Kenny v Rubin

2023 NY Slip Op 33318(U)

September 25, 2023

Supreme Court, New York County

Docket Number: Index No. 805157/2019

Judge: Judith N. McMahon

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JUDITH N. MCMAHON** *Justice* **PART** **30M**

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TERRENCE KENNY, ADRIANA KENNY,

Plaintiff,

- v -

MICHAEL RUBIN, ROGER HARTL, WEILL CORNELL MEDICINE, NEW YORK-PRESBYTERIAN WEILL CORNELL MEDICAL CENTER

Defendant.

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INDEX NO. 805157/2019

MOTION DATE 09/18/2023

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER .

Upon the foregoing documents, it is ordered that the motion for summary judgment by the defendants Michael Rubin, M.D., Roger Hartl, M. D[1]., Cornell University s/h/a Weill Cornell Medicine (hereinafter "Cornell") and The New York and Presbyterian Hospital s/h/a New York-Presbyterian Weill Cornell Medical Center (hereinafter "NYPH") is granted to the extent that the complaint is severed and dismissed as against the defendants Dr. Hartl, Cornell, and NYPH[2]. The balance of the motion is denied.

This medical malpractice action arises out of defendants' alleged failure to diagnose and treat the then 50-year-old plaintiff's epidural lipomatosis[3] between May 26, 2009, and February

[1] Plaintiffs assert that the action has been discontinued as to defendant neurosurgeon, Roger Hartl, M.D. (*see* plaintiffs' affirmation in opposition; NYSCEF Doc. No. 61, para 3). No Stipulation of Discontinuance has been e-filed).

[2] Plaintiffs are unable to maintain any individual claims against the institutional defendants, and there is no evidence in the record that Dr. Rubin was employed by either Cornell or NYPH for purposes of vicarious liability.

[3] A fatty mass on or outside the spinal cord.

28, 2017. Plaintiffs claim that in 2009, defendant-neurologist Dr. Rubin misdiagnosed plaintiff as suffering from diabetes related peripheral neuropathy and failed to appreciate the significance of a progressively evolving epidural lipomatosis discovered on a thoracic MRI in August of 2012 and need for an immediate neurosurgical consultation. It is further claimed that earlier intervention and removal of the epidural lipomatosis would have afforded plaintiff the best opportunity for recovery. Instead, plaintiff became paraplegic, suffered from pressure ulcers, and underwent bilateral above the knee amputations in 2017 and 2022. He is currently confined to a wheelchair.

Defendants move for summary judgment on the grounds that all care and treatment was rendered in accordance with the standard of care, and that plaintiff's injuries were a result of his vascular problems, diabetes, and obesity, and critically, his failures to follow-up with Dr. Rubin and undergo the diagnostic and imaging tests that were prescribed.

Plaintiffs oppose the motion, arguing that triable issues of fact exist as to whether the defendants departed from the standard of care by, *inter alia,* (1) failing to refer plaintiff for surgical intervention in August of 2012 and December of 2013, and (2) failing to inform plaintiff of the spinal tumor that was present on the MRI of his spine from August of 2012 onwards. Plaintiffs maintain that triable issues of fact exist as to whether these departures led to a significant delay in treatment of the epidural lipomatosis, and whether this delay was a substantial factor in causing plaintiff's poor neurological outcome and injuries.

FACTUAL BACKGROUND

Terrence Kenny was diagnosed with Type 1 diabetes at age 16, and suffered a myocardial infarction in February of 2009, at 50 years old.

On **May 26, 2009**, at the suggestion of his vascular surgeon, plaintiff presented to defendant-neurologist, Dr. Rubin, for complaints of numbness in his feet, weakness in both legs while on an exercise bike, and imbalance upon waking up and standing. Dr. Rubin's clinical impression was neuropathy, and he ordered bloodwork, a skin biopsy of the right foot to examine the small fibers, and nerve conduction studies to examine the large fibers in furtherance of his suspicion of neuropathy as well as autoimmune disease or a Vitamin B12 deficiency. Bloodwork was significant for elevated hemoglobin A1C of 7.1 and the skin biopsy showed significant reduced epidermal nerve fiber density, consistent with small fiber neuropathy.

