

**Goldstein v Hanspal**

2024 NY Slip Op 33284(U)

September 12, 2024

Supreme Court, New York County

Docket Number: Index No. 805289/2019

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY**

**PRESENT: HON. JOHN J. KELLEY PART 56M**

*Justice*

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BENJAMIN GOLDSTEIN,  
  
Plaintiff,

- v -

ERA HANSPAL, M.D., ALLEN GERBER, M.D., MATTHEW ADAMO, M.D., ALBANY MEDICAL CENTER, ALBANY MEDICAL COLLEGE, MATTHEW MURNANE, M.D., AMC NEUROLOGY GROUP, JENNIFER DURPHY, M.D., ERIC MOLHO, M.D., JOHN DOE, M.D., JAI PERUMAL, M.D., THE NEW YORK PRESBYTERIAN HOSPITAL, NASEER CHOWDHREY, M.D., SUNNYVIEW HOSPITAL AND REHABILITATION CENTER, ST. PETER'S HOSPITAL OF THE CITY OF ALBANY, and CHRISTOPHER GUZDA, D.O.,

Defendants.

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**INDEX NO. 805289/2019**

07/12/2024  
07/12/2024,  
07/12/2024,  
07/12/2024

**MOTION DATE**

**MOTION SEQ. NO. 002, 003, 004  
005**

**DECISION + ORDER ON MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 002) 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 234

were read on this motion to/for JUDGMENT - SUMMARY.

The following e-filed documents, listed by NYSCEF document number (Motion 003) 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 184, 230

were read on this motion to/for JUDGMENT - SUMMARY.

The following e-filed documents, listed by NYSCEF document number (Motion 004) 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 235

were read on this motion to/for JUDGMENT - SUMMARY.

The following e-filed documents, listed by NYSCEF document number (Motion 005) 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 185, 231, 236

were read on this motion to/for JUDGMENT - SUMMARY.

## I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, and negligent hiring, training, and retention, the defendants Era Hanspal, M.D., Allen Gerber, M.D., Matthew Adamo, M.D., Albany Medical Center (AMC), Albany Medical College, Matthew Murnane, M.D., AMC Neurology Group, Jennifer Durphy, M.D., and Eric Molho, M.D. (collectively the AMC defendants), move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them (SEQ 002). The defendant Sunnyview Hospital and Rehabilitation Center (Sunnyview) separately moves for summary judgment dismissing the complaint insofar as asserted against it (SEQ 003). The defendants Jai Perumal, M.D., and The New York Presbyterian Hospital (together the NYPH defendants) also separately move for summary judgment dismissing the complaint insofar as asserted against them (SEQ 004). In addition, the defendant Naseer Chowdhrey, M.D., moves for summary judgment dismissing the complaint insofar as asserted against him (SEQ 005).

The plaintiff opposes the motion submitted pursuant to SEQ 002 to the extent of opposing those branches of the motion which sought summary judgment on behalf of Hanspal, Gerber, and AMC. He also opposes the motion submitted pursuant to SEQ 004. The plaintiff submits no opposition to the motions submitted pursuant to SEQ 003 and SEQ 005.

The motion submitted pursuant to SEQ 002 is granted only to the extent that summary judgment is awarded to Adamo, Albany Medical College, Murnane, AMC Neurology Group, Murnane, Durphy, and Molho dismissing the entirety of the complaint insofar as asserted against each of them, to AMC dismissing the negligent hiring, retention, training, and supervision cause of action insofar as asserted against it, and to AMC, Hanspal, and Gerber dismissing the lack of informed consent cause of action insofar as asserted against them, and any claim against them based on allegations that the plaintiff sustained a stroke or hemorrhage, or that they should have administered blood tests to evaluate him for a stroke or hemorrhage.

That motion is otherwise denied. The motion submitted pursuant to SEQ 003 is granted, without opposition, and summary judgment is awarded to Sunnyview dismissing the complaint insofar as asserted against it. The motion submitted pursuant to SEQ 004 is granted only to the extent that summary judgment is awarded to NYPH dismissing the complaint insofar as asserted against it, and to Perumal dismissing the lack of informed consent cause of action insofar as asserted against her, and any claim against her that was based on allegations that the plaintiff sustained a stroke or hemorrhage, or that she should have administered blood tests to evaluate him for a stroke or hemorrhage. That motion is otherwise denied. The motion submitted pursuant to SEQ 005 is granted, without opposition, and summary judgment is awarded to Chowdhrey dismissing the complaint insofar as asserted against him.

## II. BACKGROUND FACTS

The crux of the plaintiff's claim is that the defendants failed to perform proper diagnostic testing upon him, thus failing timely and properly to diagnose and treat arteriovenous fistula (commonly known as AVF), instead incorrectly diagnosing him with the autoimmune disease neuromyelitis optica (commonly known as NMO) that manifested itself as transverse myelitis (commonly known as TM), and improperly treating him for that disease and condition, all of which caused or contributed to a significant and severe deterioration in his physical condition, a delay in the proper treatment of the fistula, and the loss of an opportunity for a better outcome.

On July 15, 2017, the plaintiff, who was then 38 years old, presented to the emergency department of the defendant St. Peter's Hospital of the City of Albany (St. Peter's), against whom he now has discontinued the action, complaining of his inability to walk and weakness in his legs, and reporting that he had begun to experience a change in sensation in his legs on the previous evening. At St. Peter's, the defendant Christopher Guzda, D.O., against whom the plaintiff also now has discontinued his claims, was the first health-care provider to evaluate the plaintiff with respect to these complaints. Guzda expressed his concern that the plaintiff suffered from a neurological condition, possibly including transverse myelitis. Technicians at St.

Peter's took a magnetic resonance imaging (MRI) scan of the thoracic region of the plaintiff's spine, which revealed an increased transverse relaxation time signal (T2 signal) within the inferior cervical spinal cord, and tiny spinal cord central syrinx extending from the mid T9 level to the superior T11 level, albeit without a demonstrated presence of a mass and no evidence of intervertebral disc herniation, stenosis, or the narrowing of the spinal canal or neural foramina. An MRI scan of the cervical spine, however, reflected an extensive confluent central increased T2 signal throughout the spinal cord, from the cervical medullary junction to the C7-T1 level, with mild patchy enhancement and spinal cord expansion, a lesion that St. Peter's personnel determined was compatible with a clinical concern for transverse myelitis. A chest X-ray taken at St. Peter's revealed no presence of acute disease.

Several hours after presenting to St. Peters, the plaintiff was transferred to AMC for further testing and treatment, and arrived at AMC's emergency department, where the defendant Murnane, who then was on call, served as the accepting neurologist. AMC's neurology department evaluated the plaintiff, ordered MRIs of his brain and spine, and began to administer a five-day course of the steroid methylprednisolone to treat neuromyelitis optica, an autoimmune disease that produces symptoms of transverse myelitis, that is, neurological inflammation of the spine, and can also produce deterioration of the optic nerve. Specifically, on July 16, 2017, Murnane allegedly evaluated the plaintiff and noted that he had experienced several days of rapidly progressive leg and arm weakness, and evinced spasms of the torso muscles upon activating his arms. Murnane's initial differential diagnosis included neuromyelitis optica, vasculitis, sarcoidosis, and lymphoma. He noted that the lesion observed on the July 15, 2017 MRI scan appeared to be atypical for multiple sclerosis and, thus, he ruled that out. The plaintiff counters that there is no legible evidence to support the AMC defendants' allegations with respect to Murnane's evaluations and differential diagnosis at that juncture.

Murnane ordered the administration of intravenous methylprednisolone and a lumbar puncture to ascertain whether there might be evidence of certain medical conditions. According

to the AMC defendants, although an MRI of the plaintiff's brain was unremarkable, an MRI of the plaintiff's cervical spine, taken at AMC, and evaluated by the defendant neurologist Hanspal on July 17, 2017, revealed extensive transverse myelitis, after which the differential diagnosis was narrowed to neuromyelitis optica and central nervous system vasculitis. The plaintiff, however, disputed that he actually ever had transverse myelitis, noting that this condition was mentioned only in his history, and erroneously at that, and was not mentioned in any findings or impressions. Hanspal reported that the plaintiff still needed to undergo a lumbar puncture and serum rheumatology studies. She prescribed the muscle relaxant Baclofen to treat the plaintiff's muscle spasms, and continued him on methylprednisolone. The lumbar puncture was administered that day, and the analysis of cerebrospinal fluid was negative for any disease.

After following up with the plaintiff on July 18, 2017 and July 19, 2017, Hanspal ordered an MRI scan of the plaintiff's thoracic spine on July 20, 2017, which, according to the AMC defendants, revealed no significant pathology and otherwise was normal. Hanspal allegedly told the plaintiff and his father that transverse myelitis caused by neuromyelitis optica was suspected, but that other inflammatory causes were possible. Although the AMC defendants asserted that the results of the plaintiff's neurologic examinations continued to "fluctuate," they recommended that he begin a regimen of intravenous immunoglobulin (IVIg) while waiting for other tests to be administered, and the results of those tests had been received. On July 21, 2017, the AMC defendants began to administer IVIg to treat suspected transverse myelitis.

On July 24, 2017, Hanspal reported that the plaintiff had responded well to the steroid and IVIg therapies, with improved movement of his legs, but that he still had sensory loss in his legs, greater on the left than on the right. According to the AMC defendants, blood serum testing for neuromyelitis optica was negative. Hanspal formulated a plan to refer the plaintiff for short-term physical rehabilitation. On July 26, 2017, Hanspal reported that the plaintiff continued to improve because of the IVIg therapy, but also memorialized her conclusion that the plaintiff had transaminitis (unusually high levels of liver enzymes in the blood), with upward

trending liver function tests, which Hanspal concluded was likely related to the administration of IVIg. A July 27, 2017 test for the Epstein-Barr virus was negative, and Hanspal reported mild improvement in the plaintiff's dorsiflexion. On July 28, 2017, Hanspal reported that the plaintiff had improved movement in his left foot, continued the administration of Baclofen and the anxiolytic drug Valium, and approved him for discharge within a few days. On July 31, 2017, Hanspal examined and treated the plaintiff for the final time, at which time AMC's neurology department reported that the plaintiff showed significant improvement.

On August 1, 2017, at AMC, the defendant neurologist Gerber saw the plaintiff for the first time. Gerber included transverse myelitis caused by neuromyelitis optica, as well as central nervous system vasculitis, in his differential diagnosis. Gerber concluded that the testing of cerebrospinal fluid from the lumbar puncture ruled out an infection as the cause of the plaintiff's symptoms, and that no rheumatological cause of the plaintiff's symptoms and condition had been discovered through blood tests. Gerber expressed his belief that, notwithstanding the fact that the plaintiff's blood serum test results were negative for markers suggestive of neuromyelitis optica, the plaintiff suffered from that disorder. That same date, the plaintiff was discharged to AMC's inpatient rehabilitation unit, with a plan to have him follow up with AMC's neurology department on an outpatient basis.

Between August 1, 2017 and August 30, 2017, the plaintiff underwent daily physical therapy at AMC's inpatient rehabilitation unit. According to the AMC defendants, upon his discharge from that unit, he was able, with "setup," to perform his activities of daily living independently, was able to walk more than 300 feet using a rolling walker with supervision, and could climb four stairs with supervision. He was discharged to his home on August 30, 2017.

