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SUPREME COURT STATE OF NEW YORK
COUNTY OF BRONX TRIAL TERM - PART 15

PRESENT: Honorable Mary Ann Brigantti

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BARBARA PHILLIPS, by her Guardian Ad Litem,
FELICIA BULLOCK,

Plaintiff,

-against-

DECISION / ORDER
Index No. 306320/2008

BETH ABRAHAM HEALTH SERVICES and
HARVEY MANDEL, M.D.,

Defendants

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The following papers numbered 1 to 10 read on the below motion noticed on November 10, 2016 and duly submitted on the Part IA15 Motion calendar of **April 17, 2017**:

Papers Submitted	Numbered
Mandel's Notice of Motion, Exhibits	1,2
Beth Abraham's Cross-Motion, Exhibits	3,4
Pl.'s Opp., Exhibits	5,6
Mandel's Reply Aff., Exhibits	7,8
Beth Abraham's Reply Aff., Exhibits	9,10

Upon the foregoing papers, defendant Harvey Mandel, M.D. ("Mandel") moves for summary judgment, dismissing the complaint of the plaintiff Barbara Phillips, by her Guardian Ad Litem Felicia Bullock ("Plaintiff"), pursuant to CPLR 3212. Defendant Beth Abraham Health Services ("Beth Abraham") cross-moves for summary judgment, dismissing Plaintiff's complaint against it in its entirety, with prejudice, pursuant to CPLR 3212. Plaintiff opposes the motion and cross-motion.

I. Background

This is a medical malpractice action wherein Plaintiff alleges that due to the defendants' negligence, she was caused to have a loss of vision in her left eye. Plaintiff alleges that defendant Mandel, an opthalmologist, departed from the applicable standards of care by failing to perform proper opthalmologic testing, examinations, or follow-up, and failed to diagnose and treat a neovascular closed-angle glaucoma ("NVG"), due to ocular ishemic syndrome ("OIG"),

that led to a central retinal arterial occlusion ("CRAO"), and the loss of vision in her left eye. Plaintiff alleges that co-defendant Beth Abraham, a residential health care facility, deprived her of rights in violation of *inter alia* Public Health Law §2801-d. Each of the defendants now move for summary judgment, seeking dismissal of Plaintiff's complaint.

The relevant facts are essentially undisputed. In December 2005, Plaintiff suffered from a serious cerebrovascular event ("CVA") that required her to be placed in various nursing homes and rehabilitation centers. Records from January and February 2006 indicated that Plaintiff suffered from bilateral occlusions of the internal carotid arteries, and an occlusion of the left carotid bulb. Studies performed at St. Luke's/Roosevelt Hospital revealed that, at that time, there was no detectable blood flow in the right and left internal carotid arteries proximal to the origins of the opthalmic arteries.

Plaintiff was admitted to Beth Abraham in June 2006 with a host of medical conditions, including the loss of use of legs, seizures, incontinence, and dementia. The status of Plaintiff's vision was unknown, except for her needing glasses. Plaintiff's care at Beth Abraham was primarily handled by internists, who would follow the residents and write examination notes in the Interdisciplinary Progress Notes section of a resident's chart. If the internists determined that Plaintiff needed to see a specialist such as an opthalmologist, they would fill out a consultation request and send it to the clinic. Defendant Mandel is an opthalmologist who only saw residents at Beth Abraham twice a week, and could otherwise be reached for emergency purposes. Beth Abraham could also send residents to Montefiore Medical Center hospital ("Montefiore") for more urgent issues.

Beginning August 3, 2006, Beth Abraham's internists noted that Plaintiff had some redness in her left eye, however she was "aphasic" meaning she had trouble communicating as a result of her medical condition. She was prescribed medication and the condition resolved itself without intervention by Mandel. Plaintiff first saw Mandel on December 19, 2006, upon consultation request to evaluate Plaintiff for corrective lenses. At this exam, records indicate that Plaintiff was generally uncooperative, and Mandel could not obtain a reading of her intraocular pressure ("IOP") due to her bobbing and weaving, as a result of her medical condition and mental state. Later, on January 25, 2007, Plaintiff was again sent to Mandel's clinic to perform a follow

up evaluation. This time, Plaintiff was sedated, but Mandel noted that she was not sufficiently sedated because during the taking of her IOP, Plaintiff was "fighting" and moving. Mandel obtained IOP of 17 mmHg in the left eye, and 22 mmHg in the right eye, but noted that it probably would have been lower if Plaintiff were not fighting him.

Mandel next saw Plaintiff in February and March due to issues with her right eye, including swelling, exudate, and cellulitis due to infection. Plaintiff was given antibiotics and the condition eventually healed. Plaintiff was told she could stop medication and return in six months.

On July 13, 2007, records indicate that Plaintiff's sister Felicia Bullock spoke to doctors about Plaintiff's eyes being swollen. An examination was performed and no swelling or conjunctiva was found. Plaintiff did not complain of any visual disturbances. The next day, July 14, Ms. Bullock called again to report that Plaintiff was unable to see out of both eyes, and she had swelling under the left eye and trouble opening it. Nursing notes indicate that Plaintiff was given medication, and a follow up with an opthalmologist would be ordered. Later that evening, another nurse's note indicated that Ms. Bullock called again regarding problems with Plaintiff's eyes. Upon examination, there was no redness or swelling and Plaintiff denied pain. At around 11:50PM, Plaintiff's left eye had redness and slight puffiness, and Plaintiff complained that she could not see well out of it. Plaintiff was administered medication, and later she stated that the eye felt better and she could see out of it.

On July 16, 2007, nursing notes indicated that Plaintiff had left eye drainage and she was unable to open it, but she did not complain of pain. Her doctors examined her and noted that the left eye was not red or swollen, conjunctiva was clear. She continued the use of medication.

Mandel examined Plaintiff on July 17, 2007, based upon a consultation request from Plaintiff's internist. The consult was requested because Plaintiff had a swollen upper lid that had improved on medication. This was the first time Plaintiff had a consult for any opthalmological problem with her left eye since becoming a Beth Abraham resident. Mandel noted that Plaintiff had no complaints in her eye. The eye only had external trace swollen conjunctiva. He could not test her IOP because Plaintiff did not cooperate. Mandel discontinued the medication Plaintiff had been taking - Cliloxin - and prescribed Tobradex instead. Mandel noted that Plaintiff could

return within 6 months if her condition improved. If not, she was to be sent for a re-consult.

Records indicate that on July 18, 2007, Plaintiff awoke complaining of pain to the left side of her head and sweating profusely. She was transferred to Montefiore for evaluation. On July 20, 2007, she refused her eye drops but had no complaints of pain. There was no redness or other issues with the eye.

A Beth Abraham note dated July 30, 2007 states that on July 27, 2007, after Plaintiff had returned from an outside pass, her sister advised nurses that Plaintiff had difficulty seeing out of her left eye. Upon a vision assessment, Plaintiff was unable to read from a magazine using her left eye. Later that day, Plaintiff's doctors examined her after she complained about a sudden decrease of vision in her left eye. The eye had no swelling or exudate, and no sign of bleeding, and Plaintiff did not complain of pain. She was referred for an opthalmology consult.

Mandel saw Plaintiff on August 2, 2007, and evaluated her for painless swelling and possible vision loss in the left eye. Mandel attempted to test her IOP but she would not cooperate. Swelling had improved and Plaintiff had no complaints at this visit. Mandel discontinued medications. She was later seen by a different doctor who noted that Plaintiff had a history of intracranial bleed, residual speech impairment, and vision loss.

Plaintiff underwent evaluations on August 6, 2007, at Beth Abraham and Montefiore, and it was noted that Plaintiff could hardly open her left eye and an examination revealed that her pupils were not reactive to light. Plaintiff eventually returned to Mandel on August 7. Upon examination, after Plaintiff was sedated with Haldol, Plaintiff had questionable/no light perception, there was swelling, and left cornea was hazy so that he could not see the anterior chamber clearly. Left eye IOP was 50. Mandel spoke to other doctors about sending Plaintiff to Montefiore. At Montefiore, doctors examined her but could not obtain her IOP despite Haldol sedation, as she was uncooperative. Plaintiff commenced medications to reduce IOP and "Pred Forte," which was a steroid medication to reduce swelling. Plaintiff was to return for a glaucoma evaluation.

On August 9, 2007, Plaintiff was seen and examined by Dr. Jeffrey M. Schultz ("Schultz"), Director of Glaucoma Service at Montefiore. He noted that Plaintiff's left eye IOP was 25. The left cornea was clear but there was rubeosis. A fundus examination of the left eye

revealed that the optic nerve was pale. Schultz diagnosed Plaintiff was rubeosis and neovascular glaucoma from a prior CRAO.

Mandel examined Plaintiff again on August 14, 2007. Plaintiff's left visual acuity was noted as "No Light Perception" but Mandel was unsure if it was accurate due to Plaintiff's lack of cooperation. Left cornea was clear, and the left pupil was mid-dilated. Left IOP could not be obtained due to Plaintiff's lack of cooperation. Mandel noted that he tried for 10 minutes. On August 21, Mandel examined Plaintiff and her left eye status remained the same except some redness of the conjunctiva. On August 28, 2007, Mandel performed a fundus exam and noted that there were "no arteries." His findings remained the same on September 11 and October 9, 2007, the last two times Mandel examined Plaintiff.

In support of his motion for summary judgment, Mandel relies on, among other things, affidavits from expert Ronald Gentile, M.D. ("Gentile"), a board-certified opthalmologist, and Plaintiff's treating physician Schultz.

Gentile states that, contrary to Plaintiff's allegations, she never had a primary acute narrow-angle closure glaucoma, that led to her vision loss. Instead, she suffered from an ocular ischemic process ("OIP") caused by an occlusion (stroke) of the carotid artery, and an eventual CRAO, which resulted in secondary rubeosis, neovascular glaucoma, retinal detachment, and subsequent vision loss in the left eye. He claims that Plaintiff's eye issues were caused by inadequate blood flow, which was directly related to the conditions that caused her occlusion in the first place. Specifically, Gentile asserts that Plaintiff's initial occlusion was most likely caused by her underlying medical conditions: hypertension and diabetes mellitus, which causes vascular disease, which is in turn the long-term cause of progressive ischemia and eventual CRAO. The CRAO is caused by plaque, narrowing, and clot or thrombus to the opthalmic central retinal artery, and most occurs in patients that have a medical history like Plaintiff. Gentile states that there is no proven treatment to prevent CRAO, and no proven treatment to reverse a CRAO vision loss once it occurs. Initially, a CRAO is painless with few symptoms aside from vision loss.

Gentile opines that Plaintiff was at risk for CRAO considering her medical history. After CRAO occurs, rubeosis ridis may occur, defined as the neovascularization of the iris. This may

give rise to secondary neovascular glaucoma or "closed-angle glaucoma" that usually causes increase IOP, pain, and redness to the eye. Gentile states that in this case, Plaintiff had a CRAO which compromised her retina and optic nerve *prior to* her neovascular glaucoma. Medical records reveal, among other things, that Plaintiff had no vitreous hemorrhage or diabetic retinopathy, therefore ocular ischemia of the retina and CRAO are the only possible conclusion that would cause Plaintiff's neovascularization of the iris, and complete pallor of the optic nerve. Gentile states that primary narrow-angle, or primary closed-angle glaucoma, is not caused by neovascularization, and that is why Plaintiff's left eye vision loss was due to CRAO, for which by the time Mandel saw Plaintiff, there was no effective treatment.

Gentile reviews Plaintiff's medical records and asserts that Mandel did not depart from any accepted standard of good medical care. He notes that Mandel was an opthalmologist who only saw Beth Abraham residents twice a week, and Mandel relied on notations and referrals from Beth Abraham doctors in rendering his treatment. Importantly, Gentile asserts that Mandel was not required to test Plaintiff's IOP at every visit, and was not required to sedate Plaintiff if she was uncooperative. Eye examinations require some voluntary cooperation on the part of the Plaintiff, and sedation or physical restraint are not without risks, and can result in inaccurate readings. Gentile note that upon his own examination of Plaintiff, she did not cooperate and did not allow him to put instruments near her eyes. Furthermore, IOP tests are generally only performed once or twice per year, unless there is reason to suspect glaucoma, an increase in IOP, or other known problem with glaucoma.

Gentile states that Mandel properly evaluated Plaintiff since he started treating her in December 2006. Up until July 17, 2007, Plaintiff's various eye symptoms, with no complaints of visual disturbances, would not alert Mandel to believe that Plaintiff had general primary glaucoma, narrow-angled glaucoma, or any secondary glaucoma of any kind. Upon until that point, Plaintiff did not report vision loss or disturbances to Mandel. Gentil asserts that by the time Mandel saw her again on August 2, 2007, she had lost vision in her left eye due to the CRAO. Subsequent examination revealed that she had significant retinal and optic nerve damage from the CRAO. Gentile asserts that the CRAO was consistent with Plaitniff's base MRI/CT scan studies, and it was due to the rubeosis/neovascularization of the iris, which caused

subsequent secondary neovascular glaucoma. Once Plaintiff had the CRAO, her prognosis was poor and there was no effective treatment to save her eye. Gentile opines that Mandel treated Plaintiff within the standard of care. Her medical history and mental problems made it very difficult for doctors to get a history and examine her. Again, Mandel was not required to take an IOP test at every exam. An elevated IOP is an indicator of a possible problem but does not always denote glaucoma. Gentile states that Plaintiff's slightly elevated January 2007 IOP was probably due to her own fighting during the exam, and as noted above, sedation is not always proper and may lead to false IOP readings.

With respect to treatment rendered between January 25 and August 2, 2007, Gentile opines that Mandel did not depart from the proper standard of care. Mandel had noted there was no need for another full exam after January 25 for at least a year unless there was a problem. Mandel had no reason to sedate Plaintiff and take her IOP when he saw her in July, because Plaintiff only had a swollen upper eyelid that was being treated with antibiotics. Gentile states that Plaintiff had already lost her vision by the time Mandel saw her again on August 2, 2007. Gentile states that the damage seen to Plaintiff's optic nerve was not caused by a sudden increase in IOP, since her vision was already gone by August 2007. Even if Mandel had administered pressure-reducing drops on August 2, that would not have prevented the vision loss due to CRAO.

Mandel also provides an affidavit from Schultz, who examined Plaintiff on August 9, 2007. He asserts that at the time of his exam, he found that Plaintiff had suffered from a CRAO. Plaintiff's medical history made her a candidate for having a CRAO. Schultz states "it is difficult to say exactly how long she had the CRAO and there would have been no way to prevent it." Schultz opines that Plaintiff did not suffer from primary glaucoma or an acute narrow-angle event, but her vision loss was the result of a prior CRAO, for which no treatment would have been possible. He states that Plaintiff's neovascular glaucoma was the result of the CRAO. In a patient with an acute narrow-angle attack, which is what Plaintiff claims to have ocurred, the lens is pushed forward and the anatomical positioning of the iris blocks the drainage of aqueous humor, causing pressure to build up quickly. Plaintiff, however, did not have an acute narrow-angle attack, but a secondary neovascular glaucoma. Schultz states that there is no

treatment that can prevent vision loss after CRAO. The main issue with Plaintiff was that she suffered from vascular disease, hypertension, and diabetes, and her CVA of the carotid artery led to the ischemic event that caused her vision loss. Schultz notes that Plaintiff's optic nerve was white and pale, which is usually caused by a stroke vent. Since Plaintiff had no signs of retinopathy at the time, and no hemorrhage in the posterior portion of the eye or retina, the only possible cause of her optic nerve damage was from a CRAO.

Mandel contends that, in light of the foregoing, he is entitled to summary judgment.

Beth Abraham's cross-motion refers to the affidavits of Gentile and Schultz, and argues that it, too, is entitled to summary judgment, as the evidence suggests that Plaintiff's injuries were proximately caused by her underlying medical conditions.

Plaintiff opposes the motion and cross-motion. Plaintiff argues that her medical records from July 8, 2007 through August 7, 2007, indicate that Plaintiff was having a neovascular closed angle glaucoma ("NVG") due to ocular ischemic syndrome ("OIS"), which went undiagnosed and untreated, which led to her developing a CRAO, and ultimately led to the loss of vision in her left eye. Plaintiff argues that this result was preventable had Mandel taken the appropriate measures to assess and lower Plaintiff's IOP.

Plaintiff relies on an affidavit from ophthalmologist Dr. Reza Dana, M.D., Msc, MPH, FARVO ("Dana"). Dana opines that Plaintiff's vision loss was caused by Mandel's departure from generally accepted standards of medical care. Notably, Mandel failed to properly diagnose Plaintiff's left eye for ocular ischemia, neovascularization, and neovascular closed angle glaucoma ("NVG") prior to August 2007. He claims that Mandel and Beth Abraham failed to diagnose, appreciate, and plan for Plaintiff's NVG and increasing intraocular pressure (IOP) in her left eye, and providing medication when necessary to reduce IOP. Furthermore, Mandel/ Beth Abraham failed to perform a complete ocular exam including visually examining the cornea, palpating the eye to see if it was "grossly" hard or soft within four (4) months of her January 25, 2007 [exam]; on or before July 17, before July 27, or before July 30, 2007. Dana notes that while manual palpation is *not* the standard of care for measuring pressure, it can be used by experienced practitioners to derive an approximate sense for whether the eye has a very high pressure, or whether it is within normal limits. Dana further contend that Mandel

improperly prescribed and administered Tobradex for unknown reasons. He states that Plaintiff's ocular disease was incorrectly attributed to an infectious disease, and Tobradex has a potent steriod which has the tendency to increase IOP. Dana further alleges that Beth Abraham failed to include a recent history of Plaintiff's left eye-related issues on the July 18, 2017 transfer form to Montefiore, thus limited its ability to assess, diagnose, and treat Plaintiff.

Dana reviewed Plaintiff's medical treatment records, and opines to a reasonable degree of medical certainty that Plaintiff suffered from Ocular Ischemic Syndrome ("OIS") related to prior medical conditions. Her OIS led to neovascularization of left eye, which in turn caused IOP to increase and eventually caused her to develop NVG. As the OIS and NVG progressed, she exhibited documented symptoms of fluctuating vision loss, tearing, discomfort, swelling, conjunctivitis. Mandel and Beth Abraham failed to appreciate Plaintiff's risk for developing OIS, failed to perform complete ophthalmological exam, failed to take action to reduce IOP which would have prevented her from developing other vascular complications such as central retinal arterial occlusion (CRAO), a known risk when allowing OIS/NVG to go untreated. Dana opines that CRAO did not precede the NVG, but rather was caused by the combination of plaintiff's OIG and NVG, increasing IOP, that went undiagnosed, untreated, and improperly medicated. Dana states that Plaintiff had OIS that placed her at risk of CRAO, "which can be prevented when the IOP is controlled." He asserts that a rise in IOP leads to more compromised blood flow to the eye, exacerbating the ischemia (poor blood flow) even further, and possibly leading to retinal artery occlusion. Dana states that while this process is taking place, and prior to the event of a secondary CRAO, it is essential to assess and control the IOP, so as to prevent secondary vascular compromise, including CRAO and vision loss.

Dana states that after Plaintiff's January 25, 2007 examination which resulted in an IOP of 22 in the left eye - which is the "high end" of normal - Mandel should have monitored Plaintiff more closely. While Dana agreed that IOP would normally be checked every 4-6 months, given this Plaintiff's medical history, as soon as she began exhibiting signs of ocular discomfort on July 8, 2007, as indicated in her progress notes, a complete ophthalmalogical exam should have been performed. This would have included testing the IOP, assessing Plaintiff's vision, as well as her cornea and pupil. As the symptoms persisted after July 8, 2007 (in the form of swelling,

complaints of discomfort, difficulty opening eyes), the need for a full exam became more apparent. Dana notes that between July 7 and July 27, 2007, Plaintiff had complaints including: swelling, headaches, difficulty seeing, tearing, and conjunctivitis, however a complete eye exam was not performed until August 7, 2007, at which time Plaintiff had a complete and permanent vision loss. At the time of her July 17 evaluation, Plaintiff should have been given a complete and thorough examination including testing for IOP, palpating the eye, and assessing clarity of cornea and pupillary light response. However, this was not done.

Dana further notes that Mandel did not conduct an IOP test between July 17 and August 2, 2007. While there are risks associated with sedating a patient, Dana states that IOP testing was "essential" and he notes that Mandel used the sedation procedure in January 2007, and it should have been done again no later than July 17. Furthermore, Dana notes that Mandel admitted that he did not read any of the interdisciplinary progress notes found in Plaintiff's chart, that documented Plaintiff's eye issues and physician orders. If he had read those notes, Mandel would have had a more complete picture of the status of Plaintiff's left eye. Dana states that those notes showed fluctuating issues with vision, redness, headaches, and discomfort, which are "classic symptoms of OIS and NVG, not CRAO." He notes that CRAO is generally not symptomatic aside from sudden vision loss.

Dana opines that while Plaintiff had issues with her eyes in mid-July, she had no visual disturbances, thus a CRAO could not have occurred prior that date, and therefore Defendants' expert opinions that a CRAO caused the NVG cannot be entirely accurate. Plaintiff had continued difficulties with her eye on July 14 and 15, which were classic signs of ischemic eye disease and resultant NVG. Because Plaintiff could see, she could not have had a CRAO at that time. Furthermore, a CRAO occurring after July 15 would not have led to neovascularization and NVG within a few weeks by August 7, 2007.

Dana states that at the July 17, 2007 Mandel examination, he wrote down conjunctive and swollen conjunctiva of the left eye but documented no visual disturbance. Mandel however failed to appreciate Plaintiff's transient fluctuatin vision loss because he did not read Plaintiff's interdisciplinary progress notes. Importantly, Mandel did not perform a complete and proper opthalmological exam at that time or take a proper history. Dana states that Plaintiff's history

placed her at increased risk of OIS/NVG. If Mandel was unable to perform proper IOP test, Plaintiff should have been sedated as she was on a prior occasion.

Dana states that after an event which led to Plaintiff's brief hospitalization, a July 19, 2007 progress note indicated that Plaintiff complained of pain to her left eye with no headaches, and no vision loss. Tobradex was started. Dana alleges again that these are classic symptoms of NVG due to OIS.

The next progress note was entered on July 30, 2007, documenting Plaintiff's sudden vision loss that occurred a few days earlier on July 27. Dana states that when Plaintiff complained of sudden vision loss, her doctor at Beth Abraham should have immediately transferred her to the hospital to have her left eye reassessed. Dana notes that on August 2, 2007, Mandel again failed to test Plaintiff's IOP and there is no evidence that he palpated the eye or examined the pupils or cornea, and he did not refer her for a full exam. At a subsequently August 7, 2007 examination, Mandel observed redness and swelling and an IOP of 50, which was very high. His impression was that Plaintiff had a narrow angle glaucoma attack of the left eye, and she was to be sent to the hospital.

Following hospital evaluations, it was determined that Plaintiff suffered a CRAO. Dana asserts, however, that accepting this diagnosis as accurate does not change his opinion as to the precipitating factors that led to this significant vascular complication. Dana states: "Dr. Gentile states that neovascularization of the eye and NVG often result in CRAO. While CRAO can occur, infrequently, from NVG, as stated above, the history of the patient as detailed above from the medical records strongly suggests that in fact NVG from ischemia preceded the CRAO." He further states "[e]ssential to Defendants' expert's opinion is the loss of vision due to a CRAO for a significant amount of time prior to onset of NVG. Although this could occur infrequently, it typically takes approximately eight (8) weeks for neovascularization to occur and the onset of NVG to become prominent - such a time course is simply not in accord with the history of [Plaintiff] as recorded in the chart."

Dana states that, importantly, primary CRAO is associated with an acute and sudden loss of vision, which is not found here. There was no history of hyperacute vision loss prior to July 27, 2007 (documented July 30, 2007). The symptoms of fluctuating/transient vision loss,

conjunctivitis, headaches, swelling, discomfort, and tearing all occurred prior to total vision loss, and there is no historic evidence supporting a CRAO occurring prior to July 27. Dana essentially alleges that before that date, Plaintiff was suffering symptoms of NVG, not CRAO. He further notes that Gentile's opinion on causation is based in part on a physical exam that took place some five years after the event. In sum, Dana opines that Plaintiff demonstrated significant signs of ischemic disease an NVG for weeks, but Mandel and Beth Abraham deviated from generally accepted standards of care by delaying diagnosis, initiating proper treatment (reducing IOP), failing to perform a full exam, failing to assess IOP through palpation or sedation; Mandel did not provide all care reasonably necessary to prevent or limit plaintiff's loss of vision. These departures were a competent producing cause of Plaintiff's irreversible vision loss in her left eye.

With respect to defendant Beth Abraham, Plaintiff argues that the cross-motion is untimely as it was made more than 120 days after Plaintiff filed her note of issue, and Beth Abraham did not establish good cause for the delay. Substantively, Beth Abraham failed to carry its initial summary judgment burden, as the moving papers failed to address their alleged violations of Public Health Law.

In reply, Mandel asserts that Plaintiff's expert affidavit fails to raise an issue of fact and failed to respond to all of the defense experts' assertions. Mandel relies on a reply affidavit from Gentile. Gentile asserts that there are no medical records to support Plaintiff's expert assertions that she had an OIS, which caused NVG – rather than a CRAO – and that by merely lowering undiagnosed IOP, Plaintiff would not have lost her vision. Gentile states that this is "erroneous" and unsupported by the record, as no ocular treatment was going to prevent Plaintiff's vision loss, and there is no medical evidence of OIS - e.g. in the form of retinal hemorrhaging and other changes- when either Mandel or Schwartz examined Plaintiff. Instead, there is more evidence supporting CRAO. Gentile notes that a CRAO had to have occurred first because a fundus exam revealed "no arteries." Plaintiff here had an ischemic event causing her blood supply to be cut off to her central retinal artery, and thus was before the NVG occurred. Gentile accuses Dana of "double-talk" to make it seem as if a CRAO comes from NVG, when this is scientifically /medically untrue. Furthermore, no amount of pressure-lowering medication would have avoided vision loss once an ischemic event occurs. Gentile asserts "[t]here was no ocular treatment that

would have saved [Plaintiff]'s vision in the left eye."

