would indicate a worsening condition under the institution's own rules and regulations.[8]

Plaintiff argues that defendant's treatment of decedent on May 23, 2016 departed from accepted medical care, and that defendant's departures caused a delay in the diagnosis and treatment of decedent's pneumonia and decedent's death. In support of her opposition, plaintiff annexes the affirmation of a physician board-certified in internal medicine with a subspecialty in infectious diseases.[9] Plaintiff's infectious disease expert asserts that defendant failed to order a PA and lateral chest x-ray and bloodwork to investigate the cause of decedent's cough and pleuritic chest pain. According to plaintiff's infectious disease expert, had defendant performed standard tests to investigate the cause of decedent's presenting symptoms, decedent's pneumonia would have been diagnosed one day earlier, which would have led to an etiologic diagnosis of MRSA pneumonia. Plaintiff's infectious disease expert explains that MRSA pneumonia can be a fulminant and fatal infection in an otherwise healthy young person, which should be considered when a patient presents with symptoms such as those exhibited by decedent on May 23, 2016. Plaintiff's infectious disease expert elaborates that severe pneumonia can cause pleuritic chest pain with the development of an infected parapneumonic effusion,[10] empyema, or pulmonary embolism or infarct. As such, plaintiff's infectious disease expert avers that defendant should have ordered a chest x-ray and bloodwork to investigate the cause of decedent's complaints on May 23, 2016.

---

[8] Plaintiff highlights that nurse Charisse Alcos ("RN Alcos") categorized decedent's ESI in the ED as 4 while PA Craig Braithwaite's ("PA Braithwaite") initial note indicates an ESI of 3. Plaintiff explains that patients with an ESI of 3 are not to be fast-tracked while an ESI of 4 would require that the patient be seen in the fast track of the ED.

[9] Plaintiff has redacted the name of her infectious disease expert, but has provided an unredacted copy for the court's review. Accordingly, plaintiff's expert will be referred to as "plaintiff's infectious disease expert."

[10] Parapneumonic effusion is a type of pleural effusion.

Additionally, plaintiff's infectious disease expert opines that defendant departed from the standard of care by not providing supportive care, observation, or monitoring to decedent on May 23, 2016. Rather, plaintiff's infectious disease expert notes that defendant diagnosed decedent with an upper respiratory infection considered to be from a viral infection on May 23, 2016, prescribed decedent with pain and cough medication, which only addressed decedent's symptoms and not the underlying cause of decedent's condition, and discharged decedent home that same day. According to plaintiff's infectious disease expert, discharging decedent home on May 23, 2016 was a departure from the standard of care as decedent should have been admitted to the hospital that same day to undergo x-rays and monitoring of his vital signs. Plaintiff's infectious disease expert also avers that had decedent been admitted to the hospital on May 23, 2016, defendant could have placed an intravenous line to administer anti-MRSA antibiotics and other medications to decedent. However, plaintiff's infectious disease expert concludes that by discharging decedent home on May 23, 2016, decedent's pneumonia was left untreated for approximately 24 hours, which caused decedent's condition to worsen into severe pneumonia and possibly empyema, thus leading to his death on May 30, 2016.

Plaintiff's infectious disease expert also opines that defendant failed to properly supervise PA Brathwaite on May 23, 2016. Plaintiff's infectious disease expert highlights that decedent was not seen by an attending physician on May 23, 2016, and that although Dr. Reynold Trowers ("Dr. Trowers") was the attending physician, PA Braithwaite did not speak with Dr. Trowers about decedent, and did not ask any attending physician to see decedent on May 23, 2016. As such, plaintiff's infectious disease expert concludes that defendant violated Harlem Hospital's Emergency Room policy on Patient Assessment and Continuity of Care which provides that "[a]ll patients must be discussed with the attending physician prior to disposition."

Moreover, plaintiff's infectious disease expert refutes Dr. Farber's opinion that decedent's vitals were normal on May 23, 2016. According to plaintiff's infectious disease expert, decedent had a low blood pressure of 100/59, and a high pulse of 95 beats per minute on May 23, 2016. Plaintiff's infectious disease expert also avers that it is questionable whether defendant properly obtained decedent's vitals upon decedent's presentation on May 23, 2016 since decedent's vitals at the time of discharge were identical to his initial vitals obtained more than two hours earlier.