On June 9, 2009[4], plaintiff underwent nerve conduction studies that revealed an absent sensory response in the left sural nerve, and decreased motor response from the left peroneal nerve. Dr. Rubin concluded, based on the EMG, biopsy, and blood work, that the cause of plaintiff's symptoms was *sensory peripheral neuropathy secondary to diabetes*, and he purportedly directed Mr. Kenny to follow up in four weeks to go over the test results and next steps. Plaintiff did not return.[5]

Three years later, on **August 16, 2012,** plaintiff saw Dr. Rubin because he "had a drastic change in my condition. I was actually falling, tripping a lot" (*see* NYSCEF Doc. No. 50, p. 111). Again, plaintiff complained of weakness in both legs and an inability to tandem walk since

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[4] The parties disagree as to the number of visits plaintiff had with Dr. Rubin in 2009: plaintiff says that he was told to return "as-needed" without a specific timeframe; Dr. Rubin attests that he scheduled plaintiff for four follow-up visits, but the plaintiff failed to show up for three of them. The medical records indicate seven visits in 2009.

[5] At his EBT, plaintiff testified that at the 2009 visits, Dr. Rubin told him to return "as needed" and "you know, come in if there are any changes" (*see* NYSCEF Doc. No. 50, pp, 91, 99).

2011. A neurological exam revealed new findings of brisk reflexes in the legs and upgoing toes in the feet (Babinski signs). Given these findings, Dr. Rubin's plan was to rule out myelopathy, and to again consider a possible B12 deficiency for the absent ankle jerks and brisk knee jerks.

A cervical MRI performed on August 16, 2012, was unremarkable, but an MRI of the thoracic spine showed a posterior epidural lipomatosis from the T3 to T9 level, measuring up to 8 mm maximally at the T6-T7 level, causing "mild mass effect upon the posterior thecal sac and anteriorly displacing the spinal cord at those levels." There was also mild flattening of the cord posteriorly at T5-T6 and T6-T7, and minimal dilation of the central canal of the lower thoracic spinal cord. Plaintiff's A1C was elevated at 8.3, but his B12 was within normal limits.

On **August 27, 2012**, plaintiff underwent an EMG study with Dr. Rubin, for "unstable gait weakness," that revealed no response in the right sural sensory nerve within the calf. Dr. Rubin's impression was sensory peripheral neuropathy. Plaintiff did not return to Dr. Rubin to review the exam results and determine next steps[6]. Plaintiff's version of the need for follow-up appointments is as follows: "[Dr. Rubin's] position has always been, you know, when I left his office, you know, if things get worse, you know, come back. I don't think I made appointments in advance. I just kinda called up" (*see* NYSCEF Doc. No. 50, p. 140, ll 11-15).

Over a year later, on **December 19, 2013**, plaintiff (now age 55) presented to Dr. Rubin for "gait difficulty" and progressive sensation of leg heaviness and instability. A neurological exam found brisk tendon reflexes and bilateral Babinski signs and, for the first time, position sense impairment. Muscle tone and strength was normal in all four extremities, and plaintiff had no atrophy or abnormal movements. Dr. Rubin appreciated the August 12th cervical and thoracic MRI studies which showed epidural lipomatosis from T3-9 with mild mass effect. He determined

[6] When asked if Dr. Rubin discussed the results of his radiology scan at the 2012 visit, plaintiff answered "No. The only thing he said was everything came back negative" (*see* NYSCEF Doc No. 50, p. 123; pp. 126-127).

that the exam was myelopathic, and the plan was for MRIs of the lumbar and thoracic spine, followed by an office visit in two weeks. Plaintiff never had the MRIs and did not return to Dr. Rubin in two weeks for a follow-up.

Three years later, on **October 19, 2016**, the 58-year-old plaintiff returned to Dr. Rubin with a chief complaint of "ataxia,[7]" which had progressively worsened. Mr. Kenny now required use of his hands to rise from a chair, and he was falling once a week. On neurological examination, plaintiff demonstrated weakness with bilateral knee flexion and ankle extension. He exhibited brisk deep tendon reflexes, absent ankle jerks, bilateral Babinski signs and a position sense impairment[8]. Plaintiff was walking with a broad-based gait, and wavered when standing with his feet together. Dr. Rubin assessed worsening leg weakness and ataxia, and the exam was myelopathic. The plan was for an MRI of the cervical and thoracic spine, bloodwork, an EMG, and a vascular surgery consult[9].

