Belmonte v North Shore-Long Is. Jewish Health Sys., Inc.
2018 NY Slip Op 33468(U)
December 18, 2018
Supreme Court, Richmond County
Docket Number: 150180/2015
Judge: Thomas P. Aliotta
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND: PART C-2

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JOHN BELMONTE AND STACY BELMONTE, AS PARENTS AND NATURAL GUARDIANS OF BRANDON BELMONTE, AND JOHN BELMONTE AND STACY BELMONTE, INDIVIDUALLY,

Plaintiffs,

-against-

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., STATEN ISLAND UNIVERSITY HOSPITAL, EMERGENCY MEDICINE SERVICES OF STATEN ISLAND, P.C., JAMES KENNY, M.D., SIU-PUN CHAN, M.D., YASIR EL-SHERIF, M.D., NWANNEKA OKOLO, M.D. AND SABRINA DESTEFANO, D.O.,

Defendants.

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DECISION & ORDER

Index No.: 150180/2015
Motion Seq.: 002
003
004

Recitation, as required by CPLR 2219(a) of the following papers numbered were fully submitted on the 5th day of December 2018.

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Upon the foregoing papers, the motion for summary judgment by defendant YASIR EL-SHERIF, is denied in part and granted in part (MS_002); the motion by defendants, NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., STATEN ISLAND UNIVERSITY HOSPITAL, EMERGENCY MEDICINE SERVICES OF STATEN ISLAND, P.C., JAMES KENNY, M.D., SIU-PUN CHAN, M.D., AND SABRINA DESTEFANO, D.O. (hereinafter "NS-LIU defendants") is granted (MS_003); and the motion by defendant, NWANNEKA OKOLO, M.D., is granted (MS_004), as follows:[1]

On the morning of January 13, 2014, Brandon Belmonte did not feel well when he woke up at approximately 6:30 A.M. (BB, 22:23-25, 23:1-4).[2] He described his condition as "pale and sweaty" (BB, 23:11:16) and his sheets were "wet" (BB, 24:16-18). After going to the bathroom, Brandon spoke to his mother, Stacy Belmonte, in the living room (BB, 25:22-15, 26:1-19, 27:2-

[1] It is noted that the City of New York and Fire Department of the City of New York moved for summary judgment (MS_001). However, this action was discontinued by plaintiff after the service of the motion and granted without opposition as to all defendants by a separate short form order on December 5, 2018.

[2] The parenthesis refers to page and line numbers of Brandon Belmonte's deposition transcript annexed to the City's motion for summary judgment as Exhibit "I".

8).[3] His mother gave him ice for his forehead but does not remember if she took his temperature (BB, 27:5-24).[4] Brandon stayed home from school with his father, John Belmonte and his mom left for work (BB, 28:12-19).[5] Brandon does not remember seeing his father from the time he woke up until his mother left for work (BB, 29:14-16, 30:19-22).[6]

Brandon went back to sleep and awoke again at approximately 11:30 A.M. or 12:00 P.M. (BB, 31:15-17). He remembers walking to the refrigerator to get food, but not whether he was sweating or if the sheets were wet (BB, 33:1-13).[7] He walked back to his bedroom with only a sandwich and then returned to the kitchen for a water bottle (BB, 34:2-17). Upon returning to the kitchen, Brandon lost his balance and fell to the floor (BB, 34:21-25, 35:1-6). It was not until his father came upstairs [from the basement] that Brandon tried, but could not get up from the kitchen floor (BB, 39:2-7, 22-24, 40:3-5). On that day, Brandon weighed approximately 220 pounds at 5’11” tall (BB, 39:13-14). Brandon testified that his father helped him up, but that he does not specifically remember this happening (BB, 40:25, 41:1-3). The last memories Brandon has of that day are an inability to sit up straight because he kept falling over and then leaving for “Southside Hospital in Staten Island” (BB, 41:8-16, 43:20-23, 44:16-17). Brandon has no further memory of the events of January 13, 2014 (BB, 46:21-25, pp.47-48).

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[3] Stacy Belmonte testified that other than appearing pale and sweaty, she did not notice anything else unusual about Brandon that morning (SB, 25:15-25, 26:1). Stacy Belmonte’s deposition is annexed to the City’s motion for summary judgment as Exhibit “J”.

