DEFENSE PRACTICE UPDATE

MARTIN CLEARWATER & BELL LLP

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Motions for Summary Judgment under the New Administrative Order

By: Barbara D. Goldberg and Gregory A. Cascino

Effective February 1, 2021, motions for summary judgment are subject to several newly enacted rules and requirements under the new Administrative Order issued by Chief Administrative Judge Lawrence Marks. Rule 19-a, which is arguably the most important, adds a new section 202.8-g to the Uniform Civil Rules for the Supreme Court and County Court.[1]

Subdivision (a) of this provision requires that "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."

Subdivision (b), in turn, requires that opposition papers "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."

Subdivision (c) requires that each numbered paragraph in the statement of material facts required to be served by the moving party "will be deemed admitted unless specifically controverted by a correspondingly numbered paragraph in the statement required to be served by the opposing party."

Finally, subdivision (d) requires that "[e]ach statement of material fact by the movant or opponent pursuant to subdivision (a) or (b), including 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."

Like many provisions of the CPLR and legal doctrines established by case law, these provisions are easily stated but potentially difficult to apply. What, exactly, is a "material fact" as to which there is no "genuine issue" to be

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1. Other new rules which pertain to motions generally are Rule 16 (which relates to the contents of the notice of motion and the exhibits required), Rule 17 (which relates to the length of the papers) Rule 18 (which relates to sur-reply and post-submission papers), Rule 19 (which relates to orders to show cause) and Rule 22 (which relates to oral arguments).

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tried? And how much detail must be provided to show the Court that the moving party has satisfied its *prima facie* burden of demonstrating that there were no departures from accepted practice, and/or that the treatment rendered or not rendered was not a substantial factor in causing the injuries alleged?

A few simple examples of what could qualify as an "undisputed" statement of material fact readily come to mind.[2] Almost as in the context of a Notice to Admit, these include, for example, whether the patient entered the hospital through the emergency room, the date that surgery was performed, the type of procedure, the indications for the procedure, the dates of subsequent return visits and, where applicable, the date and time of death.

In order to show that it has satisfied its *prima facie* burden, however, the moving party presumably should state that the surgeon performing the operation did so within the standard of care and did not depart from good and accepted standards of practice, and that no aspect of the surgery was a substantial factor in causing injury to the patient. Under subdivision (d), these statements must be supported by appropriate citations to the expert affidavit(s) submitted in support of the motion, any relevant deposition testimony, and any supporting entries in the medical records. To avoid a claim that a statement is conclusory and therefore insufficient to establish a *prima facie* entitlement to summary judgment, it may also be advisable to state the reasons for the expert's opinion.

And how much detail must be provided to show the Court that the moving party has satisfied its prima facie burden of demonstrating that there were no departures from accepted practice, and/or that the treatment rendered or not rendered was not a substantial factor in causing the injuries alleged?

Similarly, with respect to a cause of action for lack of informed consent, the Statement of Material Facts should set forth the risks, benefits and alternatives to the procedure disclosed by the physician providing the treatment or performing an invasive diagnostic procedure, together with a statement that these are the risks, benefits and alternatives that a reasonable practitioner under similar circumstances would have disclosed. See Public Health Law (PHL) § 2805-d (1). In addition, in order to satisfy the requirements set forth in PHL § 2805-d (3), the Statement of Material Facts should likewise set forth that a reasonable person in the patient's position, if fully informed, would have opted to undergo the treatment or procedure at issue. Finally, the Statement of Material Facts should state that the treatment or procedure did not cause the injury alleged. Once again, citation can be made to the expert's affidavit, any deposition testimony regarding the informed consent discussion, the consent form itself, and any additional entries in the chart regarding informed consent.

In cases where summary judgment is sought based on the expiration of the Statute of Limitations, the Statement of Material Facts should set forth the dates of treatment, which can be supported by references to the chart and any relevant deposition testimony to show that the action was commenced more than two and a half years after the last date of treatment, or more than two years after the decedent's death, in an action for wrongful death.

In cases where it is anticipated that the Plaintiff will rely on the continuous treatment doctrine, the Statement of Material Facts should also include the nature of the treatment rendered at each visit/date of treatment, who instigated the return visit(s) that is claimed to constitute continuous treatment, the reason for the return visit, and a statement that whatever was done or discussed at the return visit(s) did not constitute "treatment for the same illness, injury or condition which gave rise to the said act, omission or failure," as contemplated by CPLR § 214-a.

This can be supported by citations to the deposition testimony explaining what was done or discussed at the return visit, as for example testimony establishing that the patient simply returned to the doctor because he needed clearance for a particular prescription or procedure that was unrelated to the treatment on prior visits giving rise to the action.