On **November 3, 2016,** plaintiff had an MRI study of the cervical and thoracic spine which, when compared to the 2012 films, revealed the cervical spine within normal limits, but the thoracic spine now showed "prominent, dorsal epidural fat from the level of T3-4 through T9 with mass effect on the posterior thecal sac and anterior and mild leftward displacement of the spinal cord at these levels, compatible with epidural lipomatosis. This measures up to 8 mm in axial dimension measured at T6-7. Mass effect is most severe at T4-5 where there is increased obliteration of CSF. There is no definite signal abnormality in the cord at this level. There is

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7 Ataxia describes poor muscle control that causes clumsy voluntary movements and may cause difficulty with walking and balance.

8 The body's ability to sense its location, movements, and actions, such as the ability to walk or kick without looking at your feet or being able to touch your nose with eyes closed.

9 On November 11, 2016, Dr. Silane (a vascular surgeon referred by Dr. Rubin) ruled out that the walking difficulty was related to a peripheral arterial disease and recommended a high intensity statin and a follow up with neurosurgery.

increased prominence of T2 hyperintensity in the central spinal cord more inferiorly, at T7-8 through T9-10…possibly reflecting myelomalacia…" (*see* NYSCEF Doc. No. 56, p. 404/683) (*i.e.*, abnormal changes within the spinal cord, specifically a softening of the cord which may result from compression). An EMG study performed that day showed sensory polyneuropathy, and there were also new findings of mild right carpal tunnel syndrome and moderate right L5 radiculopathy. Dr. Rubin called plaintiff the following day to advise him of the 2016 MRI results and to refer him to a neurosurgeon (*see* NYSCEF Doc. No. 50, pp. 151-152).

On **November 22, 2016,** plaintiff presented to neurosurgeon Dr. Hartl, who found up going toes, unsteady gait, and brisk reflexes in the lower extremities. Dr. Hartl appreciated the recent MRI of the thoracic spine showing severe spinal cord compression from epidural lipomatosis in the T4 /5 area. Given plaintiff's complaints and the findings on imaging, Dr. Hartl recommended surgical decompression by way of thoracic laminectomy from T3 to T7.
The surgery (thoracic laminectomy with microsurgical decompression of the spinal cord and resection and removal of the epidural lipomatosis T3-T7) was performed on **November 28, 2016**, at NYPH without complication. He remained in the hospital until December 2, 2016.

Thereafter, plaintiff was admitted to NYPH's rehab facility, where he remained from December 2, 2016, through December 13, 2016. His recovery went very well, and plaintiff was discharged home. Shortly after returning home, however, Mr. Kenny developed worsening lower extremity weakness, instability, and neurological decline to the point of paralysis.

From December 28, 2016, through December 30, 2016 plaintiff returned to NYPH with complaints of worsening lower extremity weakness and urinary incontinence. He had difficulty rising to a standing position, and gait instability. An MRI of the thoracic and lumbar spine

revealed fluid collection that was "likely post-operative in nature." There was also an unchanged signal abnormality of the thoracic cord that likely represented an area of myelomalacia.

On December 30, 2016, plaintiff was discharged to Bayada Home Health Care.

On January 17, 2017, plaintiff followed up with both Dr. Rubin and Dr. Hartl for post-operative office visits. He presented in a wheelchair but was using a walker at home. Plaintiff reported intermittent bilateral weakness and heaviness. Dr. Hartl reviewed the most recent thoracic MRI scan, which showed areas of myelomalacia in the spinal cord that "brings up the question of transverse myelitis or other sources of pathology." A brain MRI was suggested as the next step, and plaintiff was to return to the surgeon in three weeks to check on his neurologic process and wound healing. Dr. Rubin also reviewed the December 16, 2016, thoracic spine MRI and noted the appearance of "some mid-thoracic spinal cord atrophy. Prior transverse myelitis possible". Dr. Rubin's plan was for a brain MRI and evaluation by the multiple sclerosis group.

Plaintiff did not return to either Dr. Rubin or Dr. Hartl again.

Throughout January and February of 2017, plaintiff had numerous admissions to NYPH: **January 27, 2017 – January 30, 2017,** for left arm numbness and difficulty ambulating; **January 30, 2017 - February 7, 2017** to the NYPH rehab service; **February 7, 2017 – February 16, 2017** to the neurology service. On **February 18, 2017,** plaintiff returned to the emergency room of NYPH with complaints of bilateral lower extremity numbness. An EMG showed severe sensorimotor polyneuropathy affecting the lower extremities with mild sensory involvement of the upper extremity, thought to be the result of diabetes versus critical illness neuropathy. A February 20, 2017, MRI of the brain was negative for acute pathology.

Plaintiff was discharged to Kessler Rehab on **February 22, 2017.** He did not return to NYPH again in 2017. Throughout his time at NYPH, he was evaluated for pressure ulcers, and none were found.

Plaintiff returned home on **April 4, 2017**, with "modified independence at wheelchair level."

From April 28, 2017, through April 30, 2017, plaintiff was admitted to Jersey Shore Medical Center for treatment of bilateral foot ulcers.

The pressure ulcers worsened to the point that plaintiff underwent amputation of the left leg at Hackensack Jersey Shore on October 20, 2017, rectal pressure wound surgery and rehabilitation at Mount Sinai Hospital in Baltimore in 2021, and above the knee amputation for wounds to the right leg at Mount Sinai in Baltimore in 2022 (*see* Supplemental Verified Bill of Particulars; NYSCEF Doc. No. 49).

MOTION FOR SUMMARY JUDGMENT

Defendants seek judgment dismissing the complaint on the grounds, *inter alia*, that plaintiff received appropriate medical treatment, and that the defendants did not proximately cause any of the injuries alleged. Additionally, Dr. Rubin seeks summary judgment on all of plaintiff's claims concerning the May-June 2009, August 2012, and December 2013 office visits as time-barred under the two-and-one-half year statute of limitations.

The Court finds at the outset that the continuous treatment doctrine serves to toll the statute of limitations under the facts of this case, and that plaintiffs' 2009, 2012 and 2013 claims remain viable.

Generally, a medical malpractice action accrues on the date of the alleged wrongful act (*see Plummer v. NYCHH,* 98 NY2d 263 [2002], *citing Nykorchuck v. Henriques,* 78 NY2d 255,

258-259 [1991]). However, where there is a continuous course of treatment for the conditions giving rise to the malpractice action, the running of the applicable statutory period is tolled during the period of continuous treatment (*see Young v. NYCHH,* 91 NY2d 291 [1998]); CPLR §214-a: "[a]n action for medical malpractice must be commenced within two years and six months of the act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure").

Essential to the application of the continuous treatment doctrine is "a course of treatment established with respect to the condition that gives rise to the lawsuit" (*Nykorchuck v. Henriques,* 78 NY2d 255, 258-259 [1991]). "Routine examinations of a seemingly healthy patient, or visits concerning matters unrelated to the condition at issue giving rise to the claim, are insufficient to invoke the benefit of the doctrine" (*Plummer v. NYCHH*, 98 NY2d 263, 268 [2002]).

Dr. Rubin has met his burden of demonstrating that the complaint was filed after the two-and-one-half year limitations period expired with respect to any conduct occurring before October of 2016. In opposition, however, plaintiff has raised "issues of fact whether plaintiff and defendant 'reasonably intended plaintiff's uninterrupted reliance upon defendant's observation, directions, concern, and responsibility for overseeing plaintiff's progress'" (*Lohnas v. Luzi,* 30 NY2d 752 at 755 [2018]; [*internal citations omitted*]).

Here, the record indicates that plaintiff returned to Dr. Rubin between 2009 and 2016, over the course of eight years, for "the same original condition or complaint" (*Borgia v. City of New York*, 12 NY2d 151, 155 [1962]), namely, progressively deteriorating bilateral leg weakness. These were plaintiff's *only* complaints to the neurologist (*see, e.g., O'Donnell v. Siegel,* 49 AD3d 415 [1st Dept. 2008]). Mr. Kenny's testimony that Dr. Rubin told him to return

"as needed" does not foreclose a finding that the parties anticipated further treatment (*see Lohnas v. Luzi,* 30 NY2d 752 at 757 [2018]).

Accordingly, that branch of Dr. Rubin's motion for summary judgment dismissing all of plaintiffs' claims prior to 2016 is denied.

As for the balance of defendants' motion, it bears repeating that in order to prevail on a motion for summary judgment, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, through admissible evidence demonstrating the absence of any material issue of fact (*see Klein v. City of New York*, 89 NY2d 833 [1996]; *Ayotte v. Gervasio,* 81 NY2d 1062 [1993]; *Alvarez v. Prospect Hospital*, 68 NY2d 320 [1986]). "Since summary judgment is the equivalent of a trial, it has been a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that it is entitled to judgment as a matter of law" (*Ostrov v. Rozbruch,* 91 AD3d 147 [1st Dept. 2012]).

In support of the motion, defendants attach, *inter alia,* the expert affirmation of a neurologist, Kiril Kiprovski, M.D. (*see* NYSCEF Doc. No. 43), who opines that plaintiff "received appropriate neurological treatment and care at all times during the period at issue" and that "no purported act and/or omission caused any injury" (*id.,* para 63) to the plaintiffs.

According to Dr. Kiprovski, (1) plaintiff's **May 2009** complaints, history, neurological exam findings, and test results following bloodwork, a skin biopsy, and nerve conduction studies all confirmed the "appropriate diagnosis of peripheral neuropathy," and no indication of spinal cord disease or the need for imaging; (2) plaintiff's **August 2012** thoracic MRI study revealing epidural lipomatosis, showed only "mild" flattening of the cord posteriorly, meaning "there was nothing urgent or emergent about the patient's condition then" (*id.,* para 81) given that epidural

lipomatosis is a condition which can progress slowly (*i.e.*, "[i]t can take months or years before progression is seen...[and] years before severe symptoms develop, if at all" [*id.*, para. 78]); (3) Dr. Rubin "appropriately determined that plaintiff's **December 2013** exam was again myelopathic" (*id.*, para 85) and, in addition to reviewing the August 2012 thoracic MRI, the doctor appropriately planned for further MRI imaging of the lumbar and thoracic spine based on the new finding of positional sense, but plaintiff failed to follow up with the doctor or the imaging; (4) Dr. Rubin appropriately referred plaintiff to a spinal surgeon for evaluation of the fat deposits on the spinal cord uncovered by the thoracic MRI taken after plaintiff's **October 2016** office visit; (5) plaintiff was appropriately managed post-operatively, and there is no indication that any purported act and/or omission by defendants caused the worsening of plaintiff's condition thereafter; (6) there is no merit to plaintiff's claims that any medications concealed or diminished his symptoms; (7) there is no merit to plaintiff's claims that there was a failure to prevent and/or timely diagnose transverse myelitis, which was ultimately ruled out; (8) there is no merit to plaintiff's claims that he was not appropriately advised of his high risk for developing pressure ulcers and infection, and no pressure ulcers developed while plaintiff was at NYPH up and through the end of February 2017; (9) there is no evidence that plaintiff was not promptly referred to infectious diseases, and (10) all post-operative treatment and care rendered at NYPH as well as plaintiff's returns to NYPH up and through late February 2017 was "appropriate from a neurological perspective" (*id.,* para 100).

Dr. Kiprovski concludes that plaintiff's ultimate need for amputations of his left and right legs is related to his long-standing history of diabetes and vascular issues, and not his resultant paraplegia.

Also attached in support of the motion is the expert affidavit of neurosurgeon E. Antonio Chiocca, M.D. (*see* NYSCEF Doc. No. 44), who opines, to the extent relevant, that: (1) "all treatment and care rendered by Dr. Hartl and NYPH was appropriate and within good and accepted medical standards at all times, and no act and/or omission on the part of Dr. Hartl or NYPH caused any injury to this patient" (*id.*, para. 66); (2) the November 28, 2016 decompression surgery was indicated, as conservative treatment (*i.e.*, weight loss) had already been exhausted, and this patient's progression of symptoms was "very unusual"; (3) the surgery was in all respects properly performed; (4) plaintiff was not on any medication that masked his neurological deficits; (5) plaintiff was appropriately worked up for possible post-operative complications at NYPH emergency room on December 28, 2016, following his call to Dr. Hartl complaining of gait instability and urinary incontinence; (6) Dr. Hartl appropriately determined that there was no indication for further neurosurgical intervention, and (7) the subsequent treatment and care rendered at NYPH, as well as plaintiff's returns to NYPH up and through late February of 2017—including monitoring for pressure ulcers--were all appropriate from a neurosurgical perspective" (*id,* para. 85). Dr. Chiocca opines that "there is no surgical explanation" for plaintiff's condition to have progressively deteriorated (*id.,* para 82) following the surgery and rehabilitation. This expert is also of the opinion that plaintiff's complications were a result of his preexisting metabolic condition.

