SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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MELISSA FENSTERSTOCK and MICHAEL FENSTERSTOCK,

Plaintiffs,

- v -

MARINA KREMYANSKAYA, M.D., ALYSSA KAPLAN, MSN, FNP-BC, KHADEEN CHEESMAN, M.D., MT. SINAI HOSPITAL RUTTENBERG TREATMENT CENTER, and MT. SINAI HOSPITAL,

Defendants.

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INDEX NO. 805371/2018

MOTION DATE 04/22/2022

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88

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

In this action to recover damages for medical malpractice based on departures from good and accepted medical practice and failure to obtain fully informed consent, the defendants Marina Kremyanskaya, M.D., Alyssa Kaplan, MSN, FNP-BC, Khadeen Cheesman, M.D., and Mount Sinai Hospital (collectively the movants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiffs oppose the motion. The motion is granted to the extent that summary judgment is awarded to Kaplan and Cheesman dismissing the complaint insofar as asserted against them, and summary judgment is awarded to Kremyanskaya and Mount Sinai Hospital dismissing the lack of informed consent cause of action insofar as asserted against them. The motion is otherwise denied.

The crux of the plaintiffs' claim is that the movants committed malpractice in failing to recognize that the plaintiff Melissa Fensterstock (hereinafter the patient), who had recently given birth to her second child, was susceptible to a stroke or a transient ischemic attack (TIA), a brief episode during which parts of the brain do not receive enough blood. They also assert that the

movants departed from good and accepted practice in failing to diagnose strokes or TIAs when the patient actually sustained them, and in failing to recommence platelet-lowering treatment at the appropriate time. The plaintiffs assert that the events that injured the patient were a series of at least six left cerebellar infarcts in the anterior interior cerebellar artery (AICA) distribution and two medullary infarcts that caused ischemic damage to the patient's left inner ear, leading her to lose hearing in that ear that, in turn, necessitated a cochlear implant. Specifically, the plaintiffs contend that the movants' failure, between February 8, 2018 and February 13, 2018, to reintroduce the administration of a platelet-lowering drug---a drug that the patient had been taking for approximately 18 months prior to the birth of her second child on December 23, 2017---and instead continuing her solely on the anticoagulant Lovenox, constituted a departure from good practice that caused her to sustain the strokes. They also contend that the movants' failure to order appropriate diagnostic scans, immediately after the patient began complaining of dizziness and lightheadedness on February 8, 2018, constituted a departure from good practice that delayed proper diagnosis and treatment that would have averted the February 19, 2018 stroke that was the immediate cause of the patient's hearing loss.

Prior to October 2, 2012, the patient had been diagnosed with essential thrombocythemia (ET), a chronic myeloproliferative neoplasm characterized by an increased number of platelets in the blood that causes increased blood clotting or bleeding. The diagnosis included a finding that she was positive for the presence of a mutation in the Janus kinase 2 (JAK2) gene, which causes the body to produce an abnormal number of blood cells and platelets. On October 2, 2012, the patient began treating with Kremyanskaya, a Mount Sinai hematologist and medical oncologist. At the time, the patient was on a regimen of daily low-dose baby aspirin to thin her blood. On that date, blood tests revealed that the patient's platelet count was 843,000 per microliter (µl) of blood, far above the normal range of 150,000/µl to 450,000/µl. The patient simultaneously was undergoing a neurology work-up due to two prior

episodes of what she described as “word-finding difficulties” that her primary care physician concluded was a TIA due to her ET, inasmuch as the patient was in a high risk category.

On November 21, 2012, Kremyanskaya recommended that the patient consider participating in a randomized controlled trial comparing the effectiveness and safety of Pegasys, an antiviral and immunosuppressive drug also used to treat ET, and Hydroxyurea, another medication used to treat that condition. The patient agreed to take part in the trial, was randomly assigned to take Pegasys for cytoreductive, or cell-reducing, therapy, and began taking the drug on February 6, 2013, while continuing with her regimen of low-dose aspirin. The patient returned to Kremyanskaya regularly for follow ups and, by May 2, 2013, was noted to be in hematological remission, with a platelet count of 334,000/µl, a level within the reference range. She continued to see Kremyanskaya regularly for follow-up visits for the next few years, through January 2016, when it was confirmed that she was pregnant.

At around the same time, the patient also treated with Cheesman, an endocrinologist, to regulate her production of thyroid hormone and monitor prescriptions for Synthroid, a synthetic thyroid hormone.

The patient saw Kremyanskaya on February 6, 2016, when, according to that doctor, the patient requested to be placed on the lowest dose of Pegasys possible to control her platelet count. At that time, her dosage was decreased from 90 micrograms (µg) weekly to 45 µg weekly. On March 2, 2016, Kremyanskaya further reduced the patient’s Pegasys dosage to 45 µg every other week, which remained unchanged during the course of her pregnancy, after which she maintained a stable platelet count. On August 8, 2016, when the patient was 36 weeks pregnant, she returned to Kremyanskaya, and reported that she was discontinuing her low-dose aspirin regimen at the recommendation of her obstetrician and in preparation for her impending delivery. Kremyanskaya documented a discussion with the patient regarding the limited data concerning Pegasys and breastfeeding, and recorded that they planned to discuss the risks and benefits of discontinuing Pegasys while breastfeeding at their next visit.

