At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 30th day of November 2021.

P R E S E N T:
HON. PAMELA L. FISHER,
J.S.C.

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ROBERT SAVAGE,

Plaintiff,

DECISION/ORDER

- against -

Index No: 501375/2019

TODD SCHLIFSTEIN, MD, WINDSOR PHARMACY CORP., and WINDSOR PHARMACY EAST, LLC,

Defendants.

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Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

	Papers Numbered
Notice of Motion and Affidavits (Affirmations) Annexed	1, 2
Opposing Affidavits (Affirmations)	3
Reply Affidavits (Affirmations)	4

Upon the foregoing papers in this medical malpractice action, plaintiff moves, pursuant to CPLR § 3212, for summary judgment, and pursuant to CPLR § 3126, to strike defendant, Todd Schlifstein, M.D.'s answer for spoliation of evidence.

Background/Procedural History

Plaintiff was "referred" to defendant, Dr. Schlifstein for treatment of "back pain before and after a spinal fusion surgery" (Plaintiff's Affirmation in Support at 3). Plaintiff had previously abused narcotics, and was taking Suboxone, a medication that "control[s] drug cravings" at the time he first presented to Dr. Schlifstein's office in October 2015 (*Id.* at 7). Dr. Schlifstein treated plaintiff's back pain from October 2015 to August 2016 by prescribing opioid medications (*Id.*). Plaintiff alleges that the narcotics prescribed by Dr. Schlifstein caused him to become "re-addicted" to narcotics (*Id.* at 8).

Plaintiff commenced this action by filing a summons and complaint in January 2019 (*Id.* at 9; Plaintiff's complaint, annexed as Exhibit 7 to plaintiff's motion papers). Prior to the commencement of this lawsuit, in July 2018, plaintiff's counsel sent Dr. Schlifstein a letter and HIPAA authorization, requesting plaintiff's medical records, but received no response (Plaintiff's Affirmation in Support at 9; Letter and HIPAA authorization annexed as Exhibit 6 to plaintiff's motion papers). In March 2019, defendant provided plaintiff with a copy of his medical records (Plaintiff's Affirmation in Support at 9-10). Dr. Schlifstein's employment terminated in October 2019, and "plaintiff served a demand for a litigation hold on all electronic records" in January 2020 (*Id.* at 10; NYSCEF #50). Defendant's electronic medical records were stored on hard drives on his office computers (Dr. Schlifstein's EBT tr. 48, lines 6-9, annexed as Exhibit 1 to plaintiff's motion papers). Defendant last saw his office computers in February 2020, when he visited his office (*Id.* at 52, lines 9-12). At some point after February 2020, Dr. Schlifstein's office computers were allegedly "repossessed," and he was provided with a "computer memory stick," which is "unreadable" without a "data extrapolation expert" and access to eClinicalWorks software (*Id.* at 54, lines 10-16; at 55, lines 1-20; Plaintiff's Affirmation in Support at 10). In March 2020, plaintiff moved to compel defendant "to produce an audit trail/meta data from his electronic medical records" (Plaintiff's Motion for Audit Trail, annexed as Exhibit 8 to plaintiff's motion papers). In October 2020, plaintiff's motion to compel defendant "to produce an audit trail/meta data from his electronic medical records" was denied with leave to renew after defendant's deposition (*Id.*; Order Denying Plaintiff's Motion for Audit Trail, annexed as Exhibit 10 to plaintiff's motion papers).

Parties' Contentions

In support of his motions, plaintiff argues that Dr. Schlifstein "reckless[ly]" and "wanton[ly]" destroyed medical records that he had an obligation to preserve, and that the missing items are necessary to establish a prima facie case (Plaintiff's Affirmation in Support at 13, 20, 22). Plaintiff

alleges that the "[m]issing records include prescriptions, [the] doctor's handwritten notes, patient's handwritten complaints, and telephone messages" (*Id.* at 1). He also maintains that the records provided by the defendant are "unreliable," in that all entries were electronically signed the same day, and the same information is repeated "from month to month," even if no longer accurate, due to problems with Dr. Schlifstein's electronic medical records' software, eClinicalWorks (*Id.* at 1, 18-19). Plaintiff has submitted Dr. Schlifstein's deposition testimony, in which he testified that he last saw his office computers in February 2020, and that he later found out that these computers were "repossessed" (Dr. Schlifstein's EBT tr. 52, lines 9-12; at 54, lines 10-13). He stated that the IT company provided him with a memory stick, which is unreadable without a "data extrapolation expert" and access to software (*Id.* at 54, lines 13-25; at 55, lines 8-13). Further, upon reviewing the records, Dr. Schlifstein testified that certain records were missing, including telephone messages, sheets filled out by the patient at follow-up visits, and the doctor's notes, which were normally written on the patient's follow-up sheet (*Id.* at 46, lines 10-25; at 47, lines 1-20). Further, he confirms that his office encountered problems with the eClinicalWorks software, including "duplication of notes," issues "retrieving the notes," issues with saving notes, and the fact that printing the notes resulted in them being automatically signed as of the date of printing (*Id.* at 30, lines 12-25; at 31, lines 1-24).

In opposition, defendant argues that plaintiff has failed to establish his entitlement to summary judgment, as he has failed to include an "affidavit of an expert witness" (Defendant's Affirmation in Opposition ¶ 26). Defendant contends that both of plaintiff's motions are premature, as discovery is incomplete (*Id.* at ¶ 36). Further, defendant maintains that plaintiff's motion to strike the answer must be denied, as plaintiff has not established that Dr. Schlifstein "willful[ly], contumacious[ly], wanton[ly], or reckless[ly]" destroyed medical records, Dr. Schlifstein has provided "270 pages" of medical records to the plaintiff, and the medical records provided by defendant contain sufficient "information and documentation" for plaintiff to "attempt to prove his case" (*Id.* at ¶¶ 40, 41).

Defendant has submitted 270 pages of plaintiff's medical records as an exhibit to his opposition papers, including typed and dated progress notes, lab tests, some handwritten forms filled out by plaintiff documenting his complaints and medical history, lists of prescriptions with dates, name of prescriber, dosage, quantity, and number of days supplied, plaintiff's pain assessment forms, MRI/X-ray reports, and office notes written by Dr. McCance, the physician who referred plaintiff to Dr. Schlifstein (*Id.* at ¶¶ 18, 40; Dr. Schlifstein's records, annexed as Exhibit D to defendant's opposition papers).

In reply, plaintiff claims that he is entitled to summary judgment without an affidavit from an expert, based on Dr. Schlifstein's deposition testimony, wherein he testified that the "fail[ure] to have a conversation" with a patient, or "perform a physical exam" before changing a patient's prescription, would be a departure from acceptable medical practice (Plaintiff's Affirmation in Reply at 6). Plaintiff also reiterates that defendant had a statutory duty to preserve plaintiff's medical records, and he cannot blame others, such as his partner or the IT company he hired, for his failure to fulfill his obligation (*Id.* at 3-5). He maintains that striking the answer is warranted, as plaintiff cannot prove his claim without the missing records (*Id.* at 1, 8).

Law

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant "deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v. Streiter*, 83 AD3d 18, 23 [2d. Dept. 2011]). On a motion for summary judgment, a party is "generally" required to produce "an affidavit or affirmation from an expert medical provider to meet its prima facie burden, or to raise a triable issue of fact in opposition" (*Rivers v. Birnbaum*, 102 AD3d 26, 42 [2d. Dept. 2012]; *Alvarez v. Prospect Hospital*, 68 NY2d 320, 327 [1986]). Expert testimony is "necessary to prove a deviation from accepted standards

of medical care and to establish proximate case unless the matter is one which is within the experience and observation of the ordinary juror" (*Lyons v. McCauley*, 252 AD2d 516, 517 [2d. Dept. 1998]).