Gentile states that it is disingenuous to suggest that Mandel departed from the accepted standard of care when he failed to take Plaintiff's IOP prior to July 17, 2007. Plaintiff's expert failed to acknowledge the seriousness of the difficulty Mandel had in performing proper examination without Plaintiff's cooperation, and he also failed to acknowledge that even when sedated, obtaining Plaintiff's IOP was difficult and inaccurate. Gentile notes that - as acknowledged by Dana - palpating the eye is not the proper method of obtaining IOP. Gentile further alleges that Mandel should not have done more comprehensive examinations prior to July 17, 2007, because he received no referrals from Plaintiff's doctors before that time and there was no need to give IOP-reducing medication. By the time Plaintiff came to him on July 17, 2007, the ischemic event had already occurred and giving IOP medication would not have prevented vision loss. Gentile alleges that Plaintiff showed no signs of redness, pain, or visual disturbances prior to July, however her right eye had such symptoms in February that were resolved using medication in March 2007. When Mandel saw Plaintiff on July 17, it was for similar symptoms in the left eye, and therefore Mandel acted within the standard of care in handling redness and swelling as he did. Gentile also disagrees that the prescription of Tobradex was improper, as Plaintiff was only on the medication for five days, and Tobradex can reduce swelling of the eye.

Gentile ultimately opines that Plaintiff's vision was already compromised when Mandel saw her on July 17 and August 2, and there was nothing to be done to reverse it. Furthermore, when Mandel saw Plaintiff one time prior to July 17, Mandel was not apprised of her vision complaint problems. None of the issues that Plaintiff had prior to July 17 were imparted to Mandel. "Regardless, no medication was going to prevent the eventual vision loss in the left eye since the ischemic event, CRAO, occurred before the NVG." Gentile notes again that a fundus examination in August revealed ischemic caused by CRAO consistent with what caused the damage to the retina and optic nerve. Plaintiff's expert never examined her. No pressure-reducing drops would have saved Plaintiff's vision. Gentile further asserts that the condition of Plaintiff's optic nerve could not have existed on August 9, 2007, had Plaintiff not already had a CRAO weeks earlier, which led to NVG. The NVG did not cause the vision loss, the CRAO did.

Mandel's actions or inaction did not cause the vision loss.

Beth Abraham also submits a reply affirmation. It alleges that its cross-motion is not untimely, as five days may be added to the statutory summary judgment time limits where, as here, Plaintiff mailed its Note of Issue via regular mail. Beth Abraham also argues that its cross-motion is timely because it seek identical relief as Mandel's timely motion. With regard to the merits, Beth Abraham argues that Plaintiff's expert fails to identify any individual at Beth Abraham who departed from good and accepted standards of care, and fails to allege any facts to support a violation of Public Health Law.

II. Standard of Review

To be entitled to the "drastic" remedy of summary judgment, the moving party "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact from the case." (*Winegrad v. New York University Medical Center*, 64 N.Y.2d 851 [1985]; *Sillman v. Twentieth Century-Fox Film Corp.*, 3 N.Y.2d 395 [1957]). The failure to make such prima facie showing requires denial of the motion, regardless of the sufficiency of any opposing papers. (*Id.*, see also *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]). Facts must be viewed in the light most favorable to the non-moving party (*Sosa v. 46th Street Development LLC.*, 101 A.D.3d 490 [1st Dept. 2012]). Once a movant meets his initial burden, the burden shifts to the opponent, who must then produce sufficient evidence, also in admissible form, to establish the existence of a triable issue of fact (*Zuckerman v. City of New York*, 49 N.Y.2d 557 [1980]). When deciding a summary judgment motion the role of the Court is to make determinations as to the existence of bonafide issues of fact and not to delve into or resolve issues of credibility (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499 [2012]). If the trial judge is unsure whether a triable issue of fact exists, or can reasonably conclude that fact is arguable, the motion must be denied. (*Bush v. Saint Claire's Hospital*, 82 N.Y.2d 738 [1993]).

III. Applicable Law and Analysis

"The required elements of proof in a medical malpractice action are a deviation or

departure from good and accepted standards of medical practice, and evidence that such departure was a proximate cause of the injury" (*Elias v. Bash*, 54 A.D.3d 354, 357 [1st Dept. 2008], *lv. den.*, 11 N.Y.3d 711 [2008]). In order to establish entitlement to summary judgment, a defendant must "'rebut[] with factual proof plaintiff's claim of malpractice'" (*Pullman v. Silverman*, 28 N.Y.3d 1060, 1062 [2016], quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 325 [1986]). "'[B]are conclusory assertions ... with no factual relationship to the alleged injury' are insufficient to 'establish that the cause of action has no merit so as to entitle defendant[] to summary judgment'" (*id.*, quoting *Winegrad v. New York Univ. Medical Center*, 64 N.Y.2d 851,853 1985]).

In this case, Mandel carried his initial burden of demonstrating entitlement to summary judgment. Defendant's medical experts established prima facie that Mandel's care comported with all applicable standards, and Plaintiff's eventual vision loss was the result of her long-term vascular disease and arteriosclerosis, which caused progressive ischemia - or impeded blood flow to the eye - resulting in an unavoidable central retinal artery occlusion or "CRAO." The experts alleged that there was no ophthalmic treatment which could have prevented the CRAO or reverse the CRAO-related vision loss once it occurred. The experts also established that Plaintiff's closed-angle glaucoma, or neovascular glaucoma, was secondary to the CRAO event, and not primary. Because of her medical history, Plaintiff always ran the risk of ischemia or CRAO. Her mental problems made it difficult for doctors to obtain a medical history or properly examine her. Once the CRAO occurred, no amount of pressure-reducing medication would have saved Plaintiff's vision.

Crucially, Gentile has competently established prima facie that Mandel did not depart from accepted standards of care during examinations between January 25 and August 2, 2007. The doctor notes that Mandel was an ophthalmologist who only saw residents at Beth Abraham twice per week, and he relied on Plaintiff's general doctors to document medical issues in her Interdisciplinary Progress Notes and/or refer her for further evaluation if necessary. While Plaintiff was referred to Mandel for various issues in her right eye, she was only referred for left eye treatment for the first time on July 16 and July 17, 2007. At that examination, Mandel had no reason to sedate Plaintiff to take her IOP, as her only symptoms were mild swelling of the eye,

and no other complaints were conveyed to Mandel. By the time Mandel saw her again on August 2, she had already lost her vision due to the CRAO that must have occurred in the weeks prior. Gentile notes that Mandel's alleged inaction did not cause Plaintiff's loss of vision. Rather, the main issue with Plaintiff was that she suffered from severe vascular disease, hypertension, diabetes, and a prior CVA of the carotid artery that eventually led to an ishemic event that caused her vision loss. The experts further note that an August 28, 2007 fundus examination revealed that her left optic nerve was pale - a condition that occurs from ischemia such as a CRAO, for which there was no proven opthalmic treatment.

In opposition to the motion, Plaintiff does not dispute that Mandel carried his initial summary judgment burden of proof. Accordingly, the burden shifted to Plaintiff to raise a triable issue of fact with respect to her claims of malpractice. In order to do so, it is incumbent upon a medical malpractice plaintiff to "produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice'" (*Frye v. Montefiore*, 70 A.D.3d 15, 24 [1st Dept. 2009], quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320). Usually, the opinion of a qualified expert that the plaintiff's injuries were the result of a departure from relevant industry or medical standards is sufficient to preclude entry of summary judgment in favor of a defendant (*id*). "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'" (*id.* at 24, quoting *Diaz v. New York Downtown Hosp.*, 99 N.Y.2d 542 [2002]). Furthermore, "[a]n expert opinion that is contradicted by the record cannot defeat summary judgment" *Bartolacci-Meir v. Sassoon*, 149 A.D.3d 567, 572-73 [1st Dept. 2017]).

In opposition to the motion, Plaintiff's expert competently raises an issue of fact as to whether Mandel departed from accepted standards of medical care in treating plaintiff, and whether those departures proximately caused her vision loss of the left eye.

First, Plaintiff's expert does not dispute that Plaintiff had an extensive medical history, but alleges that these conditions resulted in ocular ischemic syndrome ("OIS"), which led to the neovascularization of the left eye, which caused an increase in IOP, and eventually caused

Plaintiff to develop neovascular closed angle glaucoma ("NVG"). He claims that Plaintiff exhibited symptoms of this problem, which Mandel and Beth Abraham failed to appreciate, in the form of vision loss, eye tearing, headaches, pain, swelling, and conjunctivitis. He alleges that Defendants' failed to perform a complete and proper ophthalmological exam, or take action to reduce Plaintiff's IOP, which would have prevented Plaintiff from developing other vascular complications such as CRAO, a known risk that results when allowing OIS and NVG to go untreated. Dana asserts that complications such as CRAO can be prevented when IOP is controlled. He explains that a rise in IOP leads to more compromised blood flow to the eye, exacerbating the ischemia even further, and possibly leading to CRAO (*id*). While this process is occurring, it is essential to assess and control the IOP, so as to prevent secondary vascular compromise including CRAO and vision loss.

With respect to Mandel's specific departures, Dana acknowledges that Mandel took Plaintiff's IOP on January 25, 2007, which was 22, or the high end of normal range. While it is true that normally, IOP is only checked every 4-6 months, Dana opines that Mandel should have appreciated the risk for developing OIS and NVG, and should have been monitoring plaintiff more closely. Specifically, Dana states that as soon as Plaintiff began exhibiting symptoms of ocular discomfort as first documented in July 8, 2007, a plan to perform a complete and proper opthalmological exam should have been made. While Plaintiff was not referred to Mandel at that time, Dana notes that between July 8 and July 27, 2007, Plaintiff had documented symptoms including "headaches, difficulties seeing, tearing, and conjunctivitis" and difficulty opening her eye, and yet no "proper and complete ocular exam" was performed until August 7, 2007, at which point plaintiff had already suffered permanent vision loss in her left eye.

At the time of Mandel's July 17, 2007 examination, Plaintiff should have been given a complete and thorough exam, including testing for increased IOP, palpating her eye, and assessing the clarity of the cornea and the pupillary light response. However, this was not done. While Dana acknowledges that "palpation" testing of the eye is *not* the standard of care, he also stated that Mandel should have sedated Plaintiff in order to obtain a proper IOP test earlier than August 7, 2007 - such as when he examined Plaintiff on January 25, 2007. Dana further asserts that, if Mandel had reviewed Plaintiff's interdisciplinary progress notes or complaints, he would

have realized that Plaintiff had fluctuating issues with her vision, redness in her eye, headaches and discomfort, all of which were "classic symptoms" of OIS and NVG, not CRAO. He explains that aside from sudden vision loss, CRAO is generally not symptomatic.

Dana further asserts that Plaintiff did not suffer from a CRAO before July 30, 2017. He notes that Plaintiff's medical records from July 13, 14, 15, and 16, and 17 all document various issues with the eye including redness and puffiness, but no visual disturbances - suggesting "classic signs of ischemic eye disease and resultant NVG" but no CRAO. Dana opines that Mandel should have performed a proper opthalmological exam including IOP test at this point, especially when considering the fact that Plaintiff had increased IOP in January 2007 and that she was at increased risk for OIG and NVG. Importantly, Dana opines that if Mandel was unable to perform the IOP test, he should have had Plaintiff sedated, as he did in January and again later in August. While Defendants' argue that there were risks and other problems associated with sedating a patient in order to obtain an IOP, Plaintiff competently raised an issue of fact as to whether sedation should have been employed here.

After it was later discovered that Plaintiff had lost vision in her left eye, Mandel performed another examination on August 7, 2007. This time, Plaintiff was sedated and it was noted that she had a left eye IOP of 50 which was "very high," and his impression was that Plaintiff had a narrow angle glaucoma attack of the left eye and should be sent to the hospital. Records following consultation from Beth Abraham and Montefiore suggest that Plaintiff suffered a CRAO.

Dana states that the medical records here strongly suggest that NVG from iscehmia preceded the CRAO. He claims that CRAO is usually associated with very acute vision loss, not one described by the history of Plaintiff's care. Here, there was no history of hyperacute vision loss prior to July 27 (documented July 30), and her various symptoms all occurred prior to total vision loss, and there was no historic evidence supporting a CRAO prior to July 27. The symptoms plaintiff was experiencing were not CRAO - they were symptoms of NVG, which brought about the CRAO, and the loss of vision.

In a reply affidavit, Gentile seeks to discredit the opinion of Dana. Gentile asserts that "there is no evidence of proximate cause since no ocular treatment or medication was going to

prevent the vision loss." He states that there was no evidence of OIS here - normally signaled by mid-peripheral retinal hemorrhages and changes not seen by Schwartz, Mandel, or Gentile - during any examinations. However, Gentile does not dispute that Dana's assertion that Plaintiff demonstrated "classic" signs and symptoms of OIS and NVG during July 2007 in the form of headaches, difficulties seeing, tearing, and conjunctivitis.

Gentile states that there is "more evidence supporting CRAO over OIS," because a fundus examination on August 28, 2007 revealed "no arteries," and a pale optic nerve, which Gentile opines was caused by a prior CRAO. He goes on to state that it is clear that Plaintiff had an ischemic event causing the blood supply to be cut off to her central retinal artery, and this was before NVG occurred, and no amount of intraocular pressure lowering medication would have changed the vision loss. Gentile states that Plaintiff had poor perfusion which caused her initial carotid artery occlusions back in December 2005, and no ocular treatment would have saved her vision in her left eye. However, this opinion merely conflicts with the opinion of Dr. Dana, who stated that CRAO could have been prevented if IOP was controlled, vascular compromise could have been avoided, and her vision loss could have been "prevented" or "limited." Both experts' opinions are admissible insofar as they are based on their own personal knowledge acquired through professional experience (*see Mitrovic v. Silverman*, 104 A.D.3d 430, 431 [1st Dept. 2013]; *Diaz v. New York Downtown Hosp.*, 99 N.Y.2d 542, 544 [1st Dept. 2002]), and this court cannot value one expert's non-speculative opinion over the other on summary judgment.

Gentile states that Plaintiff had no discernable signs of "redness, pain, swelling, or visual disturbances prior to July" and when he saw her for the first time on July 17, 2017, she presented with problems that had been resolved in her right eye using medication. However, Dana states that if Mandel viewed Plaintiff's interdisciplinary progress notes at the July 17, 2017 exam, he would have seen that Plaintiff had various issues in her left eye including classic signs of OIS/NVG - inability to open the left eye, slight redness, fluctuating vision, and should have conducted a more thorough opthalmological exam.

Gentile asserts that by the time Plaintiff was sent to Mandel on July 17 and again on August 2, her vision had already been compromised and there was nothing that could be done to reverse it. This issue, however, is not settled. There are factual issues concerning whether, in

light of her medical history and her interdisciplinary progress notes, Plaintiff had a deteriorating condition that could have been avoided or limited had Mandel conducted a proper assessment and evaluation of the left eye, and controlled Plaintiff's IOP. The parties' experts disagree as to whether it would have been appropriate and/or necessary to sedate Plaintiff in order to obtain her IOP. While Gentile argues that there are attendant risks to doing so, the standard of care on this discrete issue is not clear, as there is evidence that Mandel found it appropriate to sedate Plaintiff in January and again in August 2007, but apparently deemed it inappropriate on other occasions. Defendants' experts further argue that Mandel was an opthalmologist who only saw residents at Beth Abraham twice a week, and he relied on Plaintiff's internists and nurses to alert him of problems or refer to Plaintiff to his clinic or Montefiroe. Dana, however, asserts that Mandel should have read the progress notes, that would have revealed "classic symptoms" of OIS and NVG. Furthermore, because Plaintiff did not have complete vision loss as of July 17, it is not known whether by that point she had suffered from an irreversible CRAO. Plaintiff had documented signs of OIS/ NVG though and yet Mandel did not perform a comprehensive exam. It was not until July 27 that she reported total vision loss.

The experts further disagree as to whether the prescription of Tobradex was appropriate, and Dana states that there was no reason to prescribe this, as it contains a potent steriod that has the tendency to increase IOP. Gentile claims that Tobradex was proper to reduce swelling, and it was only prescribed for 5 days, which was proper, and not enough time to increase IOP.

Gentile asserts that Dana did not address the significance of Plaintiff's left eye optic nerve being noted with complete pallor on August 9, 2007, denoting optic nerve atrophy that takes weeks to develop, and could not have existed had Plaintiff not already had a CRAO weeks earlier, which led to secondary NVG. Gentile, however, did not address the significance of the fact that Plaintiff was able to see out of the left eye between approximately July 13 and 17, 2007, thus giving credence to Dana's suggesting that Plaintiff had not actually suffered from a CRAO during that time, but instead had ongoing symptoms of OIS/NVG that were being left improperly treated or addressed.

In light of the foregoing, Plaintiff's expert affidavit is sufficient to raise a triable issue of fact as to whether Mandel deviated from good and accepted medical practice, and whether those

deviations proximately caused Plaintiff's injuries.

Beth Abraham's Cross-Motion

Beth Abraham cross-moves for summary judgment, relying upon the same medical evidence, deposition transcripts, and expert affidavits that were submitted in support of Mandel's motion. The cross-motion must be denied as untimely. CPLR 3212(a) requires that a motion for summary judgment be made no later than 120 days of the Note of Issue being filed, "except with leave of court on good cause shown." (*Brill v. City of New York*, 2 N.Y.3d 648 [2004]). A motion is "made" as of the date it is served (CPLR 2211). The First Department has emphasized that the 120-day deadline is "clear and strict" and "may not be approached causally..." (*Perini Corp. v. City of New York*, 16 A.D.3d 37 [1st Dept. 2005]). "[I]n the wake of recent Court of Appeals decisions, parties may no longer rely on the merits of their cases to extricate themselves from failing to show good cause for a delay in moving for summary judgment pursuant to CPLR 3212(a)." (*id.*). "No excuse at all, or a perfunctory excuse, cannot be "good cause" (*Brill, supra*, at 652). In this case, Plaintiff's Note of Issue was filed on June 17, 2016. Beth Abraham's cross-motion was not made until it was served on October 19, 2016, or 124 days later, and the moving papers offer no excuse for the delay.

In reply, Beth Abraham asserts that Plaintiff's attorney served a copy of the Note of Issue upon defendant by mailing it on June 16, 2016. CPLR 2103(b)(2) entitles defendants to five additional days from the date of mailing, to account for service my mail. Beth Abraham argues that this extended the statutory period of time in which defendants could file for summary judgment (citing *Krasnow v. JRBG Mgt. Corp.*, 25 A.D.3d 479, 480 [1st Dept. 2006]), and consequently, Beth Abraham's motion was timely filed. However, in a decision that post-dates *Krasnow*, the First Department specifically held that CPLR 2103(b)(2) "is inapplicable to the making of a summary judgment motion, for which the period prescribed by CPLR 3212(a) is measured not by the service of a paper but by the *filing* of the note of issue" (*Group IX, Inc. v. Next Printing & Design, Inc.*, 77 A.D.3d 530 [1st Dept. 2010]). Here, because Beth Abraham's motion was made more than 120 days after the note of issue was filed, without good cause, it must be denied as untimely.

Beth Abraham further argues that its motion may be considered because "a cross motion for summary judgment made after the expiration of the statutory 120-day period may be considered by the court, even in the absence of good cause, where a timely motion for summary judgment was made seeking relief 'nearly identical' to that sought by the cross-motion" (citing *Filannio v. Triborough Bridge & Tunnel Auth.*, 34 A.D.3d 280 [1st Dept. 2006]). However, Beth Abraham's motion is not a true "cross-motion," as it did not seek any relief against Mandel, the party who timely moved for summary judgment (*see Kershaw v. Hospital for Special Surgery*, 114 A.D.3d 75, 88 [1st Dept. 2014]; *Borges v. Placeres*, 123 A.D.3d 611 [1st Dept. 2014]; *cf. Filannio v. Triborough Bridge & Tunnel Auth.*, 34 A.D.3d 280).

Even assuming, *arguendo*, that the cross-motion is timely, Beth Abraham failed to carry its initial burden of demonstrating entitlement to summary judgment as a matter of law. The complaint alleges that Beth Abraham, *inter alia*, deprived Plaintiff of her rights as protected under Public Health Law §2801-d and 2803-c. "The basis for liability under [Public Health Law] 'is neither a deviation from accepted standards of medical practice nor a breach of duty of care. Rather, it contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule'" (*Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 1001 [2nd Dept. 2016], citing *Zeides v. Hebrew Home for Aged at Riverdale*, 300 A.D.2d 178, 179, [1st Dept. 2002]). Here, Plaintiff's bill of particulars alleged that Beth Abraham violated several State and Federal codes. Beth Abraham's cross-motion did not include any expert affidavit alleging that it did not violate any contract, statute, regulation, code or rule, or allege that any violations did not proximately cause plaintiff's injuries (*see, e.g., Henry v. Sunrise Manor Center for Nursing and Rehabilitation*, 147 A.D.3d 739, 741 [2nd Dept. 2017]), and the affidavits from Gentile and Schwartz failed to address the specific code violations cited in Plaintiff's bill of particulars (*see Pichardo v. St. Barnabas Nursing Home, Inc.*, 134 A.D.3d 421 [1st Dept. 2015]). Furthermore, as determined *supra*, Plaintiff has raised an issue of fact as to whether Plaintiff's vision loss was unavoidable.

IV. Conclusion

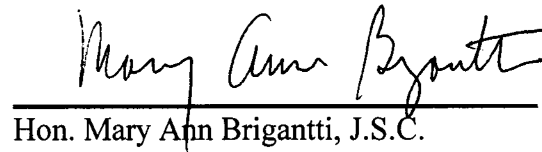
Accordingly, it is hereby

ORDERED, that Mandel's motion for summary judgment is denied, and it is further,

ORDERED, that Beth Abraham's cross-motion for summary judgment is denied.

This constitutes the Decision and Order of this Court.

Dated: September 25 2017



Hon. Mary Ann Brigantti, J.S.C.

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INSYNC

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

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BARBARA PHILLIPS, by her Guardian Ad Litem,
FELICIA BULLOCK

Index No.: 306320/2008

Plaintiffs,

NOTICE OF MOTION
SUMMARY JUDGMENT

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendant.

---x

TA4
11/10/16

PLEASE TAKE NOTICE that upon the annexed affirmation of Deborah I. Meyer, Esq. dated October 13, 2016, and the exhibits annexed thereto, Defendant HARVEY MANDEL, M.D. by and through his attorneys, EKBLOM & PARTNERS, LLP, will move before the Supreme Court of New York, Bronx County located at 851 Grand Concourse, RM 217 Motion Support, Bronx, NY 10451 on the 10th day of November, 2016 at 9:30 o'clock on the forenoon of that day or as soon thereafter as counsel may be heard, for an Order:

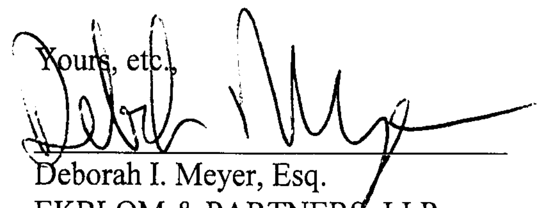
SJD
SUB

a. Granting summary judgment pursuant to CPLR § 3212 to defendant Dr. Harvey Mandel dismissing the Complaint in its entirety with prejudice; and
b. Granting such other and further relief as this Court may deem just and proper.

PLEASE TAKE FURTHER NOTICE that answering affidavits, if any, must be served upon the undersigned no later than seven (7) days prior to the return date of this motion.

Date: New York, New York
October 13, 2016

Yours, etc.



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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

---x

BARBARA PHILLIPS, by her Guardian Ad Litem,
FELICIA BULLOCK

Index No.: 306320/2008

Plaintiffs,

-against-

ATTORNEY AFFIRMATION
IN SUPPORT OF THE MOTION

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendant.

---x

DEBORAH I. MEYER, an attorney duly licensed to practice law before the Courts of the State of New York, hereby affirms that the following statements are true under the penalties of perjury:

1. I am a member of the law firm of Ekblom & Partners, LLP, attorneys for defendant, HARVEY MANDEL, M.D. As such, I am fully familiar with the facts and circumstances concerning the within action based upon a review of the file maintained by my office.

2. This affirmation is submitted in support of the within motion which seeks an Order:

   a. Granting summary judgment pursuant to CPLR § 3212 to defendant Dr. Harvey Mandel dismissing the Complaint in its entirety with prejudice; and

   b. Granting such other and further relief as this Court may deem just and proper.

3. This is a medical malpractice action wherein plaintiff alleges that due to the negligence of the defendant Dr. Harvey Mandel, the plaintiff Barbara Phillips was caused to have diminished vision in the left eye.

SUMMARY OF ARGUMENT

4. As shown by the affidavit of defendant's expert, Dr. Ronald Gentile and his IME report, (A copy of Dr. Gentile's Affidavit and IME report are annexed collectively hereto as Exhibit "A"), an affidavit from plaintiff's treating physician, Dr. Jeffrey Schultz, (A copy of Dr. Schultz's affidavit is annexed hereto as Exhibit "B"), and the medical records, defendant Dr. Harvey Mandel was not negligent in his care and treatment of plaintiff Barbara Phillips. Specifically, Dr. Mandel's treatment of the plaintiff complied with accepted standards of medical care and at no time did Dr. Mandel depart from the standard of care. Moreover, it will be shown that plaintiff's long term vascular disease and arteriosclerosis caused progressive ischemia and a central retinal artery occlusion ("CRAO") which caused plaintiff's vision loss in her left eye. There is no proven local ophthalmic treatment to prevent a CRAO and no effectively proven treatment to reverse a CRAO's vision loss. Accordingly, the treatment rendered to the plaintiff by Dr. Mandel was not the proximate cause of plaintiff's injuries. Therefore, defendant Dr. Mandel moves to dismiss any and all claims, with prejudice.

PROCEDURAL HISTORY

5. Plaintiff instituted the action on or about July 28, 2008 by filing a Summons and Complaint with Clerk of the Supreme Court of New York County. (A copy of the Summons and Complaint is annexed hereto as Exhibit "C") Defendant submitted an Answer accordingly. (A copy of the defendants Answer is annexed hereto as Exhibit "D").

6. On or about May 4, 20010, plaintiff served a Bill of Particulars as to defendant. (Copy of the Bill of Particulars are annexed hereto as Exhibit "E")

7. On November 30, 2011, the Court granted plaintiff's motion to have Felicia Bullock assigned as the Guardian Ad Litem due to plaintiff, Barbara Phillips, being mentally

incapable of adequately prosecuting her rights pursuant to CPLR 1201. (Copy of Court Decision Appointing Felicia Bullock annexed hereto as Exhibit "F")

8. On January 25, 2012, the Felicia Bullock's examination before trial was conducted. (Copy of the transcript is annexed hereto as Exhibit "G").

