SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, PART 10

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JOHN HAROLD **Index №. 805011/2015**

Plaintiff

-against-

NEW YORK CITY & HOSPITALS CORPORATION

Defendant

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HON. GEORGE J. SILVER:

In this medical malpractice action, defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION ("NYCHHC") moves for summary judgment and an order dismissing plaintiff JOHN HAROLD's ("plaintiff") complaint as against it. Plaintiff opposes NYCHHC's application.

BACKGROUND

On April 9, 2013, plaintiff was seen in the neurosurgery clinic for the first time due to complaints of an unsteady gait that had reportedly become worse over the course of the previous year. He had previously undergone a T1-T2 tumor resection and laminectomies in 2002. MRIs of the cervical and thoracic spine performed on June 19, 2013 evinced a mass at T1 that was severely compressing the adjacent cord and displacing it to the right. The mass was correctly suspected to be indicative of a recurrent meningioma, a kind of tumor that forms on the membranes that cover the brain and spinal cord. Degenerative disc disease and multiple herniations were also present. Stephen Russell, M.D. ("Dr. Russell"), an employee of NYCHHC, recommended surgical removal of the tumor with monitoring.

After a follow-up visit on July 2, 2013, plaintiff underwent preoperative testing on October 18, 2013 with Dr. Russell, who noted the possibility of increased risk due to scar tissue in the area, as this was a reoperation following the 2002 resection. On November 6, 2013, plaintiff underwent a C7-T1 laminectomy for a recurrent thoracic meningioma. Dr. Russell was listed as the attending surgeon, with an accompanying operating surgeon and a resident assistant. The operative report provides extensive detail and gives no indication of any complications, stating that there were no changes in the neuromonitoring signals throughout the entirety of the case. The November 6, 2013 operative report specifically states that "[a]ll risks, benefits, and alternatives to the surgery were discussed with the patient including risks of bleeding, infection, CSF leak, requiring lumbar drain, or reoperation, incomplete resection with potential need for further treatment including reoperation or radiation, injury to the spinal cord including, but not limited to, paralysis, bowel or bladder dysfunction, sexual dysfunction that could be temporary or permanent in nature. The patient understood these risks and was eager to proceed with the surgery"

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During plaintiff's immediate post-surgical course he complained of discomfort and blisters on his tongue, prompting an anesthesia consult that diagnosed soft tissue trauma secondary to biting during the procedure. However, because the edema, anterior abrasion, and posterior blisters on the tongue caused slurred speech, serial neuro checks were conducted every 30 minutes. Plaintiff remained neurologically stable. Brimonidine/timolol combination eye drops, indicated for the treatment of plaintiff's previously diagnosed glaucoma, were regularly administered as of November 6, 2013.

On November 13, 2013, the same day that plaintiff had two Jackson Pratt drains removed, he complained of pain in his head that scored as a six out of ten, which was initially treated with Fioricet. On November 14, 2013, Dr. Russell noted that no cerebrospinal fluid was leaking, but serosanguinous fluid was leaking from one of the drain incisions, so a stitch was placed.

At 1:56 p.m. on November 15, 2013, plaintiff underwent a physical therapy consultation during which he slumped to his left when seated in a chair and "required verbal cueing in order to keep his eyes open." A CT scan of the head performed without contrast at 10:11 p.m. revealed subarachnoid and intraventricular density favored to represent a hemorrhage over pus and debris, and a lobulated fluid collection at the C2 level. On November 16, 2013 plaintiff was sent for a repeat CT scan and an MRI of the cervical and thoracic spine. The MRIs revealed, *inter alia*, a focus of enhancement in the left lateral recess at the T2 level and probable cord hyperintensity at T1-T2, and a brain MRI with and without contrast revealed continued bilateral dependent intraventricular debris or hemorrhage.