Plaintiff's infectious disease expert also disagrees with Dr. Farber's opinion that decedent's "type of cough [productive versus non-productive] was irrelevant to [decedent's] diagnosis and treatment." Plaintiff's infectious disease expert points out that RN Alcos noted on May 23, 2016 that decedent had a productive cough for three days, but failed to inquire as to what the cough produced or the amount of production. Similarly, plaintiff's infectious disease expert highlights that decedent's May 24, 2016 records indicated that decedent presented with three days of hemoptysis.[11] As such, plaintiff's infectious disease expert avers that while PA Braithwaite noted that decedent complained of a non-productive cough, PA Braithwaite did not clarify RN Alcos' note which stated that decedent complained of a productive cough for three days. In that regard, plaintiff's infectious disease expert maintains that PA Braithwaite's failure to clarify the conflict in decedent's medical history was a departure from the standard of care as a clinician in charge must resolve such discrepancies to avoid an incorrect diagnosis or treatment.

Furthermore, plaintiff's infectious disease expert rebuts Dr. Farber's opinion that there "was no indication to order a chest x-ray and labs." Plaintiff's infectious disease expert observes that defendant did not perform any diagnostic testing in the ED on May 23, 2016 although decedent reported that he experienced chest pain while coughing, and although PA Braithwaite documented

[11] Hemoptysis is the coughing up of blood.

that decedent had "pleuritic chest wall pain." According to plaintiff's infectious disease expert, severe pneumonia can cause pleuritic chest pain with the development of parapneumonic effusion, empyema, or pulmonary embolism or infarct. As such, plaintiff's infectious disease expert opines that a physician must be aware that pleuritic chest pain is a marker for one of these diseases, and that the standard of care requires a physician to order a chest x-ray and bloodwork to investigate the underlying cause of a cough with pleuritic chest pain. Similarly, plaintiff's infectious disease expert asserts that since decedent had hemoptysis, defendant should have considered pneumonia in this "young patient," and at a minimum, ordered a chest x-ray and bloodwork.

Finally, plaintiff's infectious disease expert disagrees with Dr. Farber's opinion that even if decedent had been diagnosed with pneumonia on May 23, 2016, decedent would have been prescribed with ceftriaxone and azithromycin, which would have been ineffective. According to plaintiff's infectious disease expert, MRSA pneumonia does not develop overnight, but was present when decedent first presented to Harlem Hospital on May 23, 2016. As such, plaintiff's infectious disease expert concludes that had defendant performed a chest x-ray on May 23, 2016, decedent would have been diagnosed with pneumonia, and would have been admitted to the hospital and started on IV antibiotic therapy, possibly ceftriaxone and azithromycin. Moreover, plaintiff's infectious disease expert posits that a physician would not wait for sputum or blood culture results to identify the organism causing the pneumonia.

Plaintiff also annexes the affirmation of a physician specialized in critical care.[12] According to plaintiff's critical care expert, defendant deviated from accepted medical practice by failing to intubate decedent on May 24, 2016. Specifically, plaintiff's critical care expert notes that at 1:25

[12] Plaintiff has redacted the name of her critical care expert, but has provided an unredacted copy for the court's review. Accordingly, the expert will be referred to as "plaintiff's critical care expert."

a.m. on May 25, 2016, Dr. Edgardo Sosa ("Dr. Sosa") diagnosed decedent with multilobar pneumonia,[13] hemoptysis, hypoxia,[14] tachypnea,[15] and tachycardia,[16] and that at 3:44 a.m. on May 25, 2016, Dr. Yee[17] noted that decedent was "in respiratory" distress. Similarly, plaintiff's critical care expert asserts that defendant deviated from the standard of care by failing to perform a bronchoscopy on May 24, 2016 to stop decedent's bleeding. Notably, plaintiff's critical care expert highlights that although Dr. Yee observed that decedent was "blood stained on the mouth," and was "coughing bright red blood sputum" at 3:44 a.m. on May 24, 2016, defendant waited until May 27, 2016 to perform a bronchoscopy. Plaintiff's critical care expert further submits that defendant deviated from accepted practice by waiting until May 25, 2016 to obtain a sputum sample as a sputum sample would have shown MRSA. According to plaintiff's critical care expert, the initial gram stain of sputum from May 25, 2016 showed gram positive cocci in "clusters in pairs," which suggests staphylococcal aureus, which grew from the culture as MRSA.