Kremyanskaya's records documented that her plan was for the patient to begin taking the anticoagulant Lovenox after delivery, and her records for August 22, 2016 documented a discussion with the patient concerning the risks of continuing Pegasys while breastfeeding, with particular emphasis on the possible transmission of the drug to the infant. During that discussion, Kremyanskaya explained that there was not a large amount of data concerning Pegasys and breastfeeding. Kremyanskaya thus recommended that the patient discontinue the Pegasys if she elected to breastfeed, documented that the patient would begin treatment with Lovenox on the day after delivery, and recorded that a prescription had already been sent to her pharmacy. Kremyanskaya decided to discontinue the Pegasys and monitor the patient's complete blood count closely every month after delivery.

The patient delivered her first child in late August 2016, at which time her platelet count was 204,000/µl, well within the reference range. She next visited Kremyanskaya on October 10, 2016, when she was approximately six weeks post-partum, at which time the patient was off Pegasys, but on Lovenox. Her platelet count had increased to 503,000/µL, which further increased to 585,000/µl by November 7, 2016, and, after the recommencement of a low-dose aspirin regimen and the discontinuation of Lovenox, her platelet count had risen to 638,000/µl by December 14, 2016, and then to 726,000/µl by January 11, 2017.

On February 13, 2017, the patient's platelet count was 722,000/µl, and Kremyanskaya's plan was to resume the administration of Pegasys two weeks later, and thus after the patient had breastfed for six months. The patient resumed taking Pegasys on or about March 6, 2017 and, as of March 13, 2017, her platelet count had decreased to 584,000/µl.

In May 2017, the patient again was confirmed to be pregnant. When she returned to Kremyanskaya on July 5, 2017, her platelet count had fallen to 414,000/µl, and her Pegasys dosage was reduced to 45 µg every other week. According to Kremyanskaya, she spoke to the plaintiff prior to her second delivery about implementing the same procedures that she followed

after her previous delivery, specifically, discontinuing Pegasys and starting Lovenox. The patient delivered her second child on December 23, 2017.

On February 8, 2018, the patient emailed Kremyanskaya, and reported that she had experienced lightheadedness and nausea, and felt as if she were about to pass out. Inamsuch as the patient had an appointment with her obstetrician scheduled for February 9, 2018, Kremyanskaya recommended that the obstetrician obtain a current platelet count. On February 13, 2018, the patient again emailed Kremyanskaya, this time advising her that she had received the results of bloodwork ordered by her obstetrician and that her platelet count was in the range of 700,000/µl. She further reported an additional episode of dizziness on February 12, 2018; later on February 13, 2018, she again emailed Kremyanskaya to advise her that the dizziness was not abating, and inquired as to whether she should be concerned about a TIA or stroke, and whether to restart Pegasys. Kremyanskaya responded to the first February 13, 2018 email, noting that the patient's platelet count had also been in the 700,000/µl range following her previous pregnancy. Kremyanskaya recommended that the patient continue to take Lovenox, and return to see her in three weeks. According to Kremyanskaya, she spoke to the patient later that day to inquire as to her condition, and that the patient denied being symptomatic at that time.

Because Kremyanskaya was on vacation during the time that she was communicating with the patient in early February 2018, she recommended that the patient report to an emergency room if symptoms returned or worsened, and arranged for her to meet with Kaplan, a nurse practitioner, on the morning of February 14, 2018. On that date, the patient met with Kaplan, and complained that she was experiencing an episode of dizziness. Kaplan performed an examination, concluded that the patient was not experiencing any symptoms of a stroke or impending stroke, such as slurred speech, abnormal gait, or any pupil abnormalities, and found no cranial abnormalities. According to Kaplan, the patient was not in any acute distress, although the patient reported feeling "foggy" with some dullness in her ears and coughing, and

advised Kaplan that the dizziness was worse when she changed positions and sat up, asserting that she felt like the room was spinning. Kaplan documented that the patient reported having had bronchitis one month earlier. Kaplan also reported that the patient began to feel better over the course of the visit, and determined that admitting the patient into a hospital emergency room was not warranted. Kaplan reported her findings to Kremyanskaya. On February 14, 2018, the patient's platelet count was 662,000/µl, above the reference range, but lower than it had been only a few days earlier.

Based on Kaplan's findings, the patient was diagnosed with labyrinthitis, which is an inflammation of the part of the inner ear called the labyrinth, and is usually caused by a virus. To treat the symptoms of vertigo caused by the suspected labyrinthitis, the patient was prescribed the anti-air sickness drug Meclizine, at a dosage of 12.5 mg, to be taken twice per day as needed, and Kaplan instructed the patient to return in two weeks.

On February 18, 2018, the patient presented to the emergency department at Englewood Hospital in New Jersey, chiefly complaining of dizziness, along with nausea and vomiting. A physical examination revealed moderate fluid buildup behind her right and left tympanic membranes. Her platelet count was 700,000/µl, and a CT scan of the head without contrast revealed no acute intracranial process. According to that hospital's records, the patient was administered 12.5 mg of Meclizine. No computed tomography angiography (CTA) was performed. The patient ultimately was reported as asymptomatic by the end of her visit. She left the emergency department in stable condition, with the clinical impression reported as acute dizziness and acute vertigo. The patient was instructed to follow up with her primary care physician as well as with a neurologist and otolaryngologist. Later that day, the patient emailed Kremyanskaya to inform her that she had missed one day's dosage of Meclizine, recounted her visit to Englewood Hospital, and advised Kremyanskaya that her CT scan was normal. According to Kremyanskaya, upon receiving that email, she spoke to the patient over the phone, and planned for the patient to meet with a neurologist the following week.