According to plaintiff's chart, November 16, 2013 was also the first day that he began having vision difficulties. The ophthalmology house staff notes are timed at 9:15 and 9:25 p.m. and were written by Sara Ghobraiel, M.D. ("Dr. Ghobraiel"). The note reads "53 y/o M with acute? Bilateral [no light perception] vision [in both eyes]. May be due to posterior ischemic optic neuropathy due to long surgical case/positioning; will follow up MRI read and discuss with neuro-ophthalmology attending once read is back; patient with [no light perception] vision while minimally responsive in a.m., please re-consult when patient more responsive to see full extent of vision; once true vision is assessed then can assess need for further management; continue current [eye drops] as is; would recommend medical optimization; no acute management recommended; headache unlikely to be due to ophthalmologic pathology."

Dr. Ghobraiel further documented that ophthalmology was consulted because "it was noticed that patient is also unable to count fingers." The narrative continues "[n]eurosurgery house staff brought patient down to consult room. Patient examined on stretcher and was minimally responsive but able to report that he cannot see light in either eye. Patient had dilated and fixed pupil with perhaps minimal reactivity [in the left eye] although very difficult to assess. When patient was being moved to SICU he became unresponsive, patient then was taken emergently to CT scanner. MRI was then done. Patient was reexamined in SICU and found to be minimally responsive, sometimes opening his eyes when prompted."

The aforementioned CT scan of the head was timed at 10:39 a.m. on November 17, 2013 and showed increased prominence to the intraventricular and scattered subarachnoid densities over the bilateral convexities. Thereafter, a lumbar puncture was attempted, but was unsuccessful. Plaintiff was started on Vancomycin and Cefepime. Numerous labs were sent, which were largely unremarkable except for an

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elevated Amylase of 653. At 1:33 p.m. on November 17, 2013, plaintiff underwent an external ventricular drain placement, and cerebral spinal fluid began to escape under pressure. Plaintiff tolerated the procedure well and showed increased awareness after the bloody fluid was drained.

On November 21, 2013, Dr. Russell noted that ischemic visual loss of uncertain etiology had begun approximately one-week post-op, that it was unlikely related to surgical position or blood loss, and that ophthalmology was consulting. Plaintiff's neurology exam was also noted to have shown slight improvement. On November 22, 2013, Bora Chae, M.D. ("Dr. Chae") from ophthalmology followed-up with plaintiff and noted that his acute vision loss was again verified on exam. Floyd Warren, M.D. ("Dr. Floyd") a neuro-ophthalmologist, was to consult with plaintiff.

On November 23, 2013 Brendan Butler, M.D. ("Dr. Butler") from ophthalmology followed-up and noted plaintiff had a questionable history of poor vision in the right eye prior to November 6, 2013. He noted the concern for possible pituitary apoplexy as a cause of vision loss. He felt the MRI on November 16 had been inadequate to evaluate for pituitary apoplexy secondary to the subarachnoid hemorrhage and recommended further evaluation. It is further noted that Dr. Butler discussed this case with Dr. Warren.

On December 2, 2013, a PEG tube was placed, and on December 4 plaintiff underwent a right frontal ventriculostomy, coupled with a subsequent shunt placement, which was deemed to have been effective. A December 7 renal consult found nephrogenic diabetes insipidus which was treated with desmopressin but otherwise, plaintiff stabilized. Though his temperature had spiked to 102 degrees prior to his ten-day course of antibiotics, he thereafter remained afebrile with a heart rate ranging from the 80s to the 100s and a systolic BP between 100 and 140. Plaintiff remained alert and oriented to person and place, and his pupils were equal and reactive to light. He could move his extremities well and with good strength

On December 12, 2013, plaintiff was discharged and transferred to acute rehabilitation, but was transferred back as an inpatient two days later due to two episodes of passing black stool, which is associated with upper gastrointestinal bleeding. Enterococcal bacteremia was diagnosed and after a course of Vancomycin, Ceftriaxone, and Ampicillin, he was again transferred to acute rehabilitation on December 18, 2013.

On January 30, 2014 plaintiff was discharged to home from the facility. At the time of discharge, plaintiff was eating normally but noted to have an unsteady gait, so he was given a rolling walker, standard wheelchair and tub bench. He was able to ambulate about 150 feet with-the rolling walker and was able to independently negotiate 10 short steps. He was directed to follow up with the Neurosurgery Clinic in two weeks, the Rehabilitative Medicine clinic in one month, and the Ophthalmology Clinic once by appointment.

The Bellevue records indicate that plaintiff was seen in the hypertension clinic on February 7, 2014. He also attended one medical screening walk-in visit on February 11, 2014. It was noted that plaintiff has been "doing well at home" since his January discharge, but complained of increased blurry vision in his left eye and mild abdominal pain with nausea which began that morning. However, his neurological exam was normal with "no red flag signs" and his surgical site was well-healed. He was directed to follow up with neurosurgery and neurology as scheduled. No further appointments were made or kept with NYCHHC.

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ARGUMENTS

In support of its instant motion for summary judgment, NYCHHC annexes the pleadings, exhibits, records and affirmations of two experts to advance the position that plaintiff's claims of malpractice against NYCHHC are lacking in merit, thus entitling NYCHHC to judgment in its favor.

The first expert affirmation annexed to NYCHHC's moving papers is that of Martin Zonenshayn, M.D. ("Dr. Zonenshayn"), a board-certified neurosurgeon, who states within a reasonable degree of medical certainty that the care and treatment rendered to plaintiff by NYCHHC was within the parameters of good and accepted medical practice. Dr. Zonenshayn affirms that there were no aspects of the care and treatment of plaintiff that caused any injury to plaintiff, and that no act or omission of NYCHHC or its staff can be identified as a departure from the applicable standard of care during his admission from November 6 through December 12 of 2013. Dr. Zonenshayn sets forth that the case at bar is somewhat unusual in that plaintiff did not develop his hemorrhage or complain of vision loss until nine days after he underwent the laminectomy and meningioma resection. Nevertheless, he concludes that no neurosurgical departure occurred and thus no such departure can be said to have caused plaintiff any injury. Dr. Zonenshayn affirms that intracerebral bleeds like the one sustained by plaintiff are rare, but cannot be avoided in certain circumstances. He confirms Dr. Russell's assertion that plaintiff's intracranial hemorrhage was not related to any of the blood loss during the surgery, and in this case, the cerebrospinal fluid did in fact reabsorb and eventually resolve.

Dr. Zonenshayn further states that despite the difficulties associated with a repeat spinal tumor resection, Dr. Russell's procedure was successful. He notes that the opening of the dura was a necessity due to the location of the tumor, and that the dura was thereafter appropriately repaired. Dr. Zonenshayn concludes that "the surgery performed by Dr. Russell and his team was necessary, and the resection was successful. Mr. John's intracerebral bleed was a rare event that was in no way caused by any negligence on the part of his providers. There was no delay in diagnosing the bleed once it did occur, and the patient was appropriately treated throughout the remainder of his admission. Every surgical procedure was medically necessary, and all requisite testing was performed."

The second affirmation annexed to NYCHHC's moving papers is that of Steven Odrich, M.D. ("Dr. Odrich"), a board-certified ophthalmologist, who states that plaintiff came to NYCHHC with extensive pre-existing glaucoma and that no act or omission of the hospital staff can be said to have caused or worsened his injuries. To be sure, Dr. Odrich opines, within a reasonable degree of medical certainty, that plaintiff's injury did not occur or become worse while he was in the care of NYCHHC, that his vision difficulties can be attributed to long-term chronic disease as opposed to the surgical procedure at issue, and that neither NYCHHC nor its staff deviated from any applicable standard of care in the care and treatment of plaintiff. Dr. Odrich concludes his affirmation by stating that no act or omission of NYCHHC or its providers caused or contributed to any injury sustained by plaintiff.

Collectively, based on the affirmations of Drs. Zonenshayn and Odrich, the pleadings, testimony and records in this case, NYCHHC submits that there are no triable issues of fact, and that this motion should be granted in its entirety.

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In opposition, plaintiff annexes the affirmation of a physician board-certified in neurology who opines that NYCHHC's actions ran athwart of the applicable standard of care. Plaintiff's expert highlights plaintiff's postoperative bleeding from the tumor bed of the operative site, and the manner in which that same postoperative bleeding caused plaintiff's subarachnoid hematoma and intraventricular hemorrhages. Plaintiff's expert further opines that plaintiff's subarachnoid hematomas and intraventricular hemorrhages caused plaintiff to have an altered mental status and acute blindness in both eyes. It is plaintiff's expert's opinion, within a reasonable degree of medical certainty, that Dr. Russell and Dr. Huang departed from the required standard of care in failing to timely identify the source of the ongoing bleed from the surgical site, ongoing severe headaches, and altered mental status. In plaintiff's expert's view, if diagnosis of the subarachnoid hemorrhage and intraventricular hemorrhage had been made earlier, there would have been earlier intervention to address the subarachnoid hematoma and intraventricular hemorrhage. Specifically, plaintiff's expert states that Dr. Russell and Dr. Huang's departures included the failure to timely order CT scans or MRIS of the head or cervical spine. As a result of these departures, plaintiff's expert concludes that Dr. Russell and Dr. Huang's actions were substantial factors in causing plaintiff's injuries.

In reply, NYCHHC challenges plaintiff's expert affirmation and the conclusions drawn therefrom. To be sure, NYCHHC argues that plaintiff failed to submit qualified expert testimony capable of proving a deviation from accepted standards of medical care in the field of neurosurgery. Indeed, NYCHHC submits that plaintiff's expert, an neurologist, does not possess the requisite background to opine on matters related to neurosurgery. Even if he did, NYCHHC argues that the conclusions drawn from plaintiff's expert's affirmation are insufficient to raise triable issues of fact. To be sure, NYCHHC argues that even if a CT Scan had been requisitioned, it would not have changed plaintiff's ultimate diagnosis and outcome. As such, NYCHHC argues that it did not proximately cause plaintiff's injuries, and therefore is entitled to prevail on the instant motion. NYCHHC further reiterates the arguments made in its moving papers, and renews its argument that judgment in its favor is warranted.

DISCUSSION

In an action premised upon medical malpractice, a defendant doctor or hospital establishes prima facie entitlement to summary judgment when he or she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d Dept. 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d Dept. 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). In claiming that treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g., Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept2008]). The opinion must be based on facts within the record or personally known to the expert (*Roques*, 73 AD3d at 207, *supra*). Indeed, it is well-settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice

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action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish prima facie entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars do not establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108, *supra*; *Wasserman*, 307 AD2d at 226, *supra*). To be sure, the defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept 2003]).

Once the defendant meets its burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept. 2008]; *Koeppel v Park*, 228 AD2d 288, 289 [1st Dept. 1996]). To meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston*, 66 AD3d at 1001, *supra*; *Myers,* 56 AD3d at 84, *supra*; *Rebozo*, 41 AD3d at 458, *supra*).

Here, NYCHHC's submission of deposition transcripts, medical records and expert affirmations based upon the same established a prima facie defense entitling NYCHHC to summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). To be sure, Dr. Zonenshayn specifically provided that the care and treatment rendered to plaintiff by NYCHHC was within the parameters of good and accepted medical practice. To be sure, Dr. Zonenshayn affirms that intracerebral bleeds like the one sustained by plaintiff are rare but cannot be avoided even where surgical procedures are performed with unimpeachable accuracy. Moreover, Dr. Zonenshayn corroborates Dr. Russell's assertion that plaintiff's intracranial hemorrhage was not related to any of the blood loss during the surgery, and in this case, the cerebrospinal fluid did in fact reabsorb and eventually resolve. Dr. Zonenshayn further states that despite the difficulties associated with a repeat spinal tumor resection, Dr. Russell's procedure was successful, further diminishing the viability of plaintiff's claims.

Moreover, Dr. Odrich opines that plaintiff's vision-related complaints were not due to his intracerebral bleeds, but rather were the result of plaintiff's pre-existing glaucoma. He also opines that vision difficulties are a risk of any neurosurgical procedure, but that based on the plaintiff's medical records and the fact that he did not report any vision difficulties until several days after the procedure, plaintiff's vision-related complaints were likely not related to any deviations of care attributable to NYCHHC or its staff. As NYCHHC's expert's opinions are predicated upon ample support within the record, NYCHHC has shown that plaintiff was treated in full accord with good and accepted standards of medical care during his

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admission, and that there were no departures of care attributable to NYCHHC and its staff that proximately caused plaitniff's injuries.

In opposition to NYCHHC's prima facie showing, plaintiff raises triable issues of fact sufficient to preclude summary judgment. To be sure, plaintiff highlights that while NYCHHC may have appropriately performed surgery on plaintiff, the hospital's post-surgical intervention departed from applicable standards of care in a material manner. Indeed, it is plaintiff's expert's opinion, within a reasonable degree of medical certainty, that Dr. Russell and Dr. Huang departed from the required standard of care in failing to timely identify the source of plaintiff's ongoing intracerebral bleed from the surgical site, ongoing severe headaches, and altered mental status. In plaintiff's expert's view, if diagnosis of the subarachnoid hemorrhage and intraventricular hemorrhage had been made earlier, there would have been prompter intervention to address the subarachnoid hematoma and intraventricular hemorrhage. While NYCHHC's experts state that there was no delay in diagnosing the bleed once it occurred, plaintiff's expert opines that there *was* such a delay. Specifically, plaintiff's expert opines that the bleed was not diagnosed until November 15, 2013, even though plaintiff made complaints of severe headaches as early as November 12, 2013. Therefore, it is plaintiff's expert's opinion that there was at least a three-day delay in diagnosing the subarachnoid hematoma and intracerebral hemorrhages following plaintiff's surgery. Had plaintiff's bleed been detected earlier, plaintiff's expert concludes that it is axiomatic that plaintiff's outcome would have been better. In the realm of medical malpractice jurisprudence, a plaintiff's claim of injury can be premised on such a diminished chance at a better outcome (*see Goldberg v. Horowitz*, 73 AD3d 691 [2d Dept 2010]).

NYCHHC's challenges to plaintiff's expert's credentials are without merit. Plaintiff's expert is a board-certified neurologist, who has been practicing within the field for several years. In preparing his affirmation, plaintiff's expert affirms that he was supplied with the relevant medical records of plaintiff, deposition transcripts, and pleadings. Working as a neurologist, plaintiff's expert states that he has "performed thousands of neurologic consults in a hospital setting." More specifically, he states that he has been "requested to perform consultations to determine if patients are suffering from neurologic conditions, including altered mental status." Additionally, he opines that he is "familiar with treating patient[s] following cerebral spinal fluid leaks, intraventricular hemorrhages, and subarachnoid hemorrhages." Finally, plaintiff's expert adds that he has "reviewed thousands of CT Scans of the head, CT Scans of the spine, and MRIs of the head/brain, amongst other radiographic modalities." In that regard, plaintiff's expert has observed numerous admissions such as plaintiff's admission at NYCHHC in the instant lawsuit, and therefore can opine within a reasonable degree of medical certainty whether NYCHHC's medical intervention was at all times appropriate, and in accordance with accepted standards of care. Relevantly, much of plaintiff's expert's opinion within the instant lawsuit does not relate to the manner in which plaintiff's surgery was performed. Rather, as a neurologist, plaintiff's expert submits that NYCHHC should have properly observed plaintiff to detect potential neurological compromise *after* plaintiff's surgery. This is an important issue to highlight, because the breadth of case law that NYCHHC cites for the proposition that plaintiff's expert cannot opine outside his area of expertise has optimal applicability if this case related squarely to the manner in which plaintiff's surgery was performed. In such a circumstance, plaintiff's expert would necessarily be required to either be a specialist in neurosurgery, or an individual with an articulated foundational knowledge in the