Movants' expert affirmations are detailed, specific and factual in nature and are based upon the facts in the record (*see Roques v. Noble,* 73 AD3d 204, 206 [1st Dept. 2010]; *see also Pascocello v. Jibone*, 161 AD3d 516 [1st Dept. 2018]; [internal citations omitted]). Accordingly, "[t]he affirmations of defendants' experts were sufficient to meet defendants' *prima facie* burden of establishing the absence of a departure from good and accepted medical practice, or that any

such departure was not a proximate cause of plaintiff's alleged injuries" (*Einach v. Lenox Hill Hosp.*, 160 AD3d 443 [1st Dept. 2018]).

"Where a defendant makes a *prima facie* entitlement to summary judgment dismissing a medical malpractice action by submitting the affirmation from a medical expert establishing that the treatment provided to the injured plaintiff comported with good and accepted practice, the burden shifts to the plaintiff to present evidence in admissible form that demonstrates the existence of a triable issue of fact" (*Bartolacci-Meir v. Sassoon,* 149 AD3d 567, 570 [1st Dept. 2017]; *see also DeCintio v. Lawrence Hosp.*, 25 AD3d 320 [1st Dept. 2006]; *Ducasse v. New York City Health & Hosps. Corp.*, 148 AD3d 434 [1st Dept. 2017]).

In opposition to the motion, plaintiffs submit, *inter alia,* the redacted and detailed expert affirmation of a neurologist (*see* NYSCEF Doc. No. 62), who sets forth "to a reasonable degree of medical certainty, that the epidural spinal lipomatosis which was discovered during the MRI of August 2012...was surgically treatable and in fact necessitated surgical intervention at that time" and opines that "had this occurred, Mr. Kenny's neurological outcome would have been greatly improved and he would have had a substantial chance of not suffering from the devastating paraplegia which he now has" (*id.*, para 32). According to the plaintiff's expert, (1) the "mild" flattening of the cord posteriorly, as evidenced by the August 2012 MRI, combined with plaintiff's symptoms, warranted a more aggressive approach by Dr. Rubin, and (2) "a surgical consultation at the very least should have been initiated as of August 2012 and on" (*id.*, para. 35).

Plaintiffs' expert, who specifically disagrees with each opinion offered by Dr. Kiprovski, is unwavering that "the ultimate need for amputations of both legs was related to paraplegia and not solely his long-standing history of diabetes and vascular issues" (*id.,* para. 38).

The plaintiffs have raised triable issues of fact sufficient to defeat summary judgment via their expert's opinion that the findings on plaintiff's 2012 thoracic MRI coupled with Mr. Kenny's specific complaints, warranted an urgent referral to a neurosurgeon. Additionally, a triable issue of fact was raised through the discrepancy between the office records and the parties' EBT testimony as to the frequency of plaintiff's office visits to Dr. Rubin.

Accordingly, it is

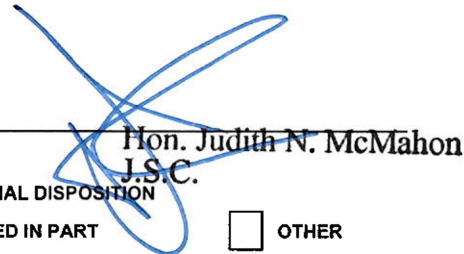
ORDERED that the motion for summary judgment by the defendants Roger Hartl, M.D., Cornell University, and The New York and Presbyterian Hospital is granted; and it is further

ORDERED that the motion for summary judgment by the defendant Michael Rubin, M.D., is in all respects denied; and it is further

ORDERED that the Statute of Limitations issue as to Dr. Rubin's treatment of plaintiff is a question of fact to be determined by the jury; and it is further

ORDERED that the Clerk is directed to enter judgment in favor of Dr. Hartl, Cornell University and The New York and Presbyterial Hospital severing and dismissing the complaint; and it is further

ORDERED that the parties shall appear for a pre-trial conference on **November 30, 2023, at 12:00 p.m**. via Microsoft Teams.



9/25/2023
DATE

Hon. Judith N. McMahon
J.S.C.

CHECK ONE:	☐ CASE DISPOSED		☒ NON-FINAL DISPOSITION			
	☐ GRANTED	☐ DENIED	☒ GRANTED IN PART		☐ OTHER	
APPLICATION:	☐ SETTLE ORDER		☐ SUBMIT ORDER			
CHECK IF APPROPRIATE:	☐ INCLUDES TRANSFER/REASSIGN		☐ FIDUCIARY APPOINTMENT		☐ REFERENCE	