On February 19, 2018, the patient presented to otolaryngologist Kenneth Remsen, M.D., with complaints of vertigo, nausea, vomiting, and loss of balance, and reported decreased hearing in her left ear. Dr. Remsen diagnosed the patient with sudden idiopathic hearing loss in the left ear and left asymmetrical low frequency sensorineural hearing loss, with vertigo, dizziness, and giddiness. He referred her for a number of studies, including an MRI of the brain and internal auditory canals. That night, the patient emailed Kremyanskaya to advise her of her visit with Dr. Remsen, and to report that she had sustained severe hearing loss in her left ear on that date. On February 20, 2018, the patient underwent an MRI at Englewood Hospital, and thereafter provided Kremyanskaya with medical reports showing that the scan revealed two tiny foci of abnormal restricted diffusion within the left hemisphere inferiorly, compatible with tiny infarcts of 4 mm and 5 mm, respectively. On February 20, 2018, the patient underwent both a CT and CTA of the head at Mount Sinai, along with a neck CTA. February 21, 2018 and February 24, 2018, the patient underwent a brain MRI, and underwent additional CTAs of the head and neck on February 25, 2018. The scans revealed the presence of six cerebellar infarcts within the bilateral cerebellar hemispheres, as well as two acute infarcts within the pons (medulla). On February 21, 2018, the patient consulted with Mount Sinai otolaryngologist Maura Cosetti, M.D., who confirmed the findings of infarcts, and noted that the patient's hearing in her left ear was unlikely to return naturally.

The patient has since undergone cochlear implant surgery in her left ear.

In their complaint, the plaintiffs alleged that the movants committed medical malpractice in failing and neglecting to treat the patient in accordance with good and accepted medical customs, practices, and standards, to promptly and/or timely diagnose the true nature and severity of her medical condition, to perform the necessary and requisite diagnostic tests and procedures or properly interpret those tests, to obtain the necessary and requisite medical consultations, and to obtain the patient's fully informed consent.

In their bills of particulars, the plaintiffs alleged that, based upon the patient's post-partum status and the concomitant withdrawal her usual medication regimen for her underlying condition of ET, the movants failed and neglected to appreciate her medical history, which the plaintiffs asserted was significant for ET, previous TIAs, and an increased risk of thrombosis. They further asserted that the movants neglected to perform a complete and thorough physical examination of the patient and all the necessary and proper tests, x-rays, including MRIs, CTs, and other diagnostic tests, which would have revealed the presence or increased risk of TIA or stroke. Specifically, the plaintiffs asserted that the defendants failed and neglected to appreciate the importance of the patient's complaints of dizziness, lightheadedness, nausea, and mental fogginess, her elevated platelet count, and other warning signs of an impending TIA or stroke. The plaintiffs further alleged that the defendants failed to develop an appropriate differential diagnosis in light of the fact that the patient was a post-partum patient with a history of essential thrombocytosis and new and concerning complaints of signs and symptoms of TIA.

In addition, the plaintiffs asserted that the movants departed from good and accepted medical practice in failing and neglecting to order appropriate post-partum therapy to lower the patient's platelet count, specifically, the administration of anti-coagulants and platelet-lowering medication to prevent blood clotting or occlusion. They stated that, in light of the fact that the movants did not conduct a complete and thorough diagnostic work-up and laboratory studies, they improperly diagnosed the patient with idiopathic vertigo and nausea, rather than a potential TIA or stroke due to the restriction of blood flow, and thus failed to initiate the administration of aspirin, Hydroxyurea, or other platelet-lowering medications, and failed immediately to refer plaintiff to the emergency room for a work-up. The plaintiffs additionally asserted that, since the movants failed to recognize the onset of a TIA, they did not seasonably take steps to prevent ischemic damage to the left inner ear and left cerebellar infarcts in the AICA distribution system.

In support of their motion, the movants submitted the pleadings, the bills of particulars, transcripts of the parties' deposition testimony, and relevant medical records, along with the

expert affirmations of Kenneth B. Hymes, M.D., a physician who is board certified in internal medicine, hematology, and medical oncology, Athos Patsalides, M.D., a physician who is board certified in diagnostic radiology, with training in interventional neuroradiology and neurointerventional surgery, Loren Weissner Greene, M.D., a physician who is board certified in internal medicine, with training and experience in endocrinology and obstetrics/gynecology, and Alan Z. Segal, M.D., a physician who is board certified in neurology, with a specialty in vascular neurology and sleep medicine, and training and experience in both internal medicine and neurological critical care/stroke care.

Dr. Hymes opined that none of the movants departed from good and accepted medical practice, and that none of their actions or inactions caused or contributed to the patient's injuries.

With respect to Kremyanskaya, Dr. Hymes asserted that the differential diagnosis in connection with the patient's complains of dizziness in early February 2018 remained very broad, as the patient did not report any other symptoms of a stroke such as numbness or weakness in her arms, legs, or facial muscles, difficulty speaking, or vision problems. He further asserted that, inasmuch as the patient advised Kremyanskaya during their February 13, 2018 phone conversation that she felt fine and did not feel as though she needed to go the emergency room, it was not a departure from good medical practice for Kremyanskaya to decline to refer the patient for admission to a hospital for a full stroke work-up, including imaging studies.