On September 3, 2017, the plaintiff presented to AMC's emergency department with worsening leg spasms, after allegedly forgetting to take the Baclofen and neuro-painkiller Gabapentin that had been prescribed to him. AMC emergency personnel gave the plaintiff the nonsteroidal anti-inflammatory drug ibuprofen, as well as the anxiolytic Valium, and reported

that he showed significant improvement. He was discharged to his home on that date. On September 9, 2017, the plaintiff again presented to the AMC emergency department, complaining of radiating right leg pain, and health-care personnel examined him. According to AMC's records, the examination was consistent with neuropathic pains and muscle spasms. AMC personnel thus recommended that the doses of Gabapentin and Baclofen be increased.

On September 20, 2017, the plaintiff again saw Gerber, who reported a 50% improvement in the plaintiff's ability to walk after his IVIg and steroid treatments, and asserted that he discussed his findings with respect to the plaintiff's MRI scan and blood test results with the plaintiff and his father. According to Gerber, the central location of the plaintiff's lesion was highly suggestive of neuromyelitis optica, and he claimed to have discussed with the plaintiff the possibility that he had monophasic transverse myelitis, as opposed to a potentially recurring disease, such as neuromyelitis optica, which produces the condition of transverse myelitis. Gerber allegedly reported to the plaintiff on this visit that testing had been negative for neuromyelitis optica, but that this testing might have generated a false negative result, and conceded that the prior testing of the plaintiff's cerebrospinal fluid had not included an analysis of oligoclonal banding, which might have revealed the presence of neuromyelitis optica or multiple sclerosis, as well as and other neurological and blood diseases.

According to the AMC defendants, the plaintiff informed Gerber that he had scheduled an appointment at NYPH to obtain a second opinion, and that he was thinking of also scheduling an appointment at Johns Hopkins Hospital (JHH) in Baltimore, Maryland. Gerber recommended that the plaintiff obtain myelin oligodendrocyte glycoprotein (MOG) blood testing to determine whether the plaintiff was suffering from an inflammatory demyelinating disease such as neuromyelitis optica, and that he repeat the testing for Aquaporin-4 to determine whether that protein was present at higher levels than those detected upon prior testing, which also would be suggestive of neuromyelitis optica. Even in the absence of results from those further tests, Gerber's assessment was that the plaintiff suffered from neuromyelitis optica.

Gerber referred the plaintiff for a urology consultation due to the plaintiff's complaints of urinary urgency. According to the AMC defendants, the plaintiff requested to be treated with the monoclonal antibody drug Rituximab, which is employed to treat certain autoimmune diseases. Gerber prescribed the treatment, but asked plaintiff to consider waiting until he obtained the second opinion that he was seeking. Gerber directed the plaintiff to return in six weeks.

On September 25, 2017, the plaintiff presented to AMC with increased painful spasms and weakness in his lower extremities, along with new painful spasms and weakness in his upper extremities and chest, and he was readmitted to AMC as an inpatient for spasm control. AMC's records reflected that an MRI scan of the spine, taken upon the plaintiff's readmission, showed disc desiccation at the L5/S1 interspace, along with a small posterior annular tear centrally at the midline. The new MRI scan of the spine reportedly depicted the same lesion that previously had been seen on the July 15, 2017 scan in the cervical region of the spine. On September 26, 2017, AMC personnel completed an admission history and a physical examination which, according to AMC's records, reported that he had new spasms affecting his chest, upper extremities, and the right side of his forehead. At that time, the plaintiff had no changes to his vision, complaining only of low-grade, general headaches that had occurred sporadically over the prior several days, and which usually had responded to ibuprofen.

AMC's charts indicated that Gerber would be contacted for updates on any diagnostic findings and to give him the opportunity to order any additional studies. On September 27, 2017, the defendant neurologist Durphy evaluated the plaintiff, and reported her impression that he had transverse myelitis, based, among other things, on the new cervical MRI findings and a brain MRI scan depicting one focal lesion. She ordered further IVIg therapy and Rituximab in light of that assessment, and also due to the failure of the steroid therapy to improve the plaintiff's condition. She ordered another MRI scan of the brain, purportedly to rule out brain involvement as a cause of the plaintiff's symptoms. While at AMC during this admission, the plaintiff underwent another lumbar puncture, and his cerebrospinal fluid was tested, but the

results were not immediately available. On September 28, 2017, Durphy again evaluated the plaintiff, and continued with the treatment that she previously had ordered. On September 29, 2017, Durphy evaluated the plaintiff, noting that he was scheduled to follow up with Gerber as an outpatient for his second dose of IVIg and Rituximab. On September 30, 2017, the defendant neurologist Molho assessed the plaintiff, who, according to the AMC defendants, reported that the weakness in his arm had abated somewhat. It was only after Molho saw the plaintiff that the results of the new cerebrospinal fluid testing were obtained, which showed negative results both for neuromyelitis optica and the presence of oligoclonal banding, which, as noted above, may be an indicator either of multiple sclerosis or neuromyelitis optica. On October 1, 2017, Molho again assessed the plaintiff, who reportedly complained of severe leg spasms, after which Molho adjusted the dosages of his then-current medications. The AMC defendants formulated a plan that consisted of inpatient rehabilitation for the plaintiff upon his discharge from AMC, and the continuation of Rituximab therapy.

On October 4, 2017, the plaintiff was transferred to the defendant rehabilitation center, Sunnyview, where he remained until October 27, 2017. During that interval, the plaintiff underwent inpatient rehabilitation therapy to improve his lower extremity strength and for pain management. On October 6, 2017, Sunnyview's attending physiatrist, Lynne T. Nicolson, M.D., consulted with the defendant neurologist Chowdhrey, who was affiliated with Ellis Hospital (Ellis) in Schenectady, New York. Chowdhrey recorded the plaintiff's recent diagnosis and treatments, and, upon examination, reported that his muscle strength was 4+ out of 5 in the bilateral arms, 1 out of 5 in the right leg, and 0 out of 5 in the left leg. Chowdhrey's assessment was transverse myelitis paraplegia, and he concluded that the plaintiff had received appropriate treatment. Chowdhrey formulated a plan that included no acute intervention, but that did include the continuation of physical therapy, pain medications, and muscle relaxants, adding that repeat IVIg treatment in four to six weeks could be considered if the plaintiff remained at Sunnyview or if he could follow up and be treated as an outpatient at Ellis. On or about October 20, 2017, the

plaintiff experienced a decline in his overall strength. On October 24, 2017, MRI scans of the plaintiff's brain and cervical spine were obtained at Sunnyview, which reportedly revealed unchanged findings that allegedly were consistent with the working diagnosis of transverse myelitis. On October 27, 2017, after the plaintiff evinced signs of respiratory distress and upper extremity weakness, Sunnyview transferred the plaintiff to Ellis's emergency department. Upon examination of the plaintiff, health-care providers at Ellis reported that he displayed diminished strength in his upper extremities that was not then present in his lower extremities, while his sensation was present in both his upper and lower extremities. In light of the plaintiff's sudden respiratory deterioration, however, Ellis placed him on a bilateral positive airway pressure (BPAP) ventilator, and thereafter intubated him. On that date, Ellis transferred the plaintiff to AMC's neurological intensive care unit (ICU).

Despite the fact that prior cerebrospinal fluid testing had been negative for neuromyelitis optica, AMC's working diagnosis upon the plaintiff's new readmission continued to be transverse myelitis, with a likely etiology of neuromyelitis optica, which the AMC defendants claimed to have based on the lesions that they had seen on MRI imaging. The plaintiff was successfully extubated at AMC after 48 hours, and then received an additional five-day regimen of IVIg, although that therapy produced minimal improvement in his developing lower extremity weakness. A November 1, 2017 MRI scan of the plaintiff's spine showed no new lesions, while the AMC defendants described the condition of his spine as "grossly stable since July 15, 2017," with no new areas of demyelination or enhancement. On November 2, 2017, AMC personnel conducted yet another lumbar puncture in order to test the plaintiff's cerebrospinal fluid. The tests yielded negative results for both neuromyelitis optica and the oligoclonal banding, as well as for meningitis and viral encephalitis. According to the AMC defendants, the etiology of the plaintiff's alleged transverse myelitis was "still unclear," and they thus took computed tomography (CT) scans of the plaintiff's chest, abdomen, and pelvis to ascertain the source of his inflammation and the mass seen on the various MRIs.

On November 3, 2017, AMC personnel, purportedly to treat transverse myelitis, began a five-day regimen of plasmapheresis (also known as plasma exchange or PLEX) treatment, in which the plaintiff's blood was extracted a little at a time, his blood plasma was separated from the blood cells present in the extracted blood to remove any extra or harmful antibodies, abnormal proteins, or other harmful substances therein, another liquid was mixed with the blood cells, and the new mixture was transfused back into the plaintiff's circulatory system. On November 11, 2017 and November 13, 2017, Durphy assessed the plaintiff, and continued his other ongoing treatments. On November 13, 2017, the plaintiff was again transferred to AMC's inpatient rehabilitation unit to improve the strength and function of his extremities.

On November 17, 2017, the plaintiff attended a neurology team meeting with Gerber and AMC resident neurologist Lisa M. Deuel, M.D., who formulated a plan involving repeat MRIs and PLEX treatment every 15 days, which allegedly was the treatment plan recommended by the defendant neurologist Perumal at NYPH, who had provided the plaintiff with the second opinion that he had sought after reviewing all of this records and test results. On November 18, 2017, the plaintiff underwent an MRI of his cervical spine, and the readings remained unchanged from his prior MRIs. Gerber purportedly requested a consultation with another physician to assess the possibility of a neurologic manifestation of sarcoidosis. On November 21, 2017, AMC pulmonologist Marc Judson, M.D., evaluated the plaintiff's case, and reported that the plaintiff evinced a clinical presentation that was "quite atypical" for neurosarcoidosis, with "no clear extra-neural evidence." Although Dr. Judson apparently concluded that this level of evidence was inadequate to pursue such a diagnosis, he nonetheless ordered various tests, as well as an ophthalmologic exam. On November 22, 2017, Gerber requested a neuroradiology review of the MRIs to identify any evidence of sarcoidosis. On November 23, 2017, Gerber memorialized a consultation with the AMC neuroradiology department for the purpose of reviewing the MRIs of the brain and spine, which reflected that neuroradiologists at AMC found that, inasmuch as

the lesion was expansile, and there were no definitive lesions consistent with neurosarcoidosis, there remained a question as to whether the lesion could be tumor or a vascular malformation.

On November 27, 2017, a neurology follow-up note in the plaintiff's AMC chart stated that the plaintiff reported no improvement since his PLEX therapy on November 24, 2017. Hence, AMC physicians recommended one PLEX treatment for the next day, with continuing PLEX treatments once per week thereafter. On that same date, the AMC neurology team ordered a myelin associated glycoprotein (MAG) antibody test. On November 28, 2017, physicians in AMC's pulmonology department expressed their continued doubt that plaintiff had neurosarcoidosis, and concluded that a biopsy was the only way to rule out that diagnosis, with Gerber asserting that he wanted the biopsy to be performed. In any event, AMC formulated a plan for continued PLEX therapy. A December 1, 2017 MRI of the plaintiff's cervical spine revealed an increased associated postcontrast enhancement compared to the November 18, 2017 scan, which AMC physicians reported as consistent with their working diagnosis of "transverse myelitis, without improvement." On December 5, 2017, NYPH's Perumal suggested that, given the lack of any improvement, the plaintiff should be administered Cytoxan, a drug indicated for leukemia, lymphomas, and nephrotic syndrome. Gerber thus discussed, with an AMC neuroradiologist, an evaluation for possible astrocytoma, after which AMC's neurologists consulted with the defendant neurosurgeon Adamo. On December 7, 2017, Adamo evaluated the plaintiff to determine whether there was an indication for a biopsy to rule out astrocytoma. On December 11, 2017, AMC's ophthalmology department ruled out optic neuritis. On December 18, 2017, the plaintiff's MAG antibody test proved to be negative.