9. On December 19, 2014, Dr. Harvey Mandel's examination before trial was conducted. (Copy of the transcript is annexed hereto as Exhibit "H")

10. On December 17, 2015, Dr. Ross Friedman's examination before trial was conducted. (Copy of the transcript is annexed hereto as Exhibit "I")

11. The Note of Issue was filed on June 17, 2016. (A Copy of the Note of Issue is annexed hereto as Exhibit "J").

FACTUAL SUMMARY

12. Based upon plaintiff's medical records, plaintiff, Barbara Phillips, was initially treated at St. Luke's/Roosevelt Hospital for weakness in her legs on December 15, 2005. (A copy of St. Luke's/Roosevelt Hospital Chart is annexed hereto as Exhibit "K") Subsequent brain MRI/CT Scans and MRA (Angiogram of Brain) studies taken at St. Luke's/Roosevelt revealed in January-February 2006 plaintiff suffered bilateral occlusions of the internal carotid arteries and an occlusion of the left carotid bulb. (A copy of the MRI/CT & MRA scan reports are annexed hereto as Exhibit "K1") These occlusions were so severe that studies done at Roosevelt Hospital revealed that at the time there was no detectable blood flow in the right and left internal carotid arteries proximal to the origins of the ophthalmic arteries. (See Exhibit K)

13. When plaintiff was admitted to Beth Abraham in June 2006, she had lost the use of both legs, dense right hemiparesis (arm), suffered seizures, incontinence of bladder and bowel, GI bleeds, excessive vomiting, and dementia. (A copy of Beth Abraham Chart is annexed hereto

as Exhibit "L") Further, her vision was unknown except for some blurriness at her previous hospital due to her needing glasses.

14. At Beth Abraham, plaintiff's overall medical care was handled by doctors whose specialty is internal medicine, such as Dr. Ross Friedman and Dr. Rawand Khader. (See Exhibit L) These general doctors followed the residents at Beth Abraham on most days of the week for all general medical problems and wrote examination notes in the Interdisciplinary Progress Notes section of a resident's chart. (A copy of Beth Abraham's Interdisciplinary Progress Notes for plaintiff is annexed hereto as Exhibit "M") Nurses also wrote notes in the Interdisciplinary Progress Notes. If Dr. Friedman or Dr. Khader determined that plaintiff required to see a specialist such as an ophthalmologist, they would fill out a consultation request form and have it sent to the clinic. (A copy of Beth Abraham Consultation Request/Report for ophthalmology clinic visits is annexed hereto as Exhibit "N")

15. Defendant Dr. Harvey Mandel is an ophthalmologist who only saw residents at a clinic in Beth Abraham twice a week; Tuesday mornings and Thursday Afternoons, and otherwise could be reached for emergency purposes. Dr. Mandel would review the Consultation Request/Report form prior to examining a resident. In addition, at times a doctor from Beth Abraham would send a resident to Montefiore Medical Center ("Montefiore") for exams, emergencies or more complicated medical problems. (A copy of the Montefiore Medical Center Chart is annexed hereto as Exhibit "O")

16. On August 3, 2006, the Beth Abraham record reflects that Dr. Friedman noted that plaintiff had redness in the lower portion of her left eye. (See Exhibit M) Further, plaintiff had not been scratching at her eye, had no history of trauma, and there was no drainage or exudate. Dr. Friedman also noted that plaintiff was alert and aphasic. Aphasic means that she had trouble communicating as a result of her medical condition. (See Exhibit B) Dr. Friedman prescribed

Ciloxin ophthalmologic drops for conjunctivitis. This resolved after the use of the drops. Plaintiff was not referred to Dr. Mandel for this condition. (See Exhibit M)

17. On December 19, 2006, plaintiff was examined for the first time by Dr. Mandel when he received a consultation request by Dr. Friedman to evaluate the plaintiff for corrective lenses. (See Exhibit N) Dr. Mandel noted that plaintiff had a history of a CVA and seizures. He was only able to obtain a "fairly accurate" visual acuity of 20/50 in the right eye and 20/100 in the left eye due to poor cooperation by the plaintiff. The record indicates that plaintiff would not allow him to examine her eyes or obtain an IOP reading. Dr. Mandel testified that he had trouble getting an accurate visual acuity and an IOP due to plaintiff bobbing and weaving, and being uncooperative due to plaintiff's medical condition and mental state. (See Exhibit H pp. 50-53, 111, 114, 117, 125) Further, the note indicates that Dr. Mandel attempted a central visual field test but he explained that he could not perform this test due to plaintiff's mental state, and the lack of cooperation. (See Exhibit N) Plaintiff was not sedated for this appointment.

18. On January 25, 2007, plaintiff was sent to the clinic to have Dr. Mandel do a follow-up evaluation. (See Exhibit N) Plaintiff was sedated but Dr. Mandel noted that he was not sufficiently sedated because during the taking of the IOP plaintiff was "fighting" and moving. He was able to get an IOP reading of 17 mmHg in the right eye and 22 mmHg in left eye but noted that the pressure would probably have been lower if she were not fighting with him. (See Exhibit N)

19. The next time Dr. Mandel saw plaintiff for treatment was on February 20, 2007, when plaintiff was referred to him for swelling, exudate and cellulitis of the right lower lid due to an infection. (See Exhibit N) He noted plaintiff's right eye had 2+ injection of the conjunctiva (redness). The IOP test was deferred. Plaintiff was given oral antibiotics of Erythromycin and Bacitracin ointment, and was to return within 2 days for follow-up. (See Exhibit N)

20. On February 22, 2007, plaintiff returned for a follow-up visit of the right eye cellulitis and lid swelling. (See Exhibit N) Dr. Mandel noted that there was marked improvement and continue with the medications. This was a limited exam to determine if the right eye had improved and he wanted plaintiff to return within one week. On March 1, 2007, plaintiff returned for the follow-up of the right eye lid swelling and noted that it had all healed. Plaintiff could stop medications and return in 6 months. (See Exhibit N)

21. On July 13, 2007, the records from Beth Abraham note that plaintiff's sister (Felicia Bullock) called and spoke to Dr. Friedman about plaintiff's eyes being swollen. (See Exhibit M) Dr. Friedman noted an examination of the plaintiff's eyes and found no swelling of the eyes or lids. Plaintiff had no exudate and conjunctiva were clear. He noted that plaintiff had no complaints of any visual disturbance. (See Exhibit M)

22. On July 14, 2007, a Beth Abraham nurse noted at 5:45 pm that plaintiff's sister came to the nurses' desk to report that plaintiff was unable to see out of both eyes and that the eyelids were swollen with swelling under the left eye. (See Exhibit M) Further, the plaintiff's sister complained that plaintiff had trouble opening her eyes but could half-open the right, not open the left eye and had trouble seeing out of the left eye. The nursing note indicates that the doctor ordered Ciloxin solution for both eyes and that Dr. Friedman would follow-up and an ophthalmology consult would be ordered. (See Exhibit M)

23. Later in the evening of July 14, 2007, another nurse's note at 7:30 pm states that plaintiff's sister called about her daughter's visit with plaintiff in which there was something wrong with her eyes. (See Exhibit M) Upon examination at that time, there was no redness and no swelling for both eyes, and plaintiff denied pain. Plaintiff was noted as saying that "my eyes feel good, there is nothing wrong with it." Both eyes were opened and there was no further complaint or abnormality seen. Further, at 11:50 pm the plaintiff was seen by nurse and she noted

the left eye had redness and slight puffiness, and that plaintiff complained that she cannot see well with the eye. On July 15, 2007, plaintiff was administered Ciloxin eye drops in the left eye. Plaintiff was examined by nurse and she denied any pain to the left eye. The left eye remained red but no discharge. The record indicates that plaintiff stated "I feel better; I can see with the eye." (See Exhibit M)

24. On July 16, 2007, the nursing notes indicated plaintiff's left eye had drainage and she is unable to open the eye with no complaint of pain. (See Exhibit M) Further, Dr. Friedman examined plaintiff this day and noted that he spoke to plaintiff's sister earlier that day and continues to complain about her eyes. Dr. Friedman examined plaintiff and noted that the left eye was slightly red and had started Ciloxin ophthalmologic drops. Dr. Friedman noted that at the time of this examination plaintiff's left eye was not red, not swollen, no exudate, plaintiff denied any discomfort and denied any visual disturbance. Conjunctiva is noted as clear. Plaintiff was alert and oriented x3. Plaintiff is continued on Ciloxin. (See Exhibit M)

25. On July 17, 2007, Dr. Mandel examined the plaintiff based upon a consultation request from Dr. Friedman dated July 16, 2007, stating the reason for consult was plaintiff had swollen left upper lid that has improved on Ciloxin. (See Exhibit N) This was the first time plaintiff had a consult for any ophthalmological problem with her left eye since becoming a resident at Beth Abraham. Dr. Mandel noted that plaintiff did not bring her glasses to take visual acuity. Plaintiff had no complaints of pain in the eye. He noted the left eye had external trace painless swollen conjunctiva. Dr. Mandel noted that IOP could not be obtained due to plaintiff's lack of cooperation. Dr. Mandel discontinued the Ciloxin and prescribed Tobradex instead. Dr. Mandel included that if improved return in 6 months but if not, to send for re-consult. (See Exhibit N)

26. On July 18, 2007 at 11:20 pm, plaintiff awoke sweating profusely and complaining of pain on the left side of her head. (See Exhibit M) She was transferred to Montefiore for evaluation. At Montefiore plaintiff had a CT scan and examination. Plaintiff was given Percocet for pain. (See Exhibit M and O)

27. On July 20, 2007, a Beth Abraham nurses note indicates that plaintiff refused Tobradex eye drops, and that she had no complaints of pain. (See Exhibit M) Later that day, a nurse's note indicates that plaintiff denies headaches or eye pain, and no redness in eye but plaintiff closes eye on and off. Plaintiff continued to not allow Tobradex eye drops. (See Exhibit M)

28. The next note in Beth Abraham chart regarding plaintiff's vision was on July 30, 2007. (See Exhibit M) A Beth Abraham nurses note states "late entry" and relays information from July 27, 2007, after the patient returned from an outside pass, Ms. Felicia Bullock had notified the nurse that plaintiff had difficulty seeing out of her left eye. Upon assessment the nurse covered the plaintiff's right eye and asked plaintiff to read from a magazine with the left eye and she was unable to read the words which the nurse claimed to be "fairly large." The nurse informed Dr. Friedman. (See Exhibit M)

29. Later in the day on July 30, 2007, Dr. Friedman examined the plaintiff who complained of a sudden decrease of vision loss in the left eye. (See Exhibit M) Dr. Friedman noted that she had no swelling on either upper or lower lid, clear conjunctiva, no exudate, no sign of bleeding. Plaintiff had no complaint of pain. Plaintiff's pupils were equal, round and reactive to light. He ordered she be continued on Tobradex. He referred plaintiff for an ophthalmology consult. (See Exhibit M)

30. On August 2, 2007, Dr. Mandel saw the plaintiff in the ophthalmology clinic. Dr. Mandel evaluated the plaintiff for painless swelling and possible vision loss in the left eye. (See Exhibit N) He noted that the swelling had improved. He attempted to get an IOP and visual acuity but plaintiff would not allow it. He discontinued the medications. Plaintiff had no complaints at this visit. (See Exhibit N)

31. Further, on August 2, 2007, plaintiff was transferred to a different floor and would be followed by Dr. Khader. Dr. Friedman's transfer note stated that plaintiff has a history of ICB (intracranial bleed), residual speech impairment and vision loss in the left eye. (See Exhibit M)

32. On August 6, 2007, Dr. Khader was asked to evaluate the plaintiff's left eye vision problem by plaintiff's sister Felicia Bullock. (See Exhibit M) He noted that plaintiff had a history of CVA, hypertension, and seizure disorder. He noted that plaintiff could hardly open her left eye and that light bothered her eye but upon examination but at the same time her pupil was unequal and not reactive to light. Plaintiff's left eye was not red or swollen. Plaintiff had no complaints of headache. Dr. Khader had plaintiff sent to Montefiore to be examined. (See Exhibit M)

33. On August 6, 2007, plaintiff was transferred to Montefiore and was examined in the ER for her left eye vision and pain. (See Exhibit O) The Montefiore nurse's notes state that plaintiff is a poor historian and it was difficult to examine the plaintiff's eyes for accurate visual acuity. (See Exhibit O)

34. Plaintiff was sent back to Beth Abraham and Dr. Mandel examined the plaintiff on August 7, 2007. (See Exhibit N) Dr. Mandel noted that plaintiff was sedated with Haldol for this examination. Plaintiff stated she was not in pain. Plaintiff's visual acuity was questionable Light Perception or No Light Perception. The left eye conjunctiva was 1-2+ chemosis (swelling), left cornea was hazy so could not see the anterior chamber clearly. The left pupil was medium

dilation. The left eye IOP was 50. Dr. Mandel spoke to Dr. Khader and Dr. Seikson about sending plaintiff to Montefiore. (See Exhibit N)

35. Plaintiff went back to Montefiore on August 7, 2007 and was examined by a resident in the ophthalmology clinic. (See Exhibit O) Plaintiff's visual acuity in left eye was No Light Perception, mid-dilated fixed pupil. There was 1+ injection in the ciliary flush. Plaintiff denied eye pain. The doctor was unable to get her IOP despite sedation of Haldol and noted she was "uncooperative." Plaintiff was started on Cosopt and Alphagan which are medications to reduce IOP and Pred Forte which is a steroid medication to reduce swelling. Plaintiff was to return for a glaucoma evaluation. (See Exhibit O)

36. On August 8, 2007, Dr. Khader referred plaintiff to Montefiore for a glaucoma evaluation appointment on August 9, 2007. (See Exhibit M) Plaintiff was seen and examined by Dr. Jeffrey Schultz, Director of the Glaucoma Service at Montefiore. (A copy of Dr. Schultz Montefiore Eye Clinic note and Beth Abraham report are annexed collectively hereto as Exhibit "P" and his affidavit explaining his notes is annexed as Exhibit B) Dr. Schultz noted that plaintiff had an afferent pupillary defect with the pupil at mid-dilation. Plaintiff's visual acuity was Light Perception. The IOP in the left eye was 25. The left cornea was clear but there was rubeosis. A fundus examination was performed and plaintiff's left optic nerve was pale. Dr. Schultz diagnosed plaintiff with rubeosis and neovascular glaucoma from a prior CRAO. (See Exhibit B and P) The key to the exam is that plaintiff had rubeosis and a pale optic nerve. Neovascularization (rubeosis) occurs from ischemia, such as a CRAO. (See Exhibit B and P)

37. On August 14, 2007, Dr. Mandel examined the plaintiff and noted the examination by Dr. Schultz, who filled out a Beth Abraham form with his findings. (See Exhibit N) Plaintiff's eye was stable. The left visual acuity was noted as No Light Perception but Dr. Mandel was unsure it was accurate due to plaintiff's lack of cooperation. The left conjunctiva and the anterior

chamber were clear. The left cornea was clear. The left pupil was mid-dilated. The left IOP could not be obtained due to plaintiff's lack of cooperation and Dr. Mandel noted he tried for 10 minutes. (See Exhibit N)

38. On August 21, 2007, Dr. Mandel examined plaintiff and her left eye was basically the same as the prior exam except some redness of the conjunctiva. (See Exhibit N) The left cornea and anterior chamber were clear. Plaintiff would not allow her IOP to be checked due to lack of cooperation. (See Exhibit N)

39. On August 28, 2007, Dr. Mandel was able to perform a fundus examination and noted that there were no arteries. (See Exhibit N) September 11, 2007 and October 9, 2007 were the last two times Dr. Mandel examined the plaintiff and his findings were the same as the previous examinations in late August. (See Exhibit N)

EXPERT OPINION AND DISCUSSION[1]

40. Based upon a review of the pleadings plaintiff, Barbara Phillips, is alleging in summary that Dr. Harvey Mandel departed from the standard of care in failing to perform proper ophthalmologic testing, examinations, or follow-up in not diagnosing and treating acute angle-closure glaucoma that allegedly caused diminished vision in her left eye. However, this is not the case. It is the opinion of defendant's expert Dr. Ronald Gentile with a reasonable degree of medical certainty that Dr. Mandel acted within the standard of care in treating plaintiff. (See Exhibit A) Further, it is Dr. Gentile's opinion that nothing Dr. Mandel did or could have done would have prevented the vision loss in plaintiff's left eye. Therefore, it is Dr. Gentile's opinion that Dr. Mandel's actions or alleged inaction were not the proximate cause of plaintiff's injuries. (See Exhibit A)

[1] All the opinions of Dr. Jeffrey Schultz and Dr. Ronald Gentile are within a reasonable degree of medical certainty.

41. As stated more fully below, it is Dr. Gentile's opinion with a reasonable degree of medical certainty that plaintiff never had primary acute narrow-angle closure glaucoma. Instead, he explained that plaintiff had an ocular ischemic process caused by an occlusion of the carotid artery and an eventual central retinal artery occlusion ("CRAO"), which resulted in secondary rubeosis, neovascular glaucoma, and vision loss in the left eye. (See Exhibit A)

Plaintiff's Medical/Mental Condition

42. It is important to note at the outset that plaintiff suffered from a very serious cerebrovascular event (CVA) starting in December 2005 which required plaintiff to be placed in various nursing home/rehabilitation centers and remains in one to this day. (See Exhibit K) The CVA involved multiple occlusions (strokes) that affected both frontal lobes and the left parietal lobe. (See Exhibit K and K1)

43. Initially, plaintiff was treated at St. Luke's/Roosevelt Hospital for weakness in her legs on December 15, 2005. Subsequent brain MRI/CT Scans and MRA (Angiogram of Brain) studies revealed in January-February 2006 that plaintiff suffered bilateral occlusions of the internal carotid arteries and an occlusion of the left carotid bulb. (See Exhibit K1) These occlusions were so severe that studies done at Roosevelt Hospital revealed that at the time there was no detectable blood flow in the right and left internal carotid arteries proximal to the origins of the ophthalmic arteries. (See Exhibit K1)

44. Dr. Gentile explains that the ophthalmic artery supplies blood to the eye and the central retinal artery, consistent with the etiology of the CRAO. (See Exhibit A) It is Dr. Gentile's opinion that as a result of the continuing hypertension over the years, vascular disease and arteriosclerosis, these conditions eventually caused plaintiff to have multiple strokes, ocular ischemia, CRAO, rubeosis and secondary neovascular glaucoma. (See Exhibit A)

45. In addition, these strokes caused plaintiff to lose the use of both legs, dense right hemiparesis (arm), suffered seizures, incontinence of bladder and bowel, GI bleeds, and dementia. (See Exhibit K, L, M) Dr. Gentile points out that plaintiff's mental status also worsened over time and she had trouble communicating with staff and doctors, and would be at times difficult to examine by doctors or obtain a clear understanding of her complaints, if any. (See Exhibit A, L, M, N) In fact, Felicia Bullock moved to be the guardian ad litem for Ms. Phillips due to the inability to help in the prosecution of her case due to memory problems, poor speech and other symptoms related to brain damage from the strokes.

46. Moreover, plaintiff alleges that Dr. Mandel should have tested plaintiff's IOP at every visit, and that if she did not comply to have her sedated and force the issue of getting an IOP. This is the key to their complaint and it shows that plaintiff does not understand the difficulty and risk in performing certain types of tests on a patient in plaintiff's condition and the seriousness of plaintiff's medical and mental condition. (See Exhibit K, M, N, O) It is Dr. Gentile's opinion that eye examinations require some cooperation and even voluntary movements to test properly. Moreover, plaintiff's bobbing and weaving of her head and sometimes pushing the doctor away while trying to obtain an IOP could risk damage to the cornea or corneal abrasion. (See Exhibit A, M, N, O) Dr. Gentile explains that sedation itself is not without risk and can cause respiratory depression, aspiration, and other untoward side effects. (See Exhibit A) Physically restraining a patient in the plaintiff's condition with or without sedation also risks not only ocular damage, but also agitation and stress that could exacerbate hypertension and additional vascular events. (See Exhibit A)

47. Even when plaintiff was sedated it was difficult to get an accurate IOP. (See Exhibit A) For example, when plaintiff was sedated and examined at Montefiore on August 7, 2007, it is noted under "T" for tonometry which is the location in an exam report for IOP to be noted it states "unable despite sedation." (See Exhibit O) Similarly, when Dr. Gentile examined plaintiff it was difficult to have her cooperate and follow-commands due to the nature of her illness and mental status. (See Exhibit A) She did not allow Dr. Gentile to put instruments near her eyes or use drops. She was not being difficult voluntarily. (See Exhibit A)

48. However, it is Dr. Gentile's opinion that patients with strokes and diminished capacity will not sit still or sometimes push a doctor's hand away making an accurate exam very difficult. (See Exhibit A) Moreover, it is Dr. Gentile's opinion that when a patient is sedated too much the test results are not always reliable and untoward side effects form over sedation become more likely. (See Exhibit A) Further, it is Dr. Gentile's opinion that plaintiff expecting to be sedated every time she is examined does not actually solve the problem of obtaining correct results. (See Exhibit A) Therefore, it's the opinion of Dr. Gentile that plaintiff's medical and mental condition make it hard for her to keep still and comply with commands during an IOP test and other tests including visual acuity. (See Exhibit A) Further, IOP tests are generally performed once to twice a year at most unless there is a reason to suspect glaucoma, increase in IOP, or a known problem with glaucoma. (See Exhibit A)

Medicine Explained

49. Dr. Gentile explained that ischemia is an inadequate blood supply to an organ or part of the body. (See Exhibit A) Ischemia is related directly to the same conditions that can cause an occlusion in the first place. It is Dr. Gentile's opinion that the plaintiff's initial stroke most likely was caused by her hypertension and diabetes mellitus which in turn can cause

vascular disease. Long term vascular disease and arteriosclerosis caused progressive ischemia and the CRAO. (See Exhibit A)

50. Dr. Gentile opined that a CRAO is caused by plaque, narrowing, and clot or thrombus to the ophthalmic central retinal artery, and mostly occurs in patients who have a history of hypertension, diabetes, and especially carotid artery disease. (See Exhibit A) It is Dr. Gentile's opinion that there is no proven local ophthalmic treatment to prevent a CRAO and no effectively proven treatment to reverse a CRAO's vision loss. He explained that prophylaxis of CRAO is typically related to treatment of the systemic risk factors and the carotid artery disease. It is Dr. Gentile's opinion that once a CRAO occurs the likelihood of serious vision loss is very high. Initially, a CRAO is painless with little symptoms except vision loss. (See Exhibit A)

51. Dr. Gentile determined plaintiff had a CRAO from his review of the records, his own examination, and the examination reports of Dr. Jeffrey Schultz, Director of Glaucoma Service at Montefiore who examined the plaintiff on August 9, 2007. (See Exhibit A, B, P) Dr. Schultz provided an affidavit that explains that plaintiff suffered a CRAO which caused the vision loss and also caused rubeosis and neovascular glaucoma. (See Exhibit B).