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2. As this is a new and emerging area of the law, this article endeavors merely to illustrate the types of statements that a movant might consider including in a statement of undisputed material facts in a given case. This list is not meant to be exhaustive or to identify undisputed material facts that must be set forth in order for a movant to meet their *prima facie* burden.

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In cases where Plaintiff contends that a facility violated Public Health Law § 2801-d, the Statement of Material Facts should state that there was no deprivation of a right conferred by contract, statute, regulation, code or rule. If the Plaintiff identifies one or more statute(s), regulation(s) code(s) or rule(s) in their Complaint or Bill of Particulars, the Statement of Material Facts should list them (either individually, or, where voluminous, by referring to the pleadings and incorporating the cited provisions by reference) and state that the statute/regulation/code/rule is not applicable. It also should state, if possible, that the injury/deprivation of rights alleged was unavoidable and that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is assessed.

When representing a hospital or other facility which the Plaintiff is seeking to hold vicariously liable for actions of a non-employee health care professional, this employment status should be stated. The movant should also state, where possible, that none of the factors which the Court will look to when determining whether it can be vicariously liable for this individual, under a theory of ostensible agency, are present. Where a patient is admitted to the hospital as a private patient of his or her attending physician, this should be stated as well.

The Plaintiff, in turn, in order to defeat the motion, will be required to reference the opinions of his/her expert that the Plaintiff claims are sufficient to raise issues of fact.

It will be essential to scrutinize the Plaintiff's responsive statement very carefully, in light of the directive in subdivision (c) that each numbered paragraph in the Statement of Material Facts "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." If the Plaintiff neglects to respond to one or more points in the Statement of Material Facts, it may be possible to obtain partial summary judgment as to the matters covered by those statements.

Section 202.8-g does not specifically reference reply papers; however, it would appear to be entirely appropriate to point out in the reply papers which of the numbered paragraphs the Plaintiff failed to specifically controvert. The reply affirmation, as under current practice, can set forth any arguments that the Plaintiff's experts' opinions are impermissibly speculative and conclusory, improperly engage in hindsight reasoning, and raise new theories of liability for the first time in opposition to summary judgment.

It remains to be seen how closely Courts will scrutinize the statement of undisputed material facts in medical malpractice actions, and whether they will instead direct their attention towards the statement of facts in the attorney affirmation and/or expert affirmation in support of the motion. For the time being, and until Courts provide further guidance otherwise, we are recommending that movants err on the side of being over inclusive rather than under inclusive. ■

It remains to be seen how closely Courts will scrutinize the statement of undisputed material facts in medical malpractice actions, and whether they will instead direct their attention towards the statement of facts in the attorney affirmation and/or expert affirmation in support of the motion.

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Balancing the Requirements of EMTALA and Patient Care During a Pandemic

By: Michael A. Sonkin and Alexandra M. Lopes

Over the last year, hospitals and critical access hospitals[1] (CAHs) have experienced an influx of presentations to their respective Emergency Departments due to the COVID-19 pandemic. As such, hospitals and CAHs have been required to assess a greater number of patients than ever pursuant to the Emergency Medical Treatment & Labor Act, more commonly known as EMTALA. While this new influx of patients has been a novel issue for emergency medicine providers, they must continue to provide the required assessments for this increased patient population, in addition to treating patients with COVID-19 symptoms.

EMTALA was first enacted by Congress in 1968. EMTALA requires any Medicare-participating hospitals and CAHs with Emergency Departments to screen all patients who present to said Emergency Department, whether by ambulance or walk-in, to assess whether an emergency medical condition is present. Specifically, EMTALA carves out a methodical, step-by-step approach to assessing each and every patient who presents to an applicable Emergency Department. The purpose of this screening is to prevent medical providers from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, first providing a medical screening to ensure they are stable for transfer.[2] This results in Medicare-participating Emergency Departments being required to render a degree of treatment to all patients regardless of insurance status or their ability to pay for medical treatment.

EMTALA requires any Medicare-participating hospitals and CAHs with Emergency Departments to screen all patients who present to said emergency department, whether by ambulance or walk-in, to assess whether an emergency medical condition is present.

As defined by EMTALA, an emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity. The condition is considered to be of "sufficient severity" if the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual in serious jeopardy; (ii) serious bodily impairment; or (iii) serious dysfunction of any bodily organ or part. If such an assessment reveals a condition of sufficient severity, the hospital must then provide further examination and/or necessary treatment to stabilize the medical condition.

In the event a hospital cannot render treatment to stabilize the medical condition itself, at a minimum, the patient must be sufficiently stabilized to safely transfer the individual to another facility. Sufficient stabilization pursuant to EMTALA requires an Emergency Department to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual. Sufficient stabilization is not required in certain, limited circumstances. For example, sufficient stabilization is not required if the individual requests a transfer in writing after being informed of hospital's obligations and the risks of the transfer. Moreover, sufficient stabilization is not required if a physician in the Emergency Department has signed a certification that based on the information available at the time of transfer the medical benefits expected from appropriate medical treatment being rendered at another medical facility outweigh the risks to the individual. Notably, if a physician is not present in the Emergency Department at the time of the transfer, a qualified medical person may sign said certification.

Once a patient is deemed stable for transfer, or one of the exceptions of stabilization has been met, an appropriate transfer may be initiated. In order for a transfer to be "appropriate," EMTALA requires the transferring

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1. Per the Centers for Medicare & Medicaid Services, a CAH is located in a state that has established a State Medicare Rural Hospital Flexibility Program, is designated by the state, and is located in a rural area. CAHs are located either more than 35 miles from the nearest hospital, or were previously certified as a CAH based on State designation as a necessary provider of health care services. CAHs maintain no more than 25 inpatient beds, maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care, comply with 42 CFR Part 485(F), and furnish 24-hour emergency care services, 7 days per week. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.
2. https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/.

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facility to provide medical treatment within its capacity to minimize the risks to the individual's health. Furthermore, all medical records related to the emergency condition available at the time of transfer must be provided to the receiving facility. The transferring facility must also confirm the receiving facility has the space and qualified medical personnel to treat the condition and has agreed to the transfer. A receiving facility that only provides specialized care may not refuse the transfer of the patient on this basis alone if the receiving facility has the capacity to render the required treatment. Qualified personnel and appropriate medical equipment must be present at the time of the transfer.

Civil penalties may be imposed upon applicable hospitals and CAHs for violations of EMTALA. These penalties include but are not limited to termination of a hospital or physician's Medicare provider agreement, hospital fines of $104,826 per violation, and physician fines of $50,000 per violation. There is a two-year statute of limitations for the enforcement of any such violation of EMTALA.[3] No violation is present when a patient refuses treatment or an appropriate transfer.

Since its enactment in 1986, hospitals and CAHs have been conscious to walk the delicate line of performing appropriate screenings and transfers of patients pursuant to EMTALA while simultaneously rendering treatment to their own hospital populations. However, this became more difficult than ever for hospitals and CAHs as the COVID-19 pandemic quickly descended. As a result, hospitals and medical providers became increasingly concerned regarding their ability to adequately satisfy the requirements of EMTALA while simultaneously treating and/or transferring COVID-19 patients in a safe manner.

In order to address these concerns, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum on March 9, 2020, which specifically provided guidance regarding the associated effects of COVID-19 in the setting of EMTALA compliance.[4] Notably, this memorandum delineated practices for identifying a COVID-19 patient in the context of EMTALA. For example, Emergency Departments are still expected to conduct the requisite screenings to assess whether an emergency medical condition exists, which now includes COVID-19. The memorandum also permitted transferring facilities to transport patients to alterative on- or off-site locations for the requisite screening. In the event COVID-19 is suspected based on this screening, the individual is to be immediately isolated. Additionally, CMS waived the requirement to stabilize patients prior to transfer, so long as the transfer arose out of an emergency, and there is no discrimination as to the source of a patient's ability to pay.

Given the novelty of the COVID-19 pandemic, in conjunction with previously issued federal and state level executive orders limiting liability on medical providers treating COVID-19 patients, the impact the COVID-19 pandemic has had on EMTALA violations and related civil litigations has yet to be seen. It is important for medical providers to recognize that an adverse patient outcome alone is not indicative of an EMTALA violation. Furthermore, CMS has advised it will take into consideration the public health guidance in effect at the time of an alleged EMTALA complaint sounding in an inappropriate transfer or refusal of transfer.[5] In addition, one of the best shields against any civil penalties or civil litigation as a result of an alleged EMTALA violation is a detailed medical record. Such medical record should memorialize the requirements for (i) an appropriate assessment for an emergency medical condition, (ii) sufficient patient stabilization for transfer in the event a transfer is appropriate, (iii) an exception to the need for sufficient stabilization if one exists, and (iv) an appropriate transfer as prescribed by EMTALA. ■

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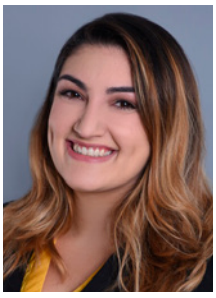

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3. https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/.
4. https://www.cms.gov/files/document/qso-20-15-emtala-requirements-and-coronavirus-0311-updated-003pdf.pdf-1; https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.
5. https://www.cms.gov/files/document/qso-20-15-emtala-requirements-and-coronavirus-0311-updated-003pdf.pdf-1.