Gerber then recommended a spinal biopsy for diagnostic purposes, but the AMC neurosurgery department recommended that the plaintiff first undergo another MRI of the cervical region of his spine. A December 19, 2017 cervical spine MRI scan reportedly remained unchanged from the previous scan. AMC physicians wrote that these continued findings might reflect neuromyelitis optica, but they did not rule out "other etiologies" at that juncture. The

imaging report, however, indicated that there were no abnormal flow voids within the cervical spine to suggest a vascular malformation. On December 20, 2017, Adamo and the plaintiff discussed whether a C4-5 laminectomy to facilitate a spinal cord biopsy was warranted. According to the AMC defendants, the plaintiff stated at that time that he felt that he was slowly improving and, therefore, he was unsure if he wanted to proceed with that procedure. An AMC nurse wrote in the plaintiff's chart that Adamo accessed the three most recent MRI scans, showed them to the plaintiff, and explained in detail the reasons why he had concluded that a spinal cord biopsy was warranted. On December 21, 2017, the plaintiff allegedly gave Adamo his consent to that procedure. On December 22, 2017, the plaintiff was transferred and admitted to AMC's inpatient facility for the spinal biopsy. On December 22, 2017, Adamo performed a C4-5 laminectomy for a spinal cord biopsy, performed the biopsy itself, and ordered additional spinal MRI scans. According to the AMC defendants, the biopsy revealed no evidence of a neoplastic, demyelination, or any other specific inflammatory and/or infectious process. AMC physicians thereafter administered another five-day course of PLEX therapy.

Adamo ordered yet another spinal MRI on January 2, 2018, which the AMC defendants alleged "showed an essentially stable mildly expansile T2 signal." On January 4, 2018, Murnane, who again was the neurologist on call, evaluated the plaintiff, and memorialized his conclusion that the plaintiff was suffering from multilevel transverse myelitis of unclear etiology, and that neuromyelitis optica remained a possible cause of the condition despite negative antibody blood and spinal fluid testing with respect to that disease. Murnane planned to speak with Gerber as to whether there was any indication for further Rituximab treatment after the five-day course of PLEX therapy had been completed.

On January 5, 2018, Murnane evaluated the plaintiff and determined that he should continue with PLEX therapy while awaiting the pathology results from the biopsy. On January 8, 2018, Murnane again evaluated the plaintiff, expressed his conclusion that there was a possible plan for monthly PLEX treatment, and allegedly informed the plaintiff that he was stable for

discharge to rehabilitation, a conclusion that Murnane acted upon after further evaluating the plaintiff on January 10, 2018, when he determined that the plaintiff no longer needed inpatient care. Murnane continued to follow the patient on January 11, 2018 and January 12, 2018. Murnane next evaluated the plaintiff on January 14, 2018, after which Murnane reported that it was unclear if the plaintiff's abdominal numbness was related to the spinal cord biopsy. Murnane evaluated the plaintiff an additional time on June 15, 2018, after which the plaintiff and his family met with Gerber later that day, who planned for the plaintiff to have a consultation with the AMC neurosurgery department to discuss a possible spinal angiogram. After Murnane again evaluated the plaintiff on January 16, 2018, he concluded that the plaintiff remained "clinically unchanged" with transverse myelitis, and noted that a transfer to a rehabilitation center was pending. The AMC neurology department reported, on January 17, 2018, that, upon review of the plaintiff's most recent MRI scan, there was no clear evidence of vascular/flow voids sufficient to warrant performing a spinal angiogram at that time. Murnane thereupon concluded that the plaintiff would receive PLEX therapy every three to four weeks. A January 18, 2018 MRI scan of the cervical spine showed expansion and a diffuse T2 cord signal, which, according to the AMC defendants, represented "progression" compared to the January 2, 2018 MRI scan because the signal extended below the T1-2 disc level.

On January 19, 2018, AMC readmitted the plaintiff to its rehabilitation department, with a plan to maintain the plaintiff on IVIg therapy once every three to four weeks, with consideration of the administration of Cytoxan, and a two-week trial of inpatient rehabilitation services to determine whether there would be any evidence of neurological improvement. The plaintiff remained at AMC until February 3, 2018, at which time Gerber arranged for the plaintiff to be admitted to JHH in Baltimore for further investigation of his condition.

Upon the plaintiff's admission to JHH on February 3, 2018 for evaluation of cervical myelopathy, JHH medical staff contacted several of his AMC physicians to discuss his condition, while JHH neurologists and neuroimmunologists met with the plaintiff, and

recommended that the plaintiff continue with PLEX therapy. The initial diagnosis of JHH medical personnel was likely neuromyelitis optica spectrum disorder. The JHH plan included MRI imaging of the brain and the cervical and thoracic regions of the plaintiff's spine. On February 7, 2018, JHH neurologist Ahmet Hoke, M.D., wrote in the plaintiff's chart that JHH "updated primary neurologist in Albany Dr. Gerber . . . and discussed his previous extensive work up and management at the outside hospital which includes Spinal biopsy (undiagnostic) in the past and management with several runs of PLEX, regardless of the management the patient's lesions has been growing which made them refer the patient here." JHH personnel thus made further recommendations, including the administration of Cytoxan following an MRI scan, and a possible continued course of PLEX therapy. An MRI scan taken at JHH reportedly revealed "confluent expansile T2 [signal] hyper-intensity throughout cervical spinal cord," but the imaging report purportedly noted that, upon comparison with earlier scans, the cervical spinal cord was deemed to be "stable." According to the AMC defendants, a vascular cause of the plaintiff's symptoms, such as dural arteriovenous fistula, was, at that juncture, deemed to be "highly unlikely" in light of the location of the plaintiff's lesion, as seen on various scans, and, hence, that JHH personnel deemed a spinal angiogram then to be unnecessary. JHH's plan continued to include PLEX treatments prior to consideration of Cytoxan. The plaintiff ultimately underwent a regimen of PLEX therapy consisting of seven weekly sessions.

A JHH neuro-immunology progress note dated February 8, 2018 indicated that JHH physicians discussed the plaintiff's case at an internal conference, at which they reported that causes of the plaintiff's symptoms that they characterized as "unlikely" would only be actively considered as part of the differential diagnosed if "enough red flags" manifested themselves prior to commencing the administration of Cytoxan. JHH personnel recommended that the plaintiff undergo a full-body positron emission tomography (PET) scan to evaluate him for systemic malignancy, advised the plaintiff to undergo a cerebral angiogram to "rule out arteriovenous fistula" as an etiology of the plaintiff's symptoms, "despite the lesion location and

degree of cord expansion making a vascular cause less likely,” and directed the continuation of PLEX therapy, pending the outcome of the PET scan.

A February 8, 2018 a PET scan at JHH revealed no evidence of malignancy, although the scan was consistent with transverse myelitis. JHH personnel reviewed the plaintiff’s prior MRI imaging studies from November 1, 2017 (cervical spine/brain), December 1, 2017 (cervical spine/thoracic spine/brain), and January 18, 2018 (cervical spine), and determined that those scans were “consistent with” transverse myelitis on the neuromyelitis optica “spectrum.”

According to the AMC defendants, there was little change in the plaintiff’s condition until the end of February 2018, when he developed worsening upper extremity symptoms. As they characterized it, on February 28, 2018, a repeat MRI scan of the plaintiff’s cervical spine at JHH revealed persistent abnormal signal intensity and expansion of the cervical spine, with slightly worsening diffused enhancement of the cord. On March 1, 2018, JHH medical personnel expressed their consideration that an angiogram and possible repeat biopsy might be indicated.

On March 2, 2018, as part of their ongoing differential diagnosis, the JHH neurosurgery department identified either a tumor or transverse myelitis as likely diagnoses, although there is no indication that they considered the etiology of the transverse myelitis. During the discussion of the plaintiff’s case, a JHH physician suggested at that time that arteriovenous fistula might be the actual etiology, and ordered the plaintiff to undergo a cerebral angiogram later that day. The cerebral angiogram revealed the presence of a dural arteriovenous fistula, located within the dorsum sellae of the plaintiff’s brain, which JHH medical personnel classified as a Merland-Cognard Type V fistula, which correlated venous drainage patterns with an increasingly aggressive neurological clinical course, and “stratified” the risk of intracerebral hemorrhage. On March 7, 2018, the plaintiff thus underwent sub-occipital craniectomy procedure, involving clipping and resection, which JHH personnel characterized as a “risky, last ditch effort to prevent further deterioration” in the plaintiff’s condition. According to the AMC defendants, the plaintiff tolerated the procedure without complication.

On March 15, 2018, the plaintiff was transferred to Kessler Institute for Rehabilitation (Kessler) in New Jersey, at which time he manifested diminished bilateral lower extremity strength, with weak reflexes and only some sensation. After remaining at Kessler for approximately seven months, the plaintiff was discharged to his home, but as of November 23, 2018, he became an outpatient at Burke Rehabilitation Hospital (Burke) in White Plains, New York, until at least November 12, 2019. The final available note from the Burke chart recited that the plaintiff was then suffering from “chronic spastic tetraplegia as the result of an arteriovenous fistula with persistent deficits in ambulation, performance of activities of daily living, and functional mobility,” and that he was at that time “being managed by outpatient neurology, and his pump settings are appropriate,” with his spasticity examination as of that date characterized as “stable and actually improved.” Nonetheless, Burke internist and physiatrist Benjamin J. Seidel, D.O., noted that there was “evidence of bilateral cubital tunnel syndrome and ulnar neuropathies bilaterally.”

### III. THE PLAINTIFF’S CONTENTIONS

In his complaint, the plaintiff alleged that all of the defendants departed from good and accepted medical practice, in that they negligently performed neurological evaluations and incorrectly diagnosed him with transverse myelitis and neuromyelitis optica, after which he underwent months of treatment with different neurological therapies including, but not limited to, administration of IVIg immunoglobulin and steroids, physical therapy, occupational therapy, PLEX therapy, spinal tap, spinal biopsy, and MRI and CT scans. He asserted that the testing did not, in fact, reveal the presence of transverse myelitis or neuromyelitis optica, and that the treatments provided him with no relief, but instead made his condition worse.

The plaintiff further averred in his complaint that the defendants’ failure timely and properly to diagnose, evaluate, test, and treat him for arteriovenous fistula, including the failure seriously to consider that condition in any differential diagnosis, along with their failure to rule out intraspinal, dural, subdural, arachnoid, and subarachnoid bleeding, constituted a departure

from good and accepted practice that caused his condition to deteriorate and deprived him of an opportunity for a cure or better outcome. As he characterized it, the defendants' failure to

“timely and/or properly rule out atriovenous [sic] malformation, the failure to timely and/or properly provide angiogram, the failure to timely and/or properly thoroughly evaluate plaintiff’s condition. the failure to timely and/or properly provide nonsurgical medical management, the failure to timely and/or properly provide interventional treatment, the failure to timely and/or properly provide neurologic treatment, the failure to timely and/or properly provide neurosurgical and medical care and treatment, the failure to timely and/or properly provide radiographic imaging and examinations, the failure to timely and/or properly provide neuro-radiographic imaging and examination, improperly prescribing immunoglobulin medication, improperly prescribing steroid medication. the failure to provide complete differential diagnosis prior to discharge and/or transfer, the failure to timely and/or properly advise, suggest and/or recommend angiogram testing, the failure to timely and/or properly provide conventional treatment, the failure to timely and/or properly appreciate, recognize, consider. rule out, and/or treat impending atriovenous fistula, the failure to timely and/or properly adhere to the standards established in the neurological treatment and evaluation, the failure to timely and/or properly perform indicated noninvasive imaging prior to performing spinal biopsy,”

caused him to sustain hemiplegia, paraplegia, paralysis, paresthesia, aphasia, incontinence, cognitive impairment, neurological injury, brain damage, and humiliation. The plaintiff further asserted that he consequently became bound to a wheelchair and bed.