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appropriate standards of care one must follow within a neurosurgical discipline. As that is not the case here, and as this case more accurately relates to whether NYCHHC, within the broad spectrum of neurology, should have detected whether plaintiff was neurologically compromised after his surgery, plaintiff's expert has set forth the requisite foundational knowledge to proffer his opinions. To be sure, plaintiff's expert's credentials do not place him within the ambit of medical professionals devoid of the requisite knowledge or experience to render an opinion outside of their discipline (*see Atkins v Beth Israel Health Servs.*, 133 AD3d 491 [1st Dept 2015]; *Mustello v Berg*, 44 AD3d 1018 [2d Dept 2007]).

Moreover, it is important to note that while there are considerable differences between neurologists and neurosurgeons, when it comes to medical management, there is a significant overlap between the two disciplines. Indeed, neurosurgery is closely associated with neurology in that both require specialized knowledge of the nervous system and its functions. Both neurosurgeons and neurologists may perform complex neurological testing like EEG, MRI, and CT scans to monitor the brain, and both may use minimally invasive procedures to repair blood vessels within the brain. While both neurologists and neurosurgeons diagnose and treat conditions that involve the nervous system, neurologists do not perform surgery. Rather, neurologists are focused on discovering diagnosis-specific neurological conditions that can be corrected — via medications or other therapies — or require close management. As such, NYCHHC and its staff, including NYCHHC's neurosurgical staff, arguably could have detected whether plaintiff was neurologically compromised. Importantly, this is not a case where plaintiff's expert is practicing in an entirely different discipline. Even if he was, as previously articulated, a medical expert need not be a specialist in a particular field in order to testify regarding accepted practice in that field (*Lopez v Gramuglia*, 133 AD3d 424 [1st Dept 2015]) so long as that medical expert provides a foundation that he or she possesses the requisite knowledge necessary to make a determination on the issues presented (*Limmer v Rosenfeld*, 92 AD3d 609 [1st Dept 2012]). Once such a foundation is laid, the issue of the expert's qualifications to render such an opinion is a question of weight for a jury resolve. Here, in addition to the noted similarities between neurological and neurosurgical procedures with respect to detecting whether or not a patient is neurologically compromised, the court finds that plaintiff's expert's noted credentials and extensive experience within the field of neurology provide the requisite foundation to opine on whether NYCHHC's actions comported with appropriate standards of post-surgical neurological care. As such, it is axiomatic that plaintiff's expert has provided a requisite foundation for his opinions.

Turning to plaintiff's expert's observations, it is notable that NYCHHC's argument that plaintiff was timely monitored throughout his admission is contravened by the content of plaintiff's expert affirmation, which repeatedly takes aim at the fact that NYCHHC did not detect plaintiff's bleed until three days after his surgery and initial complaints. Contrary to NYCHHC's assertions, plaintiff contests the fact that NYCHHC acted emergently when requisitioning a scan of plaintiff to evaluate his complaints. To be sure, plaintiff's expert opines that NYCHHC did not act with haste, and that its delays resulted in neurological compromise to plaintiff that could have been avoided. Because plaintiff's expert's opinion cannot be discounted as a matter of law, an issue of fact has been raised relative to NYCHHC's response to plaintiff's bleed and subsequent complaints as well as whether that response was a departure from appropriate care that proximately caused plaintiff's injuries. Indeed, the very fact that plaintiff's experts opinions differ from

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those proffered by NYCHHC's experts illustrates the existence of issues of triable fact. To be sure, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2d Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the fact finder (*id.*).

Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is denied in its entirety; and it is further

ORDERED that the parties are directed to appear for a conference before the court on June 25, 2019 at 9:30 AM at the courthouse located at 111 Centre Street, Room 1227 (Part 10).

This constitutes the decision and order of the court.

Dated: April 22, 2019

George J. Silver

GEORGE J. SILVER
J.S.C.

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