[4] Stacy Belmonte testified that she placed a wet wash cloth on his forehead (SB, 26:17-21).

[5] Stacy Belmonte left for work at approximately 7:30 A.M. (SB, 27:22-23).

[6] John Belmonte testified that he woke-up at approximately 9:30 A.M. or 10:00 A.M. that morning (JB, 10:11-14). Mr. Belmonte’s deposition transcript is annexed to the City’s motion for summary judgment as Exhibit “K”.

[7] The kitchen is approximately 20 to 25 feet from Brandon’s bedroom (JB, 13:1-4, 22:17-20).

Mr. Belmonte testified that his wife left him a note on the morning of January 13, 2014 that Brandon stayed home from school because he did not feel well, and that Mr. Belmonte should check on him (JB, 11:13-25). At approximately 10:45 A.M. to 11:00 A.M., Mr. Belmonte observed Brandon sleeping under the bed covers, without noticing anything unusual about his appearance or breathing, and then proceeded to the basement (JB, 12:1-4, 12:8-25, 14:10-17). Later, he heard Brandon walking from his bedroom to the kitchen when he heard a "big crash" accompanied by a "big thud" at approximately 11:20 A.M. or 11:30 A.M. (JB, p.16). Mr. Belmonte yelled to Brandon and having received no response, ran upstairs to find Brandon laying on the kitchen floor (JB, 17:2-8). Brandon was laying on his stomach and turning to his side trying to get up (JB, 24:12-22).

Mr. Belmonte observed that Brandon was trying to speak but could not get the words out (JB, 25:16-19). Mr. Belmonte was asking Brandon what was wrong, but Brandon could not respond and was "looking at me smiling, like, kind of weird" and could only shake his head in response to questions (JB, 27:1-9). Mr. Belmonte testified that Brandon felt like "dead weight" while trying to help him up with assistance from his daughter, Brianna (JB, 27:9-18). Brandon could not stand or sit up straight and kept falling over each time Mr. Belmonte tried to position his legs or "prop him up" on the couch (JB, 27:19-24). Mr. Belmonte called Mrs. Belmonte at approximately 11:30 A.M. to 12:00 P.M. about Brandon's condition that morning (JB, 28:9-25). They agreed to call Brandon's pediatrician, but receiving no answer, Mr. Belmonte called an ambulance (JB, 28:22-25, 29:1-5). He believes that the ambulance arrived some time between 12:15 P.M. to 12:30 P.M. (JB, 33:14-17). While waiting for the ambulance to arrive, Brianna was trying to hold Brandon in an upright position; his face was "droopy on one side"; and he only pointed to his head when Mr. Belmonte asked him what hurt (JB, 34:1-16). Mr. Belmonte

described Brandon's facial appearance as looking as if there was *"no movement on one side. It was, like, dead. Like the one side he'd have movement, he'd smile or laugh or look at you. The eye wouldn't move. The other eye would move, the one eye would blink, the other eye wouldn't blink"* (JB, 34:23-25, 35:1-2). Mrs. Belmonte arrived home and accompanied her son in the ambulance while Mr. Belmonte followed behind them (JB, 41:3-5, 45:8-20). To the best of his knowledge, Mrs. Belmonte provided all necessary information to the medical staff at the hospital (p.57-58).

According to Mrs. Belmonte, Brandon was awake and responsive while en route to the hospital but was going "in and out" of sleep, his left arm seemed weak and the left side of his face was drooping (SB, 38:1-17, 39:1-16). The ambulance driver advised Mrs. Belmonte that she had a choice of bringing Brandon either to Richmond University Medical Center or the South Site [Staten Island University Hospital] because its North Site was on "diversion" (SB, 41:3-10). She chose the South Site as she worked at this facility (SB, 41:9-10). Mrs. Belmonte understood "diversion" to mean that the hospital was full and did not have room for new patients (SB, 42:8-10) and the driver also informed her the North site was not an option (SB, 49:20-25, 50:1-2).

Joseph Figueroa and Salvatore Namio were the Emergency Medical Technicians who responded to Brandon's home (JF, 6:21-23, 7:6-8, 11:10-16).[8] According to Mr. Figueroa, a call was received at 12:44 [P.M.], dispatched at 12:44:12 and the ambulance was in route at 12:44:38 (JF, 15:18-25, 16:1-25). The ambulance arrived at 13:00, first contact with Brandon occurred at 13:00:56, departed for the hospital at 13:19:08 and arrived at 13:32:04 (JF, 17:1-17, 18:8-10).

[8] The parenthesis refers to page and line numbers of James Figueroa's deposition transcript annexed to the City's motion for summary judgment as Exhibit "O".

Figueroa and Namio assessed Brandon on the Glasgow Coma Scale and for medications (JF, 27:9:20). His chief complaints were dizziness, and weakness or general malaise for approximately five hours (JF, 28:4-12, 29:3-13).

Dr. James Kenny was Brandon's attending physician in the Emergency Room of Staten Island University Hospital's south site (JK, 10:15-19).[9] Upon admission, Brandon was nonverbal and unable to communicate his symptoms (JK, 11:12-24). A stroke code was activated for Brandon at 13:53 [1:53 P.M.] (JK, 23:10-12, 24:6-9). The stroke code ordered laboratory tests, a chest x-ray, an EKG, a CAT scan, an immediate neurology consultation, and the insertion of an intravenous into the patient for IV access (JK, 26:3-15). The stroke code was activated based upon the history obtained and Dr. Kenny's physical examination of Brandon (JK, 26:22-25, 27:1-4, 34:3-33). The physical examination revealed a stroke scale baseline of 11, consistent with a moderate stroke (JK, 28:25, pp.29-30). Dr. Kenny's examination was prompted by the physician's assistant who examined Brandon upon arrival and advised Dr. Kenny that he should quickly examine Brandon as he was lethargic, in moderate distress, poorly responsive, confused and exhibited left side paralysis (JK, pp.31-34).

Dr. Kenny spoke with Dr. Yasir El-Sherif, the neurologist, by telephone at 2:15 P.M. regarding the CT Scan results after speaking with the radiologist (JK, 39:7-13, 40:5-12). Upon learning Brandon's medical history (YE, pp.18-19),[10] Dr. El-Sherif advised Dr. Kenny that Brandon was not a candidate for tPA,[11] as the drug's data did not support administering it to

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[9] The parenthesis refers to page and line numbers of Dr. James Kenny's deposition transcript annexed to the City's motion for summary judgment as Exhibit "K".

[10] The parenthesis refers to the line and page number of Dr. Yasir El-Sherif's deposition transcript annexed to the City's motion for summary judgment as Exhibit "S".

[11] Tissue Plasminogen Activator, a "clot busting" drug (48:5-7).

pediatric patients and the onset of his symptoms was not entirely clear (JK, 41:10-19).[12] Dr. El-Sherif testified he was advised as follows,

> There was a young gentleman, 16 years of age, who arrived at the hospital, appeared to not be moving one side of the body. I then asked about the time last known well. We had a discussion. The family had said that he woke up feeling not well, around, seven in the morning. The mother had told him to go back to bed and then, around, 11:30 or so, the patient was found, by the father, not moving one side of the body. So, after that discussion, he said he was going to send him for a CAT scan and we would discuss after the CAT scan (19:4-19).
>
> The medical history provided by Dr. Kenny was "that he woke up no normal, not feeling normal at seven, and was asked to be kept out of school, and went back to bed, and then the next interaction was when his father found him on the floor" (YE, 44:8-17).

According to Dr. El-Sherif, there is no standard of care for treating a person under 18 years old with tPA (YE, 22:14-18). He also advised Dr. Kenny that he would call back after speaking with his colleagues as to the best course of care to administer to Brandon as he had suffered a stroke (JK, 47:6-15). The CT Scan was negative for intracranial bleeding, indicative of a non-hemorrhagic stroke (JK, 48:15-25, 49:1-2). At this juncture, the course of treatment was to be decided by the neurologist, not Dr. Kenny (JK, 49:3-9).[13] Dr. El-Sherif called back and advised that Brandon needed to be transferred to the hospital's north site for a stat MRI, MRA and MRV of the brain (JK, 49:10-25, 50:1-5, 52:2-18).[14] Based upon this conversation, Dr. Kenny placed a transport request at approximately 15:15 [3:15 P.M.] and Brandon departed by ambulance for the north site at 15:47 [3:47 P.M.] (JK, 52:1-18, 59:15-19). Dr. Kenny also

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[12] The physician's assistant, Mr. Flynn, noted at 14:02 [2:02 P.M.] that Brandon's symptoms started at 12:30 P.M. that day without prior symptoms of a stroke. However, Dr. Kenny's history from John and Stacy Belmonte revealed that Brandon was not well from the night before or early that morning. (65:17-25, 66:1-25).

[13] Dr. Kenny said that he could only administer TPA to a patient if authorized by a neurologist (JK, 47:22-24, 49:3-9, 98:21-25, 99:1-5).

[14] Staten Island University Hospital's south site did not have MRI equipment (14:20-22).

advised Dr. Heidi Baer, the emergency room physician at the north site, that Brandon needed an MRI, MRA and MRV (JK, 51:16-25, 81:18-25, 82:1-10). Dr. Kenny alerted Dr. Chan, the director of the Pediatric ICU at the north site, that Brandon was being transferred (JK, pp.83-84).

Dr. Sabrina DeStefano, the pediatric emergency room physician at the north site, spoke with Brandon and his mother (SD, 17:12-15, 18:4-9, 30:12-23).[15] According to the hospital records, Brandon arrived at the north site at approximately 15:47 or 3:47 P.M. (SD, 19:15-25, 20:1-4). It was Dr. DeStefano's understanding that Brandon was transferred to the north site to be admitted to the Pediatric Intensive Care Unit for additional imaging studies at the recommendation of the neurologist (SD, 35:7-25, 36:10-20). Based upon the notations in the pre-arrival notes regarding the stroke code, Dr. DeStefano contacted Dr. El-Sherif (SD, pp.37-40). The radiological studies were ordered at approximately 16:57 (4:57 P.M.) and performed at approximately 22:06 or 10:06 P.M. (SD, pp.40-42). It was her understanding that Dr. Si-Pun Chan was Brandon's attending physician in the pediatric intensive care unit (54:16:21).

According to Dr. Chan, he spoke with Dr. El-Sherif who confirmed that Brandon was not a candidate for tPA (SC, 10:5-19).[16] This conversation occurred while Dr. Chan was off-site at his outpatient office (SC, 40:9-25, 41:4-8). Dr. Chan arrived at the hospital between 5:15 P.M. and 5:30 P.M. and again spoke with Dr. El-Sherif about administering tPA (SC, 43:17-25, 44:1-2, 42:9-12). Dr. Chan deferred to the recommendation and opinion of Dr. El-Sherif, the neurologist (SC, 44:3-17). Based on this conversation, it was Dr. Chan's understanding that Dr. Nwanneka Okolo, the pediatric neurologist would be evaluating Brandon (SC, 47:14-25,

[15] The parenthesis refers to the line and page number of Dr. Sabrina DeStefano's deposition transcript annexed to the Dr. Okolo's motion for summary judgment as Exhibit "O".

[16] The parenthesis refers to the line and page number of Dr. Si-Pun Chan's deposition transcript annexed to Dr. Okolo's motion for summary judgment as Exhibit "N".

48:1-3). After consulting with Dr. DeStefano and Dr. Okolo, it was recommended that Doppler studies should be performed (SC, 63:3-19), which revealed a possible occlusion of the distal right internal carotid artery (SC, pp.112-114).