The plaintiff further asserted that, after misdiagnosing him with transverse myelitis and neuromyelitis optica, the defendants failed to obtain his fully informed consent to the numerous diagnostic testing regimens and pharmaceutical and blood therapies that they administered to him, inasmuch as they neglected to advise him of the likely risks and benefits of those regimens and treatments, or any alternatives thereto. As he asserted in his complaint,

“[s]pecifically, defendants failed to adequately and properly inform the plaintiff that immunoglobulin therapy is used in autoimmune diseases as a distractor to prevent the body's natural immune system from attacking itself, and that a tell-tale sign of the disease not being autoimmune is a lack of symptomatic effects or improvements with the administration of immunoglobulin therapy and/or steroids therapy and despite this clear indication, defendants continued to administer immunoglobulin therapy and/or steroid therapy treatment for approximately seven months without any other alternative treatment and/or therapy. Additionally, angiogram testing for atriovenous fistula and/or atriovenous malformation was not provided as an option to plaintiff.”

In connection with all of the institutional defendants, the plaintiff also asserted in his complaint that they negligently hired, retained, trained, certified, and supervised various medical and nursing personnel, and that this negligence caused or contributed to his injuries.

In the plaintiff's bills of particulars, he essentially reiterated the allegations set forth in his complaint, and also alleged generally that the defendants failed to comply with the applicable standards of care in taking his medical history, examining him, ordering diagnostic testing, formulating a differential diagnosis, diagnosing him, and treating him. In this respect, the plaintiff contended that the defendants failed

“to timely and/or properly suspect, detect, diagnose and/or treat plaintiff's . . . conditions including, but not limited to, paralysis, transient neurological inflammatory attacks, vascular insult, physical and/or neurological deterioration; in failing to properly administer and/or adequately provide neurological testing, vasculature testing and/or evaluation, surgical repair of blood vessel bleed into the central nervous system, and/or other medications and/or appropriate surgical treatments; in failing to properly and/or adequately use radioimaging devices, CT scans, CT angiogram and/or arteriogram, ultrasounds, MRIs, Dopplers and/or other imaging devices; in failing to utilize appropriate medications; in failing to properly appreciate the sign and/or symptoms of blood vessel hemorrhaging; in failing to timely and/or properly appreciate the risk of potentially fatal bleeding; in failing to supervise, instruct and/or train its staff, nurses and attendings in appropriate and proper care of a patient with the signs, symptoms and/or complaints made by the plaintiff; [and] in failing to conform to the Joint Commission of Accreditation of Hospitals insofar as the making and maintaining of hospital records.”

In addition, the plaintiff asserted that the defendants failed to test for, prevent, and treat temporary cerebral blood vessel occlusion, blood clots, and thromboembolism, and failed to order, recommend, or utilize certain blood tests, scanning protocols, or anticoagulant therapy.

As a consequence of these alleged departures from good and accepted medical practice, the plaintiff alleged that he was caused to sustain or undergo brain damage, multiple surgeries, hemiplegia, paralysis, paraplegia, aphasia, aphagia, neuritis, emotional pain and suffering, physical pain and suffering, dyspnea, demyelination of peripheral and central nerve cells, dysphasia, dysphagia, bilateral lower extremity weakness, fatigue, bowel and bladder incontinence, severe cognitive impairment and deficiencies, the inability to ambulate, scarring,

disfigurement, and various neurological injuries, along with sequelae to all of those conditions.

He further averred that he is now compelled to employ a wheelchair to move around.

#### IV. THE SUMMARY JUDGMENT MOTIONS

##### A. THE AMC DEFENDANTS (SEQ 002)

In support of their motion, the AMC defendants submitted the pleadings, the plaintiff's bills of particulars, the parties' deposition transcripts, relevant medical records, a statement of material facts, the note of issue, an attorney's affirmation, the expert affidavit of internist, neurologist, and psychiatrist Benjamin M. Greenberg, M.D., and the expert affidavit of surgeon and neurosurgeon Harold J. Pikus, M.D.

Dr. Greenberg opined that none of the AMC defendants departed from good and accepted practice in examining or treating the plaintiff, and that nothing that they did or did not do caused or contributed to any of the plaintiff's injuries. He explained that transverse myelitis is the term employed to describe the inflammation of the spinal cord, and that that condition can cause damage and a variety of symptoms, including numbness and weakness in a patient's arms and legs, dysfunction of the bowel or bladder, and possibly back and neck pain. He further explained that neuromyelitis optica may be the underlying cause of transverse myelitis, which he characterized as autoimmune condition in which abnormal antibodies bind to cells within the nervous system, and "initiate a cascade of events that lead to significant damage," particularly in the spinal cord and optic nerves. As Dr. Greenberg explained it,

"[b]ecause it is accepted that there are undiscovered forms of this condition for which the autoantibodies have not yet been discovered, a negative NMO-IgG [test] does not rule out the diagnosis. Some patients may have alternate abnormal antibodies that cause the same symptoms while some other patients may actually harbor the NMO-IgG but have a false negative test result. Had the plaintiff tested positive for NMO-IgG it would have been diagnostic. Thus, the standard of care is to highly consider NMO in the appropriate setting and treat patients with the plaintiff's constellation of symptoms as if they had NMO assuming no other etiology has been discovered."

He further asserted that when neuromyelitis optica produces symptoms of transverse myelitis, some common signs and symptoms are weakness, numbness, pain, or tight and painful muscle

spasms in the arms and legs, and increased sensitivity to cold and heat, with imaging often revealing evidence of significant inflammation of the spinal cord. Dr. Greenberg further asserted that treatment for neuromyelitis optica usually includes corticosteroids, PLEX therapy, and IVIg. Importantly, Dr. Greenberg explained that, generally, “*if a patient responds to treatment* and there is no other obvious cause of the symptoms,” a patient meeting these criteria will be considered to have a clinical diagnosis of neuromyelitis optica “even in the absence of positive blood test for the NMO-IgG” markers (emphasis added).

Dr. Greenberg then described the criteria for suspecting and diagnosing arteriovenous fistula, and conceded that the plaintiff had a Merland-Cognard Type V Fistula located within the dorsum sellae of his brain that caused the swelling of his spine. He characterized an arteriovenous fistula in the brain that caused symptomology in the spine as “an extremely rare occurrence” that many practitioners may never have seen.

Dr. Greenberg opined that it was appropriate for the AMC defendants to have suspected neuromyelitis optica as a cause of the plaintiff’s symptoms, both in light of his symptoms, his initial response to steroids, and his improvement upon rehabilitation. He further concluded that, inasmuch as subsequent treatment with IVIg and Rituximab “somewhat improved” the plaintiff’s condition, “mostly in his upper extremities,” an initial working diagnosis of neuromyelitis optica was proper and within the standard of care. Dr. Greenberg also asserted that, since the AMC defendants thereafter treated him with PLEX therapy, additional IVIg therapy, and additional rehabilitation therapy, and those treatments take several weeks before they could be evaluated for effectiveness, it was within the standard of care for the AMC defendants to wait and see whether there was any therapeutic value to those treatments before performing additional testing or altering their working diagnosis. After those treatments did not display much therapeutic value or confirm the diagnosis of neuromyelitis optica, Dr. Greenberg opined that it was appropriate for Gerber to have considered a possible vascular cause and have suggested a spinal angiogram, and proper for the AMC neurosurgery department to conclude that the risks

of that procedure outweighed the potential benefits, “given that there were no vascular abnormalities observed on prior MRIs,” and that the likelihood of the suspected transverse myelitis having been caused by an arteriovenous fistula was “extremely low.” He thus concluded that the

“work up was methodical, deliberate, thought out and appropriate. The unfortunate fact is, is that the plaintiff had a condition of which almost no physician can claim to have seen or treated. It cannot be understated how rare it is that an AVF in the brain caused symptoms in the spine. It is my opinion within a reasonable degree of medical certainty that Dr. Gerber timely considered a spinal angiogram on January 15, 2017 and thereafter appropriately deferred to the decision not to perform the angiogram by Neurosurgery.”

Dr. Greenberg also concluded as well that all of the care rendered by Hanspal, Murnane, Durphy and Molho were within the standard of care.

Dr. Greenberg asserted, moreover, that JHH is renowned for its work in assessing, evaluating, and treating arteriovenous fistulas and that, after the plaintiff was transferred to JHH after six and a half months of care by the AMC defendants, even JHH’s physicians did not diagnose an arteriovenous fistula but, instead, essentially reiterated the conclusion that some type of condition on the neuromyelitis optica spectrum likely was responsible for the plaintiff’s continued symptoms and lack of improvement. He noted specifically that, even though JHH physicians did consider that arteriovenous fistula might have been a cause of the plaintiff’s condition when he arrived there, they considered it highly unlikely, and its personnel neither performed a spinal angiogram to rule it out nor diagnosed it upon his arrival. According to Dr. Greenberg, these facts underscore the rarity of the plaintiff’s condition, and why the AMC defendants did not depart from good and accepted practice by ranking arteriovenous fistula quite low on various differential diagnoses, or commencing testing for that condition as early as the plaintiff now claims was warranted. As he characterized it, it was only after the plaintiff had undergone one month of unsuccessful additional treatment and investigation at JHH that “a cerebral angiogram was considered as a ‘final thought’” that ultimately revealed an arteriovenous fistula in his brain that produced symptoms in his spine and extremities.

With respect to Gerber's involvement in the plaintiff's care, Dr. Greenberg averred that, in light of the findings on the plaintiff's spinal cord MRIs, Gerber appropriately identified neuromyelitis optica in the differential diagnosis as the most likely etiology of the plaintiff's symptoms, as those symptoms were consistent with that disease and were without another apparent cause. Hence, Dr. Greenberg asserted that it was appropriate for Gerber to treat the plaintiff for myelitis secondary to neuromyelitis optica. Inasmuch as Dr. Greenberg concluded that the standard treatment for myelitis caused by neuromyelitis optica included steroids, he averred that those drugs were appropriately administered, and opined that the plaintiff demonstrated some improvement after treatment therewith. He thus further opined that it was appropriate for Gerber to recommend inpatient rehabilitation to the plaintiff after the plaintiff had positively responded to steroid and IVIg therapy while admitted to AMC. Moreover, Dr. Greenberg opined that the plaintiff's slight improvement in ambulating after steroid and IVIg therapy would have made it even less likely at that juncture for any physician, including Gerber, to suspect arteriovenous fistula as an etiology.