Additionally, plaintiff's critical care expert maintains that defendant deviated from the standard of care by failing to timely call a pulmonary consult. Plaintiff's critical care expert notes that Dr. Gene Pesola did not see decedent until the morning of May 25, 2016, which deprived decedent of treatment from a physician specialized in lung disease and pulmonary function. Plaintiff's critical care expert also avers that defendant departed from accepted medical practice by failing to provide extra corporeal membrane oxygenation (ECMO) to decedent,[18] by failing to

[13] Multilobar pneumonia is an infection in two or more lobes.
[14] Hypoxia is the diminished availability of oxygen to the body tissues.
[15] Tachypnea is very rapid respirations.
[16] Tachycardia is a common type of heart rhythm disorder (arrhythmia) in which the heart beats faster than normal while at rest.
[17] Plaintiff's critical care expert does not identify Dr. Yee's first name.
[18] ECMO is a derivative of cardiopulmonary bypass in which venous blood is withdrawn from a major vein via a cannula and, in most cases, pumped through a gas exchange device to oxygenate the blood and remove carbon dioxide.

obtain frequent blood gases (arterial blood gas test) as decedent had metabolic acidosis, and by failing to provide sufficient sedation to decedent.

Lastly, plaintiff argues that the court should deny summary judgment because there is evidence to show that decedent's medical records may have been altered. Plaintiff contends that decedent's medical records show that PA Braithwaite saw decedent in the fast track unit at 9:45 p.m. on May 23, 2016, however, such note is dated May 25, 2016 at "0736." Plaintiff also highlights that although PA Braithwaite testified that he believes that he looked at the triage note on May 24, 2016, the date and time at the end of the note is May 24, 2016 at "2209." Accordingly, plaintiff asserts that there is an issue as to whether the records were altered in an attempt to conceal malpractice. Moreover, plaintiff requests that the court reject any materials submitted in defendant's reply papers that were not attached to the original motion.

In reply, defendant asserts that decedent did not report hemoptysis on May 23, 2016, and that the staff at Harlem Hospital did not observe decedent coughing up blood on May 23, 2016. Defendant notes that PA Braithwaite testified that he did not remember decedent coughing during an examination, and that plaintiff speculates that since decedent's May 24, 2016 records documented that decedent reported hemoptysis for the past two days, decedent must have been coughing up blood on May 23, 2016. Similarly, defendant posits that plaintiff's claim that had defendant performed a more thorough evaluation on May 23, 2016, decedent would have reported hemoptysis, is capricious and insufficient to rebut defendant's *prima facie* showing. Rather, defendant contends that the information that decedent reported on May 24, 2016 is irrelevant to the treatment that defendant rendered the prior day. In that regard, defendant highlights that once decedent reported hemoptysis, and was observed to be coughing up blood on May 24, 2016, defendant quickly admitted decedent to the hospital with presumed pneumonia. Ultimately,

defendant emphasizes that decedent only complained of coughing two-to-three days prior with resultant chest wall tenderness, and that based on decedent's documented symptoms on May 23, 2016, defendant appropriately diagnosed and treated decedent.

Additionally, defendant asserts that plaintiff's claim that PA Braithwaite was not supervised by an attending physician on May 23, 2016 is false. According to defendant, PA Braithwaite testified that attendant physician supervision in the fast track unit of the ED consists of "an attending available for me to consult with for any particular clinical issues or problems that might come up, depending on my discretion and . . . the attending that I'm working with." Defendant also argues that plaintiff failed to establish how decedent's outcome would have been different had PA Braithwaite discussed decedent's care with an attending physician, or had an attending physician personally seen decedent on May 23, 2016. In that regard, defendant underscores that any argument as to whether defendant violated hospital protocol, and/or whether it was within PA Braithwaite's discretion to speak with an attending physician prior to decedent's discharge does not affect whether defendant's care and treatment of decedent comported with the standard of care or proximately caused decedent's alleged injuries.

