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

----------X

DE SAYLE GREY and MAUREEN GREY,

Plaintiff,

Index No. 805458/2016
Motion Seq. 002

-v-

DECISION & ORDER

VERONICA GARCIA-FUSCO, M.D., DEBRA SPICEHANDLER, M.D., NEW YORK PRESBYTERIAN HOSPITAL/LAWRENCE HOSPITAL, and JOHN AND JANE DOES, M.D., R.N. 1-10,

Defendants.

----------X

GEORGE J. SILVER, J.S.C.:

Defendants LAWRENCE HOSPITAL CENTER s/h/a "NEW YORK PRESBYTERIAN HOSPITAL/LAWRENCE HOSPITAL" ("Lawrence Hospital") and VERONICA GARCIA-FUSCO, M.D. ("Dr. Garcia-Fusco" collectively "defendants") move for summary judgment. Defendant DEBRA SPICEHANDLER, M.D. ("Dr. Spicehandler"), cross-moves for summary judgment, and submits an affirmation in support of Lawrence Hospital and Dr. Garcia-Fusco's motion for summary judgment.[1] Plaintiffs DE SAYLE GREY ("plaintiff") and MAUREEN GREY ("Ms. Grey" collectively "plaintiffs") oppose the motion. For the reasons discussed below, the court denies Dr. Spicehandler's motion.

In April and June of 2014, plaintiff saw Dr. Ronald Silverman ("Dr. Silverman"), a neurologist, for back pain which radiated down his right leg. Dr. Silverman documented that

[1] Pursuant to an email dated January 24, 2020, counsel for Lawrence Hospital and Dr. Garcia-Fusco advised that this action has been settled as to Lawrence Hospital and Dr. Garcia-Fusco. Accordingly, Lawrence Hospital and Dr. Garcia-Fusco's motion for summary judgment is moot. However, because Dr. Spicehandler has cross-moved for summary judgment, the court will decide the motion herein with respect to Dr. Spicehandler only.

plaintiff had undergone three epidural injections, which provided temporary relief, and that plaintiff had begun using a cane. Dr. Silverman also noted that plaintiff had some sensory and motor deficits in the L5 distribution on his right side, and that an MRI of plaintiff's lumbar spine one year earlier showed diffuse degenerative disc disease, mild to moderate recess stenosis, and facet hypertrophy.[2]

On June 13, 2014, plaintiff saw his primary care physician, Dr. Debabrata Dutta ("Dr. Dutta"), with complaints of back pain for the past five years. Plaintiff had not responded to physical therapy or epidural injections, and had planned to see Dr. Peter Angevine ("Dr. Angevine"), a neurosurgeon, at New York and Presbyterian Hospital – Columbia ("NYPH Columbia").

On July 16, 2014, plaintiff presented to NYPH Columbia because he suddenly felt unwell and was vomiting repeatedly. Plaintiff had a low-grade fever and hematuria,[3] and complained of numbness in his face, hands, and fingers. The emergency department ("ED") staff performed a blood test, and discharged plaintiff home with instructions to follow up with his primary care provider and the urology clinic for further testing.

On July 18, 2014, plaintiff's blood culture tested positive for E. coli. NYPH Columbia's ED staff called plaintiff via telephone, at which time plaintiff denied fever, chills, diaphoresis, nausea, headache, and other signs of infection. Plaintiff declined to return to NYPH Columbia, and the ED staff directly provided plaintiff's blood culture results to Dr. Dutta per plaintiff's request. The ED staff also spoke with Ms. Grey, who explained that plaintiff could go to Danbury Hospital, which was closer to their home in Connecticut to have repeat blood tests.

[2] Plaintiff's medical history included hypothyroidism, a thyroidectomy, left knee replacement surgery, prostate surgery in 2013, spinal stenosis, herniated lumbar intervertebral discs, and obesity.
[3] Hematuria is the presence of blood in urine.

On July 22, 2014, plaintiff presented to New York Neurological Institute at Columbia Presbyterian Medical Center for a consultation with Dr. Angevine. Plaintiff reported lower back pain, right leg pain, and difficulty standing and walking. Plaintiff also advised that epidural steroidal, chiropractic treatment, and physical therapy did not help. An MRI and x-rays revealed that plaintiff had degenerative discs. Dr. Angevine believed that a decompression surgery would be reasonable, but wanted to obtain scoliosis films before operating on plaintiff.

On July 29, 2014, plaintiff underwent a blood test at Lawrence Hospital, which did not show evidence of an infection. Plaintiff's C-Reactive protein level was 51.9, his erythrocyte sedimentation rate level was 49, and his white blood cell ("WBC") count was elevated at 12.6. Later that evening, plaintiff started to experience severe neck and back pain.

On July 30, 2014, plaintiff presented to Lawrence Hospital's ED with complaints of generalized weakness, chills, tactile fevers, chronic back pain that had worsened over the past two weeks, and difficulty ambulating. Plaintiff also reported that he had urinary frequency and urgency, but was only able to produce minimal urine. Plaintiff was afebrile with a pulse of 73, a respiration rate of 18, a blood pressure of 149/70, and an oxygenation rate of 96%. Labs revealed an elevated WBC count of 13.1. Dr. Karolina Weiss ("Dr. Weiss") admitted plaintiff to Lawrence Hospital with a differential diagnosis of a urinary tract infection and a bacterial infection. Dr. Weiss planned to place plaintiff on IV vancomycin and cefepime, and to obtain urine and blood cultures. Dr. Weiss did not think that there were any risks factors suggestive of a spinal infection or abscess.

Upon re-examination on July 31, 2014, plaintiff reported that he felt better with less neck pain. Plaintiff was afebrile and had stable vital signs. Dr. Weiss documented that plaintiff's neurological status was "grossly intact," plaintiff's extremities showed trace edema, and that

plaintiff's back was nontender. Plaintiff's blood and urine cultures were negative, and the etiology of plaintiff's leukocytosis was unclear given plaintiff's negative cultures. However, Dr. Weiss considered obtaining an infectious disease consult if plaintiff's WBC count was still elevated the following day. Dr. Weiss also spoke with Dr. Silverman, plaintiff's neurologist, who described plaintiff's history of spinal stenosis and degenerative disc disease. Dr. Weiss recommended that plaintiff continue tramadol for pain, and undergo an evaluation by Dr. Ralph Pici ("Dr. Pici"), a physiatrist, the following day. Dr. Weiss continued to think that there were no risk factors suggestive of a spinal infection or abscess.

On August 1, 2014, Dr. Pici evaluated plaintiff, and noted that plaintiff complained of severe pain in the cervical region. Plaintiff had a limited range of motion of the cervical spine secondary to pain. Dr. Pici found that plaintiff's reflexes were equal and symmetrical, and that his sensation was grossly intact. Plaintiff also had tenderness over the C7 spinous process, and required moderate assistance to stand. Dr. Pici's impression was to rule out cervical discitis, and recommended an MRI of plaintiff's cervical spine and an infectious disease consultation.

That same morning, Dr. Garcia-Fusco evaluated plaintiff. Plaintiff denied chest pain, shortness of breath, fever, and chills. Plaintiff's vital signs were stable, and plaintiff's cultures were negative. Dr. Garcia-Fusco noted that the etiology of plaintiff's leukocytosis was still unclear, and that plaintiff had urinary retention. Plaintiff remained on IV vancomycin and cefepime, and Dr. Garcia-Fusco requested a urology consultation.

Later that morning, Mary Amato ("Ms. Amato"), a physical therapist, evaluated plaintiff. Plaintiff complained of pain in the cervical spine and in the upper thoracic region. Upon examination, plaintiff was unable to lift his shoulders higher than 80 degrees, and Ms. Amato was unable to do further testing of the upper extremities due to plaintiff's cervical spine pain. Ms.

Amato also noted that plaintiff had numbness and discomfort in both arms, and functional limitations in ambulation, bed mobility, strength, endurance, and balance.

At 12:48 p.m. that same day, Dr. Saboor, a nephrologist, documented that plaintiff was unable to pass urine although he had the urge. A Foley catheter was placed, and Dr. Sigler, a urologist, was consulted. At 3:29 p.m., Dr. Spicehandler, an infectious diseases specialist, performed a consultation due to "sepsis." Plaintiff's WBC count was elevated at 14.9 although plaintiff's cultures were negative. Dr. Spicehandler examined plaintiff, and documented that plaintiff had chronic neck pain, and that plaintiff had no neurological symptoms. Dr. Spicehandler also noted that the source of plaintiff's E. coli sepsis was unclear, and continued plaintiff on cefepime. However, Dr. Spicehandler discontinued vancomycin. At 7:37 p.m., Dr. Sigler noted that plaintiff's blood and urine cultures showed no evidence of infection. Plaintiff reported that he felt incapacitated by his cervical and upper back pain. Dr. Sigler opined that the new onset of plaintiff's urinary retention was probably due to plaintiff's disability and lack of ambulation.

On August 2, 2014, at 7:00 a.m., Nurse Annette Bumgarner documented that Ultram had effectively relieved plaintiff's cervical and thoracic spinal pain, and that plaintiff was not in any distress, or had any complaints Dr. Garcia-Fusco reevaluated plaintiff 11:02 a.m., and noted that plaintiff complained of neck and back pain. Upon examination, Dr. Garcia-Fusco noted that plaintiff was "grossly neurologically intact," and had no point tenderness over his spine. A CT scan of plaintiff's abdomen and pelvis were suggestive of renal parenchymal disease.[4] Dr. Garcia-Fusco noted that all cultures were negative to date, plaintiff's leukocytosis was trending down, and that plaintiff was status post-vancomycin and cefepime. Dr. Garcia-Fusco discussed plaintiff's care with Dr. Spicehandler, who recommended that cefepime be discontinued, and that plaintiff

[4] A kidney disorder that can result in hypertension.

start levofloxacin. Dr. Garcia-Fusco also noted that she would order an MRI, and call Dr. Dousamanis, a neurologist.

At 12:03 p.m. plaintiff reported to Dr. Saboor that he felt better. Upon examination, Dr. Saboor found that plaintiff was not in acute distress, and plaintiff's WBC count was 12.5. Dr. Saboor assessed plaintiff with an acute urinary tract obstruction. At 5:49 p.m. Dr. Sigler reevaluated plaintiff, and noted that plaintiff felt better, but reported neck pain and numbness in both hands. Plaintiff showed mild improvement in creatinine and WBC values, and Dr. Sigler requested that neurology follow up with plaintiff.

On August 3, 2014, at approximately 12:20 p.m., Dr. Dousmanis performed a consultation, and noted that plaintiff was treated with antibiotics, but continued to have severe neck and thoracic pain. Dr. Dousmanis noted that plaintiff "failed a cervical spine MRI" the previous night because he could not lie still due to pain. Plaintiff also reported that his hands were "diffusely numb." Upon examination, plaintiff felt significant focal pain in his neck, but had normal muscle tone and full power throughout, except for mild paresis on the right great toe dorsiflexion. Plaintiff's WBC was 11.8, and his urine and blood cultures from July 30, 2014 were negative. Dr. Dousmanis was concerned about an epidural abscess in the thoracic or "more likely the cervical spine," with some cord compression, severe pain, positive blood culture a few weeks ago, and persistently elevated WBC in the setting of antibiotic use, and possible urinary retention. Dr. Dousmanis recommended continued infectious disease input, and a thoracic and cervical MRI.

At approximately 3:00 p.m., plaintiff underwent a cervical spine MRI. The impression was a large prevertebral fluid collection extending from C1 through C7, which might be related to discitis[5] and osteomyelitis[6] with associated prevertebral abscess. The findings also showed a disc

[5] Discitis is inflammation that develops between the intervertebral discs of the spine.
[6] Osteomyelitis is an infection of the bone.

osteophyte riding at C4-C5, contacting the spinal cord with associated cord compression. Dr. Dousmanis reviewed the MRI results, and noted prevertebral fluid collection at C1-C7, and multilevel cervical spine stenosis[7] with some cord signal abnormality at those levels. Dr. Dousmanis suspected that plaintiff's cervical spinal stenosis and cord signal abnormalities were chronic, but that the fluid collection was concerning for an abscess. Dr. Dousmanis spoke to an infectious diseases specialist, but did not think that neurosurgery was necessary.

At 5:57 p.m., Dr. Rita Shaw ("Dr. Shaw") added an addendum to plaintiff's cervical spine MRI report, stating that there was an enhancement in the prevertebral region, which was not concerning for an abscess. At approximately 8:14 p.m., Dr. Guy McKhann ("Dr. McKhann"), a neurosurgeon, evaluated plaintiff, and documented that plaintiff's neurological status was worsening as plaintiff's now had minimal hand function. Plaintiff was "conversant" and able to flex and extend his arms, but could not move his hands or legs voluntarily. Dr. McKhann suspected acute spinal cord compression, and noted "deteriorating neuro status not explained by meds alone, and possibilities include ventral epidural abscess, abscess with cord infarction, progressively symptomatic stenosis, and other." Dr. McKhann planned to transfer plaintiff to NYPH Columbia's neuro-intensive care unit ("NICU").

Later that evening, Nurse Sharisse Washington documented that plaintiff's condition change, and that plaintiff was lethargic. Dr. McKhann's assessment was that plaintiff should be transferred to NYPH Columbia's NICU. Plaintiff was transferred at 9:45 p.m.

At 10:25 p.m., plaintiff arrived at NYPH Columbia, where he was scheduled to undergo a cervical decompression surgery. Dr. Hannah Goldstein noted that plaintiff reported diminished

[7] Spinal stenosis is a condition in which the spinal column narrows and starts compressing the spinal cord.

sensation up to the T4 sensory level, and Dr. Angevine's preoperative diagnosis was cervical myelopathy, a degenerative condition caused by compression on the spinal cord.

On August 4, 2014, at 5:46 a.m., Dr. Angevine performed a complete decompression of plaintiff's spinal canal. The surgery was uncomplicated, and Dr. Hani Malone documented that there was no frank pus or clear infectious material encountered intraoperatively. An infectious disease consult documented that plaintiff showed improvement in his upper extremity strength, and that the rapidity of the onset of plaintiff's symptoms, plaintiff's prior diagnosis with E. coli, and the equivocal imaging weighed in favor of an infectious etiology. The plan was to continue plaintiff on cefepime, perform a urinalysis and urine culture, and have a radiologist review plaintiff's Lawrence Hospital MRI images. Dr. Yoko Furuya ("Dr. Furuya"), an attending infectious disease consultant at NYPH Columbia, noted that plaintiff's Lawrence Hospital MRI was not definitive for an infectious process, and that NYPH Columbia's surgical team could not confirm an infectious process. However, Dr. Furuya documented that she was concerned about a possible hematogenous seeding of plaintiff's cervical spine.

On August 7, 2014, a cervical MRI report revealed a significant enhancement of plaintiff's prevertebral soft tissues from the level of the nasopharynx extending to the level of C7 with associated edema. Dr. Furuya noted that plaintiff's Lawrence Hospital cervical MRI showed a fluid collection in the prevertebral space with an abnormal signal on T2 imaging, concerning for phlegmon or an early abscess.

After a follow-up MRI on August 8, 2014, an infectious disease consult noted that, "Repeat MRI with contrast revealed possible osteomyelitis/discitis and possible large prevertebral and epidural phlegmon."

On August 12, 2014, a neurology note indicated that an MRI T/L of plaintiff's spine on August 11, 2014 did not clarify the etiology of plaintiff's disease. A repeat MRI on August 15, 2014 showed stable enhancement of plaintiff's cord/bone, and no change in the C4 to C5 discitis and osteomyelitis, but there was a new change in the epidural enhancement within the cervical spinal canal region with less enhancement in the upper thoracic region. There was also persistent enhancing edema within the prevertebral compartment. The differential diagnosis included infection, granulomatous disease, and lymphoma. There was also an abnormal T2 prolongation in the cervical spinal cord from C1 through C6, which was concerning for cord infarction.

On August 19, 2014, infectious disease documented that the etiology of plaintiff's spine lesions and compression remained unclear, but the differential diagnosis included infection, disc herniation, malignancy, and myelofibrosis. On August 20, 2014, plaintiff was discharged from NYPH Columbia to Burke Rehabilitation Hospital.

ARGUMENTS

Based on the record before the court, Dr. Spicehandler argues that summary judgment must be granted, because plaintiffs cannot establish that Dr. Spicehandler's medical treatment of plaintiff deviated from accepted standards of care or proximately caused plaintiff's alleged injuries.

In support of her motion, Dr. Spicehandler annexes the affirmation of ALAN A. POLLOCK, M.D. ("Dr. Pollock"), a physician board-certified in internal medicine and infectious diseases.[8] Dr. Pollock opines that Lawrence Hospital timely began IV antibiotics upon plaintiff's admission on July 30, 2014, and properly managed plaintiff's infectious process with an

[8] Dr. Spicehandler annexes the same affirmation of Dr. Pollock that Lawrence Hospital and Dr. Garcia-Fusco submit in support of their motion for summary judgment.

appropriate antibiotic regimen throughout his admission at Lawrence Hospital. Dr. Pollock also asserts that defendants did not need to consider transferring plaintiff to a tertiary medical facility for a decompressive spinal surgery unless and until there was definitive radiographic proof of a spinal epidural abscess ("SEA").[9] In that regard, Dr. Pollock highlights that plaintiff's August 3, 2014 MRI from Lawrence Hospital ("August 3, 2014 MRI") did not show an epidural abscess, and that Dr. Shah's August 3, 2014 addendum stated that the enhancement in plaintiff's prevertebral space was not concerning for an abscess. Similarly, Dr. Pollock notes that plaintiff's August 7, 2014 MRI report of the cervical spine at NYPH Columbia ("August 7 MRI") stated that there was, "No evidence of a discrete fluid collection to suggest an abscess at this time," and that NYPH Columbia did not find any evidence of an epidural abscess during plaintiff's decompression surgery. As such, Dr. Pollock concludes that plaintiff had either a pre-vertebral phlegmon, which is not amenable to surgical drainage, or a pre-vertebral abscess, which cannot compress the spinal cord. Dr. Pollock notes that neither condition is a surgical emergency.[10]

In Dr. Pollock's opinion, at most, plaintiff's radiology images showed a pre-vertebral abscess. Dr. Pollock notes that plaintiff's radiology report stated that there was a large pre-vertebral fluid collection from C1 through C7, which might be related to a pre-vertebral abscess. However, Dr. Pollock underscores that a pre-vertebral abscess is located in front of the cervical vertebrae, and is anatomically distinct from the location of an epidural abscess. As such, Dr. Pollock posits

[9] According to Dr. Pollock, a SEA is an accumulation of purulent fluid ("pus") in the epidural space, which can expand and compress the spinal cord, causing severe neurological symptoms, including paresis, paralysis, and death. By contrast, Dr. Pollock notes that a phlegmon is a localized area of acute soft tissue inflammation in response to infection, which does not compress the spinal cord. As such, Dr. Pollock observes that unlike an abscess, a phlegmon cannot be treated surgically. Rather, a phlegmon is treated with antibiotics.

[10] Dr. Pollock contends that plaintiffs' allegation that a SEA caused plaintiff's injuries is false, and therefore, even if a cervical MRI had been performed on August 1, 2014 or August 2, 2014, plaintiff's outcome would not have changed because plaintiff never had an epidural abscess.

that assuming that plaintiff had a pre-vertebral abscess, and not a pre-vertebral phlegmon, plaintiff's medical course would not have been different even if an MRI were obtained earlier than August 3, 2014. In that regard, Dr. Pollock emphasizes that a pre-vertebral abscess is not a surgical emergency, especially in an elderly patient such as plaintiff who had higher surgical risks associated with pre-existing co-morbidities such as hypertension and coronary artery disease.

Dr. Pollock also opines that plaintiffs' allegation that defendants delayed an urgent decompression surgery is baseless since there was no material that required an emergent evacuation. Dr. Pollock points out that Dr. Angevine's August 4, 2014 operative records did not identify the presence of any purulent fluid, and that Dr. Angevine did not describe any abnormal findings within plaintiff's epidural space, including any inflammatory mass or pus that could be seen or evacuated. Dr. Pollock also notes that there was no evidence of a SEA in plaintiff's August 7, 2014 MRI or August 15, 2014 MRI. As such, Dr. Pollock reiterates that a SEA did not cause plaintiff's alleged injuries.

Instead, Dr. Pollock opines that plaintiff's spinal cord infarction occurred due to a lack of adequate blood supply resulting from inflammation near the spinal cord in response to an infectious process. Dr. Pollock contends that plaintiff contributed to his spinal cord infarction by delaying medical treatment for nearly two weeks after NYPH Columbia advised him about his blood stream infection. As such, Dr. Pollock notes that the appropriate treatment for plaintiff's spinal condition was not a surgical decompression procedure, but rather, IV antibiotics, which was promptly administered upon plaintiff's presentation to Lawrence Hospital. Moreover, Dr. Pollock opines that defendants could not have prevented plaintiff's injuries, but had plaintiff timely returned to NYPH Columbia and received IV antibiotics within 48 hours of July 18, 2014, the complications of his bacteremia could have been prevented.

In opposition, plaintiffs argue that Dr. Spicehandler's "cross-motion" is a motion for summary judgment that is filed beyond the deadline. Plaintiffs also assert that Dr. Pollack does not opine that Dr. Spicehandler's treatment was consistent with the standard of care, but only comments on plaintiff's treatment with antibiotics "on admission" at Lawrence Hospital. However, plaintiffs contend that Dr. Spicehandler did not treat plaintiff "on admission," but rather, Dr. Spicehandler treated plaintiff on August 1, 2014 at approximately 3:00 p.m.

Plaintiffs also argue that Dr. Spicehandler failed to recognize the signs and symptoms of an infectious process causing compression of plaintiff's spinal cord. Plaintiffs aver that Dr. Spicehandler failed to take an active role in assisting with the diagnosis of plaintiff's condition, failed to initiate her own orders, and failed to follow the recommendation of other consultants for an MRI of plaintiff's cervical spine. Plaintiffs further allege that as a result of Dr. Spicehandler's departures, plaintiff went from having near full control of his extremities to virtually no control at the time that his condition was ultimately diagnosed and treated.

In opposition to Dr. Spicehandler's motion,[11] plaintiffs annex the affirmation of a physician board-certified in infectious diseases and internal medicine.[12] In plaintiffs' infectious diseases/internal medicine expert's opinion,[13] Dr. Spicehandler's treatment of plaintiff on August 1, 2014 and August 2, 2014 deviated from accepted standards of care. Specifically, plaintiffs' infectious diseases/internal medicine expert asserts that Dr. Spicehandler failed to formulate a

[11] While plaintiffs also annexed an affirmation of a hospitalist expert to address Lawrence Hospital and Dr. Garcia-Fusco's claims, because plaintiffs' hospitalist expert does not address specific departures or proximate causation with respect to Dr. Spicehandler, plaintiffs' hospitalist expert's affirmation will be omitted from the decision herein.

[12] As plaintiffs have redacted the name of the expert, he/she will be referred to as "plaintiffs' infectious diseases/internal medicine expert" herein.

[13] Many of plaintiff's infectious diseases/internal medicine expert's opinion are the same, if not identical to the opinions of plaintiff's hospitalist expert. Where there are such similarities, the court will not repeat the same arguments in the interest of brevity.

differential diagnosis for plaintiff, and failed to consider a SEA or any other infectious process as the possible cause of plaintiff's condition. According to plaintiffs' infectious diseases/internal medicine expert, an infectious diseases consultant's role includes diagnosing and formulating differential diagnoses where there is a concern for an infectious process, and making recommendations to treat and/or investigate the cause of a patient's symptomology. Plaintiffs' infectious diseases/internal medicine expert also avers that Dr. Spicehandler's discussion with Dr. Garcia-Fusco on August 2, 2014 via telephone deviated from the standard of care since a patient with a clinical presentation like that of plaintiff must be examined personally when under the care of an infectious disease consultant. Similarly, plaintiffs' infectious diseases/internal medicine expert posits that Dr. Spicehandler deviated from accepted standards of care by failing to "render treatment advice" to plaintiff on August 2, 2014 without personally examining plaintiff.

Additionally, plaintiffs' infectious diseases/internal medicine expert opines that Dr. Spicehandler departed from the standard of care by failing to obtain accurate information about plaintiff's history of back pain, and plaintiff's new paresthesia and numbness. Plaintiffs' infectious diseases/internal medicine expert also submits that Dr. Spicehandler failed to recommend or order a STAT MRI of plaintiff's cervical and thoracic spine or a neurological or neurosurgical consultation on August 1, 2014 and August 2, 2014, which was required in light of plaintiff's neurological and clinical information, including plaintiff's recent urinary incontinence. Similarly, plaintiffs' infectious diseases/internal medicine expert maintains that Dr. Spicehandler failed to recommend or order close and vigilant monitoring of plaintiff's neurological symptoms after her initial examination, and failed to recommend or order additional laboratory tests on August 1, 2014

or August 2, 2014, including CRP, ESR, and bands,[14] which were required in light of plaintiff's neurological, clinical, and other information available to Dr. Spicehandler.

Plaintiffs' infectious diseases/internal medicine expert further opines that plaintiff had an infection in his cervical and upper thoracic spine that caused compression of his spinal cord on August 1, 2014, which was more likely that not a SEA, and that Dr. Spicehandler's departures proximately caused the delay in the diagnosis of plaintiff's condition. According to plaintiffs' infectious diseases/internal medicine expert, based on the constellation and progression of plaintiff's symptoms during his admission at Lawrence Hospital, and plaintiff's laboratory tests, MRI reports, and neurological assessments, plaintiff likely had osteomyelitis, discitis, inflammation, and an early abscess (or a phlegmon) in his cervical spine, and that this infectious process resulted in plaintiff's spinal cord compression, which resulted in plaintiff's quadriplegia.

Plaintiffs also annex the affirmation of a physician board-certified in neurological surgery.[15] Plaintiffs' neurology expert opines that as early as August 1, 2014 at 9:00 a.m., plaintiff had a diagnosable infection of the cervical and upper thoracic spine which resulted in compression of plaintiff's spinal cord on and after August 1, 2014. According to plaintiffs' neurology expert, plaintiff's condition would have been diagnosed sooner had plaintiff undergone an earlier MRI. Plaintiffs' neurology expert notes that an immediate MRI is necessary where a patient has new urinary retention, and where a cord compression and a spinal infection are suspected. Plaintiffs' neurology expert also avers that had plaintiff's condition been diagnosed on August 1, 2014 or August 2, 2014, he would have recommended that plaintiff be immediately transferred to a tertiary

[14] Plaintiffs' infectious diseases/internal medicine expert does not specify what these tests are.
[15] As plaintiffs have redacted the name of their neurological surgery expert, the expert will be referred to as "plaintiffs' neurology expert" herein.

medical facility to undergo a spinal decompression surgery, thus avoiding plaintiff's quadriplegia.[16]

Additionally, plaintiffs' neurology expert disagrees with Dr. Pollack's statement that "unless and until there was definitive radiographic proof of a [SEA], the Moving Defendants did not need to consider transferring the patient to a tertiary medical facility for decompression spinal surgery." According to plaintiffs' neurology expert, hospitalists make determinations based on available evidence, and if a hospitalist's suspicion is high enough that a patient will (or likely may) require an emergency spinal decompression surgery, then the patient must be transferred. In that regard, plaintiffs' neurology expert underscores that radiograph proof is not necessarily required.

Similarly, plaintiffs' neurology expert opines that plaintiff's MRI did not need to show a SEA in order for plaintiff to be transferred to a tertiary medical facility. Plaintiffs' neurology expert contends that plaintiff should have been transferred as soon as a determination was made that plaintiff had an infectious process causing spinal cord compression resulting in clinically observable neurological deficits with a risk of a progressively worsening neurological status. To highlight, plaintiffs' neurology expert notes that although there was not "definitive" proof that plaintiff had a SEA on August 3, 2014, defendants nevertheless transferred plaintiff to NYPH Columbia for emergency surgery.

Likewise, plaintiffs' neurology expert disagrees with Dr. Pollack's opinion that an epidural phlegmon cannot cause spinal cord compression. Plaintiffs' neurology expert contends that a phlegmon is a growth or inflammation of soft tissue, which is often caused by infection, and often precedes the development of a full abscess. Plaintiffs' neurology expert explains that a phlegmon

[16] The portions of plaintiffs' neurology expert's affirmation that pertain to Lawrence Hospital and Dr. Garcia-Fusco's other experts, including Dr. Nirit Weiss, will be omitted as those experts are not relevant to the decision herein.

in the epidural space can cause compression of the spinal cord, and that compression of the spinal cord can cause quadriplegia if not timely treated. According to plaintiffs' neurology expert, this is what occurred in this case, regardless of whether the growth was an early SEA or a phlegmon.

Moreover, plaintiffs' neurology expert disagrees with Dr. Pollack's opinions that plaintiff did not have a SEA. Plaintiffs' neurology expert notes that while Dr. Pollock points to the operative and post-operative reports, which did not reveal frank pus, a phlegmon would not reveal frank pus. Plaintiffs' neurology expert similarly observes that a small, early abscess on the anterior of the spinal cord would not necessarily be seen in a spinal decompression surgery from the posterior approach. Plaintiffs' neurology expert also avers that while Dr. Pollack opines that "an infectious process" caused "inflammation near the spinal cord," and that this was the source of the compression, rather than a SEA or phlegmon, this distinction is inconsequential because the treatment would be the same since it would require an emergency spinal decompression surgery to resolve the compression. Lastly, plaintiffs' neurology expert disagrees with Dr. Pollack opines that plaintiff failed to follow instructions, and therefore contributed to his own injuries. According to plaintiffs' neurology expert, there is no indication in the records that plaintiff did anything prior to his admission or while in the hospital other than follow the instructions of his physicians.

Finally, plaintiffs annex the affirmation of a physician board-certified in diagnostic radiology.[17] According to plaintiffs' radiology expert, plaintiff had an infection of the disc space (discitis), osteomyelitis, and a small left ventrolateral epidural abscess or phlegmon at C4-C5, which would have been detectable had an MRI been performed on August 1, 2014 or August 2, 2014. Plaintiffs' radiology expert also avers that plaintiff had a prevertebral infection and fluid collection, and significant cord compression which would have been detectable had an MRI been

[17] As plaintiffs have redacted the name of the expert, the expert will be referred to as "plaintiffs' radiology expert" herein.

performed on August 1, 2014 or August 2, 2014. Moreover, plaintiffs' radiology expert posits that plaintiff's August 3, 2014 MRI findings required an immediate evaluation and spinal decompression surgery.[18]

In reply, Dr. Spicehandler argues that because plaintiffs' experts cannot identify the condition that resulted in plaintiff's injuries, plaintiffs cannot demonstrate that earlier treatment would have resulted in a different outcome. Specifically, Dr. Spicehandler asserts that plaintiffs failed to show that if plaintiff had a phlegmon, and not a SEA, that such condition either can be, or should have been treated surgically. Dr. Spicehandler also avers that plaintiffs ignored Dr. Pollock's opinion that had plaintiff not delayed his medical treatment by almost two weeks, the resulting complications from his bacteremia would have been avoided. Similarly, Dr. Spicehandler contends that while plaintiffs allege that Dr. Spicehandler should have ordered an MRI and/or a neurological consult/monitoring/testing on August 1, 2014 or August 2, 2014, plaintiffs ignore the fact that an earlier MRI would not have changed plaintiff's course of treatment. Likewise, Dr. Spicehandler asserts that plaintiffs ignore the fact that plaintiff was stable, and reported that he felt better on August 2, 2014.

In addition, Dr. Spicehandler argues plaintiffs speculate that an infectious disease physician who was consulting plaintiff on medication to treat gram-negative bacteremia should order an MRI and/or a neurological consult. In that regard, Dr. Spicehandler contends that plaintiffs' infectious disease expert offers no basis for his/her opinion that a consulting infectious disease physician was in a better position to assess plaintiff's neurological status or order diagnostic tests and consults. Moreover, Dr. Spicehandler notes that plaintiff's treating physiatrist recommended an MRI prior

[18] The portions of plaintiffs' radiology expert's affirmation that pertain to the opinions of Dr. Patricia Hudgins, Lawrence Hospital and Dr. Garcia-Fusco's radiology expert will be omitted as irrelevant to the decision herein.

to Dr. Spicehandler's consultation on August 1, 2014, and therefore, whether Dr. Spicehandler recommended an MRI would not have changed plaintiff's course of treatment.

Dr. Spicehandler further argues that plaintiffs' experts did not consider that Dr. Dousmanis documented that he did not think neurosurgery was needed on August 3, 2014 based on plaintiff's clinical and radiological condition. In that regard, Dr. Spicehandler emphasizes that it was not until plaintiff's neurological condition worsened hours later that plaintiff needed to be transferred to a tertiary facility. Dr. Spicehandler further underscores that even after Dr. Dousmanis reviewed plaintiff's MRI on August 3, 2014 at 4:02 p.m., a transfer to a tertiary facility was not indicated until plaintiff's condition further degraded hours later.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 A.D.3d 204, 206 [1st Dept. 2010]). In claiming 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 A.D.3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 A.D.3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). 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 A.D.3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 A.D.2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact

which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see, Roques*, 73 AD3d at 207). "Summary 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 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, Dr. Spicehandler has failed to set forth a *prima facie* showing in favor of dismissal. Dr. Spicehandler's submission of Dr. Pollock's affirmation is insufficient to establish that Dr. Spicehandler's treatment of plaintiff comported with accepted standards of care and did not proximately cause plaintiff's alleged injuries. To be sure, Dr. Pollock's affirmation was originally submitted on behalf of Lawrence Hospital and Dr. Garcia-Fusco's motion for summary judgment, and only pertains to the treatment rendered by Lawrence Hospital and Dr. Garcia-Fusco. As such, Dr. Pollock's affirmation does not address Dr. Spicehandler's alleged departures from the standard of care as an infectious disease physician, or Dr. Spicehandler's treatment of plaintiff. Notably, Dr. Pollock does not address plaintiffs' assertions that Dr. Spicehandler failed to, *inter alia*, recognize the signs and symptoms of an infectious process, assist with the diagnosis of plaintiff's condition, obtain accurate information about plaintiff's medical history, or recommend/order a STAT MRI of plaintiff's spine or a neurological/neurosurgical consultation. As such, because Dr. Pollock's affirmation fails to satisfy the elements necessary to establish a *prima facie* showing of entitlement to summary judgment, summary judgment must be denied.

Even if Dr. Pollock's affirmation were adequate, plaintiffs nonetheless raise triable issues of fact sufficient to preclude summary judgment.[19] For example, the parties disagree as to whether plaintiff had a SEA during his admission at Lawrence Hospital. While plaintiffs maintain that plaintiff had an infection of the cervical and upper thoracic spine that caused compression of his spinal cord on August 1, 2014, which was more likely that not a SEA, Dr. Spicehandler argues that plaintiff's spinal cord infarction occurred due to a lack of adequate blood supply resulting from inflammation near the spinal cord in response to an infectious process. Plaintiffs, however, assert that Dr. Pollock's distinction between "an infectious process" that caused "inflammation near the spinal cord," which was the source of the compression rather than a SEA or phlegmon, is inconsequential as plaintiff's treatment would have been the same (emergency spinal decompression surgery). Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Moreover, plaintiffs disagree with Dr. Pollack's opinion that an epidural phlegmon cannot cause spinal cord compression. Plaintiffs aver that a phlegmon in the epidural space can cause compression of the spinal cord, leading to quadriplegia if not timely treated. Plaintiffs argue that this is what occurred in this case, regardless of whether the growth was an early SEA or a phlegmon. Dr. Spicehandler, on the other hand, posits that plaintiff may have had a pre-vertebral phlegmon, which is not amenable to surgical drainage, and does not constitute a surgical

[19] Plaintiffs' infectious diseases/internal medicine and neurology experts' affidavits lack certificates of conformity. CPLR § 2309(c) requires that an oath taken outside of New York be accompanied by a certificate of conformity. However, although plaintiffs' infectious diseases/internal medicine and neurology experts are not licensed to practice medicine in New York, the absence of a certificate of conformity is not fatal (*Matapos Tech. Ltd. v. Compania Andina de Comercio Ltda*, 68 A.D.3d 672, 673 [1st Dept. 2009]; *see also, Bey v. Neuman*, 100 A.D.3d 581, 582 [2d Dept. 2012]; *Fredette v. Town of Southampton*, 95 A.D.3d 940, 941 [2d Dept. 2012] ["[T]he absence of a certificate of conformity for an out-of-state affidavit is not a fatal defect, a view shared by the . . . First and Third Departments as well."]). Accordingly, the court will consider the affidavits of both experts, and decide the motion on its merits.

emergency. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Furthermore, the parties disagree as to whether plaintiff's condition warranted an MRI earlier than August 3, 2014. Specifically, while Dr. Spicehandler contends that there was no radiologic evidence that plaintiff had a SEA requiring surgical intervention between August 1, 2014 and August 3, 2014, plaintiffs submit that plaintiff's condition would have been diagnosed earlier had an MRI been performed on August 1, 2014 or August 2, 2014. To that point, Dr. Spicehandler underscores that even if a cervical MRI had been performed on August 1, 2014 or August 2, 2014, plaintiff's outcome would not have changed because plaintiff never had an epidural abscess. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Similarly, plaintiffs raise an issue of fact as to whether defendants should have transferred plaintiff to a tertiary medical facility for a decompressive spinal surgery. Notably, Dr. Spicehandler maintains that defendants did not need to consider transferring plaintiff to a tertiary facility for a decompressive spinal surgery unless and until there was definitive radiographic proof of a SEA *(i.e.*—there was no showing of a SEA based on plaintiff's August 3, 2014 and August 7, 2014 MRIs and Dr. Shah's August 3, 2014 addendum). Plaintiffs, on the other hand, disagree that radiograph proof is required in order to transfer plaintiff to a tertiary facility. Rather, plaintiffs emphasize that if a hospitalist's suspicion is high enough that a patient will, or likely may require an emergency spinal decompression surgery, or if it is determined that plaintiff had an infectious process causing spinal cord compression, resulting in clinically observable neurological deficits, plaintiff must be transferred to a tertiary facility for a spinal depressive surgery. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Significantly, the parties disagree as to whether defendants' failure to timely order an MRI, and timely transfer plaintiff to a tertiary medical facility caused plaintiff's alleged injuries. Plaintiffs argue that had defendants diagnosed plaintiff's condition on August 1, 2014 or August 2, 2014, and immediately transferred plaintiff to a tertiary facility for a spinal decompression surgery, plaintiff could have avoided quadriplegia and other neurological injuries. By contrast, Dr. Spicehandler asserts that a transfer to a tertiary facility was not indicated until after plaintiff's condition worsened—notably, hours after Dr. Dousmanis reviewed plaintiff's MRI on August 3, 2014 at 4:02 p.m. Moreover, Dr. Spicehandler avers that an urgent decompression surgery was not required since there was no material that required an emergent evacuation. While Dr. Pollock bases his opinion on Dr. Angevine's August 4, 2014 operative records that did not identify the presence of any purulent fluid, and the fact that Dr. Angevine did not describe any abnormal findings within plaintiff's epidural space that could be seen or evacuated, plaintiffs highlights that a phlegmon would not reveal frank pus, and that a small, early abscess on the anterior of the spinal cord would not necessarily be seen in a spinal decompression surgery from the posterior approach. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Furthermore, plaintiffs raise an issue of fact as to whether plaintiff contributed to his spinal cord infarction. While Dr. Spicehandler argues that the complications of plaintiff's bacteremia could have been prevented had plaintiff not delayed treatment for nearly two weeks after he was advised that he had a blood stream infection, plaintiffs emphasize that there is no indication in plaintiff's medical records that plaintiff did anything prior to his admission or while in the hospital to contribute to his spinal cord injuries. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Based on the foregoing, it is hereby

ORDERED that Lawrence Hospital and Dr. Garcia-Fusco's motion for summary judgment is moot; and it is further

ORDERED that Dr. Spicehandler's motion for summary judgment is denied in its entirety; and it is further

ORDERED that the caption is amended as follows:

----------X

DE SAYLE GREY and MAUREEN GREY,

Index No. 805458/2016

Plaintiffs,

-v-

DEBRA SPICEHANDLER, M.D., and JOHN AND JANE DOES, M.D., R.N. 1-10,

Defendants.

----------X

; and it is further

ORDERED that the remaining parties are directed to appear for a virtual pre-trial conference on July 15, 2020 at 9:30 a.m. at at time to be determined ~~at 111 Centre Street (Part 10, Room 1227), New York, NY 10013.~~

This constitutes the decision and order of the court.

Date: June 16, 2020

George J. Silver

HON. GEORGE J. SILVER

GEORGE J. SILVER