As Dr. Greenberg continued to explain, Gerber

"appropriately continued to investigate the cause of the plaintiff's symptoms when he visited the [AMC] Neurology Clinic on September 20, 2017. Dr. Gerber appropriately ordered additional and repeat NMO antibody tests in an attempt to definitively rule in an NMO spectrum disorder. As is set forth above, these tests cannot rule out an NMO spectrum disorder. . . . Dr. Gerber appropriately agreed to cooperate with the plaintiff's desire for a second opinion. It is my opinion that, as of this point, the plaintiff had responded to treatment for NMO and his symptoms were essentially stable so continued physical therapy was an appropriate recommendation."

In addition, Dr. Greenberg concluded that, since Gerber's continued identification of neuromyelitis optica as the most likely cause of the plaintiff's symptoms was justified, it was appropriate to prescribe Rituximab as an alternative treatment modality when those symptoms did not abate.

Dr. Greenberg opined that, after the plaintiff had been administered PLEX therapy, and had been readmitted to the AMC inpatient rehabilitation department, it was appropriate for

Gerber to assume that the plaintiff suffered from a neuromyelitis optica spectrum disorder, and to continue further PLEX therapy. He asserted that such an approach “continue[d] to demonstrate the step by step clinical judgment being used in treating the plaintiff’s symptoms while attempting to rule in and out various causes,” specifically because PLEX therapy was an appropriate course of treatment for neuromyelitis optica disorders. Inasmuch as the plaintiff’s November 18, 2017 imaging revealed what Dr. Greenberg referred to as “a stable spinal lesion,” he concluded that Gerber “continued to appropriately attempt to discover the cause of the plaintiff’s lesion by having neuro-radiology inspect the radiology for signs of neurosarcoidosis,” even though that condition ultimately was ruled out. Dr. Greenberg further concluded that Gerber ordered appropriate testing to rule out cancer as a cause, even though it was an unlikely one. Once both neurosarcoidosis and cancer were ruled out, according to Dr. Greenberg, it was appropriate for Gerber to continue to adhere to his working diagnosis of neuromyelitis optica, and to continue the plaintiff on PLEX therapy.

Moreover, Dr. Greenberg averred that, once a neurosurgeon read the AMC neuroradiology department’s January 17, 2018 imaging, and determined that a spinal angiogram was not warranted because there were no obvious signs of vascular disease, it was within the standard of care for Gerber to rely on that recommendation. Specifically, he opined that, inasmuch as Gerber did not himself perform angiograms, it was appropriate for a neurologist such as Gerber to rely on the expertise of a neurosurgeon to review the available clinical, radiologic, and pathologic information, weigh the risks and benefits of performing a spinal angiogram, and determine whether the risks outweighed the benefits.

Dr. Greenberg opined that Gerber thereafter appropriately continued the plaintiff on PLEX therapy, and properly referred him to JHH for a further work-up.

With respect to Hanspal, Dr. Greenberg noted that she only treated the plaintiff during his first admission to AMC in July 2017, at which time she appropriately “appreciated” the plaintiff’s transverse myelitis on imaging, appropriately considered neuromyelitis optica,

transverse myelitis, and central nervous system vasculitis in her differential diagnosis, ordered the appropriate blood tests to rule in or out various conditions, and appropriately ordered a lumbar puncture in an effort to ascertain the cause of the plaintiff's complaints. According to Dr. Greenberg, Hanspal's administration of steroids to the plaintiff was appropriate "given the plaintiff's TM." He asserted that Hanspal had no medical obligation to consider or order a spinal angiogram to evaluate and diagnose the plaintiff's condition.

As to Murnane, Dr. Greenberg asserted that he treated the plaintiff only in July 2017, when the plaintiff first presented to AMC, and in January 2018, during the plaintiff's last interaction with the AMC defendants. He averred that, for the same reasons as he gave for concluding that Hanspal did not depart from good practice, Murnane did not depart as well, inasmuch as all of the care that Murnane rendered in July 2017 was appropriate, and that Murnane never had an obligation to consider ordering a spinal angiogram at that time. Moreover, Dr. Greenberg explained that, by the time that Murnane again was involved in the plaintiff's care and treatment in January 2018, Murnane properly and appropriately carried forward Gerber's treatment plan, which had included steroid, IVIg, and PLEX therapy, as well as numerous serial radiology studies of the plaintiff's spine, multiple lumbar punctures, and a spinal biopsy, all of which were based on an appropriate working diagnosis of neuromyelitis optica.

In connection with the care that Durphy rendered to the plaintiff on several occasions in September and November 2017, Dr. Greenberg opined that she satisfied the appropriate standard of care, inasmuch as she properly reviewed the September 25, 2017 MRI scans, "appreciated" the plaintiff's transverse myelitis, and recommended proper treatment in conjunction with Gerber, including IVIg and Rituximab therapy. In addition, Dr. Greenberg concluded that Durphy properly and appropriately developed a plan to administer a second lumbar puncture to evaluate the plaintiff's cerebrospinal fluid. Inasmuch as Dr. Greenberg concluded that the plaintiff was stable for inpatient rehabilitation in November 2017, he further opined that Durphy appropriately treated the plaintiff on the two days that she saw him that

month, and that there were no different treatments, tests, or studies that she was obligated to have ordered. Rather, because Dr. Greenberg asserted that the working diagnosis of neuromyelitis optica remained appropriate at that juncture, he concluded that Durphy properly continued to treat the plaintiff with PLEX therapy and physical rehabilitation.

Dr. Greenberg further was of the opinion that Molho provided appropriate care to the plaintiff on September 30, 2017 and October 1, 2017, inasmuch as he properly continued with Gerber's treatment plan.

In addition, Dr. Greenberg explicitly rejected the allegations set forth in the plaintiff's bill of particulars that, as a consequence of any care rendered by the AMC defendants, the plaintiff sustained a hemorrhage, including a stroke, or a rupture of the arteriovenous fistula. Hence, he asserted that the AMC defendants could not be held liable for failing to order blood testing to track international normalized ratio, activated partial thromboplastin time, or partial thromboplastin time values, all of which are tests to evaluate a patient for a stroke or hemorrhage. With respect to considering whether the plaintiff suffered from an arteriovenous fistula during 2017, Dr. Greenberg expressly asserted that the mere presence of red blood cells in the plaintiff's cerebrospinal fluid "should not lead a clinician to consider the presence of an AVF in a patient's brain." Rather, he alleged that the plaintiff misunderstood the nature of his injury, and contended that the presence of red blood cells in the plaintiff's cerebrospinal fluid after the lumbar puncture was normal since bleeding occurs, of necessity, when the puncture is made. Moreover, Dr. Greenberg asserted that the absence of polymorphonuclear cells in the cerebrospinal fluid "should not have raised suspicion in the clinicians that the plaintiff had an AVF in his brain or obligated the ordering of an angiogram," as those cells are present only where there is an infection or inflammation, and the mere absence of infection or inflammation should not lead a clinician to suspect an arteriovenous fistula.

Dr. Greenberg further opined that the consent to all of the treatments and testing that the AMC defendants obtained from the plaintiff was qualitatively sufficient, and that all of the AMC personnel who treated the plaintiff were properly hired, retained, trained, and certified.

In his affidavit, Dr. Pikus opined that Adamo did not depart from good and accepted medical practice in treating the plaintiff. He agreed with Dr. Greenberg that neurologists do not perform spinal cord biopsies, but, rather, rely on a neurosurgeon to obtain bone samples from the spine for pathological interpretation. Dr. Pikus noted that the plaintiff's treating neurologists requested that Adamo consult with the plaintiff for the sole purpose of performing the spinal cord biopsy, and that the neurologists' role was to determine whether there was a good reason *not* to perform the biopsy. He concluded that the spinal cord biopsy was "not an unnecessary procedure as alleged by plaintiff," since there had been no definitive diagnosis of the plaintiff at the time that the biopsy was ordered, and the biopsy constituted the "next reasonable step" in formulating a diagnosis. Dr. Pikus opined that Adamo properly performed the biopsy after obtaining a qualitatively sufficient, fully informed consent from the plaintiff for that procedure. Moreover, Dr. Pikus further concluded that the plaintiff sustained no injury as a consequence of the procedure, inasmuch as the cause of the plaintiff's complaints of some thoracic/abdominal numbness many days after the procedure was "unclear," and, had there been a problem at the biopsy location, it would have affected the plaintiff's hands and arms more than his torso and legs, while the plaintiff made no complaints about his hands and arms.

Dr. Pikus further asserted that, based on the plaintiff's presenting complaints, and the extensive testing performed by AMC medical personnel, there would have been no diagnostic value in performing a spinal angiogram while he was under the care of those physicians. As he described it,

"[w]e know now that the plaintiff's AVF, causing damage to his spinal cord, was located intracranially. An intracranial AVF almost always causes venous backpressure into the cranial venous system. These dilated veins are commonly visible on MRI and commonly cause problems within the brain, due either to venous congestion or hemorrhage. It is extraordinarily rare for a cranial AVF to

cause only spinal issues. Thus, there was no obligation on behalf of the clinicians at AMC in January 2018 to have recommended or performed a cerebral angiogram. As per the analysis regarding the rationale for spinal angiography, the MRI's had shown no abnormal flow voids or evidence of an AVF in the brain or spine."

Dr. Pikus averred that the risks of performing such angiograms outweighed the benefits at that time.

#### B. SUNNYVIEW (SEQ 003)

In support of its motion, Sunnyview submitted the pleadings, bills of particulars addressed to it, relevant medical records, an attorney's affirmation, and the expert affirmation of board-certified psychiatrist, neurologist, and vascular neurologist Feliks Koyfman, M.D. Dr. Koyfman opined that no Sunnyview medical or health-care personnel departed from good and accepted practice. After explaining the plaintiff's diagnosis and treatment at AMC, the nature of transverse myelitis, and the appropriate treatments therefor, Dr. Koyfman opined that no one at Sunnyview negligently failed to suspect, consider, test for, or diagnose the etiology of the plaintiff's transverse myelitis including, but not limited to, an arteriovenous fistula. As he explained it, "[t]hat was not SUNNYVIEW's role in plaintiff's care. SUNNYVIEW's role in plaintiff's care was to provide rehabilitative care. SUNNYVIEW was not an acute care facility for diagnostic purposes." Dr. Koyfman also rejected the plaintiff's claim that Sunnyview personnel negligently administered intravenous steroids. He asserted that the plaintiff's attending physician at Sunnyview, physiatrist Lynne T. Nicolson, M.D., properly consulted with neurologist Chowdhrey, who recommended continuation of the steroid therapy. He further rejected the plaintiff's contention that Sunnyview failed to provide the plaintiff with appropriate follow-up care after the administration of intravenous steroids, and properly treated him when he complained of headaches and respiratory issues by transferring him to Ellis for acute care.

#### C. THE NYPH DEFENDANTS (SEQ 004)

In support of their motion, the NYPH defendants submitted the same documents as did the AMC defendants and Sunnyview, along with an attorney's affirmation and the expert

affidavit of board-certified neurologist, psychiatrist, and internist Joseph R. Berger, M.D. Dr. Berger opined that Perumal fulfilled her obligation as a consultant by providing the patient with a second opinion report, “with the specific understanding agreed to by the patient that Dr. Perumal had not taken on the role of treating physician,” because Perumal’s acts were consistent with good and accepted standards of medical and neurological practice, and that no act or omission on the part of either Perumal or NYPH caused or contributed to the plaintiff’s alleged injuries.