Defendant further argues that any discrepancy in decedent's ESI, as well as any alleged "alterations" in decedent's medical records are inconsequential to the issues of negligence and proximate causation. Defendant contends that an ESI measures "how many resources [a] patient is thought to need when they present to triage," and may determine whether a patient is seen in the fast track unit of the ED, but an ESI does not change a patient's symptoms, diagnosis, or treatment.

Moreover, defendant maintains that plaintiff's claim that defendant "altered" decedent's medical records was not properly plead in plaintiff's notice of claim, complaint, or bill of particulars. Similarly, defendant argues that the court should deny plaintiff's request to disregard

decedent's Harlem Hospital chart because it was not certified since plaintiff did not object to the use of the Harlem Hospital chart annexed to its motion during defendant's deposition.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 A.D.3d 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 A.D.3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 A.D.3d 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 A.D.3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 A.D.2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to 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, 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.*).

Here, defendant sets forth a *prima facie* showing in favor of dismissal, as evidenced by the submission of defendant's medical records,[19] and defendant's expert affidavit, all of which attest to the fact that defendant's treatment of decedent was in accordance with accepted standards of care and did not proximately cause decedent's alleged injuries and/or death. To be sure, defendant's expert affirmation is detailed and predicated upon ample evidence within the record. As defendant has made a *prima facie* showing, the burden shifts to plaintiff.

In opposition to defendants' *prima facie* showing, plaintiff raises triable issues of fact sufficient to preclude summary judgment. For example, while defendant asserts that decedent was properly treated at Harlem Hospital's ED on May 23, 2016, plaintiff highlights multiple instances in which defendant departed from the standard of care. Notably, while defendant argues that defendant properly diagnosed decedent with an upper respiratory infection on May 23, 2016, plaintiff asserts that defendant failed to properly diagnose decedent with CAP on May 23, 2016. Specifically, while defendant avers that there was no indication to perform a chest x-ray or labs on May 23, 2016 since decedent's vital signs were normal, and decedent's lungs were clear with no shortness of breath or respiratory distress, plaintiff contends that defendant failed to order a chest x-ray and bloodwork to investigate the cause of decedent's cough and pleuritic chest pain on May 23, 2016. Indeed, plaintiff maintains that had defendant performed standard tests such as a chest x-ray and labs on May 23, 2016, decedent would have been diagnosed with pneumonia one day

[19] Although defendant has submitted uncertified medical records in support of its motion for summary judgment, the court will nonetheless consider the medical records as they are identical to those submitted in support of plaintiff's opposition to defendant's motion. Moreover, since plaintiff does not submit sufficient evidence to "challenge the accuracy or veracity of the uncertified records," and in the interest of deciding the motion in totality, and on its merits, the court will consider the medical records annexed to defendant's motion for summary judgment (*see, Tomeo v. Beccia*, 127 A.D.3d 1071, 1073 [2d Dept. 2015]; *see also, Cook v. Peterson*, 137 A.D.3d 1594, 1597 [4th Dept. 2016]).

earlier, which would have led to an etiologic diagnosis of MRSA pneumonia. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

The parties also disagree as to the relevance and significance of the nature of decedent's cough upon his presentation at Harlem Hospital on May 23, 2016. For instance, plaintiff emphasizes that because there was a discrepancy between RN Alcos' observation that decedent had a productive cough for three days and PA Braithwaite's note that decedent complained of a non-productive cough, defendant should have clarified the nature of decedent's cough in order to avoid an incorrect diagnosis and treatment. Defendant, however, submits that a productive cough versus a non-productive cough was irrelevant to decedent's diagnosis and treatment. Similarly, while plaintiff asserts that decedent's May 24, 2016 medical records indicated that decedent presented with three days of hemoptysis, defendant contends that Harlem Hospital's staff did not observe decedent coughing up blood on May 23, 2016, and that PA Braithwaite testified that he did not remember decedent coughing during an examination on May 23, 2016. Likewise, there are conflicting expert opinions as to decedent's ESI on May 23, 2016, and as towhether PA Braithwaite was properly supervised by an attending physician on May 23, 2016. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Significantly, the parties disagree as to whether defendant departed from the standard of care by discharging decedent on May 23, 2016, and whether such departure proximately caused decedent's alleged injuries and/or death. Defendant argues that Harlem Hospital properly discharged decedent on May 23, 2016 based on decedent's history of a prior upper respiratory infection, painful cough for the past two-to-three days, normal vital signs, unremarkable physical exam, ability to speak normally, and positive response to pain medication and cough suppressants. Plaintiff, on the other hand, posits that defendant's failure to admit decedent to the hospital on May

23, 2016 caused decedent's condition to worsen into severe pneumonia and possibly empyema, and that had decedent been admitted to the hospital on May 23, 2016, decedent could have received anti-MRSA antibiotics and other medications, which could have saved decedent's life. By contrast, defendant maintains that it was proper to discharge decedent on May 23, 2016 with a prescription for pain medication and cough suppressants, and instructions to follow with his primary care physician. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Moreover, in rebutting plaintiff's theory of causation, defendant argues that even if decedent had been suffering from pneumonia on May 23, 2016, and even if decedent had been diagnosed with CAP on May 23, 2016, antibiotic treatment with ceftriaxone and azithromycin would have been ineffective since the organism that infected decedent was resistant to these antibiotics. Plaintiff, however, avers that MRSA pneumonia does not develop overnight, but was present when decedent first presented to Harlem Hospital on May 23, 2016. As such, contrary to defendant's position, plaintiff argues that had defendant performed a chest x-ray and bloodwork on May 23, 2016, decedent would have been diagnosed with pneumonia, and would have been admitted to the hospital and started on IV antibiotic therapy. Similarly, while plaintiff maintains that a physician would not wait for sputum or blood culture results to identify the organism causing decedent's pneumonia, defendant submits that decedent's CAP could not have been diagnosed on May 23, 2016 since blood cultures would not have been indicated, and that even if blood cultures were obtained, they would not have been positive for MRSA. In further disputing plaintiff's contention, defendant asserts that pleural fluid and sputum cultures could not have been obtained, and would not have come back for at least 48 hours. Because there are issues of fact as to whether defendant departed from the standard of care by discharging decedent on May 23, 2016, and as to

whether such departure proximately caused decedent's alleged injuries and/or death on May 30, 2016, summary judgment must be denied.

Furthermore, plaintiff raises a triable issue of fact as to whether defendant timely and properly treated decedent from May 24, 2016 through May 30, 2016. While defendant argues that defendant timely intubated decedent when decedent developed respiratory insufficiency, plaintiff underscores that based on decedent's diagnosis of multilobar pneumonia, hemoptysis, hypoxia, tachypnea, and tachycardia at 1:25 a.m. on May 25, 2016, and Dr. Yee's note that decedent was "in respiratory" distress at 3:44 a.m. on May 25, 2016, defendant failed to timely intubate decedent on May 24, 2016. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Finally, any issues or applications with respect to plaintiff's allegation that defendant has altered decedent's medical records in an attempt to conceal malpractice shall be made before the trial judge.

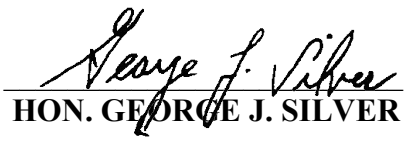
Based on the foregoing, it is hereby

ORDERED that defendant's motion for summary judgment is DENIED in its entirety; and it is further

ORDERED that the parties are directed to appear for a virtual conference before the court on July 27, 2020 at 10:00 AM.

This constitutes the decision and order of the court.

Dated: July 1, 2020



HON. GEORGE J. SILVER