52. In this case, it is Dr. Gentile's opinion that plaintiff was a typical candidate for having ischemia and a CRAO due to her having occlusions in both carotid arteries, uncontrolled hypertension, and diabetes mellitus. (See Exhibit A) After a patient has a CRAO, rubeosis iridis may occur and it is defined as neovascularization of the iris. (See Exhibit A and B) The process of neovascularization is characterized by numerous small and new branching vessels on the surface and stroma of the iris. These new blood vessels may cover the trabecular meshwork, cause peripheral anterior synechiae, and give rise to secondary neovascular glaucoma. (See Exhibit A and B)

53. Neovascular glaucoma is also referred to as secondary closed-angle glaucoma because the new blood vessels close off the angles that allow aqueous fluid to flow out from the anterior chamber. (See Exhibit A and B) When the angles close or are overgrown with new blood vessels, the intraocular pressure ("IOP") in the eye rises and this can cause pain and redness to the eye. (See Exhibit A and B) It is Dr. Gentile and Dr. Schultz's opinions that rubeosis and neovascular glaucoma are often a secondary affect from having serious underlying illnesses and retinal disease such as diabetes mellitus, diabetic retinopathy, CRAO, CRVO, and carotid artery occlusion. Here, plaintiff had the CRAO which compromised her retina and optic nerve prior to the neovascular glaucoma. (See Exhibit A and B)

54. Dr. Gentile noted in the records and upon his physical examination of the plaintiff, that she had noticeable ectropion uveae, a result of rubeosis/neovascularization of the iris. (See Exhibit A) Further, plaintiff had no vitreous hemorrhage or diabetic retinopathy, therefore, ocular ischemia of the retina and a CRAO is the only plausible conclusion that would cause both neovascularization of the iris and complete pallor of the optic nerve. (See Exhibit A and B) Dr. Gentile concurs with Dr. Schultz's opinion that primary narrow-angle or primary closed-angle glaucoma is not caused by neovascularization and that is why plaintiff's left eye vision loss was due to the CRAO for which by the time Dr. Mandel saw the plaintiff there was no effective treatment. (See Exhibit A and B)

55. It is Dr. Gentile's opinion that plaintiff had an ischemic event such as a CRAO consistent with her past MRI/CT Scans and MRA (Angiogram of Brain) studies, and we know it was a CRAO in this case due to the rubeosis/neovascularization of the iris which caused neovascular glaucoma which can cause secondary angle-closure glaucoma. (See Exhibit A) It is that order and the timing of the occurrence that is important – because the moment plaintiff had

the CRAO her prognosis was poor and there is no effective treatment once the ischemia damages the retina and turns the optic nerve pale. (See Exhibit A) It is Dr. Gentile and Dr. Schultz's opinions that plaintiff's vision was gone prior to the secondary neovascular glaucoma event and the onset of high pressure. (See Exhibit A and B) The damaged retina and optic nerve was caused by the CRAO. (See Exhibit A and B)

Dr. Gentile's Opinion As To The Care And Treatment Of Plaintiff By Dr. Mandel

56. The plaintiff was examined for the first time by Dr. Mandel when he received a consultation request by Dr. Friedman to evaluate the plaintiff for corrective lenses. (See Exhibit N) Dr. Mandel noted that the visual acuity of 20/100 in the left eye was "fairly accurate" due to plaintiff bobbing and weaving her head during the exam. (See Exhibit H and N) The record indicates that Dr. Mandel was unable to obtain and IOP reading due to plaintiff being uncooperative. (See Exhibit N) It is Dr. Gentile's opinion that Dr. Mandel did not depart from the standard of care at this visit and examination of plaintiff, and her compromised mental state would often make it difficult to examine plaintiff. Further, it is his opinion that other than a light sedative, plaintiff has to give permission for complete sedation and that makes taking certain ophthalmology tests difficult. (See Exhibit A)

57. On January 25, 2007, when Dr. Mandel examined plaintiff for a follow-up evaluation again she was fighting and moving, even though she was sedated. (See Exhibit N) Dr. Mandel was able to obtain an IOP of 22 mmHg in the left eye but he noted that the pressure was probably lower if she were not fighting with him. (See Exhibit N) It is Dr. Gentile's opinion that 22 mmHg is the high side of normal but not a reading that requires any treatment, and may have been higher due to plaintiff's interference. (See Exhibit A)

58. Dr. Gentile notes that the records reflect plaintiff was sent to Dr. Mandel for multiple visits for the right eye (not the eye in question in this case) from February through March, 2007 for conjunctivitis and lid swelling. (See Exhibit M and N) Plaintiff was given oral antibiotics as well as antibiotic eye cream and eye drops over these two months. It is Dr. Gentile's opinion that it was within the standard of care for Dr. Mandel to not take the plaintiff's IOP at these exams because he was treating a specific eye infection and wanted to focus on that and clear the condition without risking potential contamination. (See Exhibit A) Further it is his opinion that Dr. Mandel was performing limited follow-up exams to watch the progress of the right eye healing and the IOP test had been performed in January so there was no need for another test at those follow-up visits, especially with no complaints in the left eye. (See Exhibit A)

59. The next time Dr. Mandel examines the plaintiff from a consultation request is on July 17, 2007. (See Exhibit N) The consultation stated reason for the visit was plaintiff had swollen upper left lid that has improved on Ciloxin. (See Exhibit N) This was the first time plaintiff was examined by Dr. Mandel for any complaints regarding the left eye. Plaintiff had no complaints of pain. Dr. Mandel noted the left eye had external trace painless swollen conjunctiva. Dr. Mandel noted that IOP could not be obtained due to plaintiff's lack of cooperation. Dr. Mandel discontinued the Ciloxin and prescribed Tobradex instead. (See Exhibit N) It was Dr. Gentile's opinion that Dr. Mandel did not depart from the standard of care during this visit and that obtaining the IOP was not necessary at that time. (See Exhibit A)

60. Dr. Gentile points out that from plaintiff's admission to Beth Abraham up until July 17, 2007, plaintiff had lid swelling of the left eye on one occasion and lid swelling of the right eye at different times, some redness in both eyes at different times, and the one time visit of

left eye with a complaint of painless conjunctiva trace swelling (trace is minimal). (See Exhibit A, M and N) In the past, plaintiff had been responding to Ciloxin which is a brand name for Ciprofloxacin which is a general antibiotic that is usually effective for conjunctivitis. It is Dr. Gentile's opinion that these symptoms with no complaint to Dr. Mandel that plaintiff has any visual disturbances would not alert him to believe she has general primary glaucoma, narrow-angled glaucoma, or any secondary glaucoma of any kind. Up until this point, at no time did plaintiff herself or the referrals state that plaintiff had any vision loss or visual disturbances to Dr. Mandel. (See Exhibit A, M and N)

61. The next time Dr. Mandel examined the plaintiff was on August 2, 2007. (See Exhibit N) Dr. Mandel evaluated the plaintiff for painless swelling and possible vision loss in the left eye from a referral from Dr. Friedman. He noted that the swelling had improved. He attempted to get an IOP and visual acuity but plaintiff would not allow it. He discontinued the medications. Plaintiff had no complaints at this visit. (See Exhibit N) It is Dr. Gentile's opinion that plaintiff had lost her vision prior to this visit. (See Exhibit A) Dr. Gentile points to the Beth Abraham records which state that Ms. Bullock complained on July 27, 2007 that plaintiff had difficulty seeing out of her left eye and was unable to read "fairly large" words, and Dr. Friedman wrote up a note on August 2, 2007 while the ophthalmology consult was pending that plaintiff had a history of vision loss in the left eye. (See Exhibit M)

62. On August 6, 2007, Dr. Khader examined the plaintiff and noted that her left pupil was unequal and not reactive to light. (See Exhibit M) Plaintiff's left eye was not swollen or red at the time. Dr. Gentile explains in his affidavit that since plaintiff's left eye was not reactive to light then she had an afferent pupillary defect which is caused by a significant retinal and optic nerve damage over time. (See Exhibit A) In this case, it was plaintiff's CRAO which occurred at

least week earlier that caused her optic nerve to become damaged and caused the afferent pupillary defect. (See Exhibit A)

63. On August 6, 2007, plaintiff was transferred to Montefiore and was examined in the ER for her left eye vision and pain. (See Exhibit O) The Montefiore nurse's notes state that plaintiff is a poor historian and it was difficult to examine the plaintiff's eyes for accurate visual acuity. (See Exhibit O) Plaintiff was sent back to Beth Abraham and Dr. Mandel examined the plaintiff on August 7, 2007. Dr. Mandel noted that plaintiff was sedated with Haldol for this examination. Plaintiff stated she was not in pain. Plaintiff's visual acuity was questionable Light Perception or No Light Perception. The left eye conjunctiva was 1-2+ chemosis (swelling), left cornea was hazy so could not see the anterior chamber clearly. The left pupil was medium dilation. The left eye IOP was 50. It is Dr. Gentile's opinion that at this point plaintiff already had a CRAO and the neovascularization of the iris (rubeosis) was causing secondary closed-angle glaucoma (neovascular glaucoma) which is why she had high IOP.

Dr. Jeffrey Schultz's Opinion

64. On August 9, 2007, plaintiff was seen by Dr. Schultz for a glaucoma evaluation. (See Exhibit B and P). Dr. Schultz drafted an affidavit for this motion to clarify his medical notes and to further explain plaintiff's condition in the left eye as a glaucoma specialist. (See Exhibit B) At the August 9, 2007 examination of plaintiff, Dr. Schultz noted that plaintiff had an afferent pupillary defect with the pupil at mid-dilation. Plaintiff's visual acuity was Light Perception. The IOP in the left eye was 25. The left cornea was clear but there was rubeosis. A fundus examination was performed and plaintiff's left optic nerve was pale. Dr. Schultz diagnosed plaintiff with rubeosis and neovascular glaucoma from a prior CRAO. (See Exhibit B and P) The key to the exam is that plaintiff had rubeosis and a pale optic nerve. Neovascularization

(rubeosis) occurs from ischemia, such as a CRAO. (See Exhibit A, B, P) Dr. Schultz discussed in his affidavit that a patient such as plaintiff would develop rubeosis and neovascular glaucoma a few weeks or longer after the CRAO which is painless. (See Exhibit B) Neovascular glaucoma is when abnormal blood vessels form a membrane that block the drainage of the aqueous humor (liquid from the anterior chamber). Ischemic retinal disease caused by a carotid artery occlusion or as stated previously a CRAO cause this to occur. (See Exhibit B)

65. Dr. Schultz explained that different from plaintiff, in a patient with an acute narrow-angle attack (what plaintiff seems to be claiming occurred in plaintiff's left eye) is caused by an anatomical problem in which the lens is being pushed forward and the anatomical positioning of the iris blocks the drainage of the aqueous humor causing pressure to build up very quickly. (See Exhibit B) It is Dr. Schultz's opinion that Plaintiff did not have an acute narrow-angle attack but did have secondary neovascular glaucoma. (See Exhibit B) There are varying causes and in the case of a person with secondary neovascular glaucoma after a CRAO treating even noticeable elevated intraocular pressure would not change the outcome of the vision loss and cannot prevent the vision loss. The main issue with plaintiff was she suffered from severe vascular disease, hypertension and diabetes and her CVA of the carotid artery eventually led to an ischemic event that caused her vision loss. (See Exhibit B)

66. When Dr. Schultz examined plaintiff he also noted she had a white, pale optic nerve which is usually caused by an ischemic (stroke) event to the optic nerve. (See Exhibit B and P) It is Dr. Schultz's opinion that since plaintiff had no sign of retinopathy at the time, and no hemorrhage in the posterior portion of the eye or retina, the only possible cause for her optic nerve damage was from a CRAO. He explained that there is no preventive ophthalmologic treatment for a CRAO. Once the CRAO occurred plaintiff had no hope of maintaining vision in

the left eye. Further, it is Dr. Schultz's opinion that no amount of treating the neovascular glaucoma would help restore plaintiff's vision in the left eye because of the CRAO. Even giving drops to reduce intraocular pressure would not have prevented the damage that was done to the optic nerve due to the CRAO. (See Exhibit B and P)

Expert Conclusions

67. It is Dr. Gentile's opinion with a reasonable degree of medical certainty that Dr. Mandel cared and treated plaintiff within the standard of care and did not deviate in his examinations of plaintiff. Plaintiff suffered serious effects from the multiple strokes that caused her to have seizures, a PEG feeding tube due to vomiting and GI bleeds, incontinence, right hemiparesis, and dementia with speech impairment. The fact that plaintiff had occlusions of the internal carotid arteries and left carotid bulb, and that these caused no blood flow in the right and left internal carotid arteries proximal to the origins of the ophthalmic arteries, meant plaintiff always run the risk of ischemia or a CRAO. Plaintiff's medical and mental problems made it very difficult for doctors to get a history, actual complaints and had serious problems examining the plaintiff. (See Exhibit A)

68. Further, it is Dr. Gentile's opinion that Dr. Mandel did not depart from the standard of care because he did not take an IOP at every eye exam. (See Exhibit A) An elevated IOP is an indicator of a possible problem but does not always denote glaucoma. Plaintiff's IOP at the January 25, 2007 was 22 in the left eye while sedated plaintiff still bobbed and weaved her head so Dr. Mandel noted she was still fighting so could have been lower. As noted by the Montefiore chart even when plaintiff was sedated her IOP was unable to be obtained. This was a problem Dr. Gentile had when examining plaintiff. Her medical and mental status makes it hard to have her keep still and she reacts badly to when the instruments and drops have to go into or near her eyes.

(See Exhibit A) This is not her fault but is a problem that can be difficult for a doctor to overcome. Clinical examination and cooperation during the exam are necessary to get accurate information. Eye exams require cooperation and some tests simply cannot be performed without it. (See Exhibit A)

69. Further, Dr. Gentile noted that plaintiff was difficult to examine at most visits with Dr. Mandel from the first visit in December 2006 to August 2007. Dr. Mandel noted plaintiff would move, bobbing and weaving her head, and lack of cooperation so it was difficult to obtain accurate readings. Plaintiff would not allow him to take her IOP and would still fight even when lightly sedated. Dr. Gentile opined that it's important to note that overly sedating the patient may make them easier to examine but can also give a false IOP reading of too low and places the patient at higher risk of untoward side effects like respiratory depression and aspiration. (See Exhibit A)

70. Further, it is Dr. Gentile's opinion that Dr. Mandel did not depart in his care and treatment during the examinations from January 25, 2007 to August 2, 2007. (See Exhibit A) After the January 25, 2007 examination plaintiff would not need another full exam for at least another year unless there was a problem. Dr. Friedman referred plaintiff to Dr. Mandel several times in February and March 2007 for conjunctivitis and lid cellulitis in her right eye which resolved completely with antibiotics. The first time plaintiff was referred to Dr. Mandel for a problem with the left eye was on July 16, 2007 when Dr. Friedman referred plaintiff with swollen upper lid on the left eye improved on Ciloxin. It is Dr. Gentile's opinion that there was no reason to sedate plaintiff and attempt to take her IOP at this visit which was for some mild swelling and no other complaints were conveyed to Dr. Mandel, especially when it was the first time she had a problem with the left eye. (See Exhibit A)

71. At the August 2, 2007 examination Dr. Mandel noted that plaintiff's left eye swelling went down and she again refused to allow him to take her IOP and visual acuity. (See Exhibit N) However, Dr. Gentile opined that based upon the records, examinations and notes of Dr. Friedman and Dr. Khader, plaintiff had lost her vision from the CRAO by the time Dr. Mandel examined her on August 2, 2007. (See Exhibit A) The examination by Dr. Schultz confirms this because of the level of optic nerve atrophy on August 9, 2007 and the neovascularization of the iris. Therefore, plaintiff had already lost her vision by this visit with Dr. Mandel. (See Exhibit A)

72. It is Dr. Gentile's opinion with a reasonable degree of medical certainty that Dr. Mandel's alleged inaction was not the proximate cause of plaintiff's loss of vision in the left eye. As shown by the records, and especially the examinations of plaintiff in August 2007 by various doctors including Dr. Mandel, Dr. Friedman, and especially Dr. Schultz, that plaintiff suffered from a CRAO ischemic event prior to having a closed-angle glaucoma attack which was secondary. (See Exhibit A, B, P) Since a CRAO is painless and plaintiff is a poor historian and wavered on when she could or could not see out of the left eye to family and doctors it is difficult to say exactly when it occurred but clearly occurred before August, 2007. (See Exhibit A and B) However, rubeosis and neovascular glaucoma occur usually sometime after a CRAO, and the pale optic nerve noted by Dr. Schultz as of August 9, 2007, also occurs sometime after a CRAO. (See Exhibit A and B)

73. In addition, it is Dr. Gentile's opinion that the rubeosis and neovascular glaucoma are caused by an ischemic event such as a CRAO. (See Exhibit A) Further, Dr. Gentile points to Dr. Mandel notes after August 2, 2007 that plaintiff's arteries were no longer visible due to the

CRAO. When Dr. Gentile examined the plaintiff in April 2013, he noted that it was ischemia caused by a CRAO that caused the damage to the retina and optic nerve. (See Exhibit A)

74. Most important, the damage to plaintiff's optic nerve was not caused by a sudden increase in IOP since her vision was gone prior to that time. (See Exhibit A and B) It is both Dr. Gentile and Dr. Schultz's opinions that when plaintiff had her elevated IOP and pain, her vision was already compromised. (See Exhibit A and B) Even if Dr. Mandel gave plaintiff IOP reducing drops on August 2, 2007, that would not have prevented plaintiff's vision loss from the CRAO.

LEGAL ARGUMENT

75. A party seeking Summary Judgment must make a prima facie showing of entitlement to judgment as a matter of law by tendering sufficient evidence to demonstrate the absence of any material issue of fact. Weingrad v. New York University Medical Center, 64 N.Y.2d 851, 476 N.E.2d 642, 487 N.Y.S.2d 316 (1985). Once the showing has been made, the burden shifts to the party opposing the motion to produce evidence in admissible form sufficient to establish the existence of some material issue of fact which requires a trial of the action. Zuckerman v. City of New York, 49 N.Y.2d 557, 427 N.Y.S.2d 595 (1980). Summary judgment should be granted without hesitation in actions where there is no meritorious cause of action. Lomnitz v. Town of Woodbury, 81 A.D.2d 828, 829, 438 N.Y.S.2d 825, 827 (2d Dept. 1981).

76. A motion for summary judgment should be granted if "upon all the papers and proofs submitted the cause of action or defenses shall be established sufficiently to warrant the Court as a matter of law in directing judgment in favor of any party". CPLR §3212. The purpose of a summary judgment motion is to "expedite all civil cases by eliminating from the trial calendar claims which can be properly resolved as a matter of law". Andre v. Pomeroy, 35 N.Y.2d 361, 364, 362 N.Y.S.2d 131, 133 (1974).

77. For the Court to grant motions for summary judgment, the movant must establish his cause of action or defense by tender of evidentiary proof so the Court is warranted in directing judgment as matter of law. Borchard v. New York Life Insurance, 102 A.D.2d 465, 466, 477 N.Y.S.2d 167, 168 (1st Dept.) aff'd 63 N.Y.2d 1000, 483 N.Y.S.2d 1012 (1984). This proof may be supplied by way of a party defendant or even an attorney with the accompanying deposition testimony and exhibits. Alvarez v. Prospect Hospital, 68 N.Y.2d 320, 325, 508 N.Y.S.2d 923, (1986).

78. In determining whether there is an issue of fact that requires trial, the court is not obligated to ferret out speculative issues in order to force the matter to trial in the hopes that the trial may disclose something that pre-trial proceedings did not. Andre v. Pomeroy, supra. The "issues of fact" must be "bona fide issues raised by evidentiary facts". Rotuba Extruders, Inc. v. Ceppos, 46 N.Y.2d 223, 413 N.Y.S.2d 141 (1978). Frivolous issues will not preclude summary judgment. Fender v. Prescott, 101 A.D.2d 418, 476 N.Y.S.2d 128 (1st Dept.). "Mere surmise, suspicion and accusation are insufficient to defeat summary judgment". Holy Spirit assn. v. Harper and Row, 101 Misc.2d 30, 35, 420, N.Y.S.2d 56, 59 (1979).

DEFENDANTS ARE ENTITLED TO SUMMARY JUDGMENT IN THEIR FAVOR BECAUSE AS MATTER OF LAW, PLAINTIFF CANNOT MAKE OUT A PRIMA FACIE CASE AGAINST MONTEFIORE MEDICAL CENTER

79. The elements of proof in a medical malpractice action include a deviation or departure from accepted standards of care and evidence that such departure was a proximate cause of the injury or damages. Thurston v. Interfaith, 66 A.D.3d 999, 1001, 887 N.Y.S.2d 655 (1st Dep. 2009); Myers v. Ferrara, 56 A.D.3d 78, 83, 864 N.Y.S.2d 517 (1st Dept. 2008); Amsler v. Verrilli, 119 A.D.2d 786, 501 N.Y.S.2d 411 (2d Dept. 1986). Both the departure and proximate cause are needed to sustain the claim for medical malpractice. When medical

malpractice forms the basis of a wrongful death action, a defendant establishes a prima facie entitlement to summary judgment when it is established that the physicians or medical staff did not proximately cause the injuries alleged to have caused the plaintiff's death. Roques v. Noble, 73 A.D.3d 204, 899 N.Y.S.2d 193 (1st Dept. 2010); See Myers, 56 A.D.3d 78, 83, 864 N.Y.S.2d 517.

80. Additionally, it is an essential element of any malpractice claim that the defendants conduct must be based upon the facts presented at the time, and not with the benefit of hindsight. Liability cannot be based upon hindsight judgments as to what might have been done. Liability for malpractice must be based on the facts confronting the defendant at the time of the occurrence. Topel v. Long Island Jewish Medical Center, 55 NY2d 682, 685, 446 NYS2d 932, 431 NE2d 293 (1981); Garcia v. Nyack Hospital, 49 A.D.2d 937 (2d Dept., 1975); Henry v. Bronx Lebanon Medical Center, 53 A.D.2d 476 (1st Dept., 1976).

81. It is basic law that there can be no liability "for a mere error of judgment, provided [the physician] does what he thinks is best after careful examination." Pike v. Honsinger, 155 N.Y. 201, 210, 49 N.E. 760 (1898). A physician "is not required to achieve success in every case and cannot be held liable for mere errors of professional judgment." Schrempf v. State, 66 N.Y. 2d 289, 295, 496 N.Y.S. 2d 973, 977 (1985), See also Topel v. Long Island Jewish Medical Center, 555 N.Y. 2d 682, 446, N.Y.S. 2d 932, 934, where the Court held "the line between medical judgment and deviation from good medical practice is not easy to draw." "A bad outcome is not by itself proof of a departure on the part of a defendant." See Schoch v. Dougherty, 122 A.D. 2d 46, 504 N.Y.S. 2d 206 (3rd Department, 1986). "It follows therefore that a doctor may be liable only if the doctor's treating decisions do not reflect his/her own best judgment, or fall short of the generally accepted standards of care." Nestorowich v. Recata, 97 N.Y. 2d 393, 399, 740, N.Y.S. 2d 668, 678 (2002). In making this determination, the

defendant's conduct "was to be judged on the facts as the existed when the treatment was rendered and not in retrospect and in light of subsequent events." Henry v. Bronx Lebanon Medical Center, 53 A.D. 2d 476, 480-481, 385, N.Y.S. 2d 772 (1st Department, 1976). "To hold otherwise...is to subject every judgment made by a doctor, no matter what its basis, to the second guess of a jury." Topel v. Long Island Jewish Medical Center, 555 N.Y. 2d 682, 446, N.Y.S. 2d 932, 934.

82. In searching the record for an issue of fact, the court is not obligated to ferret out speculative issues in order to force the matter to trial in the hopes that the trial may disclose something that pre-trial proceedings did not. Andre v. Pomeroy, supra. The "issues of fact" must be "bona fide issues raised by evidentiary facts". Rotuba Extruders, Inc. v. Ceppos, 46 N.Y.2d 223, 413 N.Y.S.2d 141 (1978). Frivolous issues will not preclude summary judgment. Fender v. Prescott, 101 A.D.2d 418, 476 N.Y.S.2d 128 (1st Dept.). "Mere surmise, suspicion and accusation are insufficient to defeat summary judgment". Holy Spirit assn. v. Harper and Row, 101 Misc.2d 30, 35, 420, N.Y.S.2d 56, 59 (1979).

83. Here, it is undisputed that plaintiff suffered very serious strokes from occlusions in both carotid arteries, suffered from vascular disease, hypertension and diabetes. Plaintiff's serious medical condition caused an ischemic process which led to a CRAO (stroke in the eye). The CRAO cut off the blood supply to the retina and optic nerve causing plaintiff to lose vision. As detailed by defendant's expert Dr. Ronald Gentile, it is his expert opinion that Dr. Mandel appropriately acted within the standard of care and exercised sound medical judgment in the care and treatment of plaintiff when she was brought to him on 2 occasions for ophthalmological complaints of the left eye. (See Exhibit A, N)

84. More importantly, it is Dr. Gentile and plaintiff's treating physician, Dr. Jeffrey Schultz's opinion that Dr. Mandel did not proximately cause plaintiff's vision loss in the left eye because no drops to reduce IOP if given in August, 2007 would have made any difference and would not have prevented vision loss. (See Exhibit A, B) Plaintiff did not lose her vision from elevated intraocular pressure this was a secondary effect to the already ischemic process and CRAO that damaged her optic nerve. (See Exhibit A, B, M, N, O)

Dr. Harvey Mandel Did Not Depart From The Standard Of Care

85. Specifically, plaintiff alleges that Dr. Mandel did not properly test, examine or treat plaintiff for narrow-angle glaucoma, and did not take an IOP test at every visit. However, it is the opinion of defendant's expert Dr. Ronald Gentile that Dr. Mandel was not required to take her IOP at every visit and that it was difficult for Dr. Mandel to obtain an IOP at most of his exams due to her medical and mental status. (See Exhibit A, N, O)

86. Plaintiff's medical and mental status makes it hard to have plaintiff keep still and she reacts badly to when the instruments and drops have to go into or near her eyes. (See Exhibit A) Even when sedated, plaintiff will continue to move and struggle making it difficult to obtain an IOP or when an IOP is obtained it is not necessarily accurate. (See Exhibit A, M, N, O) For example, plaintiff's IOP at the January 25, 2007 exam by Dr. Mandel was 22 in the left eye while sedated plaintiff still bobbed and weaved her head so Dr. Mandel noted she was still fighting so could have been lower. (See Exhibit N) As noted by the Montefiore chart even when plaintiff was sedated her IOP was unable to be obtained. (See Exhibit O) Further, this was a problem Dr. Gentile had when examining plaintiff. (See Exhibit A) As Dr. Gentile points out this is not her fault but is a problem that can be difficult for a doctor to overcome. (See Exhibit A)

87. Dr. Gentile explains that clinical examination and cooperation during the exam are necessary to get accurate information. Eye exams require cooperation and some tests simply cannot be performed without it. (See Exhibit A) Dr. Gentile noted that plaintiff was difficult to examine at most visits with Dr. Mandel from the first visit in December 2006 to August 2007. Dr. Mandel noted plaintiff would move, bobbing and weaving her head, and lack of cooperation so it was difficult to obtain accurate readings. (See Exhibit N) Plaintiff would not allow him to take her IOP and would still fight even when lightly sedated. (See Exhibit N)

88. Further, Dr. Gentile opined that it's important to note that overly sedating the patient may make them easier to examine but can also give a false IOP reading of too low and places the patient at higher risk of untoward side effects like respiratory depression and aspiration. (See Exhibit A) Plaintiff has very serious medical conditions, such as GI bleeds, vomiting, incontinence and breathing problems so sending her to Montefiore to be sedated for an IOP test without a clinical reason would not have been sound medical treatment. (See Exhibit A, M, N, O)

89. Further, it is Dr. Gentile's opinion that Dr. Mandel did not depart in his care and treatment during the examinations from January 25, 2007 to August 2, 2007. (See Exhibit A) After the January 25, 2007 examination plaintiff would not need another full exam for at least another year unless there was a problem. (See Exhibit A) Dr. Friedman referred plaintiff to Dr. Mandel several times in February and March 2007 for conjunctivitis and lid cellulitis in her right eye which resolved completely with antibiotics. (See Exhibit M, N) The first time plaintiff was referred to Dr. Mandel for a problem with the left eye was on July 16, 2007 when Dr. Friedman referred plaintiff with swollen upper lid on the left eye improved on Ciloxin. (See Exhibit M, N) It is Dr. Gentile's opinion that there was no reason to sedate plaintiff and attempt to take her IOP

at this visit which was for some mild swelling and no other complaints were conveyed to Dr. Mandel, especially when it was the first time she had a problem with the left eye. (See Exhibit A)

90. At the August 2, 2007 examination Dr. Mandel noted that plaintiff's left eye swelling went down and she again refused to allow him to take her IOP and visual acuity. (See Exhibit N) However, Dr. Gentile opined that based upon the records, examinations and notes of Dr. Friedman and Dr. Khader, plaintiff had lost her vision from the CRAO by the time Dr. Mandel examined her on August 2, 2007. (See Exhibit A) The examination by Dr. Schultz confirms this because of the level of optic nerve atrophy on August 9, 2007 and the neovascularization of the iris. Therefore, plaintiff had already lost her vision by this visit with Dr. Mandel. (See Exhibit A)

91. Accordingly, Dr. Mandel did not depart from the standard of care in treating plaintiff.

Dr. Mandel's Care and Treatment Was Not The Proximate Cause Of Plaintiff's Injuries

92. Plaintiff alleges that if plaintiff was tested for IOP and given treatment for elevated IOP that her vision loss would not have occurred. This is not the case. Proximate cause is an important part of this case because even if the Court finds that Dr. Mandel should have done more to obtain plaintiff's IOP, it would not have mattered. What's most important is the damage to plaintiff's optic nerve in her left eye was not caused by a sudden increase in IOP but by a CRAO. When plaintiff began to complain of intense pain and had an elevated IOP that was after the vision was gone. (See Exhibit A and B) It is both Dr. Gentile and Dr. Schultz's opinions that when plaintiff had her elevated IOP and pain, her vision was already compromised. (See Exhibit A and B) Even if Dr. Mandel gave plaintiff IOP reducing drops on August 2, 2007, that would not have prevented plaintiff's vision loss from the CRAO.

93. In sum and substance of what was previously discussed in the expert discussion section, plaintiff had long term vascular disease and arteriosclerosis that caused progressive ischemia and a central retinal artery occlusion ("CRAO") which caused plaintiff's vision loss in her left eye. (See Exhibit A, B, N, O, P) There is no proven local ophthalmic treatment to prevent a CRAO and no effectively proven treatment to reverse a CRAO's vision loss. (See Exhibit A, B)

94. It is the examination of plaintiff on August 9, 2007 by Dr. Schultz and his affidavit which explains what happened to plaintiff's vision in the left eye. (See Exhibit B, P) At the examination Dr. Schultz noted that plaintiff had an afferent pupillary defect with the pupil at mid-dilation. Plaintiff's visual acuity was Light Perception. The IOP in the left eye was 25/26 (he had multiple numbers). The left cornea was clear but there was rubeosis. A fundus examination was performed and plaintiff's left optic nerve was pale. Dr. Schultz diagnosed plaintiff with rubeosis and neovascular glaucoma from a prior CRAO. (See Exhibit B and P)

95. The key to the exam is that plaintiff had rubeosis and a pale optic nerve. Neovascularization (rubeosis) occurs from ischemia, such as a CRAO. (See Exhibit A, B, P) Dr. Schultz discussed in his affidavit that a patient such as plaintiff would develop rubeosis and neovascular glaucoma a few weeks after the CRAO which is painless. (See Exhibit B) Neovascular glaucoma is when abnormal blood vessels form a membrane that block the drainage of the aqueous humor (liquid from the anterior chamber). Ischemic retinal disease caused by a carotid artery occlusion or as stated previously a CRAO cause this to occur. (See Exhibit B)

96. Dr. Schultz explained that different from plaintiff, in a patient with an acute narrow-angle attack (what plaintiff seems to be claiming occurred in plaintiff's left eye) is caused by an anatomical problem in which the lens is being pushed forward and the anatomical positioning of the iris blocks the drainage of the aqueous humor causing pressure to build up very

quickly. (See Exhibit B) It is Dr. Schultz's opinion that Plaintiff did not have an acute narrow-angle attack but did have secondary neovascular glaucoma. (See Exhibit B) There are varying causes and in the case of a person with secondary neovascular glaucoma after a CRAO treating even noticeable elevated intraocular pressure would not change the outcome of the vision loss and cannot prevent the vision loss. The main issue with plaintiff was she suffered from severe vascular disease, hypertension and diabetes and her CVA of the carotid artery eventually led to an ischemic event that caused her vision loss. (See Exhibit B)

97. When Dr. Schultz examined plaintiff he also noted she had a white, pale optic nerve which is usually caused by an ischemic (stroke) event to the optic nerve. (See Exhibit B and P) It is Dr. Schultz's opinion that since plaintiff had no sign of retinopathy at the time, and no hemorrhage in the posterior portion of the eye or retina, the only possible cause for her optic nerve damage was from a CRAO. (See Exhibit B) He explained that there is no preventive ophthalmologic treatment for a CRAO. Once the CRAO occurred plaintiff had no hope of maintaining vision in the left eye. (See Exhibit B and P) Further, it is Dr. Schultz's opinion that no amount of treating the neovascular glaucoma would help restore plaintiff's vision in the left eye because of the CRAO. (See Exhibit B and P) Even giving drops to reduce intraocular pressure would not have prevented the damage that was done to the optic nerve due to the CRAO. (See Exhibit B and P)

98. Dr. Gentile concurs with Dr. Schultz's opinion and when he examined the plaintiff he too noted the rubeosis and that plaintiff's optic nerve was damaged from ischemia. (See Exhibit A) To recap, no amount of IOP lowering drops would have prevented vision loss, the vision loss was due to a medical process caused by plaintiff's underlying medical conditions of vascular disease, hypertension and diabetes, and once the vision was lost there was no treatment.

99. In addition, more evidence that a CRAO was the cause of the vision loss is noted by Dr. Mandel at other examinations of the plaintiff after August 2, 2007, that plaintiff's arteries were no longer visible. (See Exhibit N) Dr. Gentile explained that because a CRAO cuts off the central retinal artery, all other arteries will be damaged and were not visible upon examination. (See Exhibit A) Further, when Dr. Gentile examined the plaintiff in April 2013, he noted that it was ischemia caused by a CRAO that caused the damage to the retina and optic nerve. (See Exhibit A) Therefore, Dr. Mandel's action or inaction was not the proximate or actual cause of plaintiff's vision loss in the left eye.

100. Accordingly, as a matter of law and there being no material issues of fact in dispute, all of plaintiff's claims against defendant Dr. Harvey Mandel should be dismissed with prejudice.

DEFENDANT DR. HARVEY MANDEL CANNOT BE HELD LIABLE TO STATE AND FEDERAL NURSING HOME STATUTES AS AN INDIVIDUAL AND PUNITIVE DAMAGES ARE IMPROPER IN THIS CASE

101. Plaintiff has alleged various state and federal statutes related to nursing homes against defendant Dr. Mandel individually, and made general allegations that punitive damages through these statutes should be applied. However, those statutes such as the NY State Public Health Law § 2801-d, 2803, and 10 NYCRR § 415.12 et seq. al and the federal statute 42 C.F.R 483.25 et seq. (equivalent of 10 NYCRR § 415.12(c)) all relate to finding a residential health care facility or nursing home liable for violating statutes, codes, rights of residents and are not an action to be brought against an individual doctor. See Zeides v. Hebrew Hone for the Aged at Riverdale, Inc., 300 A.D.2d 178 (1st Dep't 2002); Butler v. Shorefront Jewish Geriatric Center, Inc., 33 Misc.3d 686 (Kings Cty Sup. Ct. 2011).

102. Moreover, plaintiff alleges a violation of 42 U.S.C. 1395i-3 et seq. which specifically applies only to "skilled nursing facility[es]." See 42 U.S.C. 1395i-3 et seq. (Requirements for, and assuring quality of care in, skilled nursing facilities), and 42 U.S.C. 1396r which specifically applies to nursing home facilities. See 42 U.S.C. 1396r et seq. Again, these federal statutes are requirements for a nursing home or skilled nursing facility to comply with and do not mention any acts related to individual physicians. See Id. The plain language of the statutes discussing how, when and in what way a nursing home should evaluate residents, comply with agreements

103. The Public Health Law and the Federal nursing home statutes were designed to protect the rights of nursing home residents in getting medical treatment but also for evaluations, physical and mental therapy, preventing bed sores, preventing falling, proper feeding and all around care. However, Dr. Mandel is an independent contractor that is a specialist that came to Beth Abraham twice a week to offer ophthalmological care and treatment to the residents. His actions are not subject to individual liability under these statutes because they are all designed to hold the facility itself liable.

104. Further, plaintiff alleges generally that punitive damages should be awarded. However, punitive damages are wholly improper in this case as against to Dr. Mandel. Punitive damages are only warranted where the conduct of the party being held liable evidences a high degree of moral culpability, so flagrant as to transcend mere carelessness, and willful and reckless that the actions created a substantial and unjustifiable risk of harm. See Butler, 33 Misc.3d 686, 694-95.

105. Punitive damages under the Public Health Law do not apply to Dr. Mandel. Even if the statute and/or punitive damages could apply, Dr. Mandel in no way acted with willful carelessness and recklessness with a high degree of moral culpability. Based upon a review of the

records, the expert affidavit of Dr. Ronald Gentile and affidavit of Dr. Jeffrey Schultz, Dr. Mandel was not negligent in his care and treatment of the plaintiff. Dr. Mandel saw plaintiff from January 2007 through March 2007 for examinations mostly related to complaints about conjunctivitis in the right eye. At the January 25, 2007, plaintiff was sedated to attempt to have her IOP taken and although Dr. Mandel was able to get a 22 for the left eye, he noted that plaintiff was fighting and being uncooperative. (See Exhibit A, N) Dr. Mandel saw plaintiff for the first time regarding any complaints of her left eye on July 17, 2007 for the complaint of lid swelling and redness, with no complaints of any visual disturbances. (See Exhibit A, M, N) Since plaintiff had conjunctivitis in the right eye for a few months that had resolved with antibiotics, it was appropriate for Dr. Mandel to treat the left eye for the same condition. (See Exhibit A, M, N) Defendant's expert Dr. Gentile opined that it is not necessary to take the IOP more than one to two times a year, and not necessary to take it when an ophthalmologist is treating a patient for a specific complaint. (See Exhibit A)

106. Dr. Mandel's second time examining plaintiff for a complaint about the left eye was on August 2, 2007. At that point her vision in the left eye was severely diminished from a CRAO. Dr. Gentile and Dr. Schultz opined that plaintiff lost vision from a CRAO which also caused neovascular glaucoma and rubeosis. (See Exhibit A, B, N, P) Dr. Gentile and Dr. Schultz also opined that Dr. Mandel giving IOP lowering drops on August 2, 2007 would not have made a difference or prevented the vision loss because a CRAO and its resulting vision loss cannot be prevented by pressure lowering drops before or after it occurs.

107. Therefore, Dr. Mandel's actions or inaction were not the proximate or actual cause of plaintiff's left eye vision loss.

108. Accordingly, as a matter of law and there being no material issues of fact in dispute, all of plaintiff's claims against defendant Dr. Harvey Mandel should be dismissed with prejudice.

CONCLUSION

109. For the foregoing reasons, it is respectfully submitted that the defendant Harvey Mandel, M.D. is entitled to have all the claims against him dismissed with prejudice and to have such other and further relief as this Court may deem just and proper.

WHEREFORE, it is respectfully requested that this Court issue an Order dismissing the Complaint, in its entirety, with prejudice and grant whatever further and additional relief is just and equitable.

Dated: New York, New York
October 13, 2016

DEBORAH I. MEYER, ESQ.

EXHIBIT INDEX

EXHIBIT

A. AFFIDAVIT OF EXPERT DR. RONALD GENTILE & IME REPORT COLLECTIVELY

B. AFFIDAVIT OF TREATING PHYSICIAN DR. JEFFREY SCHULTZ

C. SUMMONS & COMPLAINT

D. VERIFIED ANSWER OF DR. HARVEY MANDEL

E. PL'S VERIFIED BILL OF PARTICULARS AS TO DR. HARVEY MANDEL

F. COURT ORDER APPOINTING FELICIA BULLOCK GUARDIAN AD LITEM

G. TRANSCRIPT OF EXAMINATION BEFORE TRIAL OF FELICIA BULLOCK

H. TRANSCRIPT OF EXAMINATION BEFORE TRIAL OF DR. HARVEY MANDEL

I. TRANSCRIPT OF EXAMINATION BEFORE TRIAL OF DR. ROSS FRIEDMAN

J. NOTE OF ISSUE AND CERTIFICATE OF READINESS

K. ST. LUKE'S ROOSEVELT HOSPITAL MEDICAL RECORDS

K1. ROOSEVELT HOSPITAL MRI/MRA REPORTS

L. BETH ABRHAM MEDICAL CHART

M. BETH ABRAHAM INTERDISCIPLINARY PROGRESS NOTES

N. BETH ABRAHAM CONSULT REQUEST/REPORT OPHTHALMOLOGY CLINIC

O. MONTEFIORE MEDICAL CENTER CHART

P. DR. SCHULTZ MONTEFIORE EYE CLINIC NOTE AND BETH ABRAHAM REPORT

EFH (Our File No.: 8-08-099-15)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

---X

BARBARA PHILLIPS, by her Guardian Ad Litem
FELICIA BULLOCK,

Plaintiff,

-against-

BETH ABRAHAM HEALTH SERVICES,
HARVEY MANDEL, M.D., ET AL.

Defendants.

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Index No.: 306320/08

NOTICE OF CROSS MOTION

11/10

PLEASE TAKE NOTICE that upon the annexed Affirmation of Edward F. Humphries, Esq., dated October 19, 2016, the various exhibits annexed hereto, Defendant BETH ABRAHAM HEALTH SERVICES by and through their attorneys, VASLAS LEPOWSKY HAUSS & DANKE, LLP, will move before the Supreme Court of New York, Bronx County, located at 851 Grand Concourse, Room 217 Motion Support, Bronx, New York 10451 on the 10th day of November, 2016 at 9:30 o'clock in the forenoon of that day, or as soon thereafter as counsel can be heard, for an Order:

1. Pursuant to CPLR §§3212, granting summary judgment to the defendant Beth Abraham Health Services and dismissing the Complaint against them in its entirety with prejudice; and

2. For such other, further and different relief as this Court deems just and proper.

PLEASE TAKE NOTICE, that answering affidavits, if any, are required to be served upon the undersigned at least seven (7) days before the return date of this motion.

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BRONX COUNTY
CLERK'S OFFICE

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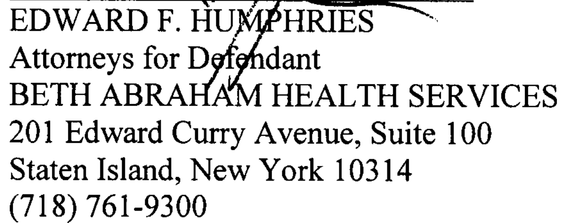
Dated: Staten Island, NY
October 19, 2016

Yours, etc.

VASLAS LEPOWSKY HAUSS & DANKE LLP

By: 

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EFH (Our File No.: 8-08-099-15)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX
---X

BARBARA PHILLIPS, by her Guardian Ad Litem FELICIA BULLOCK,

Plaintiff,

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendants.

---X

Index No.: 306320/08

AFFIRMATION
IN SUPPORT

EDWARD F. HUMPHRIES, ESQ. an attorney duly admitted to practice law before the Courts in the State of New York, hereby affirms the following to be true under the penalties of perjury:

1. I am an partner with the law firm of VASLAS LEPOWSKY HAUSS & DANKE LLP, attorneys of record for BETH ABRAHAM HEALTH SERVICES ("Beth Abraham") and as such, am fully familiar with the facts and circumstances as hereinafter set forth.

2. This affirmation is based upon information and belief, the sources of which are the files and records maintained by the law offices of VASLAS LEPOWSKY HAUSS & DANKE LLP.

3. This affirmation is respectfully submitted in support of the instant motion on behalf of Shorefront, which seeks an Order:

a. Pursuant to CPLR §§3212, granting summary judgment to the defendant Beth Abraham Health Services and dismissing the Complaint against them in its entirety with prejudice; and

b. For such other, further and different relief as this Court deems just and proper.

SUMMARY OF ARGUMENT

4. In support of the motion, the Court is directed to the affidavit and IME report of expert, Dr. Ronald Gentile (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "A"), the affidavit from plaintiff's treating physician, Dr. Jeffrey Schultz (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "B") and the medical records which establish that defendant, BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES, was not negligent in the care and treatment of the plaintiff, Barbara Phillips. In addition, the treatment rendered by defendant, BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES, was not the proximate cause of plaintiff's injuries. Specifically, the plaintiff's loss of vision in her left eye was a direct consequence of longstanding vascular disease and arteriosclerosis causing progressive ischemia and a central retinal artery occlusion ("CRAO"). No treatment could have prevented the CRAO or reversed the resulting vision loss. This motion seeks to dismiss any and all claims, with prejudice.

PROCEDURAL HISTORY

5. Plaintiff BARBARA PHILLIPS, by her Guardian Ad Litem, FELICIA BULLOCK ("plaintiff") alleges that defendant BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS

OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES, were negligent in the care of BARBARA PHILLIPS

6. The action was commenced with the filing of a Summons and Complaint on or about July 28, 2008. (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "C")

7. Defendant, Beth Abraham served a Verified Answer on August 27, 2008. (A copy of the Verified Complaint is attached hereto as Exhibit **"B."**).

8. Plaintiff served a Verified Bill of Particulars on or about May 4, 2010. (A copy of the Verified Bill of Particulars is attached hereto as Exhibit **"C."**).

9. The Bill of Particulars alleges that the negligence of the defendants caused the following injuries:

a. Permanent blindness/loss of vision to the left eye
b. Acute angle/closed glaucoma of the left eye
c. Severe pain to eyes
d. Severe headache
e. Swelling of eyes
f. Redness and puffiness of eyes
g. Conjunctivitis
h. Profuse sweating
i. Photophobia
j. Fixed left pupil and dilated pupil on the left
k. Dilated pupil on the right
l. Hazy cornea
m. Intraocular pressure of 50 on the left
n. Pain and suffering
o. Loss of dignity

10. On November 30, 2011, the Court granted plaintiff's motion to have Felicia Bullock assigned as the Guardian Ad Litem due to plaintiff, Barbara Phillips, being mentally incapable of

adequately prosecuting her rights pursuant to CPLR 1201 (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "F").

11. On January 25, 2012, the deposition of Felicia Bullock was conducted. (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "G")

12. On December 19, 2014, the deposition of Harvey Mandel, M.D. was conducted. (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "H")

13. On December 17, 2015, the deposition of Ross Friedman, M.D. was conducted. (Annexed to the co-defendant's Motion for Summary Judgment as Exhibit "I")

14. On June 16, 2016, plaintiff mailed their Note of Issue. (A copy of the Note of Issue is annexed hereto as Exhibit "**D.**").

FACTUAL SUMMARY

15. The medical records document the severity of plaintiff's vascular disease commencing with complaints of leg weakness for which the plaintiff was treated at St. Luke's Roosevelt on December 15, 2005 (A copy of the St. Luke's Roosevelt Hospital Chart is annexed to the co-defendant's motion for summary judgment as Exhibit "**K**"). Radiographic studies from St. Luke's document left bilateral carotid artery occlusions and occlusion of the left carotid bulb (MRI/CT and MRA reports are annexed to the co-defendant's motion for summary judgment as Exhibit "**K1**").

16. Upon admission to Beth Abraham in June of 2006, the plaintiff no longer had use of her legs, suffered right side hemiparesis, seizures, incontinence of bowel and bladder, GI bleeds, excessive vomiting and dementia (A copy of the Beth Abraham chart is annexed to the co-defendant's motion for summary judgment as Exhibit "L").

17. Plaintiff's pre-existing vascular condition caused the aforementioned injuries.

ARGUMENT

18. There is no triable issue of fact as to any allegation advanced in this lawsuit. The aforementioned undisputed facts demonstrate that BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES did not depart from accepted standards of medical practice with regard to the care and treatment provided to the Plaintiff. The attention of the Court is respectfully directed to the annexed affirmation of the movant's expert, Ronald Gentile, M.D, a board certified ophthalmologist.

19. In Dr. Ronald Gentile's physician's affidavit and Dr. Jeffrey Schultz' affidavit (Exhibit "A" and "B" of co-defendant's motion), Dr. Gentile and Dr. Schultz repeatedly affirms that in his opinion and within a reasonable degree of medical certainty the treatment rendered by, HARVEY MANDEL MD was at all times proper and in conformance with accepted standards of ophthalmology. Clearly since Dr. Mandel did not depart from good and accepted standards of care then BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES cannot be held to be liable for his actions.

20. Dr. Gentile and Dr. Schultz affirm that the injuries sustained by decedent were not caused by any negligence or inattentiveness on the part of defendants. Plaintiff's pre-existing vascular condition was the proximate cause the aforementioned injuries.

21. Your affirmant further submits that if the Court is inclined to grant summary judgment to Harvey Mandel MD then defendants BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES should also be granted the same relief because BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES would not be liable through the doctrine of respondent superior. It is clear that the proximate cause of the Plaintiff's injuries was her pre-existing underlying medical condition.

LEGAL AUTHORITY

22. "[T]he proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issue of fact." Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986). Once a prima facie showing has been made, the burden shifts to the non-moving party who must "produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez, 68 N.Y.2d at 324.

23. The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure is a proximate cause of the injury or damage. Holbrook v. United Hosp. Medical Center, 669 N.Y.S.2d 631, 632 (2nd Dept. 1998). See also

Prete v. Rafla-Demetrious, 638 N.Y.S.2d 700, 702 (2nd Dept. 1996), citing Bloom v. City of New York, 609 N.Y.S.2d 45 (2nd Dept. 1994) and Kletnieks v. Brookhaven Mem. Assn., 385 N.Y.S.2d 575 (2nd Dept. 1976).

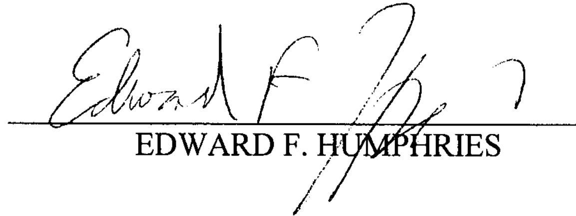
24. To carry the burden of proving a prima facie case, a plaintiff must demonstrate that defendant's negligence was a substantial factor in producing the injury. Prete, 638 N.Y.S.2d at 702. In the absence of evidence that defendant's conduct was a proximate cause of plaintiff's injury, summary judgment must be granted to defendant as a matter of law. Id.

25. In the instant matter, defendants BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES, have made the requisite prima facie showing of entitlement to summary judgment as a matter of law by demonstrating that there are no triable issues of fact through the submission of parties' pleadings, the Verified Bill of Particulars, plaintiff's medical records, pertinent deposition testimony as well as the expert affirmation of a physician board certified internal medicine and oncology. These submissions, as discussed, demonstrate that BETH ABRAHAM HEALTH SERVICES, MARGARET RIVERS AS ADMINISTRATOR AT BETH ABRAHAM HEALTH SERVICES, JOHN/JANE DOE 1-20 AS OWNERS, OPERATORS, CONTROLLING PERSONS, AND MEMBERS OF THE GOVERNING BODY OF BETH ABRAHAM HEALTH SERVICES AND JOHN/JANE DOE AS MEDICAL DIRECTOR AT BETH ABRAHAM HEALTH SERVICES, did not depart from good and accepted standards of medical practice and that no act or omission on their part can be said to be a substantial factor in causing harm or injury to the decedent.

CONCLUSION

WHEREFORE, it is respectfully requested that the Court grant summary judgment in favor of the moving defendants and dismiss plaintiff's Complaint in its entirety with prejudice.

Dated: Staten Island, NY
October 19, 2016



EDWARD F. HUMPHRIES

EFH (Our File No.: 8-08-099-15)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

---X

BARBARA PHILLIPS, by her Guardian Ad Litem FELICIA BULLOCK,

Plaintiff,

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendants.

---X

Index No.: 306320/08

REPLY AFFIRMATION

Motion Sequence No.: 003

1/31/17
IA 22

EDWARD F. HUMPHRIES, ESQ., an attorney duly licensed to practice law before the Courts in the State of New York, hereby affirms the following to be true under the penalties of perjury:

1. I am a member of the law firm of VASLAS LEPOWSKY HAUSS & DANKE LLP, attorneys of record for BETH ABRAHAM HEALTH SERVICES.

2. This affirmation is submitted based upon information and belief, the sources of which are the files and records maintained by the law offices of VASLAS LEPOWSKY HAUSS & DANKE LLP.

3. This affirmation is respectfully submitted in Reply to the plaintiff's affirmation in opposition to the instant motion on behalf of BETH ABRAHAM HEALTH SERVICES, which seeks an Order:

   a. Pursuant to CPLR § 3212, granting summary judgment to the defendant Beth Abraham Health Services and dismissing the Complaint against them in its entirety with prejudice; and

   b. For such other, further and different relief as this Court deems just and proper.

4. Plaintiff incorrectly argues that Defendant BETH ABRAHAM HEALTH SERVICES' motion for summary judgment was untimely. This is not true. Plaintiff's attorney served a copy on the note of issue (NOI) upon the defendants by mailing the NOI to the defendants on June 16, 2016. Defendant BETH ABRAHAM HEALTH SERVICES served its motion for summary judgment on October 19, 2016, 125 days after the NOI was filed.

5. Pursuant to CPLR § 3212(a), a motion for summary judgment must be made within 120 days after a note of issue is filed. (*Brill v City of New York*, 2 NY3d 648 [2004]). The motion may be made after the expiration of the deadline upon good cause shown. (*Id.* at 652). However, pursuant to CPLR § 2103 (b) (2) defendants are entitled to five (5) additional days to account for service by mail. (*See Zovas v Eckerd Corp.*, 2010 N.Y. Misc. LEXIS 3313). Pursuant to CPLR § 2103 (b) (2)

6. The First Department has explicitly added a five day extension to the statutory period of time in which defendants may file for summary judgment to account for service of a NOI by mail. (*See Krasnow v JRBG Mgt. Corp.*, 25 AD3d 479 [1st Dept 2006]

In *Krasnow*, 25 AD3d 479 at 480, the First Department applied the five day extension, holding:

> Defendant made its motion for summary judgment on October 25, 2004. The note of issue, which was dated and served by mail on August 20, 2004, was filed on August 23. The court erroneously calculated the 60-day period for making the motion from the former date rather than the latter (see Uniform Rules of Justices, NY County, Sup Ct, Civ Branch, rule 17), and **also failed to consider the additional five days allowed for service by mail** (CPLR 2103 [b] [2]). Hence, the motion was timely.

5. In this matter, plaintiff mailed the NOI on June 16, 2016 (see affidavit of service attesting to the mailing of the NOI on June 16. 2016). Annexed hereto As Exhibit "A" is the note of issue with the affidavit of service. CPLR § 3212 provides that a motion must be made within 120 days of filing. However, as discussed *infra*, CPLR § 2103 (b) (2) provides an additional 5 days to account for mailing. As a result, the deadline expires 125 days from the date of the mailing of the NOI. 125 days from June

16, 2016 is October 19, 2016. Defendant BETH ABRAHAM HEALTH SERVICES' motion was served on October 19, 2016 and is therefore timely.

6. Defendant BETH ABRAHAM HEALTH SERVICES relied on the above-referenced case law in believing that it had 125 days from the mailing of the NOI to move for summary judgment. The reliance on this well-established case law is a good cause for not serving the motion prior to the expiration of the 120 days referenced in the statue. As a result, even if this Court should chose to disregard this precedent, it should acknowledge an attorney's acceptance of case law as good cause for his actions.

7. BETH ABRAHAM HEALTH SERVICES' motion was served on October 19, 2016 and returnable on November 10, 2016. Defendant provided plaintiff sufficient notice regardless of whether the motion was a cross motion (12 days) or a regular motion (17 days). Clearly, the motion gave adequate notice to the plaintiff.

8. As noted in *Kershaw*, 114 A.D.3d at 75, courts have deemed the mislabeling of a motion as a cross motion a "technical" defect which will be disregarded.

9. Clearly, the motion of defendant BETH ABRAHAM HEALTH SERVICES was timely made.

10. Furthermore, in *Filannino v. Triborough Bridge & Tunnel Auth.*, 34 A.D.3d 280, [1st Dept 2006] the First Department held that **"a cross motion for summary judgment made after the expiration of the statutory 120-day period may be considered by the court, even in the absence of good cause, where a timely motion for summary judgment was made seeking relief *'nearly identical'* to that sought by the cross motion"** (emphasis added). According to the First Department, "an otherwise untimely cross motion may be made and adjudicated because a court, in the course of deciding the timely motion, may search the record and grant summary judgment to any party without the

necessity of a cross motion." *Id.* (See also *Altschuler v Gramatan Mgt., Inc.*, 27 AD3d 304 [1st Dept 2006]; *Fahrenholz v Security Mut. Ins. Co.*, 32 AD3d 1326, 1328 [2006]; *Bressingham v Jamaica Hosp. Med. Ctr.*, 17 AD3d 496, 497 [2d Dept 2005].

11. Here, our application is "nearly identical" to the motion of co-defendant HARVEY MANDEL, M.D. Neither of the cases cited by the plaintiff, *Kershaw v Hospital for Special Surgery*, 114 A.D.3d 75 [1st Dept 2013] or *Borges v Placeres*, 123 A.D.3d 611 (1st Dept 2014) overturn the standard established in *Filannino*.

12. Therefore, even if the Court declines to apply the 5 day rule the motion of BETH ABRAHAM HEALTH SERVICES, is nearly identical to the motion of co-defendant HARVERY MANDEL, M.D. Therefore, defendant BETH ABRAHAM HEALTH SERVICES' motion was timely made.

12. With regard to the merits of defendant BETH ABRAHAM HEALTH SERVICES' motion for summary judgment, plaintiff has failed to establish a single departure by BETH ABRAHAM HEALTH SERVICES. The affidavit of Reza Dana, M.D. alleges departures from good and accepted standards of care by Dr. Mandel and lumps BETH ABRAHAM HEALTH SERVICES in as "them too" but never identifies an individual at BETH ABRAHAM HEALTH SERVICES, even in the vaguest terms, whose act was a departure from good and accepted standards of care. To make an allegation against Dr. Mandel based upon his conduct and then to make the same allegation against BETH ABRAHAM HEALTH SERVICES without establishing any act by any individual for which BETH ABRAHAM HEALTH SERVICES is responsible is not sufficient. Plaintiff must allege a specific departure against an identifiable actor for which BETH ABRAHAM HEALTH SERVICES was responsible. The affidavit has failed to identify any such act or individual.

13. The affidavit of Reza Dana, M.D. goes on to allege certain things which should have been done at the time of transfer, but the affidavit fails to allege that the failure to do the things listed rose to the level of a departure from good and acceptable standards of care or that they proximately caused any injury.

14. Plaintiff argues violations of the Public Health Law, merely citing the statue but never alleges any facts to support a violation of the statute.

15. The affidavit of Reza Dana, M.D. fails to allege a single departure by Beth Abraham Health Services that proximately caused an injury. As such summary judgment must be granted in favor of Beth Abraham Health Services.

WHEREFORE, it is respectfully requested that the Court grant summary judgment in favor of the moving defendants and dismiss plaintiff's Complaint in its entirety with prejudice.

Dated: Staten Island, NY
January 18, 2017

Yours, etc.

VASLAS LEPOWSKY HAUSS & DANKE LLP

By: ______________________

EDWARD F. HUMPHRIES
Attorneys for Defendant
BETH ABRAHAM HEALTH SERVICES
201 Edward Curry Avenue, Suite 100
Staten Island, New York 10314
(718) 761-9300

TO: Parker Waichman Alonso, LLP
Attorneys for Plaintiff
6 Harbor Park Drive
Port Washington, New York 11050

Ekblom & Partners, LLP
Attorneys for Defendant
HARVEY MANDEL, M.D.
850 Third Avenue, 21st Floor
New York, New York 10022

EFH (Our File No.: 8-08-099-15)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX
---X
BARBARA PHILLIPS, by her Guardian Ad Litem FELICIA BULLOCK,

Plaintiff,

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendants.
---X

Index No.: 306320/08

AFFIRMATION IN SUPPORT

Motion Sequence No.: 003

EDWARD F. HUMPHRIES, ESQ., an attorney duly licensed to practice law before the Courts in the State of New York, hereby affirms the following to be true under the penalties of perjury:

1. I am a member of the law firm of VASLAS LEPOWSKY HAUSS & DANKE LLP, attorneys of record for BETH ABRAHAM HEALTH SERVICES.

2. This affirmation is submitted based upon information and belief, the sources of which are the files and records maintained by the law offices of VASLAS LEPOWSKY HAUSS & DANKE LLP.

3. This affirmation is respectfully submitted in Support of the Co-defendant Mandell's Reply Affimation affirmation and in support of the instant motion on behalf of BETH ABRAHAM HEALTH SERVICES, which seeks an Order:

a. Pursuant to CPLR § 3212, granting summary judgment to the defendant Beth Abraham Health Services and dismissing the Complaint against them in its entirety with prejudice; and

b. For such other, further and different relief as this Court deems just and proper.

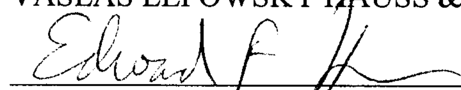
4. Your affirmant joints in the arguments articulated in the reply affirmation of Deborah I Meyer and relies upon the Affirmation of Ronald Gentile, M.D. in support of the cross motion.

WHEREFORE, it is respectfully requested that the Court grant summary judgment in favor of the moving defendants and dismiss plaintiff's Complaint in its entirety with prejudice.

Dated: Staten Island, NY
March 17, 2017

Yours, etc.

VASLAS LEPOWSKY HAUSS & DANKE LLP

By: 

EDWARD F. HUMPHRIES
Attorneys for Defendant
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(718) 761-9300

TO: Parker Waichman Alonso, LLP
Attorneys for Plaintiff
6 Harbor Park Drive
Port Washington, New York 11050

Ekblom & Partners, LLP
Attorneys for Defendant
HARVEY MANDEL, M.D.
850 Third Avenue, 21st Floor
New York, New York 10022

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
) ss.:
COUNTY OF RICHMOND)

JOANN SPERANZA, being duly sworn deposes and says: I am not a party to the action, am over 18 years of age and reside at Staten Island, New York.

On April 6, 2017, I served a true copy of the annexed **AFFIRMATION IN SUPPORT** by mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address or the address(s) as indicated below:

Parker Waichman Alonso, LLP
6 Harbor Park Drive
Port Washington, NY 11050
Attorneys for Plaintiff

Ekblom & Partners, LLP
Attorneys for Defendant
HARVEY MANDEL, M.D.
850 Third Avenue, 21st Floor
New York, New York 10022

JOANN SPERANZA

Sworn to before me on this
6th day of April 2017.

NOTARY PUBLIC

EDWARD F. HUMPHRIES
Notary Public State of New York
Qualified in Richmond County
No. 02HU4935669
Commission Expires: 6/6/18

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
---x
BARBARA PHILLIPS, by her Guardian Ad Litem,
FELICIA BULLOCK

Index No.: 306320/2008

Plaintiffs,

-against-

REPLY
ATTORNEY AFFIRMATION

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., ET AL.

Defendants.
---x

DEBORAH I. MEYER, an attorney duly licensed to practice law before the Courts of the State of New York, hereby affirms that the following statements are true under the penalties of perjury:

1. I am a member of the law firm of Ekblom & Partners, LLP, attorneys for defendant, HARVEY MANDEL, M.D. As such, I am fully familiar with the facts and circumstances concerning the within action based upon a review of the file maintained by my office.

2. This affirmation is submitted in further support of the within motion which seeks an Order:

   a. Granting summary judgment pursuant to CPLR § 3212 to defendant Harvey Mandel, M.D. dismissing the complaint against him in its entirety; and

   b. Granting such other and further relief as this Court may deem just and proper.

SUMMARY OF ARGUMENT

3. Plaintiff's opposition fails to raise a triable issue of fact because plaintiff's expert ignored important facts regarding plaintiff's ophthalmological condition, overall medical condition and cognitive limitations including speech and expression. Moreover, defendant's expert ignored material facts and issues raised by defendant's expert, overlooked and misstated facts from

the medical records. Most importantly, plaintiff's expert agrees with defendant's expert on major issues such as plaintiff, Barbara Phillips, had an ischemic event that cut off the blood supply to her central retinal artery that caused her vision loss in the left eye in July 2007. The only disagreement, is plaintiff's expert is attempting to blame Dr. Mandel for Ms. Phillips vision loss when he only saw Ms. Phillips once in July 2007 for complaints to her left eye. Specifically, Dr. Mandel did not depart from the standard of care in that he took Ms. Phillips intraocular pressure in January 2007 with her sedated and she still fought/struggled, and the intraocular pressure was normal, and there was no evidence that Ms. Phillips left eye had elevated intraocular pressure so it was not necessary for Dr. Mandel to prescribe intraocular pressure lowering drops. Moreover, there is no evidence of proximate cause since no ocular treatment or medication was going to prevent the vision loss. Therefore, any and all claims should be dismissed against Dr. Mandel.

4. Accordingly, Dr. Harvey Mandel moves to dismiss the Complaint against him in its entirety with prejudice.

LEGAL ARGUMENT

DEFENDANT'S MOTION FOR SUMMARY JUDGMENT SHOULD BE GRANTED BECAUSE PLAINTIFF FAILS TO RAISE A MATERIAL ISSUE OF FACT AS TO MEDICAL MALPRACTICE

5. A plaintiff's expert affidavit that is not specific in analysis based upon facts in the case cannot defeat a defendant's motion for summary judgment. See Diaz v. New York Downtown Hosp., 99 NY2d 542, 784 NE2d 68, 754 NYS2d 195 (2002); Lopez v. Master et al., 2009 NY Slip Op 33; 58 A.D.3d 425; 870 N.Y.S.2d 306; 2009 N.Y. App. Div. LEXIS 26 (1st Dept. 2009). Further, it is well-settled law that a plaintiff's expert affidavit is insufficient to defeat summary judgment when it actually misstates the facts and ignores the medical condition of the plaintiff. See Feliz v. Beth Israel Medical Center, 38 A.D.3d 396 (1st Dep't 2007); Carlton v. St. Barnabas, 91 A.D.3d 561 (1st Dep't 2012) (plaintiff's expert failed to raise a triable issue of fact because affidavit ignored the bulk of the record of the decedent's treatment); Ramirez v. Cruz, 92 A.D.3d

533 (1st Dep't 2012) (plaintiff's expert failed to defeat summary judgment due to being flawed by its misstatements of the evidence and unsupported assertions); Wong v. Goldbaum, 23 A.D.3d 277 (1st Dep't 2005) (plaintiff's expert affidavit failed to defeat summary judgment by its misstatements of the evidence and unsupported assertions, and conclusory)

6. Here, plaintiff's expert affidavit fails to raise an issue of fact because her expert ignores the important medical facts of the case, ignores defendant's expert's arguments, misstates the standard of care and has no evidence to show proximate cause. Specifically, plaintiff's expert opined that 1) Dr. Mandel departed from the standard of care by not obtaining Ms. Phillips' intraocular pressure, and that Dr. Mandel should have given Ms. Phillips medication to preemptively lower her intraocular pressure even though there was no such diagnosis; 2) Dr. Mandel departed from the standard of care by not performing more comprehensive examinations that would have had to be performed at the hospital; 3) Dr. Mandel departed from the standard of care for prescribing Tobradex for five days; 4) Dr. Mandel caused Ms. Phillips vision loss by not prescribing drops to lower her intraocular pressure; 5) That ocular ischemic syndrome ("OIS") was the cause of the neovascular glaucoma ("NVG") rather than a central retinal artery occlusion ("CRAO") and that some medical treatment may have prevented vision loss. However, none of these opinions are based on any facts in the case or on the proper standard of care.

7. Most importantly, plaintiff's expert ignores the fact that Dr. Mandel is an ophthalmologist, a specialist, assigned to approximately two days a week coming to treat residents at co-defendant Beth Abraham and relies on the internists and nurses to provide him with referrals and information regarding Ms. Phillips vision. Ms. Phillips lost her vision in July 2007 and it will be shown that Dr. Mandel only saw Ms. Phillips one time in July for redness and lid swelling that in no way would have left him to believe there was a more serious ocular problem. Defendant's expert, Dr. Ronald Gentile, explains further in his reply affidavit that plaintiff's expert fails to raise

an issue of fact on both the elements of standard of care and proximate cause. (See Affidavit of Dr. Ronald Gentile[1] as annexed hereto as Exhibit "Q")

8. Initially, there is no dispute that Ms. Phillips had an ischemic event that caused her to lose her vision. Further, there is no dispute that she had neovascular glaucoma ("NVG") and that it is a secondary glaucoma related to retinal ischemia. NVG is not a primary glaucoma and not a result of elevated intraocular pressure, it is a result of a more serious disease related to retinal ischemia that signifies serious underlying systemic disease including cerebral vascular disease, hypertension, and stroke. Ms. Phillips had occlusions in both carotid arteries in December 2005. Plaintiff's expert argues that Ms. Phillips had ocular ischemic syndrome ("OIS") that caused the NVG rather than a central retinal artery occlusion ("CRAO") and that by merely lowering plaintiff's undiagnosed elevated intraocular pressure than she would not have lost her vision. It is the opinion of Dr. Gentile that this is not only erroneous but there is no evidence in the medical records for this argument. (See Exhibit Q) Plaintiff's expert agrees with Dr. Gentile's opinion on major issues, such as Ms. Phillips had an ischemic event that cut off the blood supply to her central retinal artery and caused vision loss. (See Exhibit Q) The only disagreement, is that plaintiff's expert is attempting to blame Dr. Mandel for Ms. Phillips vision loss when there is no evidence of proximate cause since no ocular treatment or medication was going to prevent the vision loss. (See Exhibit Q)

9. Dr. Gentile, defendant's expert, explains that OIS is caused from chronic ischemia of the retina related to occlusion or stenosis of blood vessels located proximal to the retina. (See Exhibit Q) A tell-tale sign of OIS is mid-peripheral retinal hemorrhage and changes which were not seen by Dr. Schultz when he performed a comprehensive examination on August 9, 2007 or by Dr. Mandel during any of his examinations. (See Exhibit Q) Further, Dr. Gentile examined Ms.

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[1] All opinions by Dr. Ronald Gentile are within a reasonable degree of medical certainty.

Phillips' eyes and found no evidence of OIS, especially not in the right eye. (See Exhibit Q) The actual cause of vision loss is the patients' occlusion (stroke) from uncontrolled hypertension, diabetes, and cerebral vascular disease that resulted in an acute ischemic event similar to her past strokes with occlusion of the central retinal artery. (See Exhibit Q) Even though the risk factors for OIS and CRAO are similar, Dr. Gentile opined that there is more evidence supporting CRAO over OIS. (See Exhibit Q)

10. Further, there is medical evidence that it was a CRAO and not OIS. (See Exhibit Q) On August 28, 2007, Dr. Mandel was able to perform a fundus examination and noted that there were no arteries. (See Exhibit N) It is Dr. Gentile's opinion that this is due to the prior CRAO. (See Exhibit Q) Dr. Gentile explains that when a CRAO occurs, it damages the central artery which cuts blood supply to branch retinal arteries as well, so this is why Dr. Mandel noted "no arteries". (See Exhibit N, Q) The lack of arteries, the NVG and rubeosis all point to a CRAO which had to occur first. Plaintiff's expert may have been confused because OIS is also used as term to denote ocular signs and symptoms secondary to severe, arterial hypoperfusion to the eye in which blood supply is cut off to the central retinal artery by a stroke or occlusion – which means often doctors consider OIS to be the culmination of symptoms caused by a CRAO. (See Exhibit Q) No matter how Ms. Phillips condition is explained by plaintiff's expert or Dr. Gentile, she had an ischemic event causing the blood supply to be cut off to her central retinal artery and this was before the NVG occurred. (See Exhibit Q) Again, no amount of intraocular pressure lowering medication would have changed the vision loss. (See Exhibit Q) Plaintiff's expert is using double-talk to make it seem as if a CRAO comes from NVG and this is scientifically/medically untrue. (See Exhibit Q) Moreover, Dr. Gentile explains that intraocular pressure lowering medication/drops do not restore vision once the ischemic event occurs. (See Exhibit Q) It is not the elevated intraocular pressure that is causing the NVG in this case but ischemia due to Ms. Phillips underlying medical condition. (See Exhibit Q) Ms. Phillips had poor perfusion which was caused from the initial

bilateral carotid artery occlusions back in December 2005. It is Dr. Gentile's opinion that there was no ocular treatment that would have saved Ms. Phillips vision in the left eye. (See Exhibit Q)

Dr. Mandel Did Not Depart From The Standard of Care

11. Plaintiff's expert attempted to create an issue of fact by claiming Dr. Mandel departed from the standard of care by not obtaining Ms. Phillips' intraocular pressure, that Ms. Phillips' had an elevated intraocular pressure (even though there is no evidence of that), and that Dr. Mandel should have given her medication to preemptively lower her intraocular pressure even though there was no diagnosis. Dr. Mandel did take Ms. Phillips intraocular pressure using sedation on January 25, 2007. (See Exhibit N) Dr. Mandel noted the left eye had 22 but she was "fighting probably lower". (See Exhibit N) It is Dr. Gentile's opinion that commonly intraocular pressure that is 22 or lower is within the normal range. However, when a patient is fighting and moving during the test often the pressure is higher. (See Exhibit Q) Ms. Phillips intraocular pressure in the left eye was normal. The standard of care for taking intraocular pressure once to maybe twice a year, if necessary, is undisputed by plaintiff's expert. Plaintiff's expert is claiming that Dr. Mandel departed from the standard of care because he did not obtain Ms. Phillips' intraocular pressure prior to July 17, 2007 is disingenuous and not based upon the facts in the case. (See Exhibit N, Q).

12. Moreover, plaintiff's expert acknowledged that Ms. Phillips was difficult to examine but brushed off the seriousness of the difficulty and how diagnosing her condition was made more difficult because of her inability to cooperate. Plaintiff's expert failed to acknowledge that even sedated obtaining plaintiff's IOP was difficult and inaccurate. As stated, Dr. Mandel noted that when he sedated plaintiff for an IOP check on January 25, 2007, she was still fighting. (See Exhibit N, Q) Moreover, plaintiff's expert ignored that when Ms. Phillips was examined at Montefiore on August 7, 2007, the ophthalmology resident note stated that she was sedated on Haldol, was

uncooperative and unable to obtain an IOP. (See Exhibit O, Q) It is Dr. Gentile's opinion, and is undisputed, that if Ms. Phillips was even more heavily sedated the intraocular pressure reading could still be inaccurate while placing the patient at other risks. (See Exhibit Q) In order for plaintiff's expert to create an issue of fact, he had to make it seem this difficulty in obtaining the intraocular pressure was insignificant, rather than a major issue that Dr. Mandel faced in properly diagnosing Ms. Phillips. Dr. Mandel did not depart from the standard of care, in fact he made several attempts to check Ms. Phillips intraocular pressure and was unable to do so, similar to the doctor at Montefiore. It is this type of contradiction and misstatement of the facts in plaintiff's expert affidavit that makes the affidavit invalid in creating an issue of fact. See Feliz, 38 A.D.3d 396; Carlton, 91 A.D.3d 561; Ramirez, 92 A.D.3d 533; Wong, 23 A.D.3d 277.

13. Further, plaintiff's expert opined that Dr. Mandel should have palpated Ms. Phillips left eye to obtain intraocular pressure to make it seem as if Dr. Mandel departed from the standard of care. However, plaintiff's expert noted that palpation is not the standard of care to obtain proper intraocular pressure. This was a red herring. As defendant's expert Dr. Gentile explains, the reason palpating for pressure is not the standard of care, is there are no studies that show palpating the eye gives an accurate reading or understanding of whether the eye has elevated intraocular pressure. Many studies believe it is not accurate compared to using the tonometry device – which plaintiff pushed and fought against being used even when sedated. Again, it is this type of contradiction and misstatement of the facts in plaintiff's expert affidavit that makes the affidavit invalid in creating an issue of fact. See Feliz, 38 A.D.3d 396; Carlton, 91 A.D.3d 561; Ramirez, 92 A.D.3d 533; Wong, 23 A.D.3d 277.

14. Further, plaintiff's expert opined that Dr. Mandel should have done more comprehensive examinations, tests that would have to be performed at the hospital and possible laser treatments for the NVG. Most importantly, Dr. Mandel had seen Ms. Phillips, after his initial examination of her eyes in December 2006 and when he had her sedated for intraocular pressure

test on January 25, 2007, again in February and March 2007 for complaints regarding her right eye being red and swollen. (See Exhibit N) When Ms. Phillips came to Dr. Mandel in July 2007 by a referral from Dr. Friedman, he had not seen her since March 2007. (See Exhibit N, Q) Dr. Friedman is the internist who refers the patients to an ophthalmologist, or can call Dr. Mandel if there is an emergency, but Dr. Mandel never received any calls. (See Exhibit M, N) Defendant's expert, Dr. Gentile explains that there was no medical evidence and certainly no reason to give intraocular pressure lowering medication to a patient with no diagnosed elevated pressure or problems with that left eye. (See Exhibit Q) Yet, plaintiff's expert would have the Court believe Dr. Mandel departed from the standard of care by not prescribing medication to a patient who has not been diagnosed with a problem. When Ms. Phillips came on July 17, 2007, not only had the ischemic event occurred but giving her intraocular pressure lowering medication then would not have prevented vision loss. (See Exhibit Q) On July 17, 2007, Dr. Mandel had no reason to believe that the redness and swelling of the left eye, which was the first time he knew of any problem with the left eye, warranted such extensive testing and medical treatment. (See Exhibit N, Q)

15. Further, plaintiff's expert's entire premise that Ms. Phillips had ocular ischemic syndrome in the left eye and had symptoms such as pain, redness of the conjunctiva, swelling, and, intermittent vision starting in July 2007 which could be treated with intraocular pressure lowering drops is based upon a false premise that is another red herring. As previously stated, Ms. Phillips left eye showed no signs of redness, pain, swelling or visual disturbances prior to July 2007. However, Ms. Phillips's right eye had the exact same symptoms including red conjunctiva, occasional pain, swelling, complaints of visual disturbances starting in February and resolving with medication in March 2007. Upon Dr. Gentile's examination of the right eye, there was no evidence of OIS, NVG or Rubeosis in the right eye. (See Exhibit A, Q) Plaintiff's expert ignores that when Dr. Mandel saw Ms. Phillips on July 17, 2007 it was for similar symptoms that she had with the right eye months earlier that resolved with medication. (See Exhibit Q) It is Dr. Gentile's

opinion that Dr. Mandel acted within the standard of care in handling redness and swelling in the left eye since it had no previous problems and which the symptoms were similar to the right eye which resolved with medication. (See Exhibit A, N, Q)

16. Further, plaintiff's expert opined it was a departure from the standard of care for Dr. Mandel to prescribe Tobradex on July 17, 2007. Dr. Mandel prescribed Tobradex for the eye swelling, which is a steroid, for only 5 days. (See Exhibit N) Dr. Friedman continued Ms. Phillips on the Tobradex and did not send her back to Dr. Mandel until August 2, 2007. (See Exhibit M, N, Q) Further, Dr. Gentile explained that Tobradex is only known to possibly increase intraocular pressure after extended use and 5 days is not an abnormal prescription. (See Exhibit Q) It is the opinion of Dr. Gentile that Dr. Mandel did not depart from the standard of care in giving her Tobradex to reduce swelling. (See Exhibit Q) Swelling of the eye can lead to problems so prescribing steroids was good medical judgment by Dr. Mandel. (See Exhibit Q) Since Dr. Mandel's order was for only 5 days and to send her back if necessary, then there was nothing at this examination that would warrant Dr. Mandel to be put on notice of a more serious threat to Ms. Phillips vision. (See Exhibit Q)

17. It is undisputed that once Ms. Phillips was sent to Dr. Mandel on July 17, 2007 and then again on August 2, 2007, her vision was already compromised and no treatment was going to reverse it. Plaintiff's expert opined that Dr. Mandel should have read the progress notes in Ms. Phillips chart. However, as defendant's expert, Dr. Gentile explains, Dr. Mandel came twice a week for consultations, and relied upon the internists and nurses who saw Ms. Phillips daily to alert him to any problems, or refer her to either his clinic days or Montefiore for emergencies. (See Exhibit N, Q) However, from July 17 to August 2, 2007, Ms. Phillips was not sent to Dr. Mandel and nobody telephoned him about any emergent signs. (See Exhibit A, M, N, Q) A referral was filled out on July 30, 2007, that Ms. Phillips complained she lost vision in the left eye. (See Exhibit N) There is no dispute she had lost her vision by end of July 2007. However, Dr. Mandel was not

made aware of this until he saw Ms. Phillips on August 2, 2007. (See Exhibit N, Q) It is Dr. Gentile's opinion that Dr. Mandel did not depart from the standard of care, and that plaintiff's expert does not put forth any valid opinion based in fact as to any departure on the part of Dr. Mandel. (See Exhibit Q)

Proximate Cause

18. Plaintiff's expert fails to properly dispute that Dr. Mandel's actions or inaction did not cause Ms. Phillips vision loss. As stated previously, Ms. Phillips had an ischemic event caused by poor perfusion similar to what caused her initial strokes in December 2006. (See Exhibit A, Q) As defendant's expert, Dr. Gentile explains, Ms. Phillips suffered from diabetes mellitus, hypertension and obesity which are risk factors that cause either CRAO or OIS. (See Exhibit Q) OIS is rare and Ms. Phillips had none of the key signs of OIS such as mid-peripheral hemorrhage or changes. (See Exhibit Q) Dr. Gentile explains that OIS is an ischemic problem related to cerebral vascular disease that can involve the blood supply to the eye. (See Exhibit Q) When that occurs and NVG starts, there is very little to be done by an ophthalmologist to improve blood flow to the eye. (See Exhibit Q)

19. Further, Dr. Mandel saw Ms. Phillips one time prior to her vision loss on July 17, 2007. Dr. Friedman who handled her care as primary physician did not alert Dr. Mandel to vision complaint problems until a July 30, 2007 referral which did not get to Dr. Mandel until August 2, 2007. (See Exhibit M, N, Q) Plaintiff's expert discusses at length that Ms. Phillips had intermittent visual disturbances from July 13, 2007 on. Some of those complaints were relayed by Felicia Bullock and her daughter, and some by nurses. However, this information was not imparted to Dr. Mandel. (See Exhibit M, N, Q)

20. Regardless, no medication was going to prevent the eventual vision loss in the left eye since the ischemic event, CRAO, occurred before the NVG. (See Exhibit A, B, Q) Defendant's expert, Dr. Gentile explains that Dr. Mandel noted after August 2, 2007 that Ms. Phillips's arteries were no longer visible and this was caused by a CRAO. (See Exhibit Q) Pallor had set in by August 9, 2007, which also denotes a CRAO occurred weeks earlier. (See Exhibit P, Q) Again, Dr. Gentile examined Ms. Phillip's in April 2013 and noted that ischemia caused by a CRAO was consistent with what caused the damage to the retina and optic nerve. (See Exhibit Q) Plaintiff's expert never examined Ms. Phillips.

21. Most importantly, the damage to Ms. Phillips' optic nerve was not caused by a sudden increase in intraocular pressure. (See Exhibit Q) When Ms. Phillips had her elevated intraocular pressure in August 2007 her vision was already lost in the left eye. (See Exhibit N, O, Q) It is the opinion of Dr. Gentile, that even if Dr. Mandel gave Ms. Phillips intraocular pressure reducing drops on August 2, 2007, that would not have prevented her vision loss from the CRAO. (See Exhibit Q) Again, Dr. Mandel saw Ms. Phillips one time prior to August 2, 2007, on August 17, 2007, for lid swelling and redness of her left eye. (See Exhibit N, Q) As defendant's expert, Dr. Gentile explains it was not necessary to take her intraocular pressure for that visit since Dr. Mandel was working on treating the specific complaint that was new to Ms. Phillips and he had tested her a few months earlier with a normal pressure result. (See Exhibit A, N, Q)

22. Further, plaintiff's expert's opinion ignores the significance of Ms. Phillips' left eye optic nerve being noted with complete pallor on August 9, 2007. (See Exhibit Q) Defendant's expert, Dr. Gentile explains that pallor of the optic nerve is irreversible and when caused by an ischemic event rarely treatable. (See Exhibit Q) Dr. Gentile stated that giving a patient drops to reduce intraocular pressure has no effect on optic nerve atrophy/pallor when it comes from an ischemic event. (See Exhibit Q) Plaintiff's expert's opinion that OIS caused the NVG and that

lowering the intraocular pressure with medication would have stopped the vision loss is not just an error but ignores the obvious medical facts in this case. (See Exhibit M, N, O, Q)

23. Further, defendant's expert, Dr. Gentile explains that at the point a patient has an ischemic event such as a CRAO or OIS, eye pressure alone cannot prevent the eventual vision loss. (See Exhibit Q) Since, pallor of the optic nerve denotes optic nerve atrophy and it is undisputed that this takes approximately a few weeks to occur and even mild pallor causes significant visual loss, then plaintiff's vision in her left eye had to be diminished permanently earlier than plaintiff's expert explained or the pallor would not have set in by August 9, 2007. (See Exhibit N, O, P, Q) This is a fact that is beyond change, optic nerve pallor could not have existed on August 9, 2007 if Ms. Phillips had not already had a CRAO weeks earlier which led to the NVG. (See Exhibit Q) The NVG did not cause the vision loss, the CRAO caused the vision loss. Again, NVG is secondary problem that is the result of an ischemic event such as a CRAO. (See Exhibit Q) The ischemic event that plaintiff's expert goes on about (OIS) in his affidavit was the cause of the vision loss and not due to any alleged negligence on the part of Dr. Mandel. (See Exhibit Q) Therefore, Dr. Mandel's actions or inaction did not cause Ms. Phillips vision loss in the left eye.

24. In conclusion, plaintiff's expert affidavit fails to raise an issue of fact because plaintiff's expert ignores the facts raised by defendant's expert, Dr. Ronald Gentile, and misstates and misunderstands the standard of care and does not show proximate cause. Accordingly, plaintiff's claim of medical malpractice against defendant Dr. Harvey Mandel should be dismissed.

CONCLUSION

25. For the foregoing reasons, it is respectfully submitted that the defendant Dr. Harvey Mandel is entitled to have all the claims against him dismissed with prejudice and to have such other and further relief as this Court may deem just and proper.

WHEREFORE, it is respectfully requested that this Court issue an Order dismissing the Complaint, in its entirety, with prejudice as against Dr. Harvey Mandel and grant whatever further and additional relief is just and equitable.

Dated: New York, New York
March 16, 2017

DEBORAH I. MEYER, ESQ.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

Index No.: 306320/2008

---X

BARBARA PHILLIPS, by her attorney in fact, FELICIA BULLOCK,

Plaintiffs,

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., AND MARGARET RIVERS,

Defendants.

---X

OPP

PLAINTIFFS'

1: **AFFIRMATION IN OPPOSITION TO DR. MANDEL'S MOTION FOR SUMMARY JUDGMENT AND TO BETH ABRAHAM HEALTH SERVICES' CROSS-MOTION FOR SUMMARY JUDGMENT**

2: **INDEX OF EXHIBITS:**

EXHIBIT A: **Affidavit of Dr. Reza Dana, M.D., MSc, MIPH, Favro and his *Curriculum Vitae***

EXHIBIT B: **Montefiore Medical Center Records (inclusive of Defendant Beth Abraham Health Services Transfer Form) from July 2007 through August 2007**

EXHIBIT C: **Deposition Transcript of Dr. Harvey Mandel, M.D.**

EXHIBIT D: **Deposition Transcript of Dr. Ross Friedman, M.D.**

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

---X

BARBARA PHILLIPS, by her attorney in fact, FELICIA BULLOCK,

Plaintiffs,

-against-

BETH ABRAHAM HEALTH SERVICES, HARVEY MANDEL, M.D., AND MARGARET RIVERS,

Defendants.

---X

Index No.: 306320/2008

AFFIRMATION IN OPPOSITION TO DR. MANDEL'S MOTION FOR SUMMARY JUDGMENT AND BETH ABRAHAM HEALTH SERVICES' CROSS-MOTION FOR SUMMARY JUDGMENT

MICHAEL B. ZARANSKY, an attorney admitted to practice before the Courts of this State affirms the truth of the following under the penalty of perjury:

1. I am an attorney with the firm of Parker Waichman LLP, counsel to the plaintiff BARBARA PHILLIPS, by her attorney in fact, FELICIA BULLOCK (hereinafter "Plaintiff" and/or "Ms. Phillips") and, as such, I am fully familiar with the facts and circumstances of this action based upon a review of the case file and the investigation materials contained therein.

2. This affirmation is submitted in opposition to Defendant HARVEY MANDEL, M.D.'s (hereinafter "Dr. Mandel") motion for summary judgment seeking an Order dismissing the Complaint pursuant to CPLR 3212 and Defendant BETH ABRAHAM HEALTH SERVICES' (hereinafter "Beth Abraham") cross-motion seeking an Order granting it summary judgment pursuant to CPLR 3212.

3. Dr. Mandel's motion must be denied because Plaintiff's medical history; clinical symptoms as demonstrated by in the Interdisciplinary Progress Notes from July 8, 2007 through August 7, 2007 (Exhibit M annexed to Dr. Mandel's motion papers); the

Consult Request/Reports in July 2007 (Exhibit N annexed to Dr. Mandel's motion papers); and the Montefiore Medical Center Records from July of 2007 through August 2007 (Annexed hereto as **Exhibit "B"**) all indicate that Plaintiff was having a Neovascular Closed Angle Glaucoma ("NVG") due to Ocular Ischemic Syndrome ("OIS") which went undiagnosed and untreated which led to her developing a Central Retinal Arterial Occlusion ("CRAO") and her loss of vision in the left eye. This was preventable had Dr. Mandel taken measures to assess and lower her Intra-Ocular Pressure ("IOP"). The medicine and history is set forth more clearly in the affidavit of Dr. Reza Dana, M.D., MSc, MPH, FARVO; Vice Chairman for Academic Programs, Harvard Department of Ophthalmology and Associate Chief of Ophthalmology at the Massachusetts Eye and Ear Infirmary which is annexed hereto as **Exhibit "A"** along with his *curriculum vitae.*

4. Defendant Beth Abraham's cross-motion must be denied for several reasons. First and foremost, Beth Abraham's cross-motion is untimely as it was made after the 120 days after the filing of the Note of Issue and there has been no application for an extension of good cause presented to this Court. Second, Beth Abraham has not made a prima facie showing of entitlement to summary judgment dismissing Plaintiff's Public Health Law (P.H.L.) § 2801-d. Stated otherwise, Beth Abraham failed to establish as a matter of law that Beth Abraham did not deprive Ms. Phillips of her rights under P.H.L. 2801-d. Furthermore, Beth Abraham has not established as a matter of law that it provided all care reasonably necessary to prevent the deprivation of her rights as a resident of a "residential health care facility" and to prevent or limit her injury. Again, Plaintiff relies on the Affidavit of Dr. Dana which lays out in great detail the

failures and departures which were a substantial factor in causing Plaintiff's loss of vision.

STANDARD FOR SUMMARY JUDGMENT

5. A party seeking summary judgment 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. Zuckerman v. City of New York, 49 N.Y.2d 557, 562 (1980); Sillman v. Twentieth Century-Fox Film Corp., 3 N.Y.2d 395, 404 (1957). The failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers. Id., *citing* Winegrad v. New York University Medical Center, 64 NY2d 851 (1985); Qlisanr, LLC v. Hollis Park Manor Nursing Home, Inc., 51 AD3d 651, 652 (2d Dep't 2008); Greenberg v. Manlon Realty, 43 A.D.2d 968 (2nd Dep't 1974). If, and only if, the moving party meets its burden of eliminating all material issues of fact, then the burden shifts to the opposing party to raise such triable issues of fact. See, Zuckerman v. City of New York, 49 NY2d at 562.

6. Furthermore, the Court's proper function on adjudicating a motion for summary judgment is issue finding, not issue determination with the Court drawing all inferences favoring the non-moving party. Rose v. Da ECIB USA, 259 AD2d 258, 259 (1st Dep't 1999).

7. As will be set forth more fully below and as in the Affidavit of Dr. Dana, neither Dr. Mandel nor Beth Abraham are entitled to an Order granting them both summary judgment dismissing Plaintiff's Complaint. The fact remains that there are triable issue of facts as to the issues presented in this case.

DR. MANDEL IS NOT ENTITLED TO AN ORDER GRANTING HIM SUMMARY JUDGMENT DISMISSING PLAINTIFF'S COMPLAINT PURSUANT TO CPLR 3212

8. Plaintiff commenced this action against Dr. Mandel by filing a summons and complaint in the Bronx County Clerk's Office. A copy of the complaint is annexed to Dr. Mandel's moving papers at Exhibit C. Dr. Mandel joined issue by answering the complaint. Annexed to Dr. Mandel's moving papers at Exhibit D is Dr. Mandel's Answer. Plaintiff's Second Cause of Action sets forth a claim for medical malpractice as against Dr. Mandel. Plaintiff's Verified Bill of Particulars was served on or about May 4, 2010, a copy of which is annexed to Dr. Mandel's moving papers at Exhibit E. Paragraph 3 of Plaintiff's Verified Bill of Particulars delineates that particulars of the malpractice alleged and Paragraph 10 includes the injuries allegedly resulting from Dr. Mandel's malpractice. One of the injuries claimed is "Permanent blindness/loss of vision to the left eye". Also alleged as injuries are pain and suffering and loss of dignity.

9. Contrary to the claims and assertions of Dr. Mandel and his attorneys, Dr. Mandel departed from good and acceptable medical practice on several levels. Plaintiff's expert, Dr. Dana, opines that Ms. Phillips' loss of vision to her left eye was caused by Dr. Mandel's and Beth Abraham's departure from generally accepted standards of medical care and failure to adhere to the generally accepted medical standards was a substantial factor in causing Ms. Phillips' permanent loss of vision in her left eye. Dr. Dana states, to a reasonable degree of medical certainty, that:

- Dr. Mandel and Beth Abraham failed to properly diagnose Ms. Phillips' left eye for ocular ischemia, neovascularization and neovascular closed angle glaucoma (NVG) prior to August of 2007.
- Dr. Mandel and Beth Abraham failed to diagnose, appreciate and

plan for Ms. Phillips' NVG and increasing intraocular pressure (IOP) in her left eye by monitoring her IOP and providing, where necessary, medication to reduce IOP.

- Dr. Mandel and Beth Abraham failed to perform a complete ocular exam which includes: IOP testing; visually examining the cornea and pupil; and palpating the eye (testing to see if it was 'grossly' hard (pathological) or soft (normal) within four (4) months of her January 25, 2007; on or before July 17, 2007; before July 27, 2007 or before July 30, 2007 (while manual palpation is not a standard of care for measuring pressure, it can be used by experienced practitioners to derive an approximate sense for whether the eye has a very high pressure or whether the pressure is within the normal limits).

- Dr. Mandel and Beth Abraham improperly prescribed and administered Tobradex from July 19, 2007 through the date of discontinuance on August 2, 2007 based upon the incorrect diagnosis that ocular disease was attributed entirely, and incorrectly, to an infectious disease. This incorrect diagnosis resulted in the administration of Tobradex contains a potent steroid which has the tendency to increase IOP.

- Beth Abraham failed to include recent history of left eye related issues on the July 18, 2007 Transfer Form to Montefiore Medical Center thus limiting its ability to assess, diagnose and treat Ms. Phillips.

- Ms. Phillips suffered from Ocular Ischemic Syndrome (OIS) related to her numerous medical conditions starting with her carotid artery occlusions, hypertension, diabetes and stroke. Her OIS led to the neovascularization of the left eye, which in turn caused her IOP to increase and eventually caused her to develop NVG. As the OIS and NVG progressed, Ms. Phillips exhibited documented symptoms of transient or fluctuating vision loss, headaches, pain in her eye, tearing, discomfort, swelling and conjunctivitis. Dr. Mandel and Beth Abraham failed to appreciate Ms. Phillip's risk for developing OIS, failed to perform a complete and proper ophthalmological exam and failed to take action to reduce IOP which would have prevented her from developing CRAO and loss of vision, which is a known and significant risk when allowing OIS and NVG to go undiagnosed and untreated.

- The CRAO did not precede the NVG but rather was caused by the combination of Ms. Phillips OIS and NVG with increasing IOP that went undiagnosed, untreated and improperly medicated.

- Dr. Mandel and Beth Abraham: (a) did not provide all care reasonably necessary to prevent or limit Ms. Phillips' loss of vision to her left eye; and (b) did not provide adequate and appropriate medical care.

See Dr. Dana's Affidavit (hereafter "Dr. Dana Aff.") at paragraphs 4-6.

10. Dr. Dana opined that, Ms. Phillips had OIS, placing her at risk for developing secondary complications such as CRAO, which can be prevented when the IOP is controlled. Notably OIS can lead to the development of NVG in an eye which, in turn, can lead to a significant rise in IOP. This rise in IOP decreases the difference between mean blood pressure and the ocular pressure, which leads to more compromised blood flow to the eye, exacerbating the ischemia (poor blood flow) even further and causing the CRAO.

11. Dr. Dana further opined that while this process is taking place and prior to the event of a secondary CRAO, it is essential to assess and control the IOP so as to prevent a CRAO and vision loss. This did not take place.

12. Dr. Mandel had an opportunity on July 17, 2007 to perform such a test. He did not. Dr. Mandel should have been aware that Plaintiff was at risk for developing OIS. Dr. Mandel failed to appreciate the risk of developing NVG with increased IOP based upon Plaintiff's medical history - a medical history which Defendants rely upon to support their conclusion that the CRAO and loss of vision could not have been prevented.

13. The essential difference between Defendants' expert witnesses opinions and the opinions of Dr. Dana are that: Defendants' experts opine that the CRAO caused the neovascularization closed angle glaucoma (NVG) in the left eye resulted from the CRAO; whereas, Plaintiff's expert Dr. Dane opines that the OIS/neovascularization

caused NVG and increased IOP which, coupled with the application of the wrong medicine, caused the CRAO and loss of vision. Compare Dr. Gentile's Affidavit annexed to Dr. Mandel's moving papers at Exhibit A and Dr. Jeffrey Schultz Affidavit dated September 16, 2016 at paragraph 5 (referring to an old CRAO) with Dr. Dana's Affidavit at paragraphs 32 through 35.

14. Dr. Dana opines, after detailing Plaintiff's medical history, the symptoms and documented complaints and assessments in July 2007 preceding the August 9, 2007 diagnosis of CRAO, explains the error in Defendants' asserted positions as follows:

> 32. Accepting the diagnosis of a CRAO as accurate does not change my opinion as to the precipitating factors that led to this significant vascular complication, as detailed above. Dr. Gentile states that neovascularization of the eye and NVG often result in CRAO. While CRAO can occur, infrequently, from NVG, as stated above, the history of the patient as detailed above from the medical records strongly suggests that, in fact, NVG from ischemia preceded the CRAO. Essential to Defendants' expert's opinion is the loss of vision due to a CRAO for a significant amount of time prior to onset of NVG. Although this could occur infrequently, it typically takes approximately eight (8) weeks for neovascularization to occur and the onset of NVG to become prominent—such a time course is simply not in accord with the history of Ms. Phillips as recorded in the chart.
>
> 33. It is important to note that unilateral or primary CRAO is associated with very acute loss of vision, not one as described in the history of Ms. Phillips' care. As there was no history of hyperacute loss of vision by Ms. Phillips prior July 27th (documented on July 30th) and the symptoms of fluctuating/transient vision loss, conjunctivitis, headaches, swelling, discomfort and tearing all occurred prior to the total vision loss, there is no historic evidence supporting a CRAO occurring prior to July 27th. A CRAO as described by Defendants' experts is typically not associated with headache and pain; it is not associated with cloudy cornea, red eye or conjunctival swelling and it is not associated with fixed pupil as was also diagnosed on August 7, 2007. These are symptoms of NVG which brought about the CRAO and loss of vision.
>
> 34. I note that a CRAO causing neovascularization and NVG does not

typically occur until 8 weeks after the CRAO. I would also point out that Dr. Gentile, offers an opinion of causation based, in part, upon his physical exam some five (5) years after the event. A physical exam performed nearly six (6) years after event which undisputedly caused her vision loss offers little insight as to what occurred at that time, anatomical changes will occur over time by the mere fact of her ocular ischemia and NVG.

35. In light of the above, it is my opinion to a reasonable degree of medical certainty that:

a. Ms. Phillips had demonstrated for weeks, signs of significant ocular pathology, specifically ischemic disease and NVG (a form of secondary angle closure glaucoma);

b. Dr. Mandel and Beth Abraham deviated from generally accepted standards of care in: delaying diagnosis and initiation of proper treatment (reduction if IOP); failing to perform a full ophthalmological exam which would include checking IOP and the clarity of the cornea; and failing to implement a plan to ascertain the IOP either through palpation or sedation;

c. The facts which give rise to the departures also establish that Dr. Mandel and Beth Abraham did not provide all care reasonably necessary to prevent or limit her loss of vision and that they did not provide adequate and appropriate medical care.

d. The failures and departures listed were the competent producing cause of her irreversible vision loss in her left eye.

See Dana Aff. at paragraphs 32-35

15. The opinions of Dr. Dana are not conclusory, but rather based upon a detailed analysis of the chart and his exemplary medical experience. Dr. Dana notes that Plaintiff had difficulty opening both of her eyes on July 8, 2007. See Dana Aff. at paragraph 11. The consultation records are annexed to Dr. Mandel's moving papers at Exhibit M. Dr. Dana then refers to Dr. Friedman's assessment of July 13, 2007 where Dr. Friedman noted that there were no visual disturbances.

16. Dr. Dana then refers to the July 14, 2007, 5:45 pm note which indicates that Plaintiff had difficulty seeing out of the left eye and that an order was issued for the

treatment of conjunctivitis, redness of the conjunctiva which could be a sign of ocular ischemia. See Dana Aff. at paragraph 13 and the July 14 2007, 5:45 pm Interdisciplinary Progress Note annexed to Dr. Mandel's moving papers at Exhibit M. Dr. Dana then refers to the July 14, 2007, 11:50 pm note that Plaintiff had redness in Plaintiff's left eye with slight puffiness and that Plaintiff can't see well with the eye. See Dana Aff. at paragraph 14 and the July 14, 2007 Interdisciplinary Progress Note annexed to Dr. Mandel's moving papers at Exhibit M.

17. Dr. Dana then refers to Interdisciplinary Progress Notes from July 15, 2007 which indicates, among other things, that Plaintiff could see fine out of the left eye. Dr. Dana concludes that the CRAO could not have occurred prior to that date because she could still see and that the neovascularization and neovascular glaucoma resulting from CRAO could not have occurred by August 7, 2007 See Dana Aff. at paragraph 15 and the Interdisciplinary Progress Notes annexed to Dr. Mandel's moving papers at Exhibit M.

18. Dr. Dana then refers to the July 16, 2007 Interdisciplinary Progress Notes. Dr. Friedman did not observe redness and notes that Plaintiff denies visual disturbance. Dr. Dana then refers to a July 16, 2007 Interdisciplinary Progress Notes from before and after Dr. Friedman's assessment that there was redness observed in the left eye. See Dana Aff. at paragraphs 16-17 and Exhibit M annexed to Dr. Mandel's moving papers.

19. Dr. Dana next refers to the July 17, 2007, 6:55 am Interdisciplinary Progress Note which documents that redness to eye still persists. Dr. Friedman's note from the same day, however, identified no conjunctiva and **no visual disturbance**. See Dana Aff. at paragraphs 16-17 and Exhibit M annexed to Dr. Mandel's moving papers.

Again, Dr. Dana notes that as of the time of Dr. Friedman's July 17, 2007 assessment the CRAO had not yet occurred. See Dr. Dana's Aff. at paragraph 18.

20. Dr. Dana then reviewed Dr. Mandel's July 17, 2007 consultation request (annexed to Dr. Mandel's moving papers as Exhibit N) and Dr. Mandel's deposition testimony (annexed hereto in its entirety as **Exhibit "C"**). Dr. Dana notes that: (1) Dr. Mandel was not clear as to his assessment with regard to conjunctivitis; (2) limited documented history on the consultation report and doctor's orders; (3) Dr. Mandel did not review any of the Interdisciplinary Progress Notes concerning fluctuating complaints and observations; (4) Dr. Mandel did not perform a complete ophthalmological exam (testing for IOP); (5) or make a plan for taking a proper exam which would include sedation as she was back in January 2007 and in August of 2007. See Dr. Dana Aff. at paragraphs 8 and 19-21. Most importantly is the fact that there is no documented loss of vision which precludes a finding that the CRAO had already occurred and thus is contrary to Defendants' arguments that neovascularization resulting from the CRAO had already begun.

21. Dr. Dana next refers to July 18, 2007 records which refers to issues Plaintiff was having concerning the left side of her head. She was sweating and holding the left side of her head and her being transferred to the hospital. See Dana Aff. at paragraph 22 and Exhibit M annexed to Dr. Mandel's moving papers. Dr. Dana notes that Beth Abraham's transfer record fails to reflect any issues relating to the left eye thus failing to provide proper notice of Plaintiff's medical history to Montefiore Medical Center (the hospital she was transferred to on July 18, 2007) of the possibility of problems with the left eye. The transfer form is annexed hereto as part of **Exhibit "B"**.

22. Dr. Dana next refers to the July 19, 2007 Interdisciplinary Progress Note which indicates that Tobradex began being administered, Plaintiff complained of left eye pain but no notation regarding loss of vision. Dr. Dana noted that these are classic symptom of neovascular glaucoma due to Ocular Ischemic Syndrome. See Dana Aff. at paragraph 23. Dr. Dana again remarks that the use of Tobradex at this time was improper as it has the tendency of increasing IOP and causing a CRAO and vision loss. See Dana Aff. at paragraphs 5 and 7.

23. On July 20, 2007 there is a notation in the Interdisciplinary Progress Notes which states that Plaintiff denies pain in the left eye, and that she was refusing treatment of Tobradex and shutting her eye. There were no notations to a loss of vision in the left eye. See Dana Aff. at paragraph 24 and Exhibit M annexed to Dr. Mandel's moving papers.

24. Dr. Dana next refers to the Interdisciplinary Progress Notes dated July 30, 2007. There were two entries of note. First, an entry dated July 30, 2007 which was identified as a late entry from an assessment performed on July 27, 2007. The entry notes that Plaintiff had difficulty reading from the left eye. There is no complaint of loss of vision at this time. The next was Dr. Friedman's note on July 30, 2007 wherein "patient complaining of sudden decrease of vision in left eye". See Dana Aff. at paragraphs 25-26; Exhibit M annexed to Dr. Mandel's moving papers and Dr. Friedman's deposition testimony annexed hereto as **Exhibit "D"** at page 54, line 17 to page 55, line 14.

25. Dr. Dana eventually explains, as cited above, that neovascularization resulting from a CRAO, however rare, would take approximately eight weeks to

develop. This is something that simply could not and did not occur in the less than two (2) weeks following the report of sudden vision loss. See Dr. Dana's Aff. at paragraph 32-34.

26. It is clear that the Defendants' experts ignore the factual record of fluctuating vision, headaches, swelling, conjunctivitis and discomfort all of which occurred in July 2007 and prior to the documented hyperacute vision loss which was first documented on July 30th. See Dana Aff. at paragraph 33. These are, as Dr. Dana opines, classic symptoms of OIS leading to neovascularization, NVG and increased IOP all of which caused the CRAO and loss of vision. See Dana Aff. at paragraphs 5-7.

27. Dr. Dana agrees with Dr. Mandel that IOP should generally be tested between 4 and 6 months. See Dana Aff at paragraph 8 and **Exhibit "C"** (Dr. Mandel's deposition testimony) at page 63, line 23 to page 64, line 4.

28. Dr. Dana, however, disagrees with Dr. Mandel's opinion as to when IOP should be taken when an individual who has history such as Plaintiff's is involved. Dr. Dana opines that given Ms. Phillips' medical history and as soon as Ms. Phillips began exhibiting symptoms of ocular discomfort as documented on July 8, 2007, a plan to perform a complete and proper ophthalmological exam should have been made. A complete ocular exam includes testing the IOP, assessing vision, the cornea and pupil." See Dana Aff at paragraph 8. This was not done. Dr. Mandel, however, does not consider the issue of strokes and diabetes as being important to assessing IOP. Id. at page 64, lines 5-14.

29. Dr. Dana states that Dr. Mandel failed to appreciate Plaintiff's risk for developing OIS and NVG as well as increasing IOP given her medical history and the

documented symptoms and complaints contained in the record. See Dana Aff. generally and paragraphs 4-5.

30. Dr. Dana states that Dr. Mandel failed to perform a proper and complete ophthalmological exam (which includes testing for IOP) and consequently failed to take measures to reduce IOP. See Dana Aff. generally and paragraphs 4-5 and 35, specifically.

31. Dr. Dana states that not only did Dr. Mandel fail to take measures to assess and lower IOP prior to sudden vision loss documented on July 30, 2007, Dr. Mandel improperly proscribed Tobradex which had the known side effect of increasing IOP. See Dana Aff. generally and paragraphs 4, 5 and 35, specifically.

32. Dr. Dana concludes that these failures were substantial factors in causing Plaintiff's loss of vision. His explanation is that the increased that the increasing IOP in an eye that suffers from OIS and NVG leads to compromised blood flow in the eye, exacerbating the ischemia and resulting in a CRAO. See Dana Aff. generally and paragraphs 5-7 specifically.

33. Dr. Mandel's position that the CRAO caused the NVG is not supported by the record as explained by Dr. Dana. In fact, it is not supported by Dr. Schultz as he indicates that it would take a few weeks or longer for a patient to develop neovascularization and neovascular glaucoma. See Dr. Schultz Aff. at paragraph 6. However, the facts in this case establish the CRAO could not have occurred before July 27, 2007 as the hyperacute loss of vision was not documented until July 30th. According to the Defendants' records, and the opinions of Dr. Dana and Dr. Schultz, there was simply not enough time from the event of vision loss due to CRAO to have

brought about neovascularization and neovascular glaucoma by August 7, 2007.

34. Dr. Dana also explains that Dr. Gentile's physical examination is not relevant as the anatomical changes assessed five (5) years after the events leading up to loss of vision offer little insight as to what occurred at that time. Dr. Dana opined that it merely reflects anatomical changes that would occur over time by the mere fact of Plaintiff's ocular ischemia. See Dr. Dana Aff. at paragraph 34.

35. Dr. Dana also explains that sedation would have been appropriate given Plaintiff's history and her symptoms as well as the fact that sedation for ocular assessment had been used in January of 2007 and in August of 2007. See Dr. Dana Aff. at paragraphs.

36. For the reasons set forth above, and in the affidavit of Dr. Dana, Defendant Dr. Mandel's motion must be denied. There are material triable issues of fact that can be resolved on the papers before the court. The conclusions and opinions proffered by the relative experts require denial of the motion.

DEFENDANT BETH ABRAHAM'S CROSS-MOTION FOR SUMMARY JUDGMENT MUST BE DENIED.

37. Defendant Beth Abraham's cross-motion must be denied for two (2) separate reasons. First, the motion was improperly made as a cross-motion more than 120 days after Plaintiff filed her Note of Issue. Thus, in the absence of an application and showing of good cause, Beth Abraham's Cross-Motion must be denied. Second, Beth Abraham's motion must be denied as they have made no showing of an entitlement to summary judgment on the issue of Plaintiff's P.H.L. 2801-d claims and Plaintiff's expert affidavit establishes the failures of both Defendants Mandel and Beth Abraham with regard to providing care, treatment and services and how said failures led

to Ms. Phillips loss of vision in her left eye.

A. Beth Abraham's "Cross-Motion" Must Be Denied As It Is Untimely Pursuant To CPLR 3212(a)

38. Defendant Beth Abraham's motion, improperly designated as a cross-motion, was filed more than 120 days after the filing of the Note of Issue. As Beth Abraham did no make an application to extend its time to file such motion and has made not showing of good cause for considering the late motion, the Court must deny the motion as untimely. Kershaw v. Hospital for Special Surgery, 114 A.D.3d 75 (1st Dep't 2013); Borges v. Placeres, 123 A.D.3d 611 (1st Dep't 2014).

39. CPLR 3212(a) states that:

> **(a) Time; kind of action.** Any party may move for summary judgment in any action, after issue has been joined; provided however, that the court may set a date after which no such motion may be made, such date being no earlier than thirty days after the filing of the note of issue. If no such date is set by the court, such motion shall be made no later than one hundred twenty days after the filing of the note of issue, except with leave of court on good cause shown.

40. Plaintiff filed her Note of Issue on June 17, 2016. A copy of the Note of Issue with the County Clerk's stamp is annexed to Defendant Dr. Mandel's motion papers as Exhibit J. The Court has not set a date for the making of dispositive motions and as such dispositive motions were required to be made within 120 days of June 17, 2016. The expiration of the time to file such a motion expired on October 15, 2016. Since, October 15, 2016 was a Saturday, the day of reckoning was Monday, October 17, 2016. Beth Abraham's cross-motion (improperly designated as such) was made on October 19, 2016 and is therefore untimely.

41. The First Department has addressed situations similar to this where one defendant serves a timely motion for summary judgment and another defendant serves

an untimely cross-motion. See, Kershaw v. Hospital for Special Surgery, 114 A.D.3d 75 (1st Dep't 2013). In Kershaw, the Court held that defendant New York University Medical Center Hospital for Joint Disease ("HJD") had timely moved for summary judgment but that the defendant Hospital for Special Surgery ("HSS") had not. Remarkably similar to the case before the Court, HSS filed its late motion as a cross-motion relying on HJD's expert affidavit and was submitted without any explanation, let along showing of good cause. 114 A.D.3d at 80-84.

42. The Court also went on to hold that the motion was not a cross motion holding that a "cross motion is 'merely a motion by any party against the party who made the original motion, made returnable at the same time as the original motion.'" Id. at 87. The Court went on to hold that:

> The rule is that a cross motion is an improper vehicle for seeking relief from a nonmoving party (citation omitted). While courts have deemed this mislabeling a "technical" defect which will be disregarded where the nonmovant does not object and it results in no prejudice to the nonmoving party (citation omitted), in this case the nature of nonmovant plaintiff's opposition is that there was prejudice because to the extent the court deems HSS's motion a cross motion, the Brill rule is ignored.
>
> Allowing movants to file untimely, mislabeled "cross motions" without good cause shown for the delay, affords them an unfair and improper advantage.

Id. at 88. The First Department adhered to Kershaw in Borges v. Placeres, 123 A.D.3d 611 (1st Dep't 2014) (holding that "[t]he motion for summary judgment did not seek relief against a party whose timely motion for summary judgment was returnable the same day, and therefore did not fall within the exception permitting a court to entertain an untimely motion for summary judgment).

43. What is critical here is that Beth Abraham is not seeking relief as against

the movant, Defendant Harvey Mandel, M.D. Equally as important is that Beth Abraham did not submit their own expert affidavit and simply relied upon Dr. Mandel's moving papers. This is precisely what the First Department rejected in both Kershaw, surpa and Borges, supra. Beth Abraham had 120 days to put papers together and failed to do so. Beth Abraham had the opportunity to make an application for an extension of time based upon good cause and failed to do so. The summary judgment motion process does not draw a distinction of being late by two days or two months. Consequently, Beth Abraham's motion must be denied as untimely

B. Beth Abraham's Motion For Summary Judgment Must Be Denied Because There Are Triable Issues Of Fact As To Whether It Exercise All Care Reasonable Necessary To Prevent The Deprivation of Plaintiff's Rights And Her Injuries

44. Notwithstanding the above, Defendant Beth Abraham's motion for summary judgment seeking must be denied in its entirety. As noted above, a party seeking summary judgment 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. Zuckerman v. City of New York, 49 N.Y.2d 557, 562 (1980); Sillman v. Twentieth Century-Fox Film Corp., 3 N.Y.2d 395, 404 (1957). The failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers. Id., *citing* Winegrad v. New York University Medical Center, 64 NY2d 851 (1985); Qlisanr, LLC v. Hollis Park Manor Nursing Home, Inc., 51 AD3d 651, 652 (2d Dep't 2008); Greenberg v. Manlon Realty, 43 A.D.2d 968 (2nd Dep't 1974). If, and only if, the moving party meets its burden of eliminating all material issues of fact, then the burden shifts to the opposing party to raise such triable issues of fact. See, Zuckerman v. City of New York, 49 NY2d at 562.

45. Furthermore, the Court's proper function on adjudicating a motion for summary judgment is issue finding, not issue determination with the Court drawing all inferences favoring the non-moving party. Rose v. Da ECIB USA, 259 AD2d 258, 259 (1st Dep't 1999).

46. Defendant Beth Abraham's burden is different than Defendant Dr. Mandel's burden. Plaintiff's First Cause of Action as against Beth Abraham allege that the Defendants had a statutorily mandated responsibility to provide the Plaintiff with the rights granted to nursing home residents under P.H.L. §§ 2801-d and 2803. See paragraph 28 of Plaintiff's complaint which is annexed to Dr. Mandel's moving papers as Exhibit C. Plaintiff alleges that Defendant Beth Abraham was a nursing home and a residential health care. See Paragraphs 20 and 21 of Plaintiff's complaint which is attached to Dr. Mandel's moving papers as Exhibit C. Plaintiff alleges that Defendant Beth Abraham, its employee, agents, consultants and independent contractors deprived Plaintiff of her rights as protected under P.H.L. §§ 2801-d and 2803-c. See Paragraphs 26 through 42 of Plaintiff's complaint which is attached to Dr. Mandel's moving papers as Exhibit C.

47. Defendant Beth Abraham joined issue by interposing its answer on or about August 27, 2008. A copy of Beth Abraham's answer is annexed to its moving papers as Exhibit B.

48. As a nursing home and residential health care facility, Defendant Beth Abraham Public Health Law § 2801-d provides a *private statutory cause of action* for residents of nursing homes injured as a result of the nursing home's deprivation of certain "*resident's rights.*" It is a separate and distinct cause of action and may be pled

"*in addition to and cumulative with other remedies available to the plaintiff at law,*" such as medical malpractice, negligence or wrongful death. A "resident right" is established in part by a regulation, state or federal, pertaining to nursing home care. Public Health Law § 2801-d (1) provides in relevant part:

> Any residential health care facility that deprives a resident of the facility of any *right or benefit*, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation, except as hereinafter provided. For purposes of this section, a '*right or benefit*' of a patient of a residential health care facility shall mean any right created or established for the well-being of the patient by the terms of any contract, by any *state statute, code, rule or regulation* or by any *applicable federal statute, code, rule or regulation* where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority. No person who pleads and proves, as an affirmative defense, that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is asserted shall be liable under this section. For the purposes of this section, "injury" shall include, but not be limited to, physical harm to a patient; emotional harm to a patient; death of a patient; and financial loss to a patient.

49. New York State's Legislature further stated that "[T]he remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings." P.H.L. § 2801-d(4). Finally, any party to an action brought under this section shall be entitled to a trial by jury pursuant to P.H.L. § 2801-d(8), and the court has discretion to award attorney's fees if judgment in an action under this section is rendered in favor of the plaintiff pursuant to P.H.L. § 2801-d(6).

50. Liability under P.H.L. § 2801-d is a separate and distinct cause of action that does not require providing a departure from a standard of care or a breach of duty owed. In the seminal case of <u>Zeides v. Hebrew Home for Aged at Riverdale</u>, 300

A.D.2d 178, 179-180 (1st Dep't 2002) the First Department articulated the basis for a claim pursuant to P.H.L. § 2801-d as being not only separate and distinct from ordinary negligence or medical malpractice claims but setting forth a significant difference in how to evaluate said claims. Id. The Court correctly observed that liability is predicated upon the deprivation of a right conferred upon a nursing home resident. To that end, the Court held:

> Article 28 of the Public Health Law contains nothing that would indicate an intent to equate its private right of action with one for either medical malpractice or ordinary negligence. **The statutory basis of liability is neither deviation from accepted standards of medical practice nor breach of a duty of care. Rather, it contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code, or rule...** Id at 179 *[emphasis added]*

51. Consistent with Zeides, is the above cited reference to P.H.L. 2801-d(4) which provides that the "[T]he remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings."

52. The Legislature intended to provide remedies for nursing home residents far greater than what was available at common law in an effort not only to provide compensation for some of the most vulnerable in our society but to incentive nursing homes to provide the proper level of care and supervision. See, Morissette v. Terence Cardinal Cooke Health Care Center, 8 Misc.3d 506 (Sup. Crt., NY Co. 2005). In Morissette, Justice Sklar documented the legislative history of Public Health Law § 2801-d which reveals it's desire is to stem the tide of nursing home abuse to protect the residents from nursing homes and to increase the potential values of lawsuits so that the potential for larger recoveries serve to encourage the private bar to bring suits on

behalf of nursing home patients.

53. There are no issues with regard to the application of P.H.L. § 2801-d to Defendant Beth Abraham as it admits it is a residential health care facility and nursing home. Compare Plaintiff's Complaint at paragraphs 20 and 21 (annexed to Dr. Mandel's moving papers as Exhibit C) with Beth Abraham's answer at paragraphs SIXTH, SEVENTH and EIGHTH (annexed to Beth Abraham's moving papers as Exhibit B). Furthermore, Defendant Beth Abraham admits at paragraph FIFTH that it is a facility providing therein nursing care to sick, invalid, inform, disabled or convalescent persons in addition to lodging and board or health related services. A residential health care facility is defined as a nursing home or a facility providing health related services. P.H.L. 2801(3). A nursing home is defined under P.H.L. 2801(2) as:

> [A]facility providing therein nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, providing nursing care and health-related service, or either of them, to persons who are not occupants of the facility.

54. These admissions establish that Beth Abraham is a residential health care facility subject liability under P.H.L. 2801-d. See, Zeides, supra

55. What is also not really in dispute is that Beth Abraham is liable for the medical care the physicians it utilizes to perform services at its facility. See, Mduba v. Benedictine Hospital, 52 A.D.2d 450, 453 (3rd Dep't 1976) (holding, among other things, that the defendant hospital remained liable for the emergency room physicians malpractice where the patient entered the hospital for treatment and the defendant hospital undertook to treat the patient and furnished the doctors and staff to render that treatment). Consistent with Mduba, is the statutory framework by which Beth Abraham

was obligated under 10 NYCRR 415.3(e)(1)(i) and 10 NYCRR 415.13 to provide medical care for its residents. What is also clear is that Dr. Mandel had been providing medical care at Beth Abraham since 1974. See, Dr. Mandel's deposition transcript annexed hereto as **Exhibit "C"** at page 18, line 13 to page 19, line 15. Dr. Mandel was the only ophthalmologist in 2007 providing services at Beth Abraham and that he was seeing residents two days per week. Id. at page 19, line 21 to page 20, line 7 and page 15, lines 11-18. Lastly, the treatment he provided was in the ophthalmology clinic at Beth Abraham located on the 2nd floor. Id. at page 22, line 25 to page 26, line 25. Clearly, Beth Abraham utilized Dr. Mandel to provide medical and ophthalmological services as part of its obligation under the aforementioned code provisions as well as 10 NYCRR 415.12(b) which states that the facility shall ensure that each resident receives proper treatment to maintain vision abilities.

56. It is alleged in Plaintiff's Bill of Particulars response to Defendant Beth Abraham's demands that, among other things, Defendant Beth Abraham violated several State and Federal Codes which include, but are not limited to:

- 10 NYCRR 415.3(e)(1)(i) which states that each resident shall have the right to adequate and appropriate medical care.
- P.H.L. § 2803-c(3)(e) which states that the statement of resident rights must be posted and must contain a statement that "every patient shall have the right to receive adequate and appropriate medical care, ..."
- 42 CFR 483.15 and 10 NYCRR 415.5 both of which state that a facility must care for its' residents in a manner and in an environment that promotes the maintenance and enhancement of each resident's quality of life.
- 42 CFR 483.15(a) and 10 NYCRR 415.5(a) both of which state that a facility shall promote care for residents in a manner in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- 10 NYCRR 415.11 requires that the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and that the facility shall develop and keep current an individualized comprehensive plan of care to meet each resident's needs.
- 42 CFR 483.20 states that the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
- 42 CFR 483.20(k)(1) states that the facility must develop a comprehensive care plan for each resident that includes measurable objections and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
- 10 NYCRR 415.12 which states that each resident shall receive and that the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessments and plan of care.
- 10 NYCRR 415.12(l) states that each resident's drug regimen shall include only those medications prescribed to treat a specific documented illness or condition and not otherwise contraindicated for a given resident. The drug regimen shall be monitored for evidence of both adverse actions and therapeutic effect. Dose changes or discontinuation of the drug must be made if the drug is ineffective and/or is causing disabling or harmful side effects and/or the condition for which it was prescribed has resolved.
- 42 CFR 483.25 states that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.
- 10 NYCRR 415.15 which states that the nursing home shall develop and implement medical services to meet the needs of its residents and that the resident shall be provided care that meets prevailing standards of medical care and services.
- 10 NYCRR 415.15(b) must care for its' residents in a manner and in an environment that promotes the maintenance and enhancement of each residents' quality of life.

57. The above codes are but a few of the code violations that have been alleged in Plaintiff's Bill of Particulars (Exhibit C to Beth Abraham's moving papers) as a predicate for liability under P.H.L. § 2801-d.

58. Defendant Beth Abraham, as the movant, has the burden of establishing that there are no triable issues of fact with regard to these alleged violations. Defendant Beth Abraham has made no such showing. In fact, nothing in the Defendant Beth Abraham's moving papers address its statutory obligations or the claims of the Plaintiff in this regard.

59. Consider Defendant Beth Abraham's "SUMMARY OF ARGUMENT" as stated at paragraph 4 of its motion. All that Defendant Beth Abraham states is that it was not negligent in the care and treatment of Plaintiff and that the treatment provided was not the cause of her injuries. Defendant Beth Abraham goes on to state that Plaintiff's loss of vision was the direct longstanding vascular disease and atherosclerosis causing ischemia and CRAO and that no treatment could have prevented the CRAO. See paragraph 4 of Edward Humphries Attorney Affirmation dated October 19, 2016 (hereinafter "Humphries' Aff."). The remainder of Defendant Beth Abraham's arguments is simply an adopting of the arguments of Dr. Mandel and there is no reference to Plaintiff's Public Health Law claims. This alone requires denial of Defendant Beth Abraham's motion.

60. Furthermore, the attorney statement of a long standing vascular disease and arteriosclerosis causing progressive ischemia necessarily requires evidence of assessments and care planning for the risks associated with this condition as required under 42 CFR 483.20, 10 NYCRR 415.11, 42 CFR 483.25 and 10 NYCRR 415.12. Defendant Beth Abraham failed to address this in anyway and as such Defendant Beth Abraham's motion must be denied.

61. According to these code provisions, "the resident must receive and the

facility must provide" the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the plan of care." Beth Abraham makes no showing that this was done and as such the motion must be denied.

62. Relying on Dr. Mandel's experts, Beth Abraham simply states that there was no negligence and the CRAO was unavoidable. As set forth above in response to Dr. Mandel's motion, this is simply not the case.

63. Dr. Reza Dana, M.D., MSc, MPH, FARVO; Vice Chairman for Academic Programs, Harvard Department of Ophthalmology and Associate Chief of Ophthalmology at the Massachusetts Eye and Ear Infirmary clearly explained how Plaintiff's medical history required closer attention to her vision as there was a risk of ischemia, neovascularization and neovascular closed angle glaucoma and secondary CRAO. See paragraphs 9-36, supra along with the affidavits and exhibits referenced therein.

64. Had Beth Abraham and its assigned physicians properly appreciated the risks of Plaintiff developing ocular ischemia (all the experts in this case say she had because of her carotid arterial occlusions; strokes and arteriosclerosis) they would have known immediately to check for an increase in IOP and to reduce the IOP so as to avoid complications such as secondary CRAO.

65. Dr. Dana opined explained that:

> 7. As mentioned above, Ms. Phillips had OIS, placing her at risk for developing secondary complications such as CRAO, which can be prevented when the IOP is controlled. OIS can lead to the development of NVG in an eye which in turn can lead to a significant rise in IOP. This rise in IOP decreases the difference between mean blood pressure and the ocular pressure, which leads to more compromised blood flow to the eye, exacerbating the ischemia (poor blood flow) even

> further and possibly leading to retinal artery occlusion. While this process is taking place and prior to the event of a secondary CRAO, it is essential to assess and control the IOP so as to prevent secondary vascular compromise including CRAO and vision loss.

See Dr. Dana Aff. at paragraph 7, specifically and paragraphs 5-7.

66. The facts as recited by Dr. Dana and as referenced above in response to Dr. Mandel's motion establish that Beth Abraham's doctors, Dr. Friedman and Dr. Mandel, failed to provide proper and appropriate medical care and treatment as required under 10 NYCRR 415.3(3(e)(1)(i). Dr. Dana stated specifically and clearly that Beth Abraham and Dr. Mandel should have done a complete ocular exam which would include testing of IOP on or before July 17, 2007. Dr. Dana stated that Beth Abraham and Dr. Mandel should have set-up a plan to take the IOP as soon as ocular symptoms began on July 8, 2007 based upon Plaintiff's medical history.

67. Dr. Dana explained that the record of fluctuating vision, discomfort and pain for weeks prior to July 27, 2007 are classic signs neovascular glaucoma. That these symptoms could not have been caused by a pre-existing CRAO (as suggested by Defendants' experts) because it was documented that she could see during this period.

68. Dr. Dana explained that the first report of sudden loss of vision was documented on July 30, 2007. The first note refers to an assessment on July 27, 2007 which simply indicates that Plaintiff was unable to read the magazine with her right eye covered even though the print was large. The second note is Dr. Friedman's note dated July 30, 2007 which refers to the sudden loss of vision in the left eye. According to Dr. Dana, it was not possible for a CRAO to have occurred on or after July 27, 2007 which would then result in neovascularization and neovascular closed angle glaucoma within such a short period of time. I would also point out that the Court must accept the

inference that the sudden or hyper-acute loss of vision did not occur until July 30, 2007 as the late entry of July 30, 2007 referring to July 27, 2007 simply states that Plaintiff was unable to read a line with her left eye on July 27, 2007. There was nothing in the note that says she is unable to see. Thus, given the fact that the court must view every favorable inference in favor of the Plaintiff (non-moving party), it must be inferred that while Ms. Phillips lost her vision in her left eye on July 30, 2007.

69. Even Dr. Schultz, the doctor who diagnosed the CRAO and who submits an affidavit in support of Dr. Mandel's motion, concedes that it would take a few weeks or longer after a CRAO for neovascularization to occur. A few weeks is not ten (10) days. I would also point out that Dr. Schultz and Dr. Mandel had a personal and professional relationship which raises the issue of bias and credibility which can be subject to cross-examination during trial. See, Luce v. St. Peter's Hosp., 85 A.D.2d 194 (3rd Dep't 1982). According to Dr. Mandel's testimony, he and Dr. Schultz worked together at Montefiore Medical Center and had, at one point, socialized together. Furthermore, they had actually conferred with regard to Plaintiff. See **Exhibit "C"** at pages 41-42 and 102-110. This creates a bias which goes to credibility which can be explored during trial.

70. In light of the above, Defendant Beth Abraham failed to show that Beth Abraham did not deprive Plaintiff of her rights as protected under the law.

- There are clearly triable issues of fact as to whether Beth Abraham provided Plaintiff with adequate and appropriate medical care as required under 10 NYCRR 415.3(e)(1)(i) and P.H.L. 2801-c(3)(e). Dr. Dana provides a detailed assessment and analysis on this issue; not planning to take IOP, failing to take IOP, failing to reduce IOP, improperly proscribing Tobradex which increases IOP.

- There are clearly triable issues of fact as to whether Beth Abraham

provided the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive plan of care as required under 10 NYCRR 415.12 and 42 CFR 483.25. The necessary care would have been to assess and lower IOP which was increasing as a result Ms. Phillips ocular ischemia which brought about the neovascular closed angle glaucoma.

- Beth Abraham made no showing that it provided care to Ms. Phillips in a manor it promoted the maintenance and enhancement of her life as required under 42 CFR 483.15 and 10 NYCRR 415.5. The care that was provided failed to take into consideration Ms. Phillips' risks for ocular disease based upon her known medical past. The failure is in and of itself a failure to provide care that promoted the maintenance and enhancement of her life.

- Beth Abraham made no showing that it conducted a comprehensive assessment and plan of care to meet her needs as required under 10 NYCRR 415.11 and 42 CFR 483.20. In fact, the testimony of Dr. Mandel reflects a complete lack of understanding of Ms. Phillips' medical history and recent symptomology.

- Beth Abraham made no showing to that Ms. Phillips' drug regiment was appropriate, that the Tobradex was used to treat a specific documented illness/condition or that it was properly monitored for both adverse actions and therapeutic effect as required under 10 NYCRR 415.12(l). In fact, Dr. Dana explains why Tobradex was not appropriate because it has a tendency to increase IOP which should not have been done.

- Beth Abraham has made no showing that it developed and implemented medical services to meet Ms. Phillips' needs and provided care that met the then prevailing standards of medical care as required by 10 NYCRR 415.15. Dr. Dana explains why the care provided by Beth Abraham departed from generally accepted standards of care.

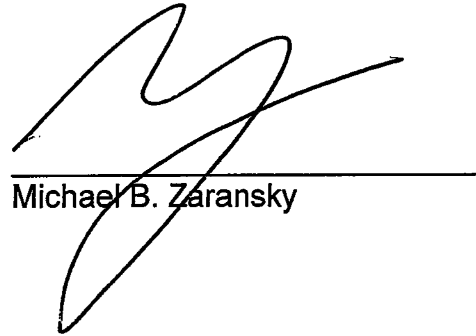
71. Defendants' argument that the CRAO was not preventable is simply contrary to the opinion of Dr. Dana, whose opinion is neither conclusory nor speculative.

72. For the reasons set forth above, Defendant Beth Abraham's motion must be denied. First, the motion was untimely and no showing of good cause for the late motion was presented. Second, Beth Abraham simply cannot meet its burden of proof

of this motion and Dr. Dana explains how and when Defendants' errors and mistakes led to Ms. Phillips' vision loss in the left eye.

WHEREFORE, Plaintiff respectfully requests and Order denying Defendant Dr. Mandel's motion and Defendant Beth Abraham's cross-motion in their entirety and for other and such relief this Court deems just and proper.

Dated: Port Washington, NY
January 9, 2017



Michael B. Zaransky