Dr. Berger explained that, in response to a request for a second opinion that she received from a physician referral service known as Grand Rounds, Perumal rendered such an opinion, that she relied solely on the plaintiff’s existing medical records, and that she never personally examined, ordered testing for, or treated the plaintiff. In fact, as Dr. Berger described it, the plaintiff cancelled an October 24, 2017 appointment to meet in person with Perumal, and never rescheduled it. According to Dr. Berger, the plaintiff had been advised of the process and the limited purpose of the Grand Rounds second opinion report, and specifically was advised that this “remote consult did NOT establish a patient physician relationship,” which the plaintiff allegedly agreed to by executing forms that Grand Rounds had prepared.

Dr. Berger opined that the medical charts that had been generated up until the time when Perumal reviewed the plaintiff’s case, including the examinations, testing, imaging, and treatment responses of the plaintiff, were wholly consistent with transverse myelitis and a neuroinflammatory disorder. He explained that, although the findings in the initial July 2017 MRIs were “nonspecific,” in light of the “extensive findings of demyelination throughout the cervical and thoracic spinal cord,” it was believed that this reflected the sequela of demyelination. Inasmuch as there was no change in the imaging over a period of seven months, and the neuroradiologists who interpreted the spinal MRIs “did not comment on vascular disorders,” Dr. Berger averred that Perumal reasonably relied on the MRI reports in preparing her report, particularly in light of the fact that JHH specialists had also initially determined there was no vascular abnormality seen on the MRI results from AMC. He further

contended that Perumal reasonably relied on and interpreted the laboratory testing results in her possession, including cerebrospinal testing, which he characterized as “values that are of little import in supporting or refuting any potential etiologies” of the plaintiff’s symptoms.

Dr. Berger thus concluded that, based on the information available to her at the time that she wrote her second opinion report between July and September 2017, Perumal’s recommendations were wholly appropriate. In this respect, he noted that, based on the medical records that Perumal reviewed, she properly considered causes of the plaintiff’s symptoms other than neuromyelitis optica, including:

“systemic lupus erythematosus and other connective tissue disorders, Lyme disease, Sjogren’s disease, Behçet’s disease, and others [and] appropriately recommended additional follow up imaging including CTs and repeat MRIs; testing for the human T-lymphotropic virus, and a repeat NMO IgG lab test to determine the etiology of Mr. Goldstein’s disorder. She also appropriately recommended corticosteroids, the first line of treatment for inflammatory diseases, and IVIG, to be considered by the patient’s treatment team in the event of any acute relapses. Dr. Perumal appropriately concluded that a definitive cause for Mr. Goldstein’s myelopathy had yet to be determined.”

According to Dr. Berger, Perumal correctly recommended that, to the extent that the plaintiff was not responding to steroid treatment, PLEX and IVIg therapy should be considered, along with diagnostic MRI imaging at reasonable intervals to evaluate any change in the plaintiff’s condition, as well as the administration of Rituximab in the event that he had recurrent disease.

Moreover, Dr. Berger stated that, since Perumal never ordered, nor was in a position to order, any workup for the plaintiff, or to assist in managing his care in Albany, and was not provided with any relevant medical records or additional data after issuing her initial impression, she cannot be held liable for any alleged failure to order further workups or make additional recommendations based on information post-dating her report.

Dr. Berger also explained that Gerber “acknowledged” that he did not initiate a request that Perumal provide a second opinion or a written report, but only that it was Gerber’s decision whether to consider Perumal’s second opinion in formulating his treatment plan. As it turned out, Gerber nonetheless agreed with Perumal’s recommendations, but, as Dr. Berger

interpreted the medical records, Gerber did not affirmatively alter the plaintiff's treatment based on Perumal's report, and would have elected the treatment protocol ultimately developed at AMC regardless of Perumal's opinions. Hence, Dr. Berger asserted that Perumal cannot be held liable for any alleged negligence committed by any of the AMC defendants. Dr. Berger nonetheless opined that, "[t]o the extent that Dr. Gerber testified he relied on Dr. Perumal's recommendation for repeat MRIs and PLEX, these recommendations were wholly appropriate and within the standard of care for all of the reasons set forth above."

Dr. Berger concluded that,

"[a]s there was no evidence of clinical or radiographic progression of Mr. Goldstein's disease process from the time of Dr. Perumal's Second Opinion Report in October 2017 through the time of her last e-mail exchange with Mr. Goldstein on December 19, 2017, Mr. Goldstein's course of treatment or his outcome would not have been different had the dural AVF been diagnosed at the time of Dr. Perumal's Second Opinion Report in October 2017, or even as of her last e-mail exchange/correspondence with Mr. Goldstein on December 19, 2017. Whether the dural AVF had been diagnosed in October 2017, or even by December 19, 2017, Mr. Goldstein would have undergone the same surgical procedure including a dural AVF resection/left suboccipital craniectomy for closure of the fistula."

With respect to the lack of informed consent claim against Perumal, Dr. Berger explained that, inasmuch as she did not order any particular treatment, and was not in a position to do so, she did not need to obtain the plaintiff's informed consent to any invasive testing or treatment regimen. He also expressly rejected the basis for the plaintiff's negligent hiring, retention, and training cause of action against NYPH, asserting that all of the medical personnel involved in evaluating the plaintiff's case were properly trained and credentialed.

#### D. CHOWDHREY (SEQ 005)

In support of his motion, Chowdhrey submitted a statement of allegedly undisputed material facts, an attorney's affirmation, a memorandum of law, and several medical records that already had been submitted by the AMC defendants, Sunnyview, and the NYPH defendants, as well as the expert affirmation of internist and board-certified psychiatrist and neurologist Alexander E. Merkler, M.D., M.S., who specializes in neurocritical care. Dr. Merkler

opined that Chowdhrey did not depart from good and accepted medical practice in evaluating the plaintiff's condition while the plaintiff was at Sunnyview or Ellis, and that nothing that Chowdhrey did or did not do caused or contributed to the plaintiff's injuries.

As Dr. Merkler explained it, Chowdhrey, a neurologist, was available on call on behalf of Sunnyview to provide neurological input with respect to a patient's rehabilitation therapy. He stated that, in that capacity, Chowdhrey did not provide acute care to patients, but only supplemental treatment in the context of physical therapy and other rehabilitation modalities. Dr. Merkler asserted that, if a rehabilitation patient required acute care, "the patient would be transferred from the rehab center to an acute care facility." Thus, Dr. Merkler explained that, when the plaintiff reported increased neck and shoulder pain and weakness on October 6, 2017, Chowdhrey was consulted by Sunnyview's in-house physiatrist, Dr. Nicolson, but that this consultation did not require or involve the reassessment or additional workup of the plaintiff to determine whether Chowdhrey agreed or disagreed with the working diagnosis of transverse myelitis. Rather, according to Dr. Merkler, Chowdhrey was consulting with Dr. Nicolson only with respect to the deterioration of the plaintiff's condition and adverse change in symptoms. Thus, although Chowdhrey agreed with other physicians' opinions as to the continuation of steroid therapy, and this type of treatment is not usually administered in a rehabilitation setting, Dr. Merkler concluded that it properly was ordered for the plaintiff after the plaintiff and Dr. Nicolson communicated with his primary treating neurologists at AMC.

Dr. Merkler opined that, in cases where the cause of transverse myelitis is found to be a dural arteriovenous fistula, it usually is diagnosed due to some attributable finding on MRI studies, such as imaging of slow voids and abnormal vessels in the spinal cord. Inasmuch as all of the physicians who examined and treated the plaintiff in 2017 noted that those types of findings were absent from the MRI studies conducted prior to Chowdhrey's involvement, Dr. Merkler concluded that there was no clear radiological information that would have supported a request for further workup of the plaintiff at Sunnyview.

Thus, according to Dr. Merkler, since Chowdhrey was not the investigating physician, he did not have the capacity or authority to overrule the decision for acute treatment in a rehabilitation setting. In this respect, Dr. Merkler opined that the standard of care did not require Chowdhrey, as a physician consulting with other physicians at a rehabilitation facility, “to rework a diagnosis that has been ongoing as a result of extensive and thorough testing.” He further concluded that,

“at all times Dr. Chowdhrey complied with the standard of care, having performed a thorough examination for the reported complaints of the patient, and appropriately prescribing muscle relaxers to aid the patient in being more comfortable to engage in necessary therapies. This was all in a goal to prepare the patient for discharge and ultimately to ensure the patient is able to perform activities of daily living with limited assistance.”

Moreover, Dr. Merkler averred that, in connection with Chowdhrey’s consultation on October 6, 2017, “there were no additional findings, or significant changes in Mr. Goldstein’s presentation that required Dr. Chowdhrey to transfer the patient to acute care or perform any investigatory treatment” at that juncture.

With respect to Chowdhrey’s October 26, 2017 consultation, which was undertaken after the plaintiff’s condition had deteriorated at Sunnyview, Dr. Merkler opined that, after Chowdhrey examined the plaintiff, he properly ordered an additional five days of intravenous steroid therapy. Dr. Merkler further asserted that, as of that date, there were no indications that Chowdhrey should have transferred the plaintiff to an acute care facility.

#### E. THE PLAINTIFF’S OPPOSITION

The plaintiff opposed neither Sunnyview’s motion under sequence 003, nor Chowdhrey’s motion under sequence 005. He did, however, partially oppose the AMC defendants’ motion under sequence 002, and the NYPH defendants’ motion under sequence 004. In his opposition papers, the plaintiff relied on many of the same documents that had been submitted by the AMC and NYPH defendants, and he also submitted counter statements of fact, attorney’s affirmations, and the expert affirmation of a board-certified neurosurgeon, who allegedly had

examined and treated a number of patients with arteriovenous fistulas, and has regularly worked with neurologists. The plaintiff's expert did not address any alleged departures from accepted practice that allegedly had been committed by Adamo, Durphy, Murnane, or Molho, but addressed only such departures to the extent alleged against Hanspal, Gerber, AMC, and Perumal. Nor did he address the several defendants' experts' opinions with respect to the lack of informed consent and negligent hiring and retention causes of action.

The plaintiff's expert neurosurgeon opined that Hanspal, Gerber, and AMC deviated from good and accepted practice by failing adequately to investigate the etiology of the plaintiff's symptoms, despite three negative antibody tests for neuromyelitis optica. The extent of these failures, as alleged by the expert, included their failure to include arteriovenous fistula in their differential diagnoses, and their failure to order or perform an angiogram in a timely fashion to assess whether the plaintiff was suffering from arteriovenous fistula. The expert concluded that those deviations caused or contributed to the plaintiff's injuries. The expert further opined that Perumal, despite considering arteriovenous fistula when formulating her differential diagnosis, failed formally to include it in her report, and failed to recommend an angiogram in a timely manner. The plaintiff's expert further concluded that Gerber deviated from good and accepted practice by ordering steroid treatment, and Perumal deviated from good and accepted practice by recommending steroid treatment, despite the plaintiff's previous adverse reactions to such treatment, as well as the ongoing uncertainty as to his diagnosis, and that those deviations also were substantial contributing factors in causing those injuries.

The plaintiff's expert explained that, when the plaintiff was admitted to Sunnyview in October 2017, he experienced increased weakness in his extremities and respiratory distress shortly after having been administered intravenous steroids. The expert further characterized the plaintiff's reaction to IVIg and PLEX therapy as evincing "minimal improvement." As the expert characterized it, by the time that the plaintiff had been readmitted to AMC on November 13, 2017, and continuing through December 22, 2017,

“despite Dr. Gerber’s knowledge of Mr. Goldstein’s previous severe adverse reaction to steroids, Dr. Gerber believed that steroids were only relatively contraindicated, meaning that they could still be administered if the provider managing the care – here, Dr. Gerber – felt the benefits outweighed the risk . . . He also testified that Mr. Goldstein’s adverse reactions to steroids – treatments designed to target NMO – did not hold any significance to Dr. Gerber when determining the diagnosis of Mr. Goldstein’s condition . . .”