CPLR § 3126(3) states that a court is allowed to issue an order "striking out pleadings or parts thereof" if a party "refuses to obey an order for disclosure or willfully fails to disclose information which the court finds ought to have been disclosed pursuant to this article" (CPLR § 3126(3)). To be entitled to sanctions under CPLR § 3126, the movant "must demonstrate that the responsible party's actions were willful and contumacious" (*Falcone v. Karagiannis*, 93 AD3d 632, 633 [2d. Dept. 2012]). "Under the common law doctrine of spoliation, when a party negligently loses or intentionally destroys key evidence, thereby depriving the non-responsible party from being able to prove its claim or defense, the responsible party may be sanctioned by the striking of its pleading" (*Coleman v. Putnam Hosp. Center*, 74 A.D.3d 1009, 1011 [2d. Dept. 2010]; *Falcone*, 93 AD3d at 634; *Baglio v. St. John's Queens Hosp.*, 303 A.D.2d 341, 342 [2d. Dept. 2003]). "The party requesting sanctions for spoliation has the burden of demonstrating that a litigant intentionally or negligently disposed of critical evidence, and fatally compromised its ability to defend [or prosecute] the action" (*Utica Mut. Ins. Co. v. Berkoski Oil Co.*, 58 A.D.3d 717, 718 [2d. Dept. 2009]; *see also Coleman*, 74 A.D.3d. at 1011 (refusing to strike the answer of defendant hospital because fetal heart rates were noted in the hospital chart, thereby indicating that plaintiff "failed to clearly establish that the unavailability of the fetal heart monitoring data fatally compromised his ability to prosecute [the] action"); *Tawedros v. St. Vincent's Hosp. of N.Y.*, 281 AD2d 184, 184 [1st Dept. 2001] (refusing to strike the answer of defendant hospital that "produc[ed] an incomplete and allegedly altered copy" of the medical record, as "it [did] not appear that plaintiff [would] be unable to prove his case without the items of information missing from the copy")). "A party that seeks sanctions for spoliation of evidence must show that the party having control over the evidence possessed an obligation to preserve it at the time of its destruction" (*Pegasus Aviation I, Inc. v. Varig Logistics S.A.*, 26 N.Y.3d 543, 547 [2015]). A physician

is required to "retain" "patient records" "for at least six years" (NY Education Law § 6530(32); 8 NYCRR 29.2(a)(3)).

Analysis

Plaintiff's motion for summary judgment, pursuant to CPLR § 3212, is denied, as plaintiff has failed to provide an affidavit or affirmation from an expert in support of his motion (*Rivers*, 102 AD3d at 42; *Alvarez*, 68 NY2d at 327 (holding that plaintiff failed to raise a triable issue of fact in opposition to defendant's motion for summary judgment where she failed to submit an affirmation from an expert); *Koster v. Davenport*, 142 AD3d 966, 968 [2d. Dept. 2016] (affirming trial court's denial of plaintiff's motion for summary judgment, on the grounds that "plaintiff failed to establish a prima facie case of medical malpractice," as "she did not present any expert medical testimony"); *Lyons*, 252 AD2d at 517). Plaintiff alleges that expert testimony is not necessary, based on Dr. Schlifstein's deposition testimony that changing a patient's prescription without an office visit, or a telephone conversation with the patient, would constitute a deviation from the standard of care (Plaintiff's Affirmation in Reply at 6; Dr. Schlifstein's EBT tr. 227, lines 20-25; at 229, lines 6-11). However, plaintiff overlooks Dr. Schlifstein's testimony that no deviation occurred in this case, because the patient called the office to report that he was "running out of medication" (*Id.* at 226, lines 20-25; at 228, lines 10-19). Therefore, since not all telephone conversations between the plaintiff and Dr. Schlifstein are documented in the record, triable issues of fact remain as to whether these conversations occurred, and whether Dr. Schifstein deviated from acceptable medical practice. Accordingly, plaintiff's motion for summary judgment is denied.

Plaintiff's motion, pursuant to CPLR § 3126, to strike defendant's answer for spoliation of evidence, is also denied. Although Dr. Schlifstein had a statutory obligation to retain plaintiff's medical records, striking his answer is not an appropriate sanction, as plaintiff has failed to demonstrate that defendant "willful[ly] and contumacious[ly]" destroyed evidence (NY Education Law

§ 6530(32); 8 NYCRR 29.2(a)(3); *Falcone*, 93 AD3d at 633). Further, he has also failed to establish that the loss of evidence "fatally compromised his ability to prosecute [the] action," as defendant has produced hundreds of pages of medical records, including a list of plaintiff's prescriptions maintained by the Prescription Monitoring Program (PMP), "a database established by New York State" "that record[s] all prescriptions of controlled substances" (*E.g.*, Dr. Schlifstein's records at 227; Dr. Schlifstein's EBT tr. 129, lines 21-24; *Coleman*, 74 A.D.3d. at 1011; *Geffner v. North Shore University Hosp.*, 57 AD3d 839, 841 [2d. Dept. 2008] (affirming trial court's denial of plaintiff's motion to strike defendant hospital's answer where there was "no showing that [defendant] willfully and contumaciously discarded specimens, samples, blood, bodily fluids or any other physical matter of the plaintiff's decedent which it was directed to preserve pursuant to two temporary restraining orders," and "the failure to preserve certain specimens did not prevent plaintiff from proving her case"); *Hughes v. Covey*, 131 AD3d 581, 583 [2d. Dept. 2015] (reversing trial court's decision striking the answer of defendants even though the "record" "support[ed] the trial court's "determination that the [defendants] failed to properly preserve" the "images of the nuclear stress test," as the "plaintiffs failed to establish that the unavailability of the images" "left them prejudicially bereft of the ability to prosecute [the] action")).

Further, the cases cited by plaintiff in support of his spoliation motion are distinguishable. In *Herrera v. Matlin*, 303 AD2d 198 [1st Dept. 2003], defendant "simply left all of his patient's records" "in a filing cabinet in the medical office where he worked without arranging for their transfer to another doctor or return to his patients" when he retired (*Id.*) The court granted plaintiff's motion to strike defendant's answer, since plaintiff's "[a]ttempts to procure these records from the medical office" were "unsuccessful," and the loss of all of plaintiff's records "deprive[d] [her] of any means of establishing a prima facie case" (*Id.*). This case is different, as defendant has produced hundreds of pages of records, and defendant alleges that he transferred the records to his partner before he stopped

practicing medicine (Defendant's Affirmation in Opposition ¶¶ 12, 40). *Gray v. Jaeger*, 17 AD3d 286 [1st Dept. 2005], also cited by the plaintiff, is another case where the court determined that defendant's failure to "retain plaintiff's medical records" "deprived plaintiff of any means of establishing a prima facie case," and warranted the striking of defendant's answer (*Id.* at 287). However, it is unclear from the record how factually similar *Gray* is to this case, as the decision does not recite specific facts. *Baglio v. St. John's Queens Hospital*, 303 AD2d 341 [2d. Dept. 2003], is also distinguishable, as that case involved the loss of fetal monitoring strips, which the court determined were "the most critical evidence to determine fetal well-being at the time of treatment, and in evaluating the conduct of health care providers with regard to obstetrical management" (*Id.* at 342-43). Based on the information available to the Court, it does not appear that the allegedly missing evidence is the "most critical evidence," without which plaintiff would be unable to establish a prima facie cause of action (*Id.*). Based on the foregoing, plaintiff's motion, pursuant to CPLR § 3212, for summary judgment, is denied. Plaintiff's motion, pursuant to CPLR § 3126, to strike defendant's answer, is denied with leave to renew at the time of trial.

This constitutes the decision and order of the Court.

ENTER:

Hon. Pamela L. Fisher
J.S.C.

HON. PAMELA L. FISHER