Dr. Okolo spoke with Dr. El-Sherif twice prior to Brandon's arrival at the north site (NO, 10:11-25, 11:1-7).[17] She was advised that a potential pediatric stroke patient was at the south site without further details (NO, 11:8-25, 12:1-14). Dr. Okolo had never recommended the administration of tPA for a pediatric patient (NO, 13:16-25, pp.14-15). Prior to Brandon's arrival, Dr. Okolo was neither informed that he suffered a stroke nor discussed the possibility of tPA (NO, 15:4-16; 15:15-18). According to Dr. Okolo, Brandon did not have a diagnosis at the time of transfer so there was no discussion as to treatment (NO, 17:1-9). Dr. Okolo did not have privileges [including telephone privileges] at the south site in 2014 because the site did not have a pediatric department (NO, 18:12-14, 19:6-13). In 2014, it was Dr. Okolo's understanding that the window for tPA in adults was three to three and one-half hours and she did not express an opinion to Dr. El-Sherif to not administer the drug to Brandon (NO, 20:21-25, 21:1-17). Dr. Chan contacted Dr. Okolo for a consult at approximately 6:30 P.M. and inquired about administering tPA but Dr. Okolo advised that Brandon was well outside the window (NO, 41:1-17, 45:21-25, 46:1-7). Dr. Chan also informed Dr. Okolo of the imaging results and Dr. Okolo recommended the possibility of surgical intervention (NO, 49:1-23), but the family advised they were seeking to transfer Brandon to NYU for any further treatment (NO, 50:1-16, 51:7-17). In 2014, the north site did not have pediatric neurosurgeons (NO, 51:18-21, 52:6-12).

[17] The parenthesis refers to the line and page number of Dr. Nwanneka Okolo's deposition transcript annexed to his motion for summary judgment as Exhibit "M".

Dr. El-Sherif has moved for summary judgment (MS_002) claiming he did not deviate from accepted standards of care and practice and, therefore, he was not the proximate cause of Brandon's injuries. After obtaining a history of symptoms, it was Dr. El-Sherif's decision not to administer tPA to a pediatric patient absent guidelines or protocol to do so, and even if Brandon could be considered a candidate, the window of opportunity to do so had closed. Dr. El-Sherif was also made aware of each incident that could form the basis of the determination to administer tPA, i.e., that Brandon was not feeling well at approximately 7:00 A.M. and was found on the floor at approximately 11:30 A.M. His decision would have been the same if he had personally examined Brandon.

The NS-LIU defendants have moved for summary judgment (MS_003) asserting that regardless of Brandon's "last known well time," he was exhibiting the symptoms of a stroke when he woke-up at 6:30 A.M. pale and sweating. Therefore, the window of opportunity to administer tPA closed more than 1.5 hours prior to his arrival at the hospital. However, assuming arguendo that the onset was at 11:30 A.M., the decision not to administer tPA at 2:15 P.M. was solely that of the neurologist thereby severing any causal relationship between the NS-LIU defendants at the south site and Brandon's injuries. Finally, assuming again that the window opened at 11:30 A.M., it closed within minutes of Brandon's arrived at the north site – 4:00 P.M. Accordingly, the NS-LIU defendants argue that as a matter of law, there was no deviation from accepted standards of care and practice at either the north or south site of the hospital.

Dr. Okolo moves for summary judgment (MS_004) joining in the same arguments as Dr. El-Sherif and the NS-LIU defendants. However, Dr. Okolo also asserts that as she did not have privileges, including by telephone, at the south site of Staten Island University Hospital, she

could not consult with Dr. El-Sherif or engage as to Brandon's care until he arrived at the north site. Once at the north site, Dr. Okolo was not notified of Brandon's arrival, could not locate him for a consult, and the doctor-patient relationship was not formed until 6:30 P.M. when he consulted with Dr. Chan for the first time. Dr. Okolo recommended the possibility of surgery but the parents decided to transfer Brandon for further care to NYU. Accordingly, Dr. Okolo argues that there was no deviation in care by her which proximately caused Brandon's injuries.

All defendants seek summary judgment on the remaining causes of action, lack of informed consent and the derivative cause of action.

In opposition, plaintiff argues that defendants are applying the wrong standard of care to administer tPA. Plaintiff argues that the window opens at the onset of the stroke symptoms, not the "last known well" time. Once the window opens, the outside time limit to administer the drug is 4.5 hours depending upon certain factors. Plaintiff's expert opines that the onset of the stroke symptoms was 11:30 A.M. when Brandon collapsed and, therefore, the window would have closed at approximately 4:00 P.M. Plaintiff has not opposed the motion for summary judgment on behalf of Dr. Chan and Dr. DeStefano, the doctors at the hospital's north site.

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury. Thus, on a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Faicco v. Golub,* 91 AD3d 817, 818 [2d Dept. 2012] [internal citations omitted]). However, conclusory allegations by a defendant's expert are insufficient to sustain this burden, dispensing with the need to consider the sufficiency of plaintiff's opposition (Id.). Where there are conflicting

opinions as to the standard of care vis-à-vis defendant's obligations to act in the face of established protocol, summary judgment must be denied (see *Johnson v. Nassau University Medical Center,* 140 AD3d 704, 706 [2d Dept. 2016]),[18] since the Court must limit its function to issue finding rather than issue determination (*Silveri v. Glaser,* __ AD3d __, 2018 N.Y. Slip Op. 08168 [2d Dept. 2018] and *Trio Asbestos Removal Corp. v. Gabriel & Sciacca Certified Public Accountants, LLP,* 164 AD3d 864, 865 [2d Dept. 2018]).

There are two elements to a medical malpractice cause of action premised on the lack of informed consent. First, that the practitioner failed to disclose the risks, benefits and alternatives to the procedure or treatment that a reasonable practitioner would have disclosed and, second, a reasonable person in the plaintiff's position, fully informed, would have elected not to undergo the procedure or treatment (*Orphan v. Pilnik,* 15 NY3d 907, 908 [2010]).

A doctor must affirmatively assume a duty of care towards a plaintiff. A doctor will be deemed to have assumed a duty of care by undertaking to diagnose a patient's condition and directing a course of action, which could render him/her liable for medical malpractice if there is a departure from accepted medical practice (see *Johnson v. Nassau University Medical Center,* 140 AD3d 707, 708 [2d Dept. 2016]). Therefore, liability may not attach under either theory until the Court first determines as a matter of law that the defendant doctors owed a duty to plaintiff (*McAlwee v. Westchester Health Associates, PLLC,* 163 AD3d 549, 551 [2d Dept. 2018] and *McNulty v. City of New York*, 100 NY2d 227, 232 [2003]). This determination is not an appropriate subject for expert opinion (*McAlwee v. Westchester Health Associates, supra*).

[18] The Second Department issued two separate decisions in the same action on June 1, 2016.

For the defendants to succeed on summary judgment on the first cause of action, the Court must first determine as a matter of law the lack of a standard of care or good and accepted medical practice for the administration of tPA to an adult sized teenager in the absence of drug guidelines and hospital protocol in 2014 (Plaintiff's Exhibit "E" – NYSCEF DOC. #142).[19] If the Court finds the existence of a good and accepted medical practice and Brandon met the additional criteria for tPA, the Court must then also determine as a matter of law that Brandon was outside the window of opportunity to administer tPA. Based upon the deposition testimony and conflicting expert opinions, questions of fact exist as to each of the foregoing (*Johnson v. Nassau University Medical Center,* 140 AD3d 706). However, these questions do not preclude summary judgment as to all defendants.

From the outset, the second cause of action for lack of informed consent must be dismissed against all defendants as the allegations are not grounded in the fact that Brandon's injuries were due to some affirmative violation of his physical integrity in the absence of informed consent, but instead that Dr. El-Sherif negligently failed to evaluate his condition thereby resulting in affirmative treatment [tPA] not being administered in a timely manner (see *Schel v. Roth,* 242 AD2d 697, 698 [2d Dept. 2010] [internal citations omitted]).

The NS-LIU defendants have established as a matter of law and uncontroverted by plaintiff that only the neurologist [Dr. El-Sherif] could order the administration of tPA to a patient. Plaintiff's expert's affidavit is silent on this issue. Further, plaintiffs and their expert have not opposed the motion as to Dr. Chan and Dr. DeStefano, thereby conceding their

[19] It is noted that plaintiff's and defendants' expert agree that the use of tPA was not recommended for pediatric patients in 2014. There were also no guidelines for the its use in pediatric/teenage patients such as Brandon, i.e., 16 years of age, with the height and weight of an adult.

entitlement to summary judgment. Next, assuming arguendo the window opened at 11:30 A.M., Dr. El-Sherif's decision not to administer tPA at approximately 2:15 P.M. after ruling out an intercranial bleed would have been within the window of opportunity, thereby severing any causal connection between defendants, North Shore-Long Island Jewish Health System, Inc., Staten Island University Hospital, Emergency Medicine Services of Staten Island, P.C., P.A. Flynn and Dr. Kenny, and Brandon's injuries. Dr. El-Sherif's decision was based on Brandon's age, the diagnostic testing results, and the medical history indicative of the onset of a stroke conveyed to Dr. El-Sherif by telephone, i.e., the events at 11:30 A.M. in Brandon's home and that he could not move one side of his body. Therefore, any purported failure to document or communicate Brandon's medical history to Dr. El-Sherif was not, as a matter of law, the proximate cause of Brandon's alleged injuries.

With respect to Dr. Okolo, plaintiff's expert summarily states that she should have engaged in the care of Brandon. Plaintiffs and their expert have offered no authority, legal or otherwise, for Dr. Okolo to engage a patient in a hospital without privileges or that a doctor-patient relationship formed during the limited conversation between Dr. El-Sherif and Dr. Okolo (*see generally, McNulty v. City of New York, supra*). The facts establish that Dr. Okolo, as a pediatric neurologist, did not undertake a duty to supervise Dr. El-Sherif or have a special relationship with plaintiff (see *McAlwee v. Westchester Health Associates, PLLC,* 163 AD3d 551). The facts also establish that Dr. Okolo did not undertake to diagnose Brandon's condition or direct Dr. El-Sherif's course of action (*Johnson v. Nassau Medical Center,* 140 AD3d 708). Therefore, absent a doctor-patient relationship, Dr. Okolo is entitled to summary judgment on all causes of action.

Dr. El-Sherif's motion for summary judgment is denied as to the first cause of action for deviation from an accepted standard of care and the derivative cause of action. There is a question of fact whether Dr. El-Sherif should have inquired as to Brandon's size and thereafter advised the family that although the onset of Brandon's symptoms was uncertain, and no guidelines existed for the administration of tPA to children under the age of 18, tPA was an option to be considered based upon his weight and height. The experts and Dr. El-Sherif disagree as to the onset of symptoms and the course of treatment for children on the cusp of adulthood rendering both a question of fact for resolution by a jury.

Based on the foregoing, the motion by defendant, Yasir El-Sherif, M.D., is denied as to the first cause and third cause of action and granted as to the second cause of action. The motions by defendants, NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., STATEN ISLAND UNIVERSITY HOSPITAL, EMERGENCY MEDICINE SERVICES OF STATEN ISLAND, P.C., JAMES KENNY, M.D., SIU-PUN CHAN, M.D., NWANNEKA OKOLO, M.D. AND SABRINA DESTEFANO, D.O., are granted in their entirety. Accordingly, it is hereby

ORDERED, the motion for summary judgment by defendant YASIR EL-SHERIF, is denied as to the first and third causes of action, and granted as to the second cause of action for lack of informed in consent (MS_002), and it is further

ORDERED, that the motion by defendants, NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., STATEN ISLAND UNIVERSITY HOSPITAL, EMERGENCY MEDICINE SERVICES OF STATEN ISLAND, P.C., JAMES KENNY, M.D., SIU-PUN CHAN, M.D., AND SABRINA DESTEFANO, D.O., is granted in its entirety and this action, together with all cross-claims, is dismissed as against these defendants (MS_003), and it is further

ORDERED, that the motion by defendant, NWANNEKA OKOLO, M.D., is granted in its entirety and this action, together with all cross-claims, is dismissed as against this defendant (MS_004), and it is further

ORDERED, that the caption of this action is amended as follows:

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND
---X
JOHN BELMONTE AND STACY BELMONTE, AS PARENTS AND NATURAL GUARDIANS OF BRANDON BELMONTE, AND JOHN BELMONTE AND STACY BELMONTE, INDIVIDUALLY,

Index No.: 150180/2015

Plaintiffs,

-against-

YASIR EL-SHERIF, M.D.,

Defendant.
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and it is further

ORDERED, that this Order shall be served with Notice of Entry upon all parties, and the Clerk of the Court and the Calendar Clerk who shall amend their records accordingly, and it is further

ORDERED, that the Clerk shall enter judgment in accordance with the foregoing.

This constitutes the decision and order of this Court.

E N T E R:

HON. THOMAS P. ALIOTTA, J.S.C.

Dated: December 18, 2018