The plaintiff’s expert noted that a spinal cord biopsy performed at AMC already had ruled out a tumor, infection, and inflammation, was inconsistent with transverse myelitis and neuromyelitis optica, did not demonstrate a demyelinating process as would be seen in a patient with neuromyelitis optica or multiple sclerosis, and was “non-diagnostic” for arteriovenous fistula. According to the expert, JHH’s subsequently generated records reflected that the biopsy also “caused worsening of the patient’s status.” The expert neurosurgeon further noted that AMC’s Adamo had by then concluded that the cerebrospinal fluid studies and blood tests both had ruled out an inflammatory condition, that the AMC ophthalmology department had noted no optic nerve deterioration or optical symptoms associated with neuromyelitis optica, and that the treatments identified in Gerber’s treatment plan, which had been directed at transverse myelitis and neuromyelitis optica, were not working, instead causing the plaintiff to grow “clinically worse.” The expert explained that AMC physicians nonetheless still had not reached a definitive diagnosis by November and December 2017, and the differential diagnosis remained “idiopathic versus neuromyelitis optica versus multiple sclerosis,” while the December 21, 2017 transfer discharge summary questioned whether the cervical lesion “was truly transverse myelitis or whether there was another underlying etiology.”

The plaintiff’s expert further noted that an MRI taken on January 2, 2018, in fact, reflected the presence of congestive edema, which even Gerber noted could have been attributable to arteriovenous fistula, but that Gerber still did not investigate the possibilities of central nervous system vasculitis or arteriovenous fistula by means of an angiogram. The neurosurgeon also faulted Gerber for continuing to consider cancer as a possible cause, despite prior testing that had ruled it out from the differential diagnosis. While noting that Gerber finally

suggested on January 15, 2018 that an angiogram should be performed in order to investigate possible vascular malformation, the plaintiff's retained neurosurgeon faulted neurosurgeons at AMC for ultimately denying Gerber's request, despite the absence of a definitive diagnosis. The expert further criticized AMC's January 19, 2018 conclusion that the plaintiff's condition was "most consistent with neuromyelitis optica spectrum disorder," despite the "numerous negative NMO antibody tests, the normal findings on the Evoked Potential Test, the lack of ocular involvement, and his adverse reaction to steroid treatment designed to address NMO."

As the plaintiff's expert interpreted JHH's records, the report of a February 28, 2018 MRI taken at JHH found the imaging to be "unusual for neuromyelitis optica," and indicated that the scan depicted an "[u]nchanged evaluation of the brain with predominant signal intensity abnormality at the cervical medullary junction," which the expert characterized as "correspond[ing] with the MRI findings at St. Peters and AMC as early as July 2017." The plaintiff's expert suggested that, based on the February 28, 2018 MRI scan, JHH medical personnel determined to perform a cerebral angiogram two days later, which finally revealed the cause of the plaintiff's symptoms as a Merland-Cognard type V arteriovenous fistula. In addition, the expert asserted that JHH neurologist Michael Kornberg, M.D., confirmed, during a June 6, 2018 follow-up visit with the plaintiff at JHH, that the plaintiff's quadriparesis was secondary to the arteriovenous fistula, that imaging had shown progressive enlarging of the cervical lesion since July 2017, and that the plaintiff's condition had worsened beginning in July 2017 "despite many immunological therapies, including intravenous methylprednisolone, IVIG, plasmapheresis, and rituximab." Moreover, the expert noted that, when the plaintiff began treatment at Burke in November 2018, Burke internist and physiatrist Dr. Seidel summarized the patient's history, describing "longstanding neurologic issues from what was initially thought to be NMO," and reporting that, by the time that the arteriovenous fistula was identified and treated at JHH, "irreversible damage had already occurred to his cervical spinal cord."

The plaintiff's expert asserted that,

“[a]ll of Mr. Goldstein’s symptoms were consistent with an AVF, a fact confirmed by multiple defendants, including Dr. Gerber . . . , who testified that AV fistulas can affect strength, limb movement, and sensation, and Dr. Hanspal, . . . who testified that the symptomatology of AVF would be similar to TM if the AVF was located in the cervical spine. Consequently, it is my opinion, within a reasonable degree of medical certainty, that good and accepted practice required AVF be included within the differential diagnosis and be investigated via angiogram to either rule out or confirm AVF.

“ . . . Dr. Hanspal, Dr. Gerber, Dr. Perumal, and AMC deviated from good and accepted practice by failing to order, perform, or recommend an angiogram to investigate CNS vasculitis or AVF, which was a necessary diagnostic tool due to the ongoing uncertainty of Mr. Goldstein’s diagnosis, the inclusion (or inappropriate omission) of those conditions on the differential.”

The expert explained that the absence of blood flow voids on MRI imaging should not have led Hanspal, Gerber, or Perumal to rule out arteriovenous fistula as a cause of the plaintiff’s symptoms, and did “not negate the need for an angiogram for CNS vasculitis,” since even “prominent flow voids without other imaging are poorly predictive of AVF.” The expert neurosurgeon thus opined that the absence of abnormal findings related to flow voids should not have ruled out arteriovenous fistula, and that, inasmuch as other tests were negative for other conditions on the differential diagnosis, an angiogram to investigate the possibility of central nervous system vasculitis or arteriovenous fistula “was required by good and accepted practice.” The expert further opined that,

“[i]n addition, despite the relative invasiveness of an angiogram, it remained the appropriate diagnostic tool and should have been ordered. First, Mr. Goldstein underwent a spinal biopsy, which is a much more invasive and dangerous procedure than the angiogram. Second, a different non-invasive test called a CT angiogram could have been (and should have been) performed to check the blood vessels . . . Third, Mr. Goldstein was suffering from progressive paralysis, a severe condition that warranted the performance of an angiogram to identify its cause and treat it before it progressed further.”

The plaintiff’s expert neurosurgeon further concluded that the failure of Hanspal, Gerber, and AMC to include arteriovenous fistula in their differential diagnoses, and their concomitant failure to order an angiogram in a seasonable and timely fashion, which the expert asserted would have revealed the arteriovenous fistula in time to provide the plaintiff with treatment to

retard the spread of its deleterious effect, caused and contributed to the plaintiff's worsening condition and his permanent injuries. In this respect, the expert explained that,

“[t]he progressive injuries that developed during the delay in treatment of AVF from July 17, 2017 through the surgery on March 7, 2018 are confirmed by various medical records and testimony, including but not limited to the MRIs in January 2018 that both showed progression of the lesions . . . ; Dr. Murnane's note describing Mr. Goldstein's progressive leg weakness from July 2017 to January 2017 due to his worsening lesion . . . ; the MRI report history from January 2, 2017 describing new upper torso decreased sensation that as per Dr. Adamo developed after December 22, 2017 . . . ; the spinal biopsy record stating that Mr. Goldstein, 'continued to progress clinically in a negative manner' . . . ; the injuries suffered due to the biopsy . . . , which would not have been performed if the AVF [were] identified in a timely manner; Dr. Adamo's description of the worsening weakness in Mr. Goldstein's limbs that progressed over months . . . ; the additional injuries suffered as a result of the NMO/TM-directed steroid treatment at Sunnyview in October 2017, including respiratory distress requiring intubation, additional limb weakness, and core weakness detailed above,”

as well as by Guzda's testimony comparing the condition of the plaintiff in June 2017 with his condition in December 2018, Murnane's testimony describing worsening left hand weakness, a neurosurgery consultation record generated by JHH neurosurgeon Jennifer E. Kim, M.D., describing how the plaintiff's lower extremity weakness progressed to paraplegia and upper extremity weakness, with lower cranial nerve dysfunction and impaired respiratory drive, Dr. Kornberg's record from JHH describing quadriparesis as secondary to the arteriovenous fistula and observing that the cervical lesion had progressively been growing since July 2017 despite the administration of numerous immunological therapies, and Dr. Seidel's November 23, 2018 entry in the Burke chart describing the deterioration of the plaintiff's condition, as quoted above.

With respect to Perumal's involvement in reviewing the plaintiff's case, the plaintiff's expert asserted that, by preparing and providing a report recommending a diagnosis and course of treatment, good and accepted practice required Perumal to do so in a thoughtful and thorough manner, without omitting information such as the potential for arteriovenous malformation or arteriovenous fistula, or the need for an angiogram. The expert concluded that her failure to include in her report a recommendation for an angiogram or the differential diagnosis of those conditions constituted a deviation from good and accepted practice.

The expert noted that Perumal's involvement did not stop with the report, as she spoke with Sunnyview's Dr. Nicolson to arrive at a plan of care that included steroid treatment for transverse myelitis, Sunnyview followed her recommendations, and she also made specific recommendations and reassurances directly to the plaintiff. The plaintiff's expert thus concluded that good and accepted practice required Perumal to communicate a recommendation for an angiogram to evaluate the plaintiff for arteriovenous malformation or arteriovenous fistula, and that her failure to do constituted a deviation from good practice.

The plaintiff's expert expressly asserted that the fact that AMC's neurosurgeons recommended to Gerber that he forego ordering an angiogram did not alter his opinion. In this respect, the expert asserted that the standard of care required Gerber to seek the involvement of interventional radiologists, as they are eminently qualified to perform and interpret an angiogram. As the expert further explained it, if Gerber had requested the angiogram at an earlier date and was denied his request, the plaintiff

"would have been equipped with the necessary information to seek a second opinion or have the testing done elsewhere. His persistent pursuit of a diagnosis, including his engagement of Dr. Perumal and his attempts to transfer to Johns Hopkins, demonstrates that Mr. Goldstein was willing and able to seek outside medical help when he questioned the care provided by AMC's physicians."

Ultimately, the plaintiff's expert explicitly rejected the opinions of Drs. Greenberg, Pikus, and Berger as to how rare or unlikely it was for the plaintiff's cranial arteriovenous fistula to cause paralysis of the extremities and torso, whether the extent of rarity or unlikelihood in this case excused Hanspal, Gerber, AMC, and Perumal from considering that condition, testing for it, and ordering or recommending specific treatment for it, and whether that excused those defendants from pursuing therapies that were ineffective and harmful. The expert also rejected those experts' opinions that the plaintiff would have had the same course of deterioration had his condition been appropriately diagnosed in July through December 2017, and appropriate treatment had commenced during that period of time. The plaintiff's expert neurosurgeon further concluded that Perumal's role was more than that of a mere remote consultant.

The plaintiff's expert did not address the qualitative sufficiency of the consent given by the plaintiff to the defendants with respect to intravenous steroid, IVIg, and PLEX therapies, lumbar punctures, physical therapy regimens, and a spinal biopsy. The expert also did not address the defendants' experts' opinions with respect to whether any defendant departed from good and accepted practice by failing to consider or diagnose a hemorrhage or stroke, or order testing therefor. Nor did he comment upon whether AMC, NYPH, or Sunnyview negligently hired, retained, or credentialed any of the health-care providers involved in this action.

In reply, the AMC and NYPH defendants submitted attorneys' affirmations, in which counsel argued that the plaintiff's expert's opinions failed to raise a triable issue of fact as to the allegations of negligence and malpractice against Hanspal, Gerber, AMC, and Perumal, and that the opinions rendered by that expert were speculative, conclusory, and not supported by the medical records and testimony.

#### V. SUMMARY JUDGMENT STANDARDS

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see CPLR* 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie

showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

“The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even ‘arguable’” (*De Paris v Women's Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; see *Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

A. MEDICAL MALPRACTICE BASED ON ALLEGED DEPARTURES FROM GOOD PRACTICE

“To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury” (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Foster-Sturup v Long*, 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and such insufficient care or delay proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (see *Zabary v North Shore Hosp. in Plainview*, 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] [(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to

the level or standard of care expected of a physician in the community”]; *O’Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (see *Pullman v Silverman*, 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; see generally *Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (see *Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert’s opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant’s expert should specify “in what way” the patient’s treatment was proper and “elucidate the standard of care” (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant’s expert’s opinion must “explain ‘what defendant did and why’” (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff’s bill of particulars (see *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert’s affidavit or affirmation attesting to a

departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

The submissions of Sunnyview and Chowdhrey established their prima facie entitlement to judgment as a matter of law by demonstrating, through the medical records and their experts' affirmations, that they did not depart from good and accepted medical practice, and that nothing that they did or failed to do caused or exacerbated any neurological, vascular, or other injury to the plaintiff. Inasmuch as the plaintiff did not oppose their motions, he did not raise a triable issue of fact in opposition to their respective showings. Hence, summary judgment must be awarded to Sunnyview and Chowdhrey dismissing the medical malpractice cause of action insofar as asserted against them.

The AMC defendants made a prima facie showing, through their submission of the relevant medical records, deposition testimony, and their two expert affidavits, that Hanspal, Gerber, Adamo, Murnane, Durphy, Molho, and AMC did not depart from good and accepted practice. They further established that Albany Medical College had no involvement whatsoever in the treatment of the plaintiff, and that AMC Neurology Group was not an independent corporate or jural entity, but merely an unincorporated division or department of AMC that was

not amenable to suit in its own right (see *Sheldon v Kimberly-Clark Corp.*, 111 AD2d 912, 912 [2d Dept 1985]; *Playboy Enters. Intl., Inc. v Meredith Corp.*, 2020 NY Slip Op 34295[U], \*18, 2020 NY Misc LEXIS 10847, \*25 [Sup Ct, N.Y. County, Dec. 23, 2020]; see also *Chestnut v United Methodist Church*, \_\_\_\_\_AD3d\_\_\_\_\_, 2024 NY Slip Op 03726, \*7, 2024 NY App Div LEXIS 3781, \*25-26 [2d Dept, Jul. 10, 2024]; *Holtzman v KTB Athletics SB TM*, 113 AD3d 656, 656 [2d Dept 2014]). In addition, the AMC defendants established, prima facie, that the plaintiff did not sustain a stroke or hemorrhage and that, consequently, they could not be held liable for failing to order testing for, or failing to diagnose, such conditions.

Inasmuch as the plaintiff's expert did not address the AMC defendants' showings with respect to Adamo, Murnane, Durphy, and Molho, and the plaintiff made no arguments with respect to Albany Medical College and AMC Neurology Group, summary judgment must be awarded to those defendants dismissing the complaint insofar as asserted against them. The plaintiff, however, raised triable issues of fact as to whether Hanspal and Gerber departed from good and accepted medical practice in failing to include arteriovenous fistula in their differential diagnoses over a substantial period of time, in failing timely to order or perform a spinal angiogram, and in administering improper treatments, and whether those departures caused or contributed to his injuries. The plaintiff's neurosurgeon, in his affirmation, explicitly identified the manner in which those two defendants departed from good and accepted medical practice, and explicitly explained the way in which those departures caused or allowed the plaintiff's condition to worsen, and deprived him of an opportunity for a cure or a better outcome (see *Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). The expert did not, however, address the issue of stroke or hemorrhage. Consequently, those branches of the AMC defendants' motions seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Gerber and Hanspal are granted only to the extent of

dismissing any claim involving allegations arising from their alleged failure to test for or diagnose a stroke or hemorrhage, and those branches of the motion must otherwise be denied.

The NYPH defendants established Perumal's prima facie entitlement to judgment as a matter of law by demonstrating, with the relevant medical records, deposition testimony, and their expert's affidavit, that Perumal did not depart from good and accepted practice. The plaintiff, however, raised triable issues of fact as to whether Perumal departed from good and accepted practice in failing to memorialize, in her report, her consideration of arteriovenous fistula as part of her differential diagnosis, in concluding that the plaintiff likely suffered from neuromyelitis optica, and in recommending both to the plaintiff himself and to his primary care providers that they continue treating him for neuromyelitis optica. The court rejects the NYPH defendants' contention that the plaintiff and Perumal did not have a physician-patient relationship, notwithstanding the plaintiff's execution of a purported waiver form provided to him by the nonparty entity that referred him to Perumal. There is no dispute that Perumal affirmatively advised the plaintiff to continue his treatments for neuromyelitis optica, and that he reasonably relied on such advice, "such that an implied physician/patient relationship resulted between the parties" (*Rojas v McDonald*, 267 AD2d 130, 130 [1st Dept 1999]). Hence, that branch of the NYPH defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Perumal is granted only to the extent that, as with Gerber and Hanspal, claims based on her failure to test for or diagnose stroke and hemorrhage must be dismissed as against her. That branch of the motion is otherwise denied.

#### B. LACK OF INFORMED CONSENT

The elements of a cause of action to recover for lack of informed consent are:

"(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; see *Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; see CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; see *Lewis v Rutkovsky*, 153 AD3d at 456). In addition to invasive diagnostic testing arising from a failure properly to diagnose a medical condition, the administration of nonindicated medications arising from a misdiagnosis may also be the basis for a lack of informed consent cause of action (see *Lyons v Vassar Bros. Hosp.*, 30 AD3d 477, 478 [2d Dept 2006]). The plaintiff here alleged that the various defendants' failure to diagnose arteriovenous fistula caused them to perform numerous invasive diagnostic tests, administer intravenous drugs that were not indicated, and administer invasive PLEX therapy, and that the testing, drugs, and PLEX therapy caused or contributed to his injuries.

Nonetheless, all of the defendants who ordered or administered such testing, medications, and treatment established, prima facie, that the consent that they obtained from the plaintiff as to the risks and benefits thereof was qualitatively sufficient. Because the plaintiff's expert did not address the opinions of these defendants' experts, summary judgment

must be awarded to all of the moving defendants dismissing the lack of informed consent cause of action insofar as asserted against each of them.

C. NEGLIGENT HIRING, TRAINING, AND SUPERVISION

AMC, Sunnyview, and NYPH demonstrated that they neither “knew, [n]or should have known,” of their employees’ “propensity for the sort of conduct which caused the injury” (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; see *Kuhfeldt v. New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). Inasmuch as the plaintiff did not address this issue in his opposition papers, he failed to raise a triable issue of fact in opposition to those defendants’ prima facie showing in this regard. Hence, those branches of the institutional defendants’ motions seeking summary judgment dismissing the negligent hiring, training, and supervision claim must be granted.

D. VICARIOUS LIABILITY

“In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself” (*Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; see *Hill v St. Clare’s Hosp.*, 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2d Dept 2018]). Since Hanspal and Gerber were employed by AMC and assigned by AMC to care for the plaintiff, and the court has concluded that there are triable issues of fact as to whether those physicians departed from good and accepted medical practice, thus causing or contributing to the plaintiff’s injuries, that branch of the AMC defendants’ motion seeking summary judgment dismissing the complaint against AMC also must be denied to the extent that its liability is premised upon those physicians’ malpractice.

Although NYPH employed Perumal, the NYPH defendants established that, in the course of reviewing the plaintiff’s medical records, making recommendations to him and his

primary providers, and following up with him, Perumal was not acting in the course of her employment with NYPH, but rather acted solely as a physician to whom the plaintiff's case was referred by a third-party referral service. In opposition to that showing, the plaintiff did not address the issue. His expert did not express any opinions as to whether NYPH could be held liable for Perumal's negligence under the circumstances of this action, nor did the expert identify any independent acts of malpractice committed by any other NYPH employee. Hence, NYPH must be awarded summary judgment dismissing any claims asserted against it that were premised upon its purported vicarious liability for Perumal's conduct.

VI. CONCLUSION

In light of the foregoing, it is,

ORDERED that the motion of the defendants Era Hanspal, M.D., Allen Gerber, M.D., Matthew Adamo, M.D., Albany Medical Center, Albany Medical College, Matthew Murnane, M.D., AMC Neurology Group, Jennifer Durphy, M.D., and Eric Molho, M.D. (SEQ 002), is granted only to the extent that summary judgment is awarded:

- (a) to Matthew Adamo, M.D., Albany Medical College, AMC Neurology Group, Matthew Murnane, M.D., Jennifer Durphy, M.D., and Eric Molho, M.D., dismissing the entirety of the complaint insofar as asserted against each of them,
- (b) to Albany Medical Center dismissing the negligent hiring, retention, training, and supervision cause of action insofar as asserted against it, and
- (c) to Albany Medical Center, Era Hanspal, M.D., and Allen Gerber, M.D., dismissing the lack of informed consent cause of action insofar as asserted against them, and any claim against Albany Medical Center, Era Hanspal, M.D., and Allen Gerber, M.D., based on allegations that the plaintiff sustained a stroke or hemorrhage, or that those defendants should have administered blood tests to evaluate him for a stroke or hemorrhage,

and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the action is severed against Matthew Adamo, M.D., Albany Medical College, Matthew Murnane, M.D., AMC Neurology Group, Jennifer Durphy, M.D., and Eric Molho, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against Matthew Adamo, M.D., Albany Medical College, Matthew Murnane, M.D., AMC Neurology Group, Jennifer Durphy, M.D., and Eric Molho, M.D.; and it is further,

ORDERED that the motion of the defendant Sunnyview Hospital and Rehabilitation Center (SEQ 003) is granted, without opposition, and summary judgment is awarded to Sunnyview Hospital and Rehabilitation Center dismissing the complaint insofar as asserted against it; and it is further,

ORDERED that, on the court's own motion, the action is severed against Sunnyview Hospital and Rehabilitation Center; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against Sunnyview Hospital and Rehabilitation Center; and it is further,

ORDERED that the motion of the defendants Jai Perumal, M.D., and The New York Presbyterian Hospital (SEQ 004) is granted only to the extent that summary judgment is awarded:

- (a) to The New York Presbyterian Hospital dismissing the complaint insofar as asserted against it, and
- (b) to Jai Perumal, M.D., dismissing the lack of informed consent cause of action insofar as asserted against her, and any claim against her that was based on allegations that the plaintiff sustained a stroke or hemorrhage, or that she should have administered blood tests to evaluate him for a stroke or hemorrhage,

and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the action is severed against The New York Presbyterian Hospital; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against The New York Presbyterian Hospital; and it is further,

ORDERED that the motion of the defendant Naseer Chowdhrey, M.D. (SEQ 005), is granted, without opposition, and summary judgment is awarded to Naseer Chowdhrey, M.D., dismissing the complaint insofar as asserted against him; and it is further,

ORDERED that, on the court’s own motion, the action is severed against Naseer Chowdhrey, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against Naseer Chowdhrey, M.D.; and it is further,

ORDERED that that all remaining parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on November 12, 2024, at 11:00 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

JOHN J. KELLEY, J.S.C.

9/12/2024  
DATE

MOTION 002:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE
MOTION 003:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input checked="" type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE
MOTION 004:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE
MOTION 005:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input checked="" type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE