SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

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JAMES DAVIS,

Plaintiff,

- against -

EVAN KRAKOVITZ, ARPAN GOEL, ERIC FISHMAN, RICHARD SCHUTZER, SERENA MAK, KONSTANTIN MILLERMAN, FRANTZ TORCHON, EVA RUBIN, MISBAHUDDIN KHAJA, ROBIN GOLDBERG, DEBRA SPICEHANDLER, JONATHAN FINEGOLD, JAMES EHRLICH, MARK PERALTA, KAROLINA WEISS, NANCY CHUNG, MARCIN KARCZ SHIRANDA RHODEN, BRONXVILLE CARDIOLOGY, ASSOCIATES, P.C., DOCTORS UNITED, INC., WESTCHESTER MEDICAL GROUP, P.C. d/b/a WESTMED, LAWRENCE MEDICAL ASSOCIATES, P.C. a/k/a NEW YORK-PRESBYTERIAN MEDICAL GROUP/ WESTCHESTER, COLUMBIA UNIVERSITY MEDICAL CENTER d/b/a COLUMBIA DOCTORS, NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM, INC., and NEW YORK-PRESBYTERIAN/LAWRENCE HOSPITAL, a/k/a LAWRENCE HOSPITAL CENTER,

Defendants.

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Index No.: 64768/2017

DECISION and ORDER
Defendant Robin Goldberg
Mtn. for Summary Judgment

Seq. No. 3

Hubert, JSC

Before the Court is the motion of the Defendant Robin Goldberg, M.D. (the Defendant or Defendant Doctor) seeking an order from the Court pursuant to CPLR § 3212 granting summary judgment against the Plaintiff James Davis and dismissing in its entirety the Plaintiff's action alleging medical malpractice against the Defendant. The Court has reviewed the submissions of the parties, as posted under NYSCEF Index No. 64768/2017, filed in support of and in opposition to the motion of the Defendant. Upon due consideration it is the decision of the Court that the Defendant's motion be granted.

The Plaintiff's action alleging medical malpractice arises from a laparoscopic appendectomy performed by colo-rectal surgeons at Lawrence Hospital (the Hospital) on April 28, 2017, and arises from the post operative treatment of the Plaintiff between April 28, 2017 and May 7, 2017 by the Critical Care Unit (CCU or ICU) in conjunction with the Defendant Goldberg.

The CCU/ICU, post operatively, was tasked with overseeing the Plaintiff's recovery from the surgery, and was tasked with administering treatment. During the surgery on April 28 2017, a laceration of Plaintiff's mesenteric artery occurred, creating significant internal bleeding that required emergency intervention by a board certified vascular surgeon (VS), Dr. Eric Fishman, who was available to the Hospital as an on-call respondent.

Along with additional help from a second vascular surgeon, Dr. Richard Schutzer, the two VS doctors were able to stop the bleeding. They then performed full inspection of the abdomen and determined that all bleeding had been controlled, i.e., "Hemostasis [was] achieved." The surgery having concluded late on April 28, 2017, the Hospital transferred Plaintiff to the Intensive Care Unit (ICU or CCU) for recovery. The Plaintiff was intubated and was evaluated as being in a critical, but stable, condition. See, Operative Report, Exhibit M, p. 424 and p. 432.

Over the next nine days (April 27 to May 7, 2017), the Plaintiff was monitored, examined and treated in the ICU area by various physicians. The Defendant Dr. Goldberg was one of the physicians, a board certified invective disease physician (IDD) and a practicing IDD consultant at the Hospital at the time of the Plaintiff's surgery and transfer to the ICU.

On April 30, 2017, she was asked to come to the Hospital ICU to see the Plaintiff, and

provide care and treatment because of an elevated white blood cell count (a/k/a leukocytosis and/or WBC). On the Defendant Doctor's patient record for that day, she noted symptoms of possible sepsis based upon, *inter alia*, the elevated WBC count, the elevated lactic acid level, temperature and heart-rate changes, and end-organ damage. At the time of the April 30th visit, Dr. Goldberg believed that the Plaintiff had a post operative respiratory issue and that there had been SMA (superior mesenteric artery) injury. Despite prior use of broad spectrum antibiotic treatment (zosyn and fluconazole) Dr. Goldgerg noted that the Plaintiff continued to have leukocytosis (high WBC count). In the April 30, 2017 physical exam of the Plaintiff, Dr. Goldberg noted abnormal lab test results indicative of infection or inflamation. She decided to continue the antibiotic treatment. Goldberg EBT at pp. 44-53.

The Defendant Doctor's next ICU visit to the Plaintiff was on the following day, May1, 2017. The Plaintiff had been extubated. However, shortage of breath was noted which could have been an indication of worsening inflamation and infectious process. Accordingly, flagyl (medicine) was added to Plaintiff's treatment because of the potential need to cover and address infectious spread that may have occurred from prior intra-abdominal procedures.

Later in that day, on examination, the Plaintiff complained of not getting enough air. He also reported minimal abdominal pain, however the Defendant noted that the Plaintiff's abdominal pain was not an abnormal finding after surgery (which had occurred on April 28, 2017).

On May 1, 2017, Dr. Goldberg undertook a physical exam of the Plaintiff. Her findings showed no oral lesions, no adenopathy (swollen glands or lymph nodes), and normal cardiovascular sounds in the heart (side 1 and side 2). However as to decreased breath sounds in

the chest, Dr. Goldberg noted it could be associated with his post operative condition. Goldberg EBT at pp. 58-68.

The Plaintiff's belly was soft, and distended with mild tenderness. The bowels had no peristalsis, and had no "ileus" or small bowel blocking which would cause the bowel not to work correctly. Dr. Goldberg stated that the abdomen distention was not an abnormal finding. Goldberg EBT at pp. 58-68.

The Defendant Doctor returned to the Hospital the next day, May 2, 2017. She reviewed the Plaintiff's progress note. Mild abdominal cramping was recorded. The Plaintiff's stool was maroon in color which, as stated by the Defendant Doctor, ". . . generally indicates some form of gastrointestinal bleeding." In addition, there was distended abdomen, an indication of some intra-abdominal process. A liver function transaminase test (AST) showed increase to 93 mean and stated " Rising bilirubin[1] this a. m. prior to GI (gastro-itestinal)." Dr. Goldberg concluded that the patient was having a gastro-intestinal bleed. Goldberg EBT at pp. 70-73.

In the "Assessment and Plan" part of the progress note, it was stated that there was:

> Leukocytosis despite no fevers. No obvious source of leukocytosis. Would consider discontinuing antibiotics in one or two days if no significant change and reevaluate off coverage. Goldberg EBT at p.73.

Dr. Goldberg conducted further examination of the Plaintiff's progress on May 4, 2017. The Plaintiff had been removed from the CCU May 3, 2017 but was transferred back to CCU on May 4, 2021. According to the report, the Plaintiff had increased shortness of breath and slight increase in body temperature. It was concluded that his condition had worsened and was declining. Goldberg

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[1] Bilirubin is contained in the blood of a patient and passes through the liver. Higher than normal levels may indicate liver or bile duct problems.

EBT at p. 81.

A CAT scan study with angiogram was conducted. The findings showed no central pulmonary embolism, but did show small bilateral pleural effusions (fluid in the plural space on both sides) with suspected bilateral atelectasis (air pockets within the pulmonary parenchyma), moderate ascites (fluid within the peritoneal cavity). The Plaintiff also underwent abdominal arterial ultrasound. It showed evidence of diffuse liver disease, steatosis, mild ascites (fluid within the peritoneal cavity). Goldberg EBT at pp. 84-86.

There was also a switch from Zosyn antibiotic to imipenem. This was done because of the Plaintiff's elevated amylase and lipase which was an indication of pancreatitis. The imipenem was an antibiotic that (according to the Defendant) has shown reduction in morbidity in patients with pancreatitis. Goldberg EBT at pp. 86-88.

As to the general responsibilities of an IDD specialist, the Defendant listed a number of responsibilities including; (1) evaluation of patients potentially affected with infections, and; (2) the treatment of the infections found on positive culture studies. Specialists also take notice of the presence and impact in patients of elevated fever, elevated or lowered temperature, elevated respiratory rate, and hypotensive blood pressure. Goldberg EBT at pp. 90-91. In the instant matter, May 4, 2017 was the last date of treatment and monitoring of the Plaintiff by Dr. Goldberg.

Summary judgment is generally not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, since conflicting expert opinions (usually) raise credibility issues which can only be resolved by the jury or fact finder. *Pinnock v. Mercy Med. Ctr*, 180 A.D.3d 1088, 1090, 119 N.Y.S.3d 559 (2d Dep't 2020); *Feinberg v. Felt*, 23 A.D.3d 517, 519, 806 N.Y.S.2d 661 (2d Dep't 2005). However, "expert opinions that are conclusory, speculative,

or unsupported by the record are insufficient to raise triable issues of fact." *Wagner v. Parker*, 172 A.D.3d 954, 955, 100 N.Y.S.3d 280 (2d Dep't 2019); *also see, Diaz v. N.Y. Downtown Hosp.*, 99 N.Y.2d 542, 544 (2002)("[w]here the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, ... [his or her] opinion should be given no probative force and is insufficient to withstand summary judgment"). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on 'specifically cited evidence in the record' " (*Tsitrin v New York Community Hosp.*, 154 AD3d 994, 996 [2017], quoting *Roca v Perel*, 51 AD3d 757, 759 [2008]). "An expert opinion that is contradicted by the record cannot defeat summary judgment" (*Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [2017]). *Lowe v. Japal*, 170 A.D.3d 701, 702–03, 95 N.Y.S.3d 363 (2019). Expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact (see *Bowe v Brooklyn United Methodist Church Home*, 150 AD3d 1067, 1068 [2017]; *Kerrins v South Nassau Communities Hosp.*, 148 AD3d 795, 796 [2017]; *703 *Spiegel v Beth Israel Med. Ctr.-Kings Hwy. Div.*, 149 AD3d 1127, 1128 [2017]). These are the issues on the motion before this Court.

In the instant matter, there are three unnamed experts retained by the Plaintiff who have submitted affirmations in support of their respective conclusions on the question of departure from standard of care by the Defendant Dr. Goldberg. Nevertheless the focus of the unnamed experts is very narrow. They raise questions limited to the presence or absence of a differential diagnosis on the part of the Defendant Doctor. However, there is lack of a factual basis for the unnamed experts' conclusions of a departure by Dr. Goldberg from the standard of care. Essentially, their presented facts do not, as presented, support their stated conclusions.

The first unnamed "Critical Care Specialist" (CCS) expert is presented as "board certified in Internal Medicine . . . and pulmonary disease." A Pulmonologist commonly treats asthma, chronic obstructive lung disease (COPD), emphysema, lung cancer,complex lung and pleural infections such as tuberculosis, pulmonary hypertension and cystic fibrosis diseases. An Internist generally sees patients with conditions such as heart disease, hypertension, diabetes, and chronic lung disease. However none of these illnesses and conditions are part of the instant cause of action filed by the Plaintiff and these areas are not addressed by the CCS expert.

The focus of the CCS expert on the standard of care ". . . relates to treating of patients with presumed or suspected bowel ischemia . . .." Thus the conclusions of the CCS expert rely completely on an assumption of "presumed or suspected bowel ischemia" on the part of the treating physicians who, according to the CCS expert, failed to adequately explore the presence of ischemia. See, CCS Affirmation at ¶ 3. As the expert readily admits, however, mesenteric ischemia is a diagnosis of exclusion, not a diagnosis of inclusion. This approach ignores the fact that the Plaintiff's symptoms reported by the IDD specialist (the Defendant), while not excluding or establishing possible ischemia, presented critical evidence of infection symptoms (such as pancreatitis) that needed immediate direct treatment, as opposed to either finding evidence of the presence of mesenteric ischemia or finding the lack thereof. This fact is either ignored or simply discounted by the CCS expert.

The physicians who were targets of criticism by the CCS expert are listed in the Affirmation simply as "the ICU Defendants." They are marked as the physicians who "deviated from accepted standards of care in their treatment of James Davis (the Plaintiff)." These "ICU Defendants," according to the unnamed CCS expert, "each individually failed to respond to Mr. Davis' manifested

signs and symptoms of bowel ischemia in a timely manner" and "this departure was a direct and proximate cause of Mr. Davis's injuries including his need for a bowel resection." What "each," physician individually or collectively did, or did not do, that departed from the standards of care, is nowhere stated other than concluding that these "physicians" should have stopped their own efforts to diagnose, evaluate and treat the Plaintiff as they did, and they should simply have assumed that the problem was bowel ischemia. Whether this would have been possible cannot be affirmatively declared or even assumed in as much as the absence (not the presence of bowel ischemia) might have been the result. But assuming bowel ischemia was found to be present (as did NYPCU) there is no way to affirm that Lawrence Hospital could have promptly undertake repair procedures, that would have avoided resection.

There were many exhibited symptoms listed in the Plaintiff's case reports that were recorded by ICU physicians each day. "Each" physician individually or collectively undertook consultations, examination, and/or treatment of the Plaintiff.

The CCS expert goes on to state that " [h]ad the Defendants timely responded to Mr. Davis's complaints, signs and symptoms, it is more likely than not that he would have received treatment in the form of a repair procedure." CCS Affirmation at ¶¶ 7 & 8. If so, when was the moment of timely response? Was it at a known time in the surgical room at Lawrence Hospital on April 28, 2017? Was it at the ICU unit on May 1, 2017 three days later?

The "Defendants" did respond to the Plaintiff's symptoms, including leukocytosis. What is missing from the CCS affirmation is the identification of the specific "complaints, signs and symptoms" of the Plaintiff that, if timely responded to, would definitely have reveled bowel ischema and resulted in a repair procedure, not a resection. The CCS expert simply rejects the decision of

Defendant Dr. Goldberg to maintain and expand antibiotic treatments of the Plaintiff. Ironically, however, resection and not repair was ultimately performed by the surgeons at New York Presbyterian-Columbia University Hospital (NYPCU) on May 9, 2017, two days after the Plaintiff's transfer from Lawrence Hospital ICU and five days after Dr. Goldberg's last visit and examination. No expert of the Plaintiff firmly establishes when the certainty of bowel ischemia was known, prior to May 8, 2017. They simply say that differential diagnosis should have been undertaken earlier.

The "untimely response" referenced by the CCS expert against Dr. Goldberger is apparently the presumed belief of the CCS expert of a lack of a "differential diagnosis" by Dr. Goldberg, i.e. a diagnosis that would have determined the etiology [the cause] of Mr. Davis's persistent leukocytosis," and perhaps (but not certainly) would have facilitated repair. As stated by the CCS expert: "Mesenteric ischemia is a diagnosis of exclusion not inclusion, meaning the best way to determine whether a patient has bowel ischemia is to rule out the existence of bowel ischemia . . . through a CT Angiogram." CCS Affirmation at ¶ 45. However, even if a differential diagnosis excluding ischemia had successfully been undertaken earlier by Dr. Goldberg, it cannot be said that repair instead of resection would definitely have been possible.

In the course of his treatment, the Plaintiff's blood analysis was undertaken by the Defendant Dr Goldberg. Based on the analysis of the blood, antibiotic treatment of the Plaintiff by the Defendant Doctor was undertaken. Physical examination of the Plaintiff (including palpitation of the Plaintiff's abdomen) along with temperature reading by the Defendant Doctor was undertaken. Consultation with other ICU physicians and more, was undertaken. Can it therefore be assumed and concluded that the extensive treatment of the Plaintiff by Dr. Goldberg and the ICU was simply a waste of time? In the Court's view the answer is no. The above referenced examinations and

treatments were conducted by the Defendant Dr. Goldberg during the time of her evaluations of the Plaintiff's symptoms and need of medication. The treatments' success, or lack thereof,were as much an effort of differential diagnosis as were CAT scans.

These procedures undertaken by Dr. Goldberg were essentially differential diagnosis efforts administered by Dr. Goldberg to determine whether the Plaintiff's symptoms and complaints were the result of infection or other causes. For example, on April 30, 2017, Dr. Goldberg's first day of examination of the Plaintiff, white blood cell count was elevated and Dr. Goldberg's conclusion was that there was strong possibility of infection and inflamation. Antibiotics were ordered by her to be continued. She stated in her EBT that continuation of zosyn and fluconazole was necessary and was to be used empirically to cover for potential gram-negative and anaerobic organisms. Goldberg EBT at pp. 53-54.

The symptoms that may possibly have been causing the elevated white blood count included much more than mesenteric ischemia. As stated previously, it included, *inter alia,* sepsis, elevated lactic acid, end-order damage, temperature changes, and heart rate changes. The Defendant Dr. Goldberger's examination of the Plaintiff, and her findings as to his post surgical medical issues on April 30, 2017, raised even more medical condition issues of the Plaintiff; e.g.: post operative respiratory problems, acute cirrhosis,[2] and SMA injury. In addition, there were laboratory tests which indicated infection or inflamation. Antibiotic medical treatment was ordered as treatment by Dr. Goldberg and was continued out of necessity.

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[2] Cirrhosis is a late stage liver disease which replaces healthy tissue with scar tissue and prevents normal function of the liver. Testing such as blood analysis, liver function tests, viral infection tests and imaging tests can be used to detect. There are no specific treatments that cure cirrhosis, however, diseases that cause it can be medically treated.

That the presence of bowel eschemia was ultimately established by NYPCU on May 8, 2017 via angiogram, the angiogram did not establish that the other medical problems, and symptoms of the Plaintiff noted herein, were not present and did not require treatment. For example, according to the CCS expert, early on, the Chief of the ICU assumed that the complaints of the Plaintiff during treatment were due to pancreatitis. The CCS expert went on to agree that "this is not an improper presumptive diagnosis" on the part of the ICU.

An abdominal CT radiology study of the Plaintiff was taken on May 4, 2017 by a Lawrence Hospital radiologist. It was published as late as May 6, 2017, and was viewed by the Defendant. It showed the absence of pancreatitis and thus at this point, according to the CCS expert, ICU should have "mov[ed] on to other potential causes such as bowel eschemia." CCS Affirmation at ¶ 54. However, even on May 6, 2017, moving on to "other potential causes," including but not limited to bowel ischemia, was not deemed by the CCS expert to be too late a date to have determined the presence or absence of bowel ischemia.

In any event, in as much Dr. Goldberg's last day of monitoring and treating the Plaintiff was May 4, 2017, a differential diagnosis of pancreatitis by Dr. Goldberg on May 5th (for example) would not necessarily have established the presence or absence of ischemia on that date. It was still an open question to be resolved.

The second unnamed expert is a "General Vascular Surgeon" (GVS), retained by the Plaintiff as an expert in opposition to the Defendant's motion. The expert's affirmation in opposition contains numerous conclusions claiming that, within a reasonable degree of medical certainty, Dr. Goldberg departed from the standard of care in her treatment of the Plaintiff, and thereby directly and proximately caused the Plaintiff serious and permanent injuries.

The facts in support of the GVS expert's conclusions seem to rest on, or revolve around, the decisions by no fewer than twelve caption listed defendants plus the Defendant Dr. Goldberg. However, out of all of the twelve defendants who were not named Goldberg, the only thing alleged against them are bare opinions (without factual proofs or analysis) that ". . . the post-operative care and treatment provided by the ICU Defendants fell far below the standard of care" and that ". . . the . . . records are laden with missed opportunities for preventing the severe harm that was done to Mr. Davis and he was clearly manifesting signs and symptoms of bowel ischemia early on his admission to the LAWRENCE HOSPITAL ICU" and that ". . . all [ICU Defendants] departed from the standard of care in their post operative treatment of Mr. Davis." GVS expert at ¶ 12.

The only fact offered by the GVS expert against Dr. Goldberg is the fact that on May 1, 2017, Dr. Goldberg went to see the Plaintiff at the ICU and saw "distended abdomen, persistent leukocytosis, and no bowel movement." The GVS expert ignores what medically was done by the Defendant Docter as well as all of the results of Dr. Goldberg's examinations that have previously been set forth herein. The Court will not take up more space and time to discuss the far larger relevant proofs and treatments already provided by Dr. Goldberg herein. See, Goldberg EBT at pp. 54-68. Needless to say, there was no absence of the necessary evaluation and treatment of the Plaintiff's multiple symptoms by Dr. Goldberg, none of which caused the Plaintiff any injuries, much less serious and permanent injuries.

The third unnamed expert is a radiologist retained by the Plaintiff as an expert in opposition to the Defendant's motion. Nowhere in the affirmation of the radiologist is any reference made to the Defendant Dr. Goldberg generally, nor does the expert make reference to any radiologic study, CAT scan, x-ray or MRI made or ordered by Defendant Dr. Goldberg. Accordingly, the affirmation

is dismissed as not relevant to the issues presented in the instant motion before the Court.

An affirmation in support of the Defendant Dr. Goldberg was submitted by Dr. Alan Pollock in response to the submissions of the Plaintiff's experts. Dr. Pollock is a board certified expert in internal medicine and infectious diseases and addresses at length, and in detail, the treatments of the Plaintiff carried out by Dr. Goldberg on the post operative dates of April 30 2017, May 1, May 2 and May 4, 2017.

The examinations and treatments given to the Plaintiff by Dr. Goldberg on the above dates have been fully set forth herein. Dr. Pollock's reviews of the Defendant's examinations and treatments of the Plaintiff by Dr. Goldberg fully support her actions and decisions as a consultant infectious disease physician. He see's no departures from standard's of care and concludes that Dr. Goldberg's treatments did not proximately cause the damages alleged. See, Dr. Pollock affirmation at ¶ 2. For example, while elevated white blood count could have been evidence of possible infection, it could also have been reasonably concluded that there was non-infectious cause from ischemia. Thus it was appropriate and reasonable to continue prophylactic treatment with broad-spectrum antibiotics in the event of sepsis Dr. Pollock affirmation at ¶ 11. Doing so was not a departure from the standard of care.

Dr. Pollock also noted that their could have been a compromised arterial repair that was a possible etiology (cause) of the leukocytosis. As such, it was appropriate for Dr. Goldberg to add additional antibiotic treatment (Flagyl) to the Plaintiff's regimen. The bowel wall could become abnormally permeable resulting in release of bacteria normally contained within the gastrointestinal tract. Flagyl was appropriate because it could cut off the development of bacterial peritonitis, a potentiall fatal infection. Under the circumstances it's addition to treatment was appropriate and

within the standards of care. Dr. Pollock affirmation at ¶ 12.

On the Defendant's last day of treatment, Dr. Pollock noted that the patient's colo-rectal surgical doctor had discontinued antibiotic treatment the prior evening without consultation with Dr. Goldberg. The plaintiff's white blood cell count was again elevated along with lipase and amylase levels. Because lipase and amylase were pancreatic enzymes, when elevated they are an indication of pancreatitis. To offset the affect of antibiotic treatment discontinuation, Dr. Goldberg recommended a switch to imipenem which had broad spectrum and affect with no contraindications. Again, Dr. Pollock opined that Dr. Goldberg's use of imipenem and continuation of vancomycin was the proper thing to do and was not a deviation from the standard of care. Dr. Pollock affirmation at ¶ 16.

Dr. Pollock's ultimate conclusion (to a reasonable degree of medical certainty) is that the Plaintiff's damages have absolutely nothing to do with the antibiotic regimen recommended by Dr. Goldberg during the time she treated plaintiff. "The Plaintiff's complicated course resulted not from alleged inappropriate treatment of an established infection but rather from ischemic necrosis of the bowel caused by the initial injury to the superior mesenteric during appendectomy on April 28, 2017.

Dr. Pollock further concluded "that it was clearly not a deviation from standard of care to start and continue plaintiff on . . . broad based antibiotics because of the suspicion that the leukocytosis was due to an infection even with the kowledge that there was a laceration of the SMA which supplies blood to the small bowel." As Dr. Pollock duelly noted ". . . the Infectious Disease physicians at Columbia Presbyterian also continued broad spectrum antibiotic coverage even after the SMA occlusion was diagnosed . . . [and] the broad spectrum antibiotic coverage . . .was warranted for both treatment of possible infection as well as for prophylaxis in case ischemic

necrosis of the bowel had caused a perforation with leakage of intestinal bacteria into the abdomen and potential life-threatening peritonitis." Dr. Pollock affirmation at ¶ 20.

Unlike Dr. Pollock, the Plaintiff's experts are unable to see both the importance and connection of the infective disease physicians' participation in the Plaintiff's monitoring and treatment. To the Plaintiff's CCS, Radiologist and GVS experts, all that mattered was a CAT scan. Anything else was a waste of time. Clearly, however, bacterial prophylactic intervention was potentially life saving.

As previously stated, expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact. *Wagner v. Parker*, *supra* at 955. Thus, it is the conclusion of the Court that triable issues of fact have not been raised in the instant matter by the Plaintiff. Accordingly, it is hereby

ORDERED, that so much of the motion by the Defendant Dr. Robin Goldberg, M.D, seeking summary judgment against the Plaintiff James Davis, is granted and the Plaintiff's complaint against the Defendant Dr. Robin Goldberg, M.D, is hereby dismissed.

The forgoing constitutes the Decision and Order of the Court.

Dated: White Plains, New York
October 7, 2021

James W. Hubert
Hon. James W. Hubert, J.S.C.