Case & Comment: Motion for Summary Judgment as a Valuable Litigation Tool

By: Daniel L. Freidlin

In select cases, motions for summary judgment can result in a dismissal of the case. To prevail, the defense must demonstrate to the court that there is no issue of fact for a jury to decide. Obtaining a complete dismissal in a medical malpractice case is difficult as the plaintiff's lawyer can often defeat the motion by submitting the affirmation of an expert witness that disputes the opinion of the defense expert. While these motions are costly, time-consuming, and can be difficult to win, they are a valuable litigation tool even if they do not result in a dismissal.

The potential benefits of a summary judgment motion include dismissal of the case, partial summary judgment dismissing some claims, narrowing the issues streamlining the defense at trial, and facilitating resolution of claims through settlement by showing the plaintiff's attorney that the case is not as strong as they may think it is. Sometimes, medical or legal arguments that may raise skepticism in the eyes of a lay jury can be effectively presented on paper for a judge's decision.

Martin Clearwater & Bell LLP recently handled a high exposure case involving a patient who presented to our client's emergency department with complaints of increased jaw pain, swelling and fever over several days. Days after initial discharge, her physicians diagnosed her with an abscess and osteomyelitis of the jaw. She underwent multiple surgeries including reconstruction of her lower jaw. Although our experts could defend the care rendered, the case had issues with the defense that a jury may not have looked favorably on. We filed a motion for summary judgment with the intention of dismissing some claims and understanding that there was a chance that the court would accept our causation defense and dismiss the entire case. As will be discussed, the outcome of the motion and the disposition of the case demonstrate that there are benefits to making a motion for summary judgment that have a low likelihood of complete dismissal as sometimes the judge deciding the motion will see things your way.

Factual History

A then 53-year-old married woman presented to our client's emergency department with complaints of increased left jaw pain, swelling, tachycardia and fever over several days. Our codefendant dentist evaluated plaintiff approximately one week earlier and prescribed oral antibiotics. In the emergency department, a dental resident evaluated plaintiff and spoke over the telephone with an oral surgery attending. The hospital radiologist interpreted a facial CT scan as negative for abscess. The hospital radiologist did not report osteomyelitis on the CT scan and testified at her deposition that imaging may not show "early" osteomyelitis. Based on the negative CT scan and telephone consult with the oral surgeon, plaintiff received one dose of intravenous antibiotics before the hospital staff discharged her with instructions to followup in the dental clinic.

The following morning, the plaintiff presented to the dental clinic where the hospital dentist identified purulent discharge from the left mandible. The hospital dentist obtained cultures of the drainage and suspected abscess. The patient received a prescription for antibiotics (the same antibiotics ordered by the patient's private dentist days earlier, albeit at a higher dose) and told to return seven days later or sooner if the swelling increased.

Obtaining a complete dismissal in a medical malpractice case is difficult as the plaintiff's lawyer can often defeat the motion by submitting the affirmation of an expert witness that disputes the opinion of the defense expert. While these motions are costly, time-consuming, and can be difficult to win, they are a valuable litigation tool even if they do not result in a dismissal.

The patient's condition continued to deteriorate with continued fever, chills and increased drainage from the tooth. She returned to the hospital emergency department the following day where the hospital staff initiated a sepsis protocol and began intravenous brought spectrum antibiotics. The plaintiff's allegations in the case included that the hospital staff should have initiated this same treatment two days earlier. The hospital obtained another CT scan by

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a different radiologist, this time imaging showed a left mandibular abscess. Oral surgery noted a left deep space infection and recommended bringing the patient "to OR ASAP." Plaintiff underwent incision and drainage with extraction of teeth 18 and 20.

Surgical pathology issued a diagnosis of chronic osteomyelitis. Plaintiff experienced a difficult treatment course that spanned over the course of the next year and required multiple surgeries including jaw reconstruction.

The plaintiff claimed that if the hospital staff admitted her to the hospital during the first emergency department presentation and initiated a prolonged course of intravenous antibiotics, she would not have progressed to deep tissue infection and sepsis.

The Motion for Summary Judgment

At the close of discovery, we filed a motion for summary judgment on behalf of the Hospital staff. In support of our motion, we submitted expert opinions from three specialists. Our experts included board certified physicians specializing in oral surgery, emergency medicine and infectious diseases. Of course, we argued that the care rendered conformed to the standard of care. More importantly, we argued that the patient's outcome could not be avoided based upon the finding of chronic osteomyelitis on pathology.

Our experts opined that chronic osteomyelitis is osteomyelitis present for greater than thirty days. Some patients with chronic osteomyelitis may be clinically well and CT scan is not always positive for osteomyelitis. The only way to diagnose chronic osteomyelitis is on pathology, a point that we emphasized since we knew the plaintiff did not have an expert pathologist to review the slides and thus would not be able to dispute the pathology. Our experts opined that an alleged three-day delay in diagnosis did not change the outcome since the plaintiff already had an infected jaw during her first presentation to the emergency department. Thus, extensive surgery was inevitable.

From a strategic standpoint, this was exactly the manner in which we hoped plaintiff would oppose the motion and one that we planned for in our initial papers.

All other parties moved for summary judgment as well. The plaintiff's attorney incredibly and unexpectedly discontinued the case against the separately insured codefendant hospital radiologist and codefendant dentist. It seems as though the plaintiff did not want to expend the time, effort and money to oppose three summary judgment motions. Plaintiff opposed our client's summary judgment motion with the opinion of an infectious disease specialist.

The plaintiff's expert opined that the hospital emergency department staff and dental consult delayed the diagnosis and treatment of an infection that resulted in development of osteomyelitis of the jaw, progression of disease and need for extensive surgery. The plaintiff's expert opined that the plaintiff developed acute osteomyelitis notwithstanding the pathology findings. The expert relied upon the negative CT scan interpreted by the radiologist (that the plaintiff discontinued from the case) and the plaintiff's lack of earlier symptoms.

From a strategic standpoint, this was exactly the manner in which we hoped plaintiff would oppose the motion and one that we planned for in our initial papers. The plaintiff's expert did not dispute that the distinction between acute vs. chronic osteomyelitis is made by pathology. This allowed us to argue that the plaintiff's expert opinion was impermissibly speculative and conclusory, as the facts did not support the position that the osteomyelitis was acute. While this argument may not have been as effective in front of a jury, we knew that the particular judge assigned to hear the motion would be receptive to it.

Court Decision and Case Disposition

The Nassau County Supreme Court IAS Judge held that the plaintiff's expert in infectious diseases did not demonstrate expertise in emergency medicine care. With regard to causation, the court ruled that the plaintiff's expert opinion was conclusory and contradictory. The expert failed to establish how earlier treatment would change the outcome based on chronic osteomyelitis on pathology. The Court dismissed the case in its entirety.

Not surprisingly, the plaintiff's lawyer filed a Notice of Appeal, which they perfected. The appellate brief was massive, would have been costly to oppose and we estimated the likelihood of success on appeal to be approximately 50%. Coming from a position of strength, we recommended that our client attempt to resolve

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the case for the cost of appellate practice or less. Ultimately, we agreed to a five-figure settlement on a case with a sustainable judgment value of well over one million dollars. Clearly a favorable outcome.

Discussion

This case demonstrates the benefit to filing a motion for summary judgment even when the likelihood of success is questionable. A well-crafted motion can set up a plaintiff's lawyer to lose if the attorney does not carefully construct the arguments in their opposition papers. In this case, the medical arguments were sound if we assume the plaintiff truly had chronic osteomyelitis as suggested by the pathologist who interpreted the surgical pathology specimen. However, this may have been questionable in the eyes of a jury where the patient did not have severe symptoms prior to her presentation to the hospital and the hospital radiologist read a CT scan as negative, i.e. no evidence of bone disease. While our expert witnesses were able to explain away these inconsistencies, whether a jury would have accepted the medical explanation in the face of an asymptomatic patient and negative CT scan was questionable. This was clearly a case where a judge was likely to be more receptive to our medical arguments as compared to a lay jury.

While we prevailed on the motion, our initial expectation was to limit the arguments for trial and demonstrate to the plaintiff that their case was not as strong as they thought which we expected would help us negotiate a better settlement at the appropriate time. When plaintiff perfected their appeal, it was economically more feasible to resolve the dismissed case for less than it would have cost to litigate. However, the settlement was a mere fraction of what it would cost to resolve the case had we not filed the motion.

Attorneys and clients alike often avoid summary judgment motions when the likelihood of receiving a dismissal is low. However, this case demonstrates how investing in a summary judgment motion can pay major dividends. We did not expect to win this motion completely and did not expect to prevail on appeal, but the relative low cost of preparing this motion saved our client hundreds of thousands of dollars on a settlement. Even if the motion was not initially successful, it likely would have served the purpose of showing the plaintiff's lawyer that their case had major weaknesses.

Even when a summary judgment motion is unlikely to result in a full dismissal, there are often significant benefits to making the motion. The cost of the motion pales in comparison to the cost savings of a streamlined defense, or in a case like ours putting us in the position to settle a case for pennies on the dollar. ■

This case demonstrates the benefit to filing a motion for summary judgment when the likelihood of success is questionable. A well-crafted motion can set up a plaintiff's lawyer to lose if the attorney does not carefully construct the arguments in their opposition papers.

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MCB CASE RESULTS

Summary Judgment Granted – Court Found Plaintiff's Expert's Opinion in Opposition to the Motion to be Conclusory

Senior Partner Sean F. X. Dugan and Partner Matthew M. Frank's motion for summary judgment was granted in Nassau County Supreme Court before Judge Steinman. Plaintiff underwent joint urogynecology and colorectal surgery and later was found to have a skin lesion on her lower back. Plaintiff claimed the electrosurgical grounding pad used during surgery was misplaced and/or our colorectal surgeon used excessive electrosurgery, leading to thermal skin burn.

Judge Steinman held that we established entitlement to summary judgment by establishing no departure from the standard of care and that plaintiff's claimed injuries were not proximately caused by our client doctor. The Court then held that the affirmation of plaintiff's anonymous general surgery expert was conclusory, riddled with speculation, and conceded to various uncertainties as to the cause. The Judge noted that plaintiff's expert failed to describe a standard of care or opine as to the manner in which our client doctor departed. Accordingly, Judge Steinman granted summary judgment, dismissing the complaint against our client doctor.

Summary Judgment Granted in Lumbar Puncture Case Based on Radiological Imaging

Partner John J. Barbera and Associate Christopher J. Daniel's motion for Summary Judgment was granted in Supreme Court Orange County. A young patient with several medical problems alleged severe and permanent neurological injuries following a lumbar puncture, (LP), performed by a resident to rule out meningitis.

Despite claiming that the spinal nerve was compressed by a pressure inducing hematoma via a negligently performed LP at the wrong level, causing nerve damage, the defense was able to establish via expert reviews that the neuro-radiology images of the spine showed the presence of an infectious collection of fluid in the spinal canal that pre-existed the LP and was responsible for causing a transient pressure inducing environment. The images were discussed extensively to allow the defense to demonstrate that the images were not consistent with a hematoma in terms of MRI signal and time line resolution over serial studies. The plaintiff was unable to rebut the expert findings put forward by the defense resulting in dismissal of a case of high exposure.

Defense Verdict in Complicated Laser Cataract Surgery Case

Senior Trial Partner Thomas A. Mobilia, Esq., assisted by Partner Aryeh S. Klonsky, Esq., obtained a defense verdict for their clients, a renowned eye surgeon and his ophthalmology group. The case was tried in New York County Supreme Court during a 4-week trial before the Honorable Frank Nervo.

Plaintiff, a retired medical malpractice trial attorney, alleged that the defendant eye surgeon negligently recommended laser cataract surgery, failed to disclose the increased risks of cataract surgery and Intraoperative Floppy Iris Syndrome (IFIS) secondary to long-term use of alpha-blockers for benign prostatic hyperplasia, and failed to take necessary preoperative and intraoperative preventative measures to prevent IFIS during cataract surgery. Plaintiff claimed that the surgeon's failure to take necessary preventative measures, including preoperative Atropine, and intraoperative Healon 5 viscoelastics, intracameral Epinephrine, and Iris Hooks, led to the development of IFIS and its symptomatology triad of sudden pupil constriction, billowing iris, and iris prolapse though the surgical incision. Plaintiff also alleged that iris injury and atrophy was due to manipulation of the iris with a cyclodialysis spatula in an effort to reposit the prolapsing iris, in addition to the phacoemulsification probe striking the iris.

Plaintiff claimed that as a result of the foregoing, he sustained permanent iris and pupillary deformity, blurry vision and glare, affecting his ability to read, use a computer, provide pro bono legal services for special needs children, walk without difficulty, and drive an automobile.

The defense successfully argued that the eye surgeon properly obtained plaintiff's informed consent for the procedure, and that cataract surgery was indicated based on the cataract's interference with plaintiff's activities of daily living, as well as the development of anisometropia. Further, that the eye surgeon properly chose and took other IFIS preventative measures. The defense also successfully demonstrated to the jury that plaintiff's vision was improved postoperatively, and that any alleged visual deficits were secondary to a pre-existing irregular astigmatism.

Successful Appeal in Orthopedic Spine Surgery Case

Partners Barbara D. Goldberg and Jacqueline D. Berger were successful on appeal in the Second Department in reversing the Westchester Supreme Court's decision which denied summary judgment as to our client orthopedic spine surgeon. This case involves treatment over a number of days, in which the plaintiff's decedent, 61 years old, complained of severe back pain to various physicians, also sued in the case. An MRI revealed suspicion for an epidural abscess and the patient was instructed to go to the ER.

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Plaintiff's decedent presented to the ER at co-defendant hospital at 12:27 p.m., and an epidural abscess was confirmed on further imaging. Our client, an orthopedic spine surgeon who was on-call, but not on-site, was first notified by phone about this patient by the ER staff at 9:00 p.m. As the patient had a stable neurologic exam at the time, as relayed to him by his resident, he decided to plan for spine surgery first thing the next morning. Four hours later, at 1:00 a.m., the patient was suddenly found to be paralyzed from the neck down. Our surgeon came to the hospital and emergently performed surgery, starting at 4:05 a.m. Motor function could not be recovered. There was also a peripheral claim against the hospital in failing to prevent decubitus ulcers. The patient suffered, completely paralyzed, for approximately 8 months in hospitals and rehab facilities, before dying, leaving a wife and 2 grown children.

In the Supreme Court, all defendants made motions for summary judgment. Judge Wood granted summary judgment as to all defendants except for the Emergency Room physicians at the hospital and our surgeon. All prior treating physicians were dismissed, and the hospital was dismissed from the case only to the extent that it was not held liable for the acts of its medical residents, as no triable issues of fact were found as to them.

On appeal, the plaintiff appealed to reverse the decision granting summary judgment as to most of those dismissed from the case. MCB cross-appealed to reverse the denial of SJ. We argued, among other things, that plaintiff failed to show any timeline in which our surgeon could have reversed the oncoming paralysis, even if he had come to the hospital as soon as he was first called, at 9 p.m. We argued that plaintiff's expert failed to raise an issue of fact in that regard.

The Second Department decision agreed with our argument, stating that plaintiff's expert engaged in speculation, without evidentiary basis, in presuming the surgeon had sufficient time after he was first notified, to adequately prepare for and perform surgery prior to the onset of paralysis.

Defense Verdict in Alleged Failure to Diagnose/Wrongful Death Case

Senior Partner Rosaleen McCrory, assisted by Partner Elizabeth Sandonato, obtained a defense verdict in Supreme Court, Nassau County. The case involved a 73-year-old woman who called our client internist's medical practice reporting that she felt ill with fever and a deep cough. She declined to present for an office visit as she felt too sick. She was told to schedule an appointment when she felt well enough and in the interim was prescribed antibiotics. On examination five days later, she reported feeling better but was fatigued and felt as though she pulled a muscle in her chest from coughing. Two days later, she was diagnosed with a heart attack and died one week later.

Plaintiff contended that the complaints were signs of an ongoing "stuttering" heart attack. The defense established through expert testimony that it was reasonable to treat decedent for a presumed infection, and that the trend of the cardiac enzymes demonstrated that the heart attack occurred after the last contact with the defendants. The jury returned a unanimous defense verdict.

Defense Verdict in False Imprisonment Case for a Major NY Hospital Health System

Senior Trial Partner Anthony M. Sola, assisted by Appellate Counsel Gregory Cascino and Associate Kathryn Blackmer, obtained a defense verdict on July 16, 2019, at the conclusion of a trial in New York County Supreme Court before Judge Barbara Jaffe. The plaintiff alleged that their client – who frequently demanded to be able to go home – was involuntarily confined in the Hospital against her wishes for 17 days without meeting the requirements of the Mental Hygiene Law for an involuntary admission.

The defense demonstrated that the elderly patient was not permitted to go home because she lived alone and her health condition rendered it unsafe for her to go home without home health aides. Pursuant to the Public Health Law, a Hospital cannot discharge a patient without a safe discharge plan in place. Moreover, it was demonstrated at trial that the plaintiff could leave the Hospital if, for example, she would agree to go to a nursing home. The jury found the patient was not confined to the Hospital as required for a case of False Imprisonment and rendered a defense verdict.

Summary Judgment Granted in Ophthalmology Surgery Case

Senior Partner Rosaleen T. McCrory, Of Counsel Maureen P. Blazowski, and Of Counsel Gregory A. Cascino secured a summary judgment on behalf of our client ophthalmologist in Supreme Court, Suffolk County. This matter involves a then 46-year-old single male, who underwent a left lateral orbitotomy and biopsy of a mass at a Suffolk County hospital on January 25, 2018, to rule out cancer behind the left eye. The procedure was performed by co-defendant plastic and reconstructive surgeon, with the assistance of our client ophthalmologist.

Plaintiff alleged that the surgery was performed negligently, that the optic nerve, the central retinal artery and the posterior ciliary artery were severed, and that he is now permanently blind in the left eye. The plaintiff also asserted a claim for punitive damages against both doctors.

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CASE RESULTS

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MCB argued that our client was not negligent, that he performed a proper ophthalmological work up, and, that he timely referred the plaintiff to a qualified specialist for possible biopsy of the mass. We further argued that the plaintiff's care and treatment following this referral was at the discretion of the specialist, including whether or not a biopsy was indicated and with regard to the manner by which the plaintiff's biopsy was carried out.

Dismissal Obtained in Case Involving Premature Delivery of Twins

Partner Barbara D. Goldberg and Senior Associate Amy Korn obtained a pre-answer dismissal of a Complaint in Supreme Court, Westchester County which alleged that the plaintiff-parents were within the "zone of danger" in witnessing the at-home premature delivery and of their twins. The Court accepted MCB's arguments that the plaintiffs were not within the zone of danger as contemplated by cases such as Bovson v. Sanperi, since the alleged negligence was not contemporaneous with the circumstances giving rise to the plaintiffs' emotional distress. Additionally, in agreeing with our position, the Court reinforced that where alleged medical malpractice causes in utero injury to a fetus that is born alive, a mother cannot recover damages for emotional harm.

Additionally, MCB secured dismissal of claims that the plaintiff-mother sustained an independent physical injury, and the Court agreed that plaintiffs failed to demonstrate an injury beyond those naturally experienced in childbirth.

Summary Judgment Granted on behalf of Major University Medical Center

Senior Partner Laurie A. Annunziato, Senior Associate Amy E. Korn, and Of Counsel Gregory A. Cascino secured a summary judgement on behalf of our client in a case involving claims of negligence surrounding the treatment at an outpatient rehabilitation facility. In this matter, the plaintiff, a 75-year-old woman was receiving therapy at a cardiac rehabilitation center on April 29, 2010, when she sustained a fall while riding an Airdyne bike. As a result, she sustained a right subdural hematoma requiring surgical evacuation.

Plaintiff's counsel was granted four adjournments to file opposition to our summary judgment motion by Judge O'Donoghue. After the fourth adjournment, plaintiff filed her opposition two weeks late. Judge O'Donoghue granted our summary judgment motion and declined to consider plaintiff's late opposition. Plaintiff thereafter sought to reargue the motion, which was denied by Judge O'Donoghue. On Appeal, we highlighted plaintiff's failure to offer any explanation as to why it took plaintiff almost six months to oppose our motion. We further argued that the granting of an adjournment rests in the sound discretion of the trial court. The Appellate Division Second Department affirmed a Supreme Court Order granting summary judgment to NYU finding that the plaintiff failed to make an adequate showing as to why they could not timely file opposition to Laurie A. Annunziato and Amy E. Korn's summary judgment motion and did not offer a valid excuse entitling them to an adjournment that did not result from a lack of due diligence on plaintiff's part. ■

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What's New at MCB?


MICHAEL C. CLARKE

MCB Welcomes Michael C. Clarke as the Firm's New Managing Attorney!

We are pleased to announce the appointment of Michael C. Clarke as the Firm's Managing Attorney. "We believe Michael's prior experience will allow him to excel in this role and we are pleased to welcome him into the position and look forward to this new chapter for the Firm" said Thomas A. Mobilia, Senior Partner and Member of the Firm's Executive Committee.

Following six years as a prosecutor in New York City, Michael joined MCB in 1994 as a Senior Associate, specializing in medical malpractice litigation, as well as handling OPMC matters. After leaving MCB, Michael worked as Counsel at Memorial Sloan-Kettering Cancer Center, and as a Director of Compliance for Pratt & Whitney's/United Technologies Corporation's global ethics and international trade compliance programs.

Immediately before his 2019 return to MCB, Michael served as Chief of Staff and Counsel, Director of Training, and Deputy Inspector General for Welfare in the New York State Offices of the Inspector General. There, Michael was responsible for the Agency's overall operations, including the training, budget, case management/intake, administration, human resources, public information, and information technology units. Along with having direct oversight of the Inspector General's employees, statewide, Michael managed the Agency's staff recruitment, retention, and training programs.

As Managing Attorney, Michael supervises the intake of all new cases and serves as the main liaison to MCB's clients, working to ensure they receive effective, efficient and results-driven counsel and defense. He also oversees professional development initiatives, education, mentoring and training for the Firm's attorneys and legal staff.

Congratulations!

We proudly congratulate Senior Trial Partner Peter T. Crean for his inclusion among the esteemed honorees of the Irish Legal 100. MCB supports Irish Legal 100 and *The Irish Voice* newspaper in honoring all who share a passion for law and take pride in their Irish heritage!

MCB applauds Senior Partner Sean F.X. Dugan on his election to Northwell Health Board of Advisors and Phelps Hospital Community Board, a prestigious position that the Firm is honored to be a part of.

Senior Partner John Barbera Presents at NYSBA

On Monday, March 22, Senior Partner John Barbera presented at New York State Bar Association's CLE program entitled *Defending And Prosecuting Controlled Substance Cases*.

MCB Article Featured in MLMIC's The Scope

Senior Partner Rosaleen McCrory and Associate Michelle Frankel's article, *Legal Considerations When Prescribing Psychotropic Medications to Elderly Patients* is now featured in MLMIC's *The Scope: Medical Edition* first quarter newsletter!

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