As to Kaplan, Dr. Hymes averred that, based on the patient's complaints on February 14, 2018, Kaplan performed a "thorough examination" that reflected that the patient was not exhibiting any signs or symptoms of a stroke or an impending stroke, as Kaplan found no abnormalities on cranial examination, and the patient had evinced no slurred speech, abnormal gait, or any pupillary abnormalities. He further asserted that Kaplan appropriately relayed, to Kremyanskaya, the results of the vertigo work-up examination and blood test results. Dr.

Hymes concluded that the patient's signs and symptoms on February 14, 2018 did not warrant admission to an emergency room, as her vital signs were normal and she was not in any acute distress. He explained that, although the patient reported feeling "foggy," with some dullness in her ears and coughing, she had reported having bronchitis one month earlier and advised Kaplan that the dizziness was worse when she changed positions and sat up, factors that were not necessarily indicative of a TIA or stroke.

Dr. Hymes asserted that

> "[b]ased upon the fact that Mrs. Fensterstock reported having experienced bronchitis one month earlier, it is my opinion . . . that it was entirely appropriate and within the standard of care to consider labyrinthitis as the cause of Mrs. Fensterstock's complaints as of February 14, 2018 despite her history of suspected TIAs. Mrs. Fensterstock's platelet count on February 14, 2018 was 662,000, below the level which it had been following her prior pregnancy, and she did not exhibit any signs or symptoms of a stroke during her examination.

He opined that

> "Kremyanskaya's treatment plan on February 14, 2018 was proper and met the standard of care and that sending the patient to the ER was not indicated given the negative vertigo work-up
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> "the standard of care did not require any further intervention on the part of Dr. Kremyanskaya [as of February 18, 2018]. Mrs. Fensterstock had just been seen in the emergency department. While an MRI may be more accurate in the diagnosis of a stroke or transient ischemic attack, the CT scan performed at Englewood Hospital did not reveal any evidence of either and it would have been unreasonable for Dr. Kremyanskaya to believe that the providers in the emergency department at Englewood Hospital would have permitted Mrs. Fensterstock to leave if they suspected that she was having a stroke without any additional workup. As such, . . . Dr. Kremyanskaya appropriately relied on the diagnosis and recommendations made in the Englewood Hospital emergency department directing Mrs. Fensterstock to follow-up with a neurologist on an out-patient basis.
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> "Dr. Kremyanskaya acted in accordance with the standard of care on February 20, 2018 when Mrs. Fensterstock called to advised her that she had undergone the MRI of her brain, which was reported as demonstrating two tiny foci of abnormal restricted diffusion within the left hemisphere inferiorly, compatible with tiny infarcts. Dr. Kremyanskaya appropriately instructed Ms. Fensterstock to

> come to the emergency room at Mount Sinai, alerted the neurology and stroke teams, and met Ms. Fensterstock in the emergency room."

Dr. Hymes characterized as "completely without merit" the plaintiffs' allegations that Kremyanskaya improperly discontinued the patient's regimen of Pegasys to treat her ET shortly before her December 23, 2017 delivery, and failed to order or administer anticoagulants and platelet-lowering medication and therapy. He stated that the determination to discontinue Pegasys as a precautionary measure, and replace it with Lovanox, "was a reasonable exercise of Dr. Kremyanskaya's professional judgment and was within the standard of care" due to the uncertainties surrounding the administration of Pegasys to a breastfeeding mother, and the general success of that approach in connection with the patient's 2016 pregnancy and delivery.

Dr. Patsalides essentially agreed with Dr. Hymes's conclusions that the movants did not depart from good and accepted practice and that nothing that they did or failed to do caused or contributed to the patient's injuries. Although Dr. Patsalides recognized that the patient suffered from infarcts in the AICA distribution, he attributed those infarcts to a vertebral artery dissection that he asserted had been revealed on the February 20, 2018 CTA scan. As he explained it, the

> "study demonstrates a bilateral vertebral artery dissection. There are partially occlusive thrombi within the bilateral vertebral arteries at the level of C5 vertebra on the right and the level of the C4 vertebrae on the left. This is evident on images series 2/224-227 and on images series 2/251-261 respectively. As a result of a tear in the lining (intima) of the wall of the vertebral arteries on both sides [the patient was] caused [to sustain] hematoma in the wall of the vertebral arteries, narrowing of the vessel lumen, impairment of blood flow and finally stroke. The small strokes identified in the MRI scans are in the territory harbored by the vertebral arteries and consistent with strokes caused by vertebral artery dissection.
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> "It is further my opinion that, following this dissection, which happened in a very focal area, a hematoma or clot occurred in the wall of the blood vessel. This clot caused the narrowing of the lumen in the vessel and a piece of the clot then broke off and traveled to the brain causing the small cerebellar and pontine strokes that were identified in the February 20, 2018 MRI study that resulted in her left-sided hearing loss."

Dr. Patsalides opined that the vertebral artery dissection that had initiated the process leading to the infarcts was completely unrelated to the patient's platelet levels or problems with blood clotting or occlusion. He asserted that, even had the patient's platelet count been within the reference range, her strokes would have occurred regardless of whether the administration of Pegasys had been resumed on February 13, 2018, as a clot would have been propagated as consequence of the vertebral dissection in any event. He explained that, had the patient become excessively susceptible to blood clotting as a consequence of increased platelet levels, her vertebral artery would have become completely occluded, but that the February 20, 2018 CTA reflected a vessel that was not completely occluded. He stated that the vessel had "normalized fairly quietly" once the dosage of the anticoagulant Lovenox had been increased following the diagnosis of a stroke. Dr. Patsalides thus concluded that the failure to resume the administration of Pegasys in response to the patient's February 13, 2018 complaints was not a departure from good and accepted medical practice, and did not cause or contribute to the patient's strokes in any event.

