Ptak v Shvartzman
2021 NY Slip Op 33224(U)
November 22, 2021
Supreme Court, Orange County
Docket Number: Index No. EF005668-2018
Judge: Robert A. Onofry
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SUPREME COURT-STATE OF NEW YORK
IAS PART-ORANGE COUNTY

Present: HON. ROBERT A. ONOFRY, J.S.C.

SUPREME COURT : ORANGE COUNTY
---X
MARGARET PTAK, as Executrix of the Estate of RAYMOND C. PTAK, and MARGARET PTAK, Individually,

Plaintiff,

-against-

ARLETTE SHVARTZMAN, M.D., ORANGE REGIONAL MEDICAL CENTER, and ORANGE REGIONAL MEDICAL GROUP,

Defendants.
---X

To commence the statutory time period for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

Index No. No. EF005668-2018

DECISION AND ORDER

Motion Date: September 29, 2021
Motion ## 1 and 2

The following papers numbered 1 to 13 were read and considered on (1) a motion by the Plaintiff, pursuant to CPLR § 3212, for summary judgment on the issue of liability; and (2) a cross motion by the Defendant Arlette Shvartzman, M.D., pursuant to CPLR 3212, for summary judgment dismissing the complaint insofar as asserted against her.

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Upon the foregoing papers it is hereby,

ORDERED, that the motion is granted in part and denied in part, and the cross motion is denied.

Introduction

The decedent Raymond Ptak died after being treated for a back injury by the Defendants Orange Regional Medical Center (hereinafter "ORMC") and Orange Regional Medical Group

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(hereinafter referred to collectively as "ORMC/ORMG").

The Plaintiff alleges, *inter alia*, that the Defendant Arlette Shvartzman, M.D. negligently failed to properly interpret a CT scan, which revealed that Ptak had suffered a fracture in his lower back, and that the Defendants' negligent failure to timely diagnose and treat the fracture led to Ptak's death.

The Plaintiff moves for summary judgment on the issue of liability.

Dr. Shvartzman cross moves to dismiss the complaint insofar as asserted against her.

The motion is granted as to Dr. Shvartzman and denied as to ORMC/ORMG, and the cross motion is denied.

Factual/Procedural Background

In support of her motion for summary judgment, the Plaintiff submits an affirmation from counsel, Edward Milstein.

As background, Milstein avers as follows.

On September 16, 2017, Raymond Ptak, age 62, was admitted to ORMC with a chief complaint of severe back pain. Apparently, he had suffered the injury when he drove his lawnmower into a backhoe.

A CT study of his chest, abdomen and pelvis was ordered while he was still a patient in the Emergency Department. The images were read by the Defendant Dr. Shvartzman, a radiologist, and by non-party Dr. Ronen Elefant, the Trauma Attending physician, and non-party Daphne Garcia, a Trauma Surgery Physicians Assistant.

Dr. Shvartzman negligently failed to diagnose a fracture/dislocation of the Ll-L2 vertebra shown on the scans.

As a consequence of this error, he argues, the fracture was not treated, *e.g.,* Ptak's spine was not immobilized, and he was encouraged to ambulate, use the commode and attend physical therapy sessions, despite his complaints of excruciating back pain.

On September 25, 2017, Ptak was transferred to the Westchester Medical Center (hereinafter "WMC").

Dr. Mohammed Siddiqi, the Trauma Medical Director at WMC, contacted Garcia and told her that Ptak had been seen by the neurosurgeon, Dr. Eric St. Clair, who reviewed the September 16, 2017, CT scan images, and that "[t]here was a misread from the radiologist [Dr. Shvartzman]."

Further, Milstein notes, on October 20, 2017 (more than one month after Ptak was discharged from ORMC, and one week following his death on October 13, 2017), Dr. Elefant made the following progress note in his records:

> I PERSONALLY DISCUSSED THE RADIOGRAPHIC FINDINGS WITH THE RADIOLOGIST WHO DID NOT APPRECIATE AN ACUTE FRACTURE ON INITIAL CT SCAN THEREFORE, NO FURTHER WORK-UP WAS PURSUED AT THAT TIME."

Similarly, he asserts, Dr. St. Clair, in a consultation note dated September 25, 2017, states:

> "CT CIA/P AT THAT TIME DEMONSTRATED A FRACTURE/DISLOCATION ROSTRAL TO HIS LUMBAR INSTRUMENTATION CONSTRUCT."

In sum, Milstein argues, as a consequence of the Defendants failing to timely identify and treat the fracture, Ptak developed paralysis and died.

In further support of the motion, the Plaintiff submits an affidavit of William Gormley, M.D.

Dr. Gormley is board certified in Neurological Surgery, is an Associate Professor of Neurosurgery at Harvard Medical School and the Director of Neurosurgical Critical Care at Brigham and Women's Hospital.

Dr. Gormley asserts that, upon review of Ptak's medical records, all pertinent radiographic images from the hospitalization; and the testimony at examinations before trial, he could opine to a reasonable degree of medical certainty as follows.

The medical treatment and management provided to Ptak by Dr. Shvartzman and by the staff of ORMC deviated from the acceptable standard of care, and directly caused and contributed to the injuries and death sustained by Ptak.

As background, he notes as follows.

Initially, Ptak reported to ORMC with back pain so significant in his lower back that he was unable to lie flat.

Several years prior, Ptak had undergone a posterior spinal stabilization operation with the insertion of rods at Ll-L2, and a posterior laminectomy.

ORMC was aware of this past back surgery.

Further, Ptak was known to suffer coronary artery disease and atrial fibrillation, diabetes mellitus, hypertension and thyroid disease. He was being treated with the anticoagulatent Coumadin.

In fact, Ptak's initial laboratory evaluation revealed that he was effectively anticoagulated with Coumadin demonstrated by an INR (internationalnormalized valve) of 2.29.

This is significant, Dr. Gormley opines, because that level of anticoagulation made Ptak more susceptible to internal bleeding.

Further, Ptak also had an elevated CPK level of 687, with normal troponin levels, which was consistent with the severity of a trauma significant enough to cause muscle destruction and rhabdomyolysis.

An initial clinical neurological evaluation by ORMC demonstrated that Ptak had full range of motion of all extremities, and he was determined to be neurologically intact with normal strength, sensation and reflexes in his lower extremities.

On September 16, 2017, he underwent radiographic evaluation with a CT scan of the chest, abdomen and pelvis while he was still in the Emergency Department.

Of note, Dr. Gormley asserts, is that Ptak had so much pain in his lower back that, in order to perform the CT scans, it was necessary to perform an anesthetic procedure utilizing Ketamine, Versed and Propofol. Ptak had to consent to the procedure given the high risk of respiratory failure from the anesthesia.

Dr. Gormley opines that Ptak's level of pain is noteworthy, as it speaks to the severe acute nature of the injury he had sustained, as such pain would not be present with a chronic injury.

Dr. Shvartzman interpreted the initial CT scan as follows:

> "There is straightening of the lumbar spine with posterior stabilization rods from Sl-L2 with posterior laminectomy. There is suspicion for chronic bony destruction of Ll with soft tissue replacement of the vertebral body and paraspinal soft tissue mass, resulting in mass effect and severe narrowing of the central canal and neural foramina best visualized on sagittal image 98 coronal images 82 and axial image 155."

Dr. Gormley notes that Dr. Shvartzman's report does not use the words fracture, fracture-dislocation, or separation and distraction of the Ll and L2 vertebral bodies.

Further, although she describes an abnormal study, she makes no recommendation for

further imaging such as an MRI of the spine.

Dr. Gormley opines that Dr. Shvartzman's failure to recommend further imaging constituted a deviation from the standard of care separate and distinct from her misreading of the images.

Further, he opines, Dr. Shvartzman misread the images, to wit: He agrees with Dr. C. Douglas Phillips (*infra*) that the images show a wide fracture dislocation with modest angulation of the Ll-L2 level, with wide separation of the Ll-L2 vertebrae. The fracture line is most discernable on the sagittal images.

Thus, Dr. Gormley opines, the correct interpretation of the initial CT scan is that it shows that Ptak suffered a "a very obvious and dramatic fracture dislocation with wide separation of the Ll and L2 vertebral bodies. The fracture is seen at the top of the spinal instrumentation, which is typical for fractures involving levels adjacent to fusion. "

Dr. Gormley opines that Dr. Shvartzman's failure to read the images correctly constituted a deviation from the standard of care, and directly contributed to the events leading up to Ptak's paraplegia and ultimate death.

In addition, he notes, Ptak was under the care of Dr. Elefant (the Trauma Attending) and Garcia.

In a progress note written by Garcia, she states:

> "ALL IMAGES FOR THIS ENCOUNTER AND RELATED READINGS REPORTED BY RADIOLOGY WERE REVIEWED BY THIS WRITER [Garcia] AND TRAUMA ATTENDING."

However, he notes, during their respective examinations before trial, both stated that a fracture was not diagnosed at that time.

Further, Garcia's notes indicate that, after Ptak's was discharged from ORMC, she received a call from Dr. Siddiqui [*supra*] of WMC and "learned that Mr. Ptak was being transferred because "THERE WAS A MISREAD FROM THE RADIOLOGIST."

Thereafter, he notes, Garcia composed an "addendum" to her notes, dated September 25,2017, in which she states: "CT scans were reviewed with Dr. Shvartzman. Dr. Elefant spoke to her via phone. The radiologist was made aware of the patient's clinical history and she reported that the abnormal findings were chronic in nature. Recon images were thought not to be necessary."

The addendum goes on to state: "Neurosurgery consult was not pursued given improvement in pain control, neurologic stability and LACK OF ACUTE INJURY FOUND ON CT."

Dr. Gormley asserts that this note "neglects to mention that both she [Garcia] and Dr. Elefant reviewed the images from the September 16, 2017 CT scan and agreed with Dr. Shvartzman's erroneous interpretation of the study."

Dr. Elefant also authored a note immediately following Garcia's, wherein he agrees with the content of Garcia's "addendum" and states: "I personally discussed the radiologic findings with the radiologist WHO DID NOT APPRECIATE AN ACUTE FRACTURE ON THE INITIAL CT SCAN. THEREFORE, NO FURTHER WORK-UP WAS PURSUED AT THAT TIME."

Dr. Gormley opines that, as a consequence of the failure to timely recognize the fracture-dislocation of Ptak's spine, the injury was not treated, *e.g.*, no immobilization devices were used, and no spinal precautions were taken. In fact, Ptak was permitted to get out of bed

and attend physical therapy.

Further, no orthopedic or neurosurgical consultations were performed until September 25, 2017, which was the ninth day following Ptak's admission on. By that time, he opines, Ptak had already suffered complete motor and sensory loss of his lower extremities, and was a complete paraplegic.

When Ptak was finally seen by a neurosurgeon, Dr. St. Clair, on September 25, 2017, the progress note states: "Patient was admitted to the ORMC Trauma Service through the Emergency Department on September 16, 2017, after a fall from a tractor. CT of chest, abdomen and pelvis AT THAT TIME demonstrated a fracture-dislocation rostral (above) to his lumbar instrumentation construct. "

Unfortunately, Dr. Gormley opines, this recognition of the correct interpretation of the CT scan was too late.

Dr. Gormley opines that there are several important points that were contributors to the paraplegia that ultimately led to the death of Ptak; Gross misinterpretation of the CT scan findings by Dr. Shvartzman, Dr. Elefant and Garcia; and the lack of any further imaging until September 25, 2017, notwithstanding Ptak's complaints of persistent severe back pain and a diagnosis of rhabdomyloysis.

Dr. Gormley opines that these are deviations from the standard of care and resulted in thoraco-lumbar spinal cord compression with resultant paraplegia, which ultimately directly caused Ptak's death one month later.

Dr. Gormley opines that, had the fracture-dislocation of the spine been correctly and timely diagnosed, "there would have been plenty of time" to transfer Ptak to a facility which

could have dealt with the fracture. Had that been done, he opines, a definitive operative fixation of the injury could have been accomplished, which would have prevented a neurological deficit and Ptak's untimely death.

In sum, he opines, the treatment and management of Ptak from September 16, 2017, until the time that the correct diagnosis was finally made, deviated from the standard of care and was the proximate cause of him developing a totally avoidable paraplegia and dying. Such departures included:

i. Failure to correctly interpret radiographic studies;

ii. Failure to make a prompt and timely diagnosis;

iii. Failure to implement spinal precautions to prevent spinal cord injury; permitting him to ambulate and attend PT;

iv. Failure to recognize the disproportionate pain, inconsistent with a "spinal strain" and to further evaluate his symptom;

v. Failure to transfer this patient to a higher level of care when his injuries could be managed prior to the onset of neurological injury (paraplegia).

In further support of the motion, the Plaintiff submits an affirmation from C. Douglas Phillips, a board certified Diagnostic Radiologist.

Dr. Phillips reviewed the CT of Ptak's chest, abdomen and pelvis which was performed on September 16, 2017, and the CT scan of his thoracic and lumbar spine which was performed on September 25, 2017.

He also reviewed pertinent portions of Ptak's ORMC file and the depositions of the parties.

Based upon the same, he asserts, he can opine to a reasonable degree of medical certainty as follows.

The initial CT performed on Ptak on September 16, 2017, was misread first by Dr. Shvartzman, and then by the medical personnel responsible for his care and treatment during his confinement for the following nine (9) days until he was transferred to the WMC. That is, the initial CT clearly shows a fracture/dislocation of the upper lumbar spine, with both fusion and DISH (diffuse idiopathic skeletal hyperostosis) or a hardening of bone and bone overgrowth. The fracture can readily be seen just at the superior extent of the fusion at the transition point between the previous surgical fusion and the native spine.

Dr. Shvartzman's report found only "a suspicion for chronic bony destruction of Ll".

However, he opines, there was clearly a fracture and marked distraction of the Ll and L2 vertebra. Indeed, he opines, "the fracture/dislocation is impossible to miss."

Further, he opines, Dr. Shvartznan's negligence does not absolve Ptak's doctors and other healthcare providers from reading the images themselves and arriving at the proper interpretation.

Thus, he opines, the failure to identify the fracture/dislocation by ORMC/ORMG was also a deviation from the standard of care.

Dr. Phillips notes that the initial CT scan revealed that Ptak's spinal alignment in the sagittal plane was near anatomic, and that the central canal and spinal cord were preserved. This, he asserts, was why Ptak continued to have the ability to move his lower extremities.

However, he opines, with progressive mobilization, the progressive malalignment and spinal cord compression leading to Ptak's death was to be expected.

Further, he asserts, Dr. Shvartzman was not the only physician to misread the initial CT images. Rather, Ptak's hospital chart reveals that both Garcia and Dr. Elefant also read the images and agreed with Dr. Shvartzman's erroneous interpretation.

In fact, he opines, every healthcare provider employed by ORMC/ORMG that read the images deviated from the standard of care (including Dr. Elefant and Garcia) by failing to identify "an extremely obvious fracture dislocation of the Ll-L2 (lumbar) spine."

Further, Dr. Phillips asserts, this led to the following "cascade of events."

Given that all of the providers who read the initial CT study failed to appreciate the clearly visible Ll-L2 fracture of Ptak's lumbar spine, no immobilization devices or neurological spinal precautions were implemented. Indeed, notwithstanding Ptak's complaints of excruciating pain and refractory to increasingly heavy doses of pain medication, Ptak was forced to ambulate, use the bathroom and attend physical therapy.

In addition, he notes, Dr. Shvartzman's report indicates that the initial CT study was abnormal. Thus, he opines, Dr. Shvartzman deviated from the standard of care by not recommending further imaging of the lumbar spine to delineate the abnormal lumbar spinal pathology.

Given all of the above, he asserts, Ptak's condition deteriorated over time.

On September 25, 2017, a second CT scan of the thoracic and lumbar spine was performed. The study was notable for kyphotic angulation at the Ll-L2 level, new from the September 16, 2017, study, with anterior displacement of the L2 posterior elements into the spinal canal. There is also marked central canal encroachment by the bony fragments. The Ll-L2level remains markedly distracted.

Dr. Phillips opines that these anatomic observations directly caused Ptak's paraplegia and ultimately his death.

In opposition to the Plaintiff's motion, ORMC/ORMG submit an affirmation from counsel, Seamus Weir.

As background, Weir asserts as follows.

In 2010, Ptak underwent significant back surgery, which resulted in metal rods being placed in his spine. Further, there were complications from the surgery. Afterward, Ptak could no longer work and qualified for disability payments.

Following that procedure, and up through 2017, Ptak could not sit for prolonged periods of time and required a cane to walk for longer distances, which he did in an hunched over manner. In addition, he could not stand fully upright, and was taking Opana twice a day and Hydrocodone for breakthrough pain.

On September 16, 2017, he was injured while riding his lawn mower and bought to ORMC. He was evaluated by Dr. Elefant and Garcia.

A CT of Ptak's chest/abdomen/pelvis was ordered.

However, he asserts, Garcia is not trained in interpreting CT scans, and neither Garcia nor Dr. Elefant interpreted the CT scan or made a diagnosis from the same. Rather, they relied on the diagnosis of the radiologist (Dr. Shvartzman). Garcia and Dr. Elefant only noted that the scan was abnormal due to the presence of hardware in Ptak's back.

Based on Dr. Shvartzman's report, and their conversation with her, Garcia and Dr. Elefant did not believe that Ptak required surgery or orthopedic or neurosurgical consultations.

Rather, Garcia and Dr. Elefant concluded that decedent should be admitted to ORMC for

pain control and critical care monitoring.

Once Ptak was admitted to ORMC, he was prescribed multiple pain medications and transferred to the ICU.

Garcia saw Ptak on September 17, 2017, the following day. Ptak appeared to have improved with pain control but still felt some pain.

A physical exam revealed that Ptak was neurologically intact and that his extremities were normal.

A neurosurgery consult was not pursued at that time due to Ptak's improved pain control, neurologic stability and lack of acute injury on the CT scan.

Ptak was seen by a member of the trauma team each day up until September 23, 2017. During each visit, Ptak's chart was reviewed, a physical examination was performed and his clinical condition was noted.

On September 23, 2017, Ptak's care was transferred from the trauma team to the medical service as, per the CT scan interpretation, Ptak did not have an acute trauma injury. Palliative care and pain management consults were ordered.

Further, Weir asserts, other avenues of treatment, such as interventional radiology, were also explored.

During this period, the trauma team continued to rely on the radiology report of the CT scan, which noted no acute injury.

Further, he opines, while Ptak did have some decreased sensation in his lower extremities over time, this was considered baseline due to his history of back issues.

In addition, Ptak suffered from marked peripheral vascular disease in his lower

extremities, which would also result in decreased sensation.

On September 25, 2017, Ptak was unable to move his lower extremities. As a result of this change in clinical condition, neurosurgery was consulted and a further CT scan was ordered.

Significantly, Weir asserts, neither Dr. Elefant nor Garcia were trained in interpreting CT scans. That is, during her examination before trial, Garcia repeatedly stated that she did not make a diagnosis based on the CT scan. Rather, she testified that she and Dr. Elefant relied on the radiology report of Dr. Shvartzman, and their subsequent conversation with her, to confirm that there was no acute fracture.

Further, Weir argues, there was no deviation from the standard of care in not ordering a neurosurgical or orthopedic consult during Ptak's initial admission. Rather, ORMC/ORMG were relying on the previously performed CT scan which showed no acute fracture.

In sum, Wier asserts, the complaint should be dismissed as against ORMC/ORMG.

In further opposition to the Plaintiff's motion, ORMC/ORMG submit an affirmation from John B. Fortune, M.D.

Dr. Fortune is a licensed physician who is Board Certified in Surgery and Surgical Critical Care.

Dr. Fortune avers that, based upon his review of the pleadings in the case, the relevant medical records, and the testimony at the examinations before trial, he can opine as follows to a reasonable degree of medical certainty.

The treatment and care rendered to Ptak by ORMC/ORMG, and their employees, including Dr. Elefant, Garcia and the entire trauma team, given the facts and information that existed at the time such treatment was rendered, was within good and accepted medical practices,

and nothing they did or failed to do was a proximate cause of any harm to Ptak.

As background, he asserts as follows.

As noted *supra*, Ptak underwent significant back surgery in 2010, which had various consequences and deficits.

On September 16, 2017, Ptak suffered the injury at issue and was transported to ORMC by ambulance. Due to the nature of his injury, a trauma consultation was ordered, and Ptak was evaluated by Dr. Elefant and Garcia as part of the same.

Ptak's medical history was obtained as well as the mechanism of the injury.

As part of that history, the prior surgery and its consequences was noted.

Upon physical examination, Ptak could move all extremities. He arrived wearing a cervical collar, which was removed during the physical exam and then replaced.

The physical examination also revealed thoracic and lumbar midline tenderness without significant deformity.

A CT of Ptak's chest/abdomen/pelvis was ordered.

Garcia is not trained in interpreting CT scans.

Thus, he asserts, although both Garcia and Dr. Elefant did look at Ptak's CT scan, neither made a diagnosis. That is, neither made a determination as to whether there was an acute fracture. Rather, they only noted that the CT was abnormal due to the presence of hardware in Ptak's back. Otherwise, he asserts, they relied on the findings of Dr. Shvartzman. Indeed, he notes, they called Dr. Shvartman to confirm the information in her report. and to provide her with the mechanism of injury. During that call, she confirmed that there was no acute injury, such as a fracture of the spine, but rather that the findings were chronic in nature.

Dr. Fortune opines that Dr. Elefent and Garcia, based on the radiologist report, as well as their conversation with Dr. Shvartzman, properly found no reason to believe that Ptak required surgery or orthopedic or neurosurgical consultations. Rather, they properly concluded that Ptak should be admitted to ORMC for pain control and critical care monitoring. Ptak was prescribed multiple pain medications and transferred to the ICU for close monitoring.

Garcia saw Ptak on September 17, 2017, the following day. Garcia noted that Ptak appeared to have improved with pain control, but still felt some pain.

A physical examination revealed that Ptak was neurologically intact and his extremities were normal.

A neurosurgery consult was not pursued at that time due to Ptak's improved pain control, neurologic stability and lack of acute injury on the CT scan. That is, overall, it appeared that Ptak had improved.

Ptak continued to be seen by a member of the trauma team each day up until September 23, 2017. During each of the visits, Ptak's chart was reviewed, a physical examination was performed and Ptak's clinical condition was noted.

On September 23, 2017, Ptak's care was transferred from the trauma team to the medical service as, per the CT scan interpretation, Ptak did not have an acute trauma injury. Palliative care and pain management consults were ordered.

Other avenues such as interventional radiology were also explored in an attempt to address Ptak's pain. Otherwise, Dr. Fortune notes, the trauma team continued to rely on the radiology report of the CT scan which noted no acute injury. Further, he notes, while Ptak did have some decreased sensation in his lower extremities, it was considered baseline due to his

history of back issues.

Further, Ptak suffered from marked peripheral vascular disease in his lower extremities, which would also result in decreased sensation.

However, on September 25, 2017, Ptak was unable to move his lower extremities. As a result of this change in clinical condition, neurosurgery was consulted and a further CT scan was ordered.

Based on all of the facts and circumstances, Dr. Fortune opines, to a reasonable degree of medical certainty, that the care rendered to Ptak by ORMC/ORMG and the treating physicians and physician assistants, including but not limited to Dr. Elefant and Garcia, was in accordance with good and accepted standards of care.

Further, it was his opinion, to a reasonable degree of medical certainty, that Dr. Elefant and Garcia properly evaluated Ptak's known history, his complaints at the time, and the findings of the physical examination in treating Ptak. Importantly, he opines, Ptak's prior back injury and surgery were noted, along with his constant pain and inability to straighten his spine prior to the most recent injury.

In addition, it was his opinion, to a reasonable degree of medical certainty, that Dr. Elefant and Garcia obtained pertinent and sufficient information to determine whether Ptak required emergent testing, and properly ordered a cervical CT, along with a CT of the chest/abdomen/pelvis.

Further, he opines, a cervical collar was appropriately initially placed on Ptak, and appropriately removed for his initial examination and then re-placed. Thereafter, the cervical collar was not fully removed until Dr. Elefant and Garcia were advised by Dr. Shvartzman there

was no acute injury to Ptak's spine. Thus, Dr. Fortune opines, Ptak was properly immobilized in accordance with good and accepted medical practices.

Dr. Fortune opines that Ptak's initial CPK level of 687 is commonly seen with direct muscle damage as a result of minor trauma. It does not, he opines, signify a level that causes or signifies generalized muscle and rhabdomyolysis. Rather, such conditions are always associated with higher CPK levels that are at least 1000 U/L, and frequently are much higher (in the thousands).

Further, he opines, in a trauma setting, it is important to distinguish a chronic condition from an acute injury.

Here, he asserts, once the initial CT was completed, Dr. Elefant and Garcia reviewed the images but did not make a diagnosis. Indeed, he opines, due to the prior insertion of hardware in Ptak's back, along with the chronic changes, it was a very complex radiologic study. Thus, he opines, Dr. Elefant and Garcia appropriately waited on the radiology report before moving forward with treatment.

Further, Dr. Fortune opines, Dr. Elefant and Garcia clearly satisfied the standard of care when they contacted Dr. Shvartzman to confirm her interpretation of the CT scan.

Moreover, he asserts, while Dr. Elefant and Garcia looked at CT scans, they had not received any training in the interpretation of such studies. As such, it was his opinion to a reasonable degree of medial certainty that Dr. Elefant and Garcia appropriately relied on the interpretation of Dr. Shvartzman.

Further, he opines, despite being advised that there was no acute injury, Dr. Elefant and Garcia appropriately admitted Ptak to the hospital to manage his pain and continue critical care

monitoring.

In addition, upon admission, the trauma team continued to appropriately treat Ptak based on their impression that there was no acute injury.

Further, he opines, while Ptak did complain of back pain and difficulty ambulating, he had very similar complaints prior to the accident, and such complaints would be consistent with a back strain exacerbating his chronic condition.

In addition, he asserts, chronic injuries can often result in severe pain as exhibited by Ptak.

Dr. Fortune opines that, when Ptak became unable to move his lower extremities, a neurosurgical consult was appropriately called and Ptak was then transferred to WMC.

Prior to that date, he opines, neither orthopedic nor neurosurgical consults needed to be ordered, as ORMC/ORMG had been advised by the radiologist that there was no acute fracture.

Dr. Fortune opines that the standard of care does not require further investigation where the appropriate radiologic study has already been performed and interpreted.

Thus, it was his opinion, to a reasonable degree of medical certainty, that ORMC/ORMG in no way deviated from the standard of care in treating Ptak.

Lastly, he opines, to a reasonable degree of medical certainty, nothing that ORMC/ORMG did or failed to do was a substantial factor in causing any of Ptak's claimed injuries. Rather, ORMC/ORMG appropriately relied on the radiology report and conversation with the radiologist in determining Ptak's course of treatment. Indeed, he asserts, assuming, *arguendo*, that an acute fracture had been identified in the radiology report, there is no non-operative treatment for that type of injury.

Dr. Fortune opines that "it is impossible to say" that, had Ptak undergone an operative fixation of the fracture, he would not have been a paraplegic or passed away. Rather, such a procedure cannot guarantee that Ptak would not have suffered from paraplegia. Indeed, he opines, even if Ptak had undergone the procedure, he would have still very likely died, to wit: Ptak coded twice during his first back surgery in 2010, and was told afterwards that he would likely not survive another surgery.

Indeed, he notes, here, when Ptak did eventually undergo the procedure, it resulted in his death. As such, Dr. Fortune opines, the care provided by ORMC/ORMG was not a substantial factor in causing any of Ptak's claimed injuries.

The Defendant Dr. Shvartzman cross moves for summary judgment dismissing the complaint as against her.

In support of the motion, she submits an affidavit from Richard Friedland, M.D., a board certified radiologist, licensed to practice medicine in the State of New York.

Dr. Friedland opines to a reasonable degree of medical certainty as follows.

In general, the standard of care for a radiologist is to review the patient's provided history, interpret the scans provided by the ordering physician, and to provide the ordering physician with an impression of the scans. It is not to decide which studies should be ordered for a patient. Rather, that choice is made by the ordering physician.

When a study "launches" on the computer system, the radiologist first ensures both name on the image and the type of study corresponds to the name and study indicated on the requisition submitted by the ordering physician.

In general, radiologists are given very little clinical information regarding a patient.

Thus, if the ordering physician wishes to discuss a case in more detail, he or she may call the radiologist to provide them with more clinical information either before or even after an interpretation is given.

Here, he notes, the initial CT scan ordered was for "trauma."

However, initially, he opines, from a "radiologist perspective," a CT of the chest, abdomen and pelvis "is not an ideal image to evaluate a spinal injury. That is, this type of imaging would be more indicative to a radiologist of an organ injury."

Otherwise, when Dr. Shvartzman received the initial CT, she correctly confirmed that the name and study correctly corresponded to those listed on the ordering physicians' report. She was told only that it was for "trauma." No further details were provided.

To the extent noted *supra,* he opines, Dr. Shvartzman met the initial standard of care.

Next, in reviewing the study itself, Dr. Shvartzman determined that there was a suspicion for "chronic bony destruction" of L1 with soft tissue replacement of the vertebral body and paraspinal soft tissue mass, resulting in a mass effect and severe narrowing of the central canal and neural foramina.

Dr. Friedland opines that, "this language, combined with the patients' complaints and the CT indication of 'trauma,' clearly indicate[d] that Dr. Shvartzman recognized and documented the significant findings of potential cord compression."

It was his opinion that the phrase, "chronic body destruction," as utilized by Dr. Shvartzman in her interpretation, was indicative of an abnormality, especially in light of the fact that the term was used in conjunction with a finding of "severe narrowing of the central canal and neural foramina."

These findings, he opines, "are a clear indication of a compromised spinal canal. Severe narrowing of the central canal and neural foramina indicates that there is an abnormality within the spine and indicates to the ordering physician the possibility of cord compression and spinal injury.

Thus, he opined, the language utilized in Dr. Shvartzman's interpretation, especially in light of the totality of circumstances surrounding her impression (the indication of "trauma," the patient's complaints, and the type of study she interpreted), comported with the standard of care in that her interpretation clearly identified an abnormality and injury of the patient's spine to the ordering physician.

Further, he opines, a neurologic injury could not be ruled out based upon the remainder of Dr. Shvartzman's interpretation. That is, she noted "soft tissue replacement of the vertebral body and paraspinal soft tissue mass, resulting in mass effect and severe narrowing of the central canal and neural foramina." A "mass effect", he asserts, is indicative of a compression upon the spinal cord or nerve roots. The term "mass" indicates a structure which occupies space. Thus, he opines, Dr. Shvartzman was not excluding the possibility of an abnormal compression of the spinal cord at that location.

Moreover, he opines, where, as here, foraminal narrowing is seen on a diagnostic study, there is always concern for spinal trauma, which in and of itself is indicative of potential cord compression.

Thus, he opines, Dr. Shvartzman's impression clearly indicated abnormal findings and she properly reported same. That is, given that a CT of the chest, abdomen, and pelvis is not an ideal image for evaluating spinal trauma, Dr. Shvartzman reported her findings appropriately based

upon what information she had, and what she was able visualize on the scans. Thus, he opines, "[t]he language utilized in her final report met the standard of care to identify an abnormality and potential spinal compression and mass effect on the spinal canal."

Finally, he notes, he had reviewed the affidavit of the Plaintiff's expert radiologist, Dr. Phillips (*supra*). Dr. Friedland asserts that Dr. Phillip wholly failed to address the entirety of Dr. Shvartzman's impression. That is, Dr. Phillip only comments on that portion of Dr. Shvartzman's impression that relates to a "suspicion of chronic bony destruction," and does not comment on its use in conjunction with other language indicative of a compromised spinal canal. Dr. Friedland argues that this lack of appreciation of the entirety of the radiologist's interpretation is misleading, as Dr. Shvartzman's total impression clearly identified significant potential cord compression, which Dr. Phillip's did not address. Moreover, he opines, the language of the impression met the standard of care in properly interpreting the diagnostic studies ordered.

Based on the foregoing, Dr. Friedland opines, Dr. Shvartzman met the accepted standard of care in interpreting the initial CT study, and in providing information sufficient to notify the ordering physician of a spinal abnormality and a spinal compression.

Further, he opines, the language utilized in Dr. Shvartzman's impression provided sufficient information to the clinical attending doctors to allow the medical and surgical staff to treat Ptak.

In reply, the Plaintiff submits an affirmation from counsel, Edward Milstein.

Initially, Milstein argues, it was clear from reading the opposition/reply papers that no Defendant is prepared to accept responsibility for Ptak's death. Rather, each seeks to blame the other.

In broad strokes, he asserts, Dr. Shvartzman's argument is, in essence, that, although she did not use the term "fracture" in her radiology report, the ORMC/OMRG Defendants "should have concluded by reading between the lines of her report that indeed Mr. Ptak had a fractured spine."

Conversely, he notes, ORMC/ORMG argues "counter intuitively that they are free from fault because Dr. Arlette Shvartzman negligently failed to inform/advise them that Mr. Ptak was indeed suffering from a fractured spine at the Ll level." That is, they argue that, had she only told them that the images revealed a fracture, they would have presumably called for a neurosurgical/orthopedic consult, and further diagnostic studies would have been undertaken, which would have led to a correct diagnosis of fractured spine, which would have been appropriately rreated.

Thus, Milstein argues, in an effort to make a case against Dr. Shvartzman, ORMC/ORMG are reduced to denigrating their own trauma surgeon, Dr. Elefant, and his Physician Assistant, Garcia, arguing they are not trained and therefore not capable of interpreting CT images.

However, Milstein asserts, this concept is absurd on its face with regard to Dr. Elefant, as there is no evidence whatsoever that he is not trained to read CT scans. Indeed, he notes, Dr. Elefant has not yet been deposed.

Further, Milstein argues, this argument is extremely short sighted, as it is entirely plausible that ORMC/ORMG may be found vicariously liable for Dr. Shvartzman's negligence under an agent/servant theory of liability.

Indeed, he contends, by "arguing that their own ad hoc employee, Dr. Arlette Shvartzman,

is negligent," the ORMC/ORMG's own expert, Dr. Fortune, may be called as a witness against them at trial.

As to the facts, Milstein asserts that no Defendant denies that the images taken on September 16, 2017, revealed a fracture at the Ll level of Ptak's spine; or denies that the fracture should have been recognized and treated in accordance with the standard of care, or that, had the images been properly interpreted, a orthopedic/neurosurgical consultation would have been undertaken in accordance with the standard of care.

In addition, he contends, no Defendant denies that Ptak should have been immobilized, and that permitting Ptak to ambulate and attend physical therapy with a fracture of the spine was a deviation from the standard of care.

As to causation, he notes that the expert for ORMC/ORMG opines only that, "it is impossible to say" whether Ptak would have been spared suffered injury and death had he been timely diagnosed and treated, and that timely treatment could not have guaranteed a result.

However, Milstein argues, "impossible to say and guarantees" are not accepted criteria for medical malpractice litigation in New York State. Rather, he asserts, there must be an expert opinion stated to a "reasonable degree of medical certainty."

Moreover, he opines, "most remarkable" is that Dr. Shvartzman's expert radiologist, Dr. Friedland, never reviewed the images from the initial CT himself. Rather, he reviewed the "imaging reports" (not the CT images themselves).

Indeed, Milstein asserts, Dr. Friedland does not refer to his own interpretation of the CT images in his affidavit. Rather, his entire affidavit only comments on the language Dr. Shvartzman used in describing her interpretation of the CT images.

Milstein argues that it is "bizarre" that Dr. Friedland did not read the CT imaging studies himself. Further, that he must conclude that this omission was intentional. "Likely, if they reviewed the images themselves, the experts could not defend their respective parties since the fracture is so obvious."

By contrast, he notes, Dr. Phillips actually reviewed the CT images, and describes a wide fracture dislocation with modest angulation of the Ll-L2 level, with wide separation of the Ll-L2 vertebrae.

Further, he asserts, given that all these findings were evident on the initial CT scan, Dr. Shvartzman failed to read the images correctly, which was departure from the relevant standard of care, and directly contributed to the events leading up to Ptak's paraplegia and ultimate death.

Indeed, he argues, Dr. Friedland spends the bulk of his affidavit trying to rationalize Dr. Shvartzman's failure to identify that Ptak had a fracture of the spine, and argues that the variety of findings in the report should have indicated to the ordering physician the possibility of cord compression and spinal injury.

However, he asserts, Dr. Elefant has yet to be deposed. Further, it was not clear whether he is a board certified trauma surgeon. "To suggest that he was not trained to read a CT scan of chest/abdomen/pelvis strains credulity since there is absolutely no evidence in this case to support that hypothesis. "

As to Garcia, Milstein notes that following colloquy occurred at her examination before trial.

Q: Did you have any training at all in reading CT scans?

A: No, not in PA school. On the job, yes. I learned over the years to, you know, look at

different Cts and be able to know what's not normal.

Q: And was that the basis by which you looked at the CT scan in this case to see if you could identify something that was not normal?

A: We. Okay. We always look at every image when we have a trauma patient. So yes.

Q: And when you looked at the image, would that be in conjunction with Dr. Elefant?

A. Yes.

Q: So the two of you would be looking at a computer screen?

A. Correct.

Concerning follow up by Garcia and Dr. Elefant, he notes as follows.

According to counsel, it was Dr. Shvartzman's custom and practice to add an addendum to her report if she spoke to an ordering physician. Here, she did not add such an addendum, "ergo no conversation took place between Dr. Shvartzman and Dr. Elefant or PA Daphne Garcia. A fool proof alibi if I ever heard one."

Finally, he notes, according to Dr. Elefant and Garcia, Dr. Shvartzman stated that all conditions seen on the CT of the Ptak's spine were chronic.

In reply, Dr. Shvartzman submits an affirmation from counsel, Elizabeth Doer.

Initially, Doer notes, Dr. Friedland did review the actual CT scan at issue, not just the report.

Further, she argues, at no point did Dr. Shvartzman assert that Ptak's clinical physicians should have "read between the lines of her report" and concluded that there was a fracture.

Moreover, she asserts, contrary to Milstein's contention, no Defendant has "conceded" that the CT scan shows a fracture.

Notably, she argues, the Plaintiff "seemingly does not rebut the fact that [her] own expert radiologist, Dr. Phillip, wholly failed to address the entirety of Dr. Shvartzman's impression and merely commented on the portion of Dr. Shvartzman's impression relating to 'a suspicion of chronic bony destruction.' Once again, Dr. Phillip does not comment on the fact that the language in the report was used in conjunction with other language indicative of a compromised spinal canal. This lack of appreciation of the entirety of the Dr. Shvartzman's interpretation is confusing at best and misleading at worst."

Finally, Doer asserts, importantly, the Plaintiff does not rebut the Defendant's position that all of the opinions of the Plaintiff's experts were speculative and conclusory.

In a supplemental affirmation, Dr. Freidland avers as follows: "In preparation of my initial affidavit, in conjunction with those materials previously mentioned, I reviewed the actual CT scan of the plaintiff's Ptak' chest, abdomen and pelvis."

Discussion/Legal Analysis

On a cause of action alleging medical malpractice, a plaintiff must prove a deviation or departure from good and accepted standards of medical practice, and that such departure was a proximate cause of damages. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010). In general, expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010]. Because causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that defendant's deviation was a substantial factor in causing the injury. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010]. A plaintiff's evidence of proximate cause may be found legally sufficient even

if his or her expert is unable to quantify the extent to which defendant's act or omission decreased plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that defendant's conduct diminished plaintiff's chance of a better outcome or increased the injury. *Semel v. Guzman*, 84 A.D.3d 1054 [2nd Dept. 2011]; *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010].

A defendant moving for summary judgment in a medical malpractice case must demonstrate the absence of any material issues of fact with respect to at least one of these elements. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. A defendant must establish, *prima facie*, either that there was no departure from good and accepted medical practice or that, if there were, the plaintiff was not injured thereby. *Contreras v. Adeyemi*, 102 A.D.3d 720, 958 N.Y.S.2d 430, (2nd Dept. 2013). The defendant is required to address the factual allegations set forth in the plaintiffs' bill of particulars with reference to the moving defendant's alleged acts of negligence and the injuries suffered with competent medical proof. Bare conclusory assertions by a defendant that he or she did not deviate from good and accepted medical practices, with no factual relationship to the alleged injury, does not establish that the cause of action has no merit so as to entitle defendants to summary judgment. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

In opposing a motion for summary judgment in a medical malpractice case, a plaintiff needs only to rebut the moving defendant's prima facie showing. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept

2017]. However, general and conclusory allegations of medical malpractice, unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant physician's summary judgment motion. Rather, the plaintiff's expert must specifically address the defense expert's allegations. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

A medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. However, the witness must be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. Thus, where a physician opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered. Where no such foundation is laid, the expert's opinion is of no probative value. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Initially, the Court addresses the following threshold issue.

Effective February 1, 2021, 22 NYCRR 202.8-g provides:

(a) Upon any motion for summary judgment, other than a motion made pursuant to CPLR 3213, there shall be annexed to the notice of motion a separate, short and concise statement, in numbered paragraphs, of the material facts as to which the moving party contends there is no genuine issue to be tried.

(b) In such a case, the papers opposing a motion for summary judgment shall include a correspondingly numbered paragraph responding to each numbered paragraph in the statement of the moving party and, if necessary, additional paragraphs containing a separate short and concise statement of the material facts as to which it is contended that there exists a genuine issue to be tried.

© Each numbered paragraph in the statement of material facts required to be served by the moving party will be deemed to be admitted unless specifically

controverted by a correspondingly numbered paragraph in the statement required to be served by the opposing party.

(d) Each statement of material fact by the movant or opponent pursuant to subdivision (a) or (b) each statement controverting any statement of material fact must be followed by citation to evidence submitted in support of or in opposition to the motion.

Here, the Plaintiff did not submit such a statement of facts.

However, although not yet decided by an appellate court, the weight of the relevant authority is that the failure to comply with 22 NYCRR 208.2-g is not in an of itself fatal. *Siegel-NYPRAC § 281; Reus v. ETC Housing Corporation*, 72 Misc.3d 479 [S. Ct. Clinton; 2021]; *Amos Financial LLC v. Crapanzano*, 73 Misc.3d 448 [S.Ct. Rockland; 2021].

Here, the Court does not find it to be.

On the merits, the Plaintiff, through her experts, demonstrated, *prima facie*, that Dr. Schvartzman was negligent in her care as to Ptak in at least two ways.

First, the initial CT scan showed abnormalities in Ptak's spine that warranted further testing, which Dr. Shvartzman negligently failed to note or recommend.

Second, more significantly, the initial CT scan showed a fracture in Ptak's spine which Dr. Shvartzman negligently failed to diagnose.

Further, the Plaintiff, through her experts, demonstrated, *prima facie*, that such departures were a proximate cause of the alleged injuries, to wit: that the failure to diagnose the fracture resulted in subsequent care and treatment which not only failed to address the fracture, but actually exacerbated the injury.

In opposition to the Plaintiff's motion, and in support of her cross motion, Dr. Shvartzman failed to demonstrate, *prima facie*, that she was not negligent, or to raise a triable

issue of fact as to the same.

Significantly, Dr. Shvartzman's expert, Dr. Friedland, does not opine that the initial CT scan did not reveal a fracture. Nor does he opine that, even if it did, Dr. Shvartzman was not negligent in failing to diagnose the same. Rather, he only opines that the type of scan ordered were not the best for detecting such a fracture.

Otherwise, the gist of Dr. Friedland's submission is, in effect, that Dr. Shvartzman noted enough abnormalities with Ptak's scan that Dr. Elefant or Garcia, or other emergency room personnel, should have known or suspected that there was an acute injury, such as a fracture, and either diagnosed the same or ordered additional testing, etc.

The Court does not find that such testimony raises a triable issue of fact whether Dr. Shvartzman was negligent in the reading of the initial CT scan, or as to causation. Indeed, the testimony is essentially speculative.

Further, the Court notes, the record indicates that Dr. Elefant and Garcia made a follow-up telephone call to Dr. Shvartzman and were told that no acute injury was present, but rather that all observations were chronic.

Dr. Shvartzman also fails to otherwise raise a triable issue of fact as to causation. Rather, little more is offered than speculation that Ptak would not have survived the necessary surgery had he been timely and properly diagnosed and treated.

In sum, the branch of the Plaintiff's motion which is for summary judgment on the issue of liability as against Dr. Shvartzman is granted.

Conversely, Dr. Shvartzman's cross motion for summary judgment dismissing the complaint as against her is denied.

The Court notes that it appears that the Plaintiff is arguing that ORMC/ORMG may be held vicariously liable for the negligence of Dr. Shvartzman.

However, on the record presented, it may not.

In general, a hospital may not be held liable for the acts of a physician who was not an employee of the hospital, but one of a group of independent contractors. *Hill v. St. Clare's Hosp.*, 67 N.Y.2d 72; *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010]. However, vicarious liability for the medical malpractice of an independent, private attending physician may be imposed under a theory of apparent or ostensible agency by estoppel. *Loaiza v. Lam*, 107 A.D.3d 951 [2nd Dept. 2013]; *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010]. In order to create such apparent agency, the plaintiff must reasonably rely on the appearance of authority, based on some misleading words or conduct by the principal, not the agent. *Loaiza v. Lam*, 107 A.D.3d 951 [2nd Dept. 2013]; *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010]. Moreover, the third party must accept the services of the agent in reliance upon the perceived relationship between the agent and the principal, and not in reliance on the agent's skill. *Loaiza v. Lam*, 107 A.D.3d 951 [2nd Dept. 2013]; *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010].

Here, it is noted, the Plaintiff's allegations concerning the relationship between Dr. Shvartzman and ORMC/ORMG are not completely clear.

In the complaint, the Plaintiff alleges that Dr. Shvartzman was "an agent, servant and/or employee" of ORMC/ORMG.

However, in her answer, Dr. Shvartzman denies that she was an employee of ORMC/ORMG.

Further, in Dr. Shvartzman's statement of uncontested facts, she denies that she was an

employee of ORMC/ORMG. The Plaintiff's lack of a response to the same means that the statement is uncontested. Indeed, the Plaintiff appears to concede this *supra*, when counsel argues that ORMC/ORMG committed a strategic error in blaming Dr. Shvartzman for negligence in reading the CT scan, as they might ultimately be held liable for the same on an agency theory.

Regardless, on the record presented, it may be found that Dr. Shvartzman was not an employee of ORMC/ORMG.

Given such, ORMC/ORMG demonstrated, *prima facie*, that it may not be held liable for the negligence of Dr. Shvartzman. *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010].

In opposition, the Plaintiff failed to raise a triable issue of fact as to whether ORMC/ORMG may be held vicariously liable for Dr. Shvartzman's malpractice under the doctrine of apparent or ostensible agency. *Sullivan v. Sirop*, 74 A.D.3d 1326 [2nd Dept. 2010]. That is, there is no evidence that Ptak was even aware of the existence of Dr. Shvartzman, let alone that he reasonably relied on misleading words or conduct by ORMC/ORMG in accepting services from her in reliance upon a perceived relationship between Dr. Shvartzman and ORMC/ORMG.

In sum, on the record presented, ORMC/ORMG may not be held vicariously liable for the negligence of Dr. Shvartzman.

However, this is not the only theory of liability as against ORMC/ORMG. Rather, the Plaintiff alleges that employees of ORMC/ORMG (*e.g.*, Dr. Elefant and Garcia) were also negligent in the diagnosis and care of Ptak, and that such negligence was a proximate cause of damages. *Zhuzhingo v. Milligan*, 121 A.D.3d 1103 [2nd Dept. 2014].

Initially, the Court notes, it is unclear why Dr. Elefant and Garcia were not named as

Defendants, as they are accused of negligence separate and distinct from Dr. Shvartzman.

Regardless, the Plaintiff demonstrated, *prima facie*, that Dr. Elefant and Garcia were negligent in their diagnosis and treatment of Ptak, and that such negligence was a proximate cause of damages. That is, the Plaintiff proffered expert evidence that there were sufficient indicators that Ptak had suffered a significant, acute injury, separate and apart from his chronic conditions, which the Emergency Room staff negligently failed to diagnose, or to investigate with additional testing, etc.

However, in opposition, ORMC/ORMG raised a triable issue of fact. However, only barely so.

Initially, the Court notes, the primary argument of ORMC/ORMG appears to be, in effect, that all negligence in the case is attributable to Dr. Shvartzman, and that neither Dr. Elefant nor Garcia, nor any other Emergency Department personnel, may be held liable for relying on Dr. Shvartzman's report in diagnosing and treating Ptak.

However, nothing in the submissions supports a finding that Dr. Shvartzman's failure to diagnose the fracture absolves all hospital personnel of liability. For example, clearly, at a minimum, Dr. Elefant and Garcia had an independent duty to diagnose and treat Ptak based on all available and relevant information, only a portion of which was the report of Dr. Shvartzman.

Further, the Court notes, there are entries in the records indicating that Dr. Elefant and Garcia both personally reviewed the initial CT scan. And while there is evidence that Garcia did not have formal training on reading the same, there is no competent evidence in admissible form that Dr. Elefant lacked the same training.

Further, there is evidence in the record that Ptak was suffering excruciating pain during

his stay, indicative of more than a chronic condition.

In addition, there is evidence that Dr. Elefant and Garcia called Dr. Shvartzman to follow-up on her report. What precipitated the call, and the nature of the inquiry, are not clear on the record.

In sum, there is a question of fact whether ORMC/ORMG may be held liable to the Plaintiff in negligence.

Thus, that branch of the Plaintiff's motion which is for summary judgment against ORMC/ORMG is denied.

Accordingly, and for the reasons cited herein, it is hereby,

ORDERED, that the motion is granted in part and denied in part, as set forth herein; and it is further,

ORDERED, that the cross motion is denied; and it is further,

ORDERED, that the parties, by and through counsel, if retained, are directed to appear for a Status Conference on Tuesday, February 1, 2022, at 1:30 p.m., at the Orange County Court House, 285 Main Street, Court Room #3, Goshen, New York.. If the Courts are not open to the public at that time, a virtual conference will be scheduled on said date, at a time to be determined by the Court.

The foregoing constitutes the decision and order of the Court.

Dated: November 22, 2021
Goshen, New York

ENTER

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