Dr. Greene explained that the patient had been taking Synthroid to treat hypothyroidism since 2014 and that, on January 23, 2017, the defendant Cheesman, an endocrinologist, noted that in her chart. According to Dr. Greene, Cheesman also noted that the patient presented with persistently suppressed thyroid-stimulating hormone (TSH) levels following the delivery of her first child in August 2016, indicating that she was taking too high a dose of Synthroid, as dosages should be increased during pregnancy and decreased immediately after delivery. Dr. Greene wrote that Cheesman had appropriately reduced the patient's dosage in the months following her August 2016 childbirth, and increased her dosage in May 2017 after learning that the patient was again pregnant. Dr. Greene further concluded that Cheesman comported with the applicable standard of care when she met with the patient on February 16, 2018 by memorializing the patient's low TSH levels, which she correlated with the patient's fatigue and dizziness. Dr Greene stated that Cheesman met the standard of care at the February 16, 2018

visit by recommending a further reduction of the patient's Synthroid dosage, with a moratorium on weekend doses, and suggesting a follow-up visit within two months. She averred that there was nothing that occurred during that examination that warranted referring the patient to a hospital emergency room or to undertake anything further to explore the basis for the patient's complaints of dizziness and lightheadedness. Moreover, Dr. Greene opined that it was not within Cheesman's purview as an endocrinologist to adjust Kremyanskaya's prescriptions concerning Pegasys or Lovenox.

Dr. Segal opined that Kremyanskaya did not depart from good and accepted medical practice in declining to refer the patient to an emergency room when the patient reported lightheadedness on February 8, 2018, as that condition "could have any number of causes regardless of Mrs. Fensterstock's underlying history of suspected TIAs." He stated that, inasmuch as the patient was then breastfeeding, that incident of lightheadedness would most likely have been attributable to dehydration. As Dr. Segal framed the issue,

> "[t]he stroke Mrs. Fensterstock sustained in the AICA vessel territory presents in an atypical and idiosyncratic manner. This artery supplies the brain (cerebellum) and also gives branches to structures outside the brain, in the inner ear (cochlea and vestibular apparatus). Because of this, AICA strokes are a rare cause of hearing loss and also positional vertigo. The vast majority of vertigo is caused by benign syndromes in the ear, such as viral inflammation or BPPV (Benign Positional Paroxysmal Vertigo)."

In light of the fact that the patient's symptoms, as she reported them on February 13, 2018, would come and go and would change based on positioning, Dr. Segal concluded that it was not a departure for Kremyanskaya to decline to refer the patient to a neurologist, or to decline to order additional radiology images, any earlier than she ultimately did.

Dr. Segal further asserted that Kaplan did not depart from the standard of care applicable to nurse practitioners when, on February 14, 2018, she diagnosed the patient with labyrinthitis. He essentially mirrored the reasoning articulated by Dr. Hymes, noting the absence of any other signs and symptoms that would have suggested a stroke, and the patient's recent history of bronchitis.

In addition, Dr. Segal concluded that none of the movants departed from good and accepted practice by failing to order an MRI on February 18, 2018, after the patient had been discharged from the emergency medicine department at Englewood Hospital, inasmuch as the patient had already undergone a CT scan, and the absence of an MRI scan would not have altered the outcome because the patient's stroke antedated both her February 13, 2018 consultation with Kremyanskaya and her February 14, 2018 visit with Kaplan, and most likely had already occurred on February 8, 2018. Specifically, he asserted that the MRI imaging that was ultimately undertaken revealed that the strokes were subacute, and up to two weeks old. He concluded that, had the stroke occurred on February 19, 2018 and, thus, after the February 14, 2018 consultation and visit, the MRI scan taken the next day would have revealed the strokes to be acute. Dr. Segal further opined that any claim that the stroke did not occur until February 19, 2018 is belied by the results of the patient's audiological testing on that date, when the patient first noted her hearing loss. He stated that she likely suffered hearing loss several weeks earlier, but that she was unaware until that test because hearing is bilateral. Dr. Segal was of the opinion that the hearing loss could only have been averted had the patient presented to a hospital emergency department within 4.5 hours of the onset of symptoms on February 8, 2018. He concluded that the patient's delay in this regard, rather than Kremyanskaya's or Kaplan's determinations not to refer the patient to an emergency department several days later, was the factor that prevented the opportunity to forestall hearing loss.

In opposition to the movants' showing, the plaintiffs relied upon the same pleadings, bills of particulars, deposition transcripts, and medical and hospital records upon which the movants had relied, and also submitted the affirmations of a physician board certified in hematology, oncology, and internal medicine (hereinafter the oncologist), a physician board certified in radiology (hereinafter the radiologist), and a physician board certified in neurology and internal medicine (hereinafter the neurologist).

The plaintiffs' oncologist opined that Kremyanskaya departed from good and accepted medical practice by failing to appreciate that the symptoms that the patient reported to her on February 8, 2018 could be indicators of a TIA or an evolving stroke, and by failing to take action at the earliest possible opportunity to rule out or treat a TIA or evolving stroke. The oncologist asserted that Kremyanskaya failed to follow up in a timely manner so as to obtain the results of blood testing that had been ordered by the patient's obstetrician on February 9, 2018, and failed to advise the patient herself that those results should be reviewed immediately by either Kremyanskaya or another hematologist, as those results were crucial in determining whether to recommence cytoreductive therapy such as Pegasys or Hydroxyurea and to cease breastfeeding. Contrary to the opinion of the movants' experts, the plaintiff's oncologist concluded that Kremyanskaya departed from the standard of care by failing immediately to refer patient to a hospital emergency department on the evening of February 13, 2018, with a request for an emergency neurological and hematological consult and a recommendation for urgent radiologic imaging. Specifically, the oncologist asserted that Kremyanskaya should have arranged for the patient to begin immediate cytoreductive therapy with the maximum dose of Hydroxyurea and aspirin at or about 6:00 p.m. on February 13, 2018, immediately after the patient's second email to Kremyanskaya, and should have continued that therapy through at least February 18, 2018. The oncologist concluded that these departures caused the patient to progress from an already elevated platelet count on February 9, 2018 to a higher platelet count in the ensuing 10 days, which, more likely than not, contributed to her hypercoagulable condition on February 19, 2018, the day that the oncologist concluded that she lost the hearing in her left ear. The oncologist rejected the movants' expert opinions that the patient actually suffered all of the strokes on February 8, 2018, and that she had already lost the hearing in her left ear by that date, but didn't notice it until February 19, 2018.

The plaintiffs' oncologist conceded that Kremyanskaya's determination to discontinue the patient on Pegasys immediately after the patient delivered her second child was a "judgment

call," but that a proper exercise of that judgment required a heightened duty closely to monitor the patient's platelet counts due to her underlying ET condition, requiring a plan for blood work to be done at closer intervals during first six months after discontinuing Pegasys. The oncologist asserted that Kremyanskaya did not have a complete frame of reference for assessing the patient's lightheadedness and nausea on February 8, 2018 because she was unaware of the patient's platelet count at that time, despite the fact that the patient was a known high-risk patient with a prior history of TIA, and seven-weeks post-partum, which independently increased the risk of an embolic stroke. The oncologist thus asserted that

> "[c]onsequently, the index of suspicion for a thromboembolic event should have been higher, and Dr. Kremyanskaya should have viewed the combination of lightheadedness with nausea as a potential symptom of another TIA, until same could be ruled out clinically. *Given that TIA is often a precursor to a full-blown stroke, Dr. Kremyanskaya should have put the most serious possible cause of these symptoms (TIA) at the top of her mental list of differential diagnoses.* That is what a prudent physician does - this approach is foundational in modern medicine. It is clear that she did not do so. Her own language, i.e., 'you might be dehydrated,' demonstrates that she assigned very little significance to the lightheadedness and nausea. Had Dr. Kremyanskaya suspected a TIA, then at the very least, she should have advised her patient that it was imperative for her to receive and review the next day's blood work results as soon as these were available. This was something she could have done easily, despite the fact that she was on vacation at the time"

(emphasis added). Failing a referral for immediate blood work, the oncologist opined that Kremyanskaya, as an alternative, should have recommended that the patient report immediately to a hospital emergency room for a full neurological workup. The plaintiffs' oncologist presumed that, by February 10, 2018 at the latest, Kremyanskaya likely would have obtained the result of the February 9, 2018 blood test that revealed a high platelet count. Given that situation, the plaintiffs' oncologist stated that, at the very least, when the patient made further complaints of dizziness, lightheadedness, and vertigo during both the afternoon and evening of February 13, 2018, Kremyanskaya immediately should have referred the patient to a hospital emergency room on an urgent or emergency basis.

The plaintiffs' oncologist opined that it was a departure from good and accepted practice for Kremyanskaya to have presumed that the absence of problems during the patient's first childbirth one year earlier, despite a similarly high platelet count, meant that there would be no risk of TIA or stroke during the second childbirth. The oncologist expressly disagreed with Dr. Hymes's opinion that the difference between a PC of 500,000/µl and 750,000/µl is a "gray area," and that Kremyanskaya's decision making on February 13, 2018 was reasonable. In addition, the oncologist opined that it was a departure from good practice for Kremyanskaya to have accepted, without further investigation, Kaplan's suggestion that the patient might be suffering from labyrinthitis.

The oncologist interpreted the records of the patient's February 20, 2018 admission to Mount Sinai as indicating bilateral vertebral artery thromboses as the likely source of her stroke, and that the administration of 1,000 mg daily of Hydroxyurea and 40 mg of Lovenox had resolved the clots.

The plaintiffs' expert radiologist expressly disagreed with Dr. Patsalides's opinion that the patient's stroke was caused by a vertebral artery dissection, unrelated to the patient's preexisting ET condition, platelet count, and blood coagulation in the AICA. As the radiologist explained it,

> "[a]fter viewing the entire [February 20, 2018 CTA] study, I then proceeded to focus on images series 2/224-227 and images series 2/251-261 respectively, as these were indicated by Dr. Patsalides as the specific images in which he reportedly saw evidence of dissection. However, my own review of the images from the CT angiogram of the neck, performed on February 20, 2018 reveals absolutely no indication of dissection, not of the left vertebral artery, nor of the right vertebral artery. I do not visualize a dissection flap lateral to either of the vertebral arteries. What I was able to see on the images was that the vertebral arteries were both hypoplastic and that both showed multiple filling defects, which are the obvious sources of thromboembolic disease to the brain."

The radiologist further noted that Dr. Puneet Pawha of Mount Sinai read and reported on the February 20, 2018 neck CTA, finding that the patient's vertebral arteries were somewhat diminutive and that there were "partially occlusive thrombi within the bilateral vertebral arteries,

on the right at the level of C5 on the left at the level of C4," but that Dr. Pawha made no mention of vertebral artery dissection.

The radiologist asserted that he identified eight areas of infarction, including several cerebellar infarcts, along with at least one medullary infarct that appeared to be acute and only one day old. The radiologist that averred that his or her findings closely corresponded with those of Dr. Kambiz Nael of Mount Sinai itself, who reported on this study and stated that "there are multiple foci of restricted diffusion within the bilateral cerebellar hemispheres. There are also 2 foci of restricted diffusion within the pons. *These are consistent with acute infarcts*" (emphasis added). Hence, the radiologist concluded that at least one stroke occurred at least 11 days after the patient's first complaints of dizziness and lightheadedness, thus suggesting that treatment at an earlier point would have given the patient an opportunity to avoid TIAs and strokes. As to the remaining strokes, the radiologist conceded that the most specific statement that one could make is that they were, at most, two weeks old, but that some of them could have been a week old, or less. Hence, the radiologist noted the importance of taking into account the patient's clinical presentation when making an educated guess about the date of a particular ischemic event.

The plaintiffs' expert neurologist similarly disagreed with Dr. Patsalides's opinion that a dissection of the patient's vertebral arteries, unrelated to ET, platelet count, and blood coagulation in the AICA, caused her strokes, essentially reiterating the opinions of the plaintiffs' radiologist. As the neurologist explained it,

> "Due to the propensity of her blood to clot – attributable to undertreatment for her essential thrombocythemia during the postpartum period - Ms. Fensterstock showed clinical signs – from February 8th to February 19th - of an ongoing process of basilar artery ischemia. It is evident that she was forming thrombi (blood clots) which were traveling into her vertebral and basilar arteries, and subsequently into the other vessels that feed the cerebellar and medullary compartments of her brain, and that this was happening along a continuum."

The neurologist asserted that, from February 8, 2018 through February 19, 2018, the patient demonstrated signs of multiple, separate, and discrete ischemic strokes. As that expert

explained, "[t]he ischemic effects of this process then continued through the first two days of her admission to Mount Sinai Hospital (February 20th and February 21st), as evidenced by the changes in radiological findings as between the February 21st MRI and the February 20th MRI." The neurologist asserted that the patient's lightheadedness and dizziness on February 8, 2018, February 12, 2018, February 13, 2018, February 14, 2018, and February 18, 2018 were all signs of basilar artery ischemia and that the patient evinced signs of a series of strokes, and that each of the eight lesions or infarcts seen on various scans beginning on February 20, 2018 represented eight different strokes. The expert concluded that the

> "strokes which occurred from February 8th through February 18th were warning signs *before the ultimate ischemic stroke which caused SNHL (sensorineural hearing loss) on February 19, 2018.* These warning signs were not recognized as such by her treating hematologist, Dr. Kremyanskaya. Had they been recognized 'early in the game,' proper intervention could have been undertaken"

(emphasis added).

The neurologist opined that the patient should have been started on a low-dose aspirin regimen on February 13, 2018 at the latest. The neurologist expressly disagreed with Dr. Segal's opinion that "the die was cast" on February 8, 2018, and with Dr. Segal's apparent conclusion that that there was a solitary stroke on that date that had already caused left-side hearing loss that somehow was not appreciated by the patient over the course of 11 days. The neurologist asserted that such a conclusion was inconsistent with imaging studies that had been interpreted as showing multiple foci of infarction, Englewood Hospital's records from February 18, 2018 indicating that the patient had "no hearing loss, tinnitus or ear pain," and the patient's testimony that she sustained a sudden loss of hearing on February 19, 2018 when she had a severe episode of nausea and "heard a pop" in her left ear. The neurologist concluded that the two medullary infarcts were of the most recent origin, and likely occurred on February 19, 2018. Contrary to Dr. Segal's explanation, the plaintiffs' neurologist concluded that it was entirely possible for a thrombus to have been in the region of the medulla on February 19, 2018 and

cause ischemic damage to the vessels that feed the eight cranial nerve, even though it was not visualized on the February 20, 2018 neck MRI, but was visible on the February 21, 2018 scan.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr*., 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc*., 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (s*ee id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

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

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v*

Hudson Val. Hosp. Ctr., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

The movants made a prima facie showing of entitlement to judgment as a matter of law with their expert affirmations and the medical records by demonstrating that they did not depart from good and accepted practice in discontinuing the patient's regimen of platelet-lowering Pegasys, in the manner in which they monitored the patient's platelet count after discontinuing the administration of Pegasys, or in responding to the patient's post-partum complaints of dizziness, lightheadedness, and vertigo. They also made a showing that any failure to

recommence platelet-lowering therapy would not have prevented the patient from suffering strokes, by demonstrating, prima facie, that the strokes were caused by a vertebral artery dissection and not coagulation, and by presenting expert evidence that the strokes had already occurred on February 8, 2018, before they were advised of any complaints or warning signs.

Inasmuch as neither the plaintiffs nor their experts addressed the showings that the movants made in connection with Kaplan and Cheesman, the plaintiffs failed to raise a triable issue of fact with respect to the claims asserted against those defendants, and summary judgment must be awarded to Kaplan and Cheesman dismissing the complaint insofar as asserted against them.

With respect to Kremyanskaya, however, although the plaintiffs failed to raise a triable issue of fact as to whether the discontinuation of Pegasys constituted a departure from good practice, they did raise triable issues of fact as to whether Kremyanskaya departed from good practice in failing timely and adequately to heed the signs and symptoms of TIA or stroke, failing timely to obtain results of platelet-count testing, failing timely to refer the patient to a hospital emergency room for an immediate neurological workup, and failing timely to reinstitute platelet-lowering therapy. They also raised a triable issue of fact as to whether these departures caused or contributed to the strokes and hearing loss, as their experts raised triable issues of fact as to whether the strokes were caused by blood coagulation in the AICA and medulla, rather than a dissection, whether the patient sustained a series of strokes that only began on February 8, 2018, rather than one stroke on that date, whether the series of strokes continued for almost 11 days, culminating in a February 19, 2018 stroke that directly caused the patient's hearing loss, and whether intervention and treatment as early as February 8, 2018, and no later than February 13, 2018, would have either prevented the hearing loss or at least provided the patient with an opportunity to arrest the onslaught of the strokes. Hence, the court must deny that branch of the motion seeking summary judgment dismissing the cause of action asserted against Kremyanskaya alleging that she departed from good practice. Inasmuch as Mount Sinai

is Kremyanskaya's employer, and a hospital that employs a physician may be held vicariously liable for the physician's malpractice (*see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]), summary judgment must be denied to Mount Sinai with respect to the cause of action alleging that Kremyanskaya departed from good and accepted practice.

The elements of a cause of action for lack of informed consent are

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

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d 450, 456 [1st Dept 2017]). Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]). In *Jaycox*, the plaintiff claimed that the defendants failed to advise her of the foreseeable risks of a vaginal birth or of alternative modes of treatment, allegedly prompting her consent to a vaginal delivery, claiming that a reasonably prudent mother would not have consented to a vaginal delivery had she known of the risks. Inasmuch as "[t]he injuries allegedly sustained by plaintiff were not the result of an invasive procedure, but instead were

alleged to have been the result of a negligent failure to undertake or negligent postponing of such procedure" (*id*. at 995), the plaintiff had no cause of action to recover for lack of informed consent (*see also Saguid v Kingston Hosp*., 213 AD2d 770, 772 [3d Dept 1995]; *Karlsons v Guerinot*, 57 AD2d 73, 82 [4th Dept 1977]).

Here, the movants' failure timely to suspect or diagnose TIAs or strokes cannot be the basis for a lack of informed consent cause of action, nor can their alleged failure seasonably to treat the patient to avoid strokes constitute a basis for such a cause of action. Hence, summary judgment must be awarded to all of the movants, including Kremyanskaya and Mount Sinai Hospital, dismissing the lack of informed consent cause of action.

Accordingly, it is

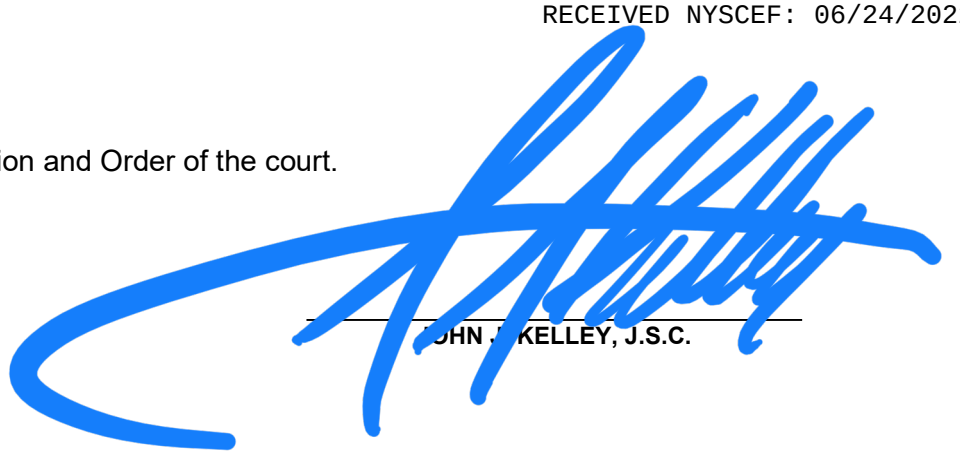
ORDERED that the motion is granted to the extent that the defendants Alyssa Kaplan, MSN, FNP-BC, and Khadeen Cheesman, M.D., are awarded summary judgment dismissing the complaint insofar as asserted against them, and the defendants Marina Kremyanskaya, M.D., and Mount Sinai Hospital are awarded summary judgment dismissing the cause of action alleging a failure to obtain the plaintiffs' informed consent insofar as asserted against them, and the motion is otherwise denied; and it is further,

ORDERED that the complaint is dismissed insofar as asserted against the defendants Alyssa Kaplan, MSN, FNP-BC, and Khadeen Cheesman, M.D., and the cause of action alleging a failure to obtain the plaintiffs' informed consent is dismissed insofar as asserted against the defendants Marina Kremyanskaya, M.D., and Mount Sinai Hospital; and it is further,

ORDERED that the action is severed against the defendants Alyssa Kaplan, MSN, FNP-BC, and Khadeen Cheesman, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendants Alyssa Kaplan, MSN, FNP-BC, and Khadeen Cheesman, M.D.

This constitutes the Decision and Order of the court.



6/23/2022
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE