May 29, 2020

Judy C. Selmeci
212.915.5159 (direct)
Judy.Selmeci@wilsonelser.com

By overnight delivery

Court of Appeals of the State of New York
20 Eagle Street
Albany, New York 12207
Attn: The Justices of the Court

Re: Barry v. Lee
APL-2020-00058
Wilson Elser: 22910.00104

To the Honorable Court:

We represent defendants-appellants Christopher C. Lee, M.D. and Bronx Lebanon Hospital Center. Pursuant to this court's May 6, 2020 directive, we submit the within letter brief.

-- *Preliminary Statement*

The defendants' summary judgment motion must be granted because they established their entitlement to such relief both on departure and on causation and because, on both issues, the plaintiff has failed to raise a question of fact.

When the plaintiff's decedent presented to Bronx Lebanon Hospital with shortness of breath but a stable blood pressure and also reporting ongoing active bleeding since she gave birth some weeks prior, it was appropriate for Dr. Lee to suspect that she may have a pulmonary embolism but to hold off on medicating her for it until that suspicion was confirmed with testing since the medications decrease clotting which is particularly dangerous for someone who is already bleeding. The necessary testing was done without delay. Even if a delay had occurred, it was not the proximate cause of patient's course since only indicated mediation (to wit, Heparin) takes days or weeks to work.

Given the defendants' entitlement to summary judgment, the Appellate Division's order was nor properly made. In addition, the First Department's decision contains several errors which render its determination improper. For these reasons, the judgment must be reinstated.

--- *Statement of the Facts*

Mariama Bah arrived by ambulance to Bronx-Lebanon Hospital on February 8, 2017 at 11:53 am. (RA. 57)[1]. She complained of shortness of breath, palpitations and dizziness. (RA. 24). She told the triage nurse that she had a baby a month prior by vaginal delivery. (R. 24). Her blood pressure was normal (at 118/85), her respiratory rate was high (at 26), her pulse was normal (at 85). She was breathing without difficulty and was moving and communicating normally. (RA. 24, 26).

Dr. Lee first saw the patient at 12:13, right after her triage assessment, initial vitals and EKG, a mere twenty minutes after the ambulance pulled up to the hospital. (RA. 34, 122). Dr. Lee noted that the patient had ongoing post-partum bleeding. (RA. 34). He suspected that she may have a pulmonary embolism but his differential diagnoses also included a congenital heart condition called SVT, anxiety, dehydration, sepsis and blood loss from her ongoing bleeding. (RA. 35, 123-125, 127).

Hospital protocol for a suspected pulmonary embolism (for a patient with stable blood pressure, as the patient had) required blood tests and a CT angiogram to confirm the diagnosis prior to starting treatment. (RA. 144). Since the CT was going to be done with contrast and contrast can damage the kidneys, before the contrast for the CT could be given, blood tests were needed to assess the patient's kidney function. (RA. 133). Dr. Lee ordered the blood tests at 12:37 pm (after about 40 minutes of virtually non-stop assessments for vitals, heart rhythm and physician's exam). (RA. 58).

Blood was drawn for testing and the results started coming in at 12:46. (RA. 51). To perform the kidney function tests, blood has to be "spun down" in a centrifuge. (A. 38). After this processing step, the last of the blood tests was completed by 2:44 pm. (RA. 69). A mere 4 minutes later, at 2:48 pm, on receiving the blood test results, Dr. Lee ordered the next step required for the patient's evaluation: a CT, with contrast. (RA. 44, 60).

The CT was performed at 3 pm and was formally read at 3:35 pm. (RA. 75, 115). It confirmed Dr. Lee's suspicion; the patient had a pulmonary embolism. (RA. 74). Dr. Lee was informed of the results even before the formal read and he immediately ordered Heparin therapy. (RA. 60, 75). After necessary nursing

[1] RA references are to the "respondent's appendix" and "A" references are to the "appendix," both as submitted to the Appellate Division and now forwarded to this court.

checks, the patient was started on Heparin and attendant safety monitoring at 3:59 pm. (R. 40, 61).

At 4:22 pm, the patient suddenly deteriorated and became unable to breathe normally. (RA 54). She was given oxygen and medication. (RA. 54). Despite these efforts, at 4:25 pm, the patient went into cardiac arrest. (RA. 54). Further medications, including tPA, were given but were not successful in returning cardiac function. (RA. 44). The patient was declared dead at 5:08 pm. (RA. 44).

Mamidou Barry, the patient's husband and the administrator of her estate, commenced suit.

--- Summary Judgment Submissions

On completion of discovery, the defendants moved for summary judgment. (A. 13). They submitted the expert affirmation of Dr. Mark Silberman who opined that the care rendered was timely and in accord with the standard of care. (A. 29). To support this conclusion, he examined and commented on each step of the treatment process; he observed and noted the times when the various treatment events occurred, stated the sequence in which things had to be done and explained why. (RA. 29-42).

Most notably, Dr. Silberman opined that for a patient whose blood pressure is stable, it is necessary to undertake treatment in sequence, just as Dr. Lee testified the hospital's protocol requires (and how it was done). This is to say that labs must be obtained first. (A. 40). The labs are not only to determine whether the patient is likely to be having a pulmonary embolism or similar issue (such as a D-Dimer test will reveal) but also to evaluate her kidney function. (A. 40). As Dr. Silberman explained, the later test is more time consuming because the blood must be treated and "spun down" in a centrifuge before it can be tested. (A. 38). It is only once these tests are done that a CT with contrast can be performed and it is only with the CT that the diagnosis is confirmed. (A. 38). Once the diagnosis is confirmed, the patient can receive anticoagulation therapy. (A. 33). In this case, as Dr. Silberman explained, the appropriate anticoagulation therapy was Heparin. (A. 35-36). Finally, Dr. Silberman explained that Heparin was appropriately and timely administered. (A. 39).

Dr. Silberman noted that since the patient had ongoing vaginal bleeding it was particularly important to determine whether Dr. Lee's suspicion for pulmonary embolism had been correct. Anticoagulation therapy posed particular risks to the patient and these risks could not be taken with an unconfirmed diagnosis. (A. 38).

Specifically, Dr. Silberman observed that "anticoagulant or thrombolytic treatment for PE carries the risk of hemorrhagic complications, which can be serious and in some cases the treatment for PE can cause death." (A. 34).

As to the administration of tPA medications, Dr. Silberman explained that they carry the life-threatening risk of altogether stopping a patient's ability to clot and thus putting the patient at risk for bleeding out. (A. 35) Dr. Silberman explained further that the standard of care permits administration of tPA only for patients who "have a higher risk of death from PE that exceeds the risk of death from complications from the tPA medication" (A. 40) and that they are thus indicated only for a patient who "first, has a confirmed diagnosis of pulmonary embolism and, second, has shock, manifested by abnormally low blood pressure, persistently less than 90 systolic." (A. 35). Dr. Silberman opined unequivocally that while the patient's blood pressure remained stable she did not meet these criteria and that, therefore, tPA was contraindicated for her since "patients with stable blood pressure have a mortality risk from complications of tPA that is greater than the mortality risk from PE." (A. 40).

With respect to the claim that Heparin should have been administered sooner, the defendants' expert opined that Heparin takes days and weeks to take effect and thus giving it earlier within the four hour window after the patient's presentation would have made no difference. (A. 37).

With respect to the causation claims flowing from the alleged failure to administer tPA, the defendants' expert opined, in effect, that tPA medication had a high risk of killing the patient in that it would have increased the risk of death from uncontrolled bleeding beyond the risk of death from the pulmonary embolism. (A. 41, stating that "[in Dr. Silberman's opinion] the benefits of tPA did not outweigh the risks of bleeding and death.")

The plaintiff opposed with the expert affidavit of Diane Sixsmith. (A. 67), Dr. Sixsmith opined that the treatment rendered was "too little too late." (A. 69). The expert did not adequately identify departures from the standard of care in the context of the fact of this case. For example, while the expert claimed that it should have taken less than the three-plus hours from the patient's arrival to administer Heparin, she did not negate the defendants' proposition that the standard of care required that before Heparin was given, the diagnosis of pulmonary embolism be confirmed. This confirmation is done by CT, as the defendants explained and the plaintiff failed to refute. The CT requires contrast. The standard of care requires

that contrast be given only after it is confirmed with blood tests that the patient is not at risk of kidney failure from contrast.

Indeed, in the face of the defendants' point-by-point showing that the treatment rendered was timely and in accord with the standard of care, the plaintiff's expert addressed none of the specific steps the defendants took in the patient's treatment and simply opined that the process overall took too long. This failure is most evident in the plaintiff's claim that the blood tests should have taken a mere hour (A. 71) but which claim fails to reckon with the reality that some of the tests required centrifuge treatment which, as the defendants' expert explained, take longer. (A. 38).

With respect to the plaintiff's claim that tPA should have been given, the plaintiff mischaracterized the record and failed to address key facts. The defendants' expert stated that tPA completely stops a person from clotting and, consequently, it is extremely dangerous to administer to a patient who is at risk for bleeding. (A. 35). The plaintiff's expert did not reckon with this proposition at all. In fact, the plaintiff's expert did not engage the reality that not only was this patient "at risk" for bleeding, she already was actively bleeding and had been bleeding for more than a month. The risk of her bleeding out is evident, should she be put in a state where her blood no longer clots at all.

Rather than address this issue head-on, the plaintiff's expert mischaracterized it entirely. The plaintiff's expert claimed that the defendants are "rationalizing" their departures by claiming that Heparin could not be given until anemia was ruled out. (A. 70). This was not the defendants' position. It is true that Dr. Lee testified that one of the things he was concerned about was that because of her month-long bleeding, the patient may have become anemic. (RA. 125-126). But this was not the reason that Heparin was not given right away. Instead, as the defendants explained quite clearly, Heparin was not given on the mere impression that the patient had a pulmonary embolism because the diagnosis had not been confirmed and, for a patient with a stable blood pressure, pursuant to protocol and the standard of care, diagnosis of the pulmonary embolism by CT was first required. This, in turn, required the lab tests, as has been explained. The plaintiff's expert's opinion sidestepped and mischaracterized these issues, failed to address the points raised by the defendants' expert and is thus insufficient to raise a question of fact. *Rivera v. Greenstein*, 79 A.D.3d 564, 568 (1st Dep't 2010) (holding that "[a]n expert offering only conclusory assertions and mere speculation that a doctor could have discovered the condition and successfully treated the patient does not support liability.")

Further, in rendering her opinion that tPA should have been given the plaintiff's expert relied on publications which explore the possibility that tPA may be effective for certain patients with a "submassive" PE (which this patient had) – except each of the articles speaks of patients who are not at risk for bleeds and who do not have a stable blood pressure. (A. 72-76). Meanwhile, this patient was not only at risk for bleeding she actually was already bleeding and her blood pressure was stable.

The plaintiff simply did not address the defendants' proposition that giving Heparin hours earlier would have made no difference. (A. 67-71). On tPA, the plaintiff's expert opined without elaboration that the claimed failure to give tPA sooner was "a cause of injury to Ms. Ban and specifically caused her to lose a substantial probability to survive." (A. 71). The expert did not address the defendants' position that giving tPA would more likely have killed her.

The defendants explained on reply including with their inclusion of a publication examining the current state of research on the topic, the plaintiff's proposition that tPA therapy may be useful to more patients than it is given to now demonstrates only that there is a dispute in the medical community about whether it should be more widely used. (A. 92). But the "standard" of care, of course, remains where the current consensus is and the plaintiff's expert has utterly failed to refute with non-conclusory statements the argument that for patients with stable blood pressure and particularly those who are at risk for bleeding excessively, tPA therapy is contraindicated.

--- *The Trial Court's Order*

In deciding the summary judgment motion, the trial court (Hon. Joseph E. Capella, J.S.C.) held (A. 6) that the plaintiff raised questions of fact concerning whether tPA should have been administered sooner and whether testing and treatment for pulmonary embolism were timely, but that the plaintiff failed to raise a question of fact concerning causation. As a result of the above determinations, the trial court awarded the defendants summary judgment and judgment was entered. (A. 6, 10).

--- *The Appeal*

The plaintiff appealed, challenging the court's determination on causation and its grant of summary judgment (A. 2, 8). The respondent's reached (pursuant to *Parochial Bus*, 60 N.Y.2d 539, 543 [1983]) both causation and negligence in their brief.

The Appellate Division reversed in a 3-2 decision. The majority found that on the question of negligence, the defendants met their prima facie burden but the plaintiff raised questions of fact and that on causation, the defendants failed to establish their entitlement to summary judgment. In so holding, the First Department relied on several statements of medicine which are *dehors* the record.

The defendants moved for reargument or leave to appeal. Leave was granted.

--- *The Defendants Established Their Entitlement to Summary Judgment*

The defendants' expert was detailed and specific in his opinion. He identified and discussed the relevant facts and stated the applicable standard of care. On this analysis he concluded that the defendants' care did not depart from the standard of care. For example, the defendants' expert opined unequivocally that the relevant marker for determining what kind of treatment and therapy a patient with suspected PE would have is her blood pressure and the nature of the pulmonary embolism. The opinion explained that this patient had a submassive pulmonary embolism with stable blood pressure. The expert stated that the standard of care for a patient in this predicament is Heparin, after confirmation of the diagnosis. The expert explained that confirmation is necessary because being wrong about the diagnosis would mean giving the treatment (in this case, anticoagulants) where the treatment itself carries significant risk (of hemorrhage).

The expert further explained that confirmation of a PE diagnosis requires a CT scan, that the CT scan requires contrast and (to avoid harming the kidneys), contrast requires checking first that the patient's kidneys are functioning well enough to handle the administration of contrast. The expert explained that the blood test that confirms kidney function takes time and explained that this is because the blood has to be spun down. The expert looked carefully at the timeline during which these sequential steps were taken and concluded that there was no delay whatsoever in rendering appropriate care to the patient.

The expert also explained that tPA would more likely have killed the patient than helped her. He explained that Heparin takes days or weeks to work (such that its administration an hour or two earlier would have made no difference to the patient's outcome. Thus the expert demonstrated the absence of proximate cause.

Overall, Dr. Silberman's opinion is admissible and proper and it establishes the defendants' prima facie entitlement to summary judgment on both (the absence

of) negligence and (the absence of) causation. *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 (1986) (holding that upon a prima facie showing and in the absence of questions of fact, the defendant is entitled to summary judgment).

--- The Plaintiff Raised no Questions of Fact

The plaintiff's expert believes that the treatment rendered was "too little, too late." (A. 69). The problem with this opinion is that it actually amounts to saying that the treatment rendered *turned out to be* too little to late – in retrospect, that is. But the plaintiff's expert failed to reckon with the fact that *before the fact* it could not be known that the patient would deteriorate.

Consider this: in the plaintiff's expert's view the only risk against which the defendants were required to guard was the one that materialized (that is, that the patient's condition would irreversibly worsen). In the plaintiff's expert's view, the risk that the contrast may overwhelm the kidneys was not one that required testing kidney function in advance of the contrast CT. Of course, only in retrospect is that not a real risk. Before the fact, before the kidney function test was performed, before the contrast was given without incident… before all that it was not possible to know whether associated risks would materialize. Not having the benefit of hindsight, it was entirely proper, as the defendants' expert explains, for the defendants to reckon with these risks and to guard against them. Similarly, though the plaintiff's expert refused to take seriously the potential consequences of the patients ongoing active bleeding (because, in retrospect, that turned out not to be the biggest problem this patient faced), at the time of her presentation the defendants had no crystal ball with which they could have foretold whether taking away a bleeding patient's ability to clot was going to kill her. Indeed, while the possibility that a patient may deteriorate may be foreseeable, the need to weigh the risk of that occurring against the potential harm which different treatment decisions may cause (such as kidney failure or uncontrollable bleeding) is the very fabric of medical care. While the defendant's expert confronted this issue, the plaintiff's expert failed to do so.

The resulting affirmation of the plaintiff's expert is conclusory and speculative and entirely insufficient to raise a question of fact. *Nguyen v. Dorce*, 125 A.D.3d 571, 572 (1st Dep't 2015) (holding that "[the] plaintiff's expert's opinion was insufficient to raise an issue of fact because it was conclusory, relied on assumptions based upon hindsight, and failed to address [the presence of atypical] factors" and summary judgment was also appropriate because "[t]he expert also failed to causally connect the alleged delay in diagnosing and treating the decedent's condition, which had a high mortality rate, to her death.")

The plaintiff's expert failed to adequately confront or refute the defendants' expert's opinion that for a submassive pulmonary embolism (such as the plaintiff's expert specifically concedes this was [A. 69]), in the presence of stable blood pressure, tPA is not indicated. The plaintiff's expert conclusorily "disagree[s] with Dr. Lee and Dr. Silberman when they say that [tPA] drugs were inappropriate for this patient" but the explanation offered for this opinion is meritless. Immediately upon stating this opinion, the plaintiff's expert proceeds to selectively quote from an article which states that there are times when a submassive pulmonary embolism needs treatment with tPA – but on the very same page, even the plaintiff's expert is forced to acknowledge that the medical literature refers to patients who have "hypotension (systolic BP < 90 mm HG) who do not have a high bleeding risk." (A. 69). There can be no dispute that the patient here met neither of these criteria as her systolic blood pressure was consistently above 90 and she was already actively bleeding.

The plaintiff's expert selective quotations continue. The plaintiff's expert claims that the patient's elevated heart rate "is indication that she was hemodynamically unstable" such as would make her fit the criteria of a cited article which states that "[h]emodynamicaly unstable PE patients are candidates for treatment with IV thrombosis or mechanical thromboectomy." (A. 69). But the plaintiff fails to cite the portion of the same article which describes what it means to be "hemodynamically unstable" in the context of a pulmonary embolism. In fact, the plaintiff failed to submit the entirety of the article. (A. 70). The only materials actually in the record that discuss a patient's "stability' in this context are those which identify (as the defendant's expert had done) blood pressure as the relevant marker. (A. 76, stating that "[t]hrombolytic therapy is not recommended for most patients with acute PE not associated with hypotension.")

Ultimately, the plaintiff's expert fails to refute the defendants' expert's conclusion that so long as the patient's blood pressure was stable, administering the tPA was more likely to kill the patient than the tPA itself. An expert opinion that fails to refute the points made by the movant is insufficient to raise questions of fact. *Abalola v. Flower Hosp.*, 44 A.D.3d 522, 522 (1st Dep't 2007) (holding that where "the affirmation of plaintiff's physician not only failed to controvert a number of points in defendant's expert affirmation, but also was conclusory and devoid of analysis or reference to scientific data" summary judgment was appropriate).

Further, nowhere did the plaintiff's expert account for the patient's ongoing bleeding since giving birth and nowhere did the expert reckon with the increased

probability of a hemorrhage because of this ongoing bleed, should she be given anticoagulants. It is partly because of this selective use of the facts that the plaintiff's expert was able opine that the patient may have been a candidate for tPA and to cause the plaintiff to submit medical literature that seemingly supports the expert's positon. Of course, on examination of that literature it is evident that it does not apply since it speaks of patients who are a "low bleeding risk" (A. 74) – and certainly, someone who is actively bleeding is not that.

The plaintiff's expert misrepresented other facts as well. For example, Dr. Sixsmith stated, for the plaintiff that upon the patient's arrival to the hospital "Dr. Lee's 'Assessment', *meaning his diagnosis*, is 'Pulmonary Embolism'." (A. 68). The expert thought that it was "[i]mportant to realize that Dr. Lee made the diagnosis of pulmonary embolism when he finished his physical examination … at 12:13 pm." (A. 68). But Dr. Lee testified that while pulmonary embolism was among his differential diagnoses, he did not make the actual diagnosis until "after the CT scan" which was read at 3:25 pm. (RA. 121). Indeed, long portions of Dr. Lee's testimony were devoted to discussing his initial "assessment" of the patient and it cannot be said (without ignoring this entire section of testimony) that Dr. Lee had diagnosed the patient with a pulmonary embolism when she first arrived. (RA. 120-123). The plaintiff's expert opinion thus fails to take into account the relevant record facts, consequently, it fails to raise a question of fact. *Messeroux v. Maimonides Med. Ctr.*, 181 A.D.3d 583 (2d Dep't 2020) (holding that where "[t]he physician's opinion [in opposition to summary judgment] was based, in part, upon an incorrect statement of the facts and assertions contradicted by the medical records, and he failed to address or rebut the opinions of the defendants' two experts" … "the affirmation of the plaintiffs' expert was insufficient to raise a triable issue of fact.")

The plaintiff's expert opines generally (which is to say, "conclusorily") that the process of confirming the diagnosis took too long. But she cannot identify any period during which the process of definitively diagnosing and ultimately treating the patient was idle. She states that the blood tests should not have taken as long as they did, but fails to confront the reality that kidney function tests take longer because they require a centrifuge. Having failed to opine (as no such opinion could be supported) that any step of the process was improperly delayed or that it should have been omitted entirely, the plaintiff's criticism of timing fails. *Kaplan v. Hamilton Med. Assoc.*, 262 A.D.2d 609, 610 (2d Dep't 1999) (holding that where "[t]he affidavit of the plaintiff's expert merely stated in conclusory terms that the appellants should have diagnosed and treated [the patient] sooner" the opinion does not raise questions of fact).

On causation, the plaintiff's expert's opinion is equally conclusory. Having outright ignored the patient's ongoing bleeding, having ignored the medical literature's reference to the blood pressure reading as the relevant marker for hemodynamic stability, the plaintiff's expert also ignored the defendants' conclusion based on these factors; that tPA would have been more likely to kill the patient than to help her. With respect to the timing of the administration of Heparin, the plaintiff's expert said exactly nothing to rebut the reality that since Heparin takes days or weeks to take effect, giving it to the patient an hour or two earlier would not have prevented her sudden deterioration that afternoon. Thus, the plaintiff has failed to raise questions of fact on causation. *Carcia v. Greif*, 182 A.D.3d 464 (1st Dep't 2020) (holding that a "conclusory assertions that 'abnormal EKG findings should raise a suspicion for PE,' which should have led defendants to 'conduct further testing'" raised no question of fact where the "[p]laintiff's expert failed to discuss or otherwise rebut the opinion proffered by defendants' experts [about the assessment of the patient's condition]")

--- *The Appellate Division's Decision is Flawed*

Quite apart from all of the above issues which are driven by the briefs and record in the case (all of which mandate reinstatement of the judgment), the First Department's Decision contains several errors which require its reversal.

The Appellate Divisions majority's discussion of the relevant medicine is *not* contained in the record. While the majority relied most heavily on its determination that the patient was "hemodynamic unstable" neither the defendants' nor the plaintiff's expert defined this term. The majority cited to Stedman's medical dictionary (which the parties had not cited) to support its understanding of the term, but failed to cite the edition and page number so the information cannot be verified.[2] The majority's understanding of the term is incorrect in that it takes into account factors for determining a patient's "stability" on which the relevant literature (as submitted even by the plaintiff) does not rely. It is only by broadening the potentially relevant factors that the majority was able to conclude that this patient was so unstable from the start that tPA should have been administered. Meanwhile, the relevant marker (that is, the patient's blood pressure) had remained stable and the literature is clear that under such circumstances, especially in the presence of a bleed, tPA is contraindicated.

[2] I have reviewed the 27th edition of Stedman's, which is the only one readily available to me and determined that it contains no entry for "hemodynamic instability." The online version of the dictionary also yields no results for "hemodynamic instability."

The First Department's analysis goes astray in other areas as well, largely as the majority adopted the plaintiff's blatantly false rendering of the facts. For example, the majority adopted the plaintiff's erroneous description of when the diagnosis of PE was made. The plaintiff stated in error that Dr. Lee diagnosed the condition upon his first examination of the patient. In reality, he suspected the condition and the necessary testing confirmed (hours later) his suspicion. The majority opinion nevertheless describes the facts as including that "Dr. Lee diagnosed [the patient] soon [after her arrival to the hospital] as suffering from a pulmonary embolism." *Barry v. Lee*, 2019 NY.Slip.Op. 09397, ***3. The court's failure to understand the difference between a presumptive diagnosis and a confirmed one meant that it missed the whole point of defendants' discussion of all the things that had to be done given the differential diagnosis; confirmation required testing, testing required precautions and those all took some time. If it had been possible to make the diagnosis upon the plaintiff's presentation, this would be a different case! But because it was not possible to do that, it is critically important to understand that the treatment that followed the suspicion of a pulmonary embolism was entirely necessary and all meant to bring the defendants closer to actually arriving at a definitive diagnosis.

The majority opinion also improperly and consequentially conflates the concepts of "anemia" and "bleeding." The majority opinion states that the patient's "postpartum bleeding was not severe enough to cause her to be anemic." *Barry*, ***3. Neither of the experts opined that the absence of anemia would rule out a sufficiently severe bleed such that tPA would become contraindicated. In fact, there is nothing in the record that would support the premise that there is a bleed that is not sufficiently serious to trigger the risk of hemorrhage from anticoagulation. Instead, the defendants' expert stated broadly that ongoing active bleeding increases the risk of medications that decrease clotting. The plaintiff's expert did not address the issue at all. Neither does the literature submitted by either side. The basis for the majority's medical conclusions thus dehors the record. Such an opinion cannot be affirmed.

The majority opinion also errs in its summary of the respective experts' statements – but these are summarized above and in the underlying briefs, plus, the affirmations themselves are, of course, part of the record being forwarded to this court. For this reason, the First Department's errors in this regard are not detailed here.

--- Conclusion

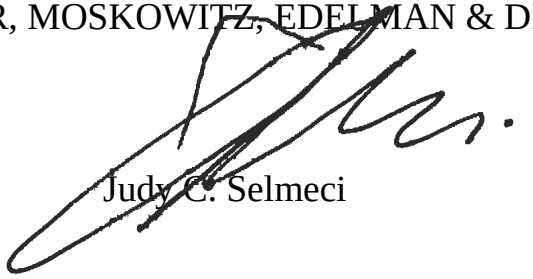
The defendants are entitled to summary judgment. They properly showed their entitlement to this relief and the plaintiff failed to raise a question of fact. The Appellate Division's order is fatally flawed and must be reversed. Consequently, the judgment must be reinstated.

* * *

For these reasons it is respectfully requested that this court reverse the Appellate Division's decision and order and that it reinstate the underlying judgment.

Respectfully submitted,

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER LLP



Judy C. Selmeci

Enclosure:

Corporate disclosure statement

cc: Landers & Cernigliaro, P.C.
Attn: Stanley A. Landers, Esq.
One Old Country Road, Suite 400
Carle Place, New York 11514
516.742.6000
landers10m@gmail.com

STATE OF NEW YORK
COURT OF APPEALS

MAMIDOU BARRY, as Administrator of the Estate of MARIAMA BAH,	:	Bronx County Index No.: 30461/2017E
Plaintiff-Respondent,	:	**Rule 500.1(f) Corporate Disclosure Statement**
- against -	:	
CHRISTOPHER C. LEE, M.D. and BRONX-LEBANON HOSPITAL CENTER,	:	
Defendants-Appellants.	:	

Judy C. Selmeci an attorney duly admitted to practice law before the courts of the State of New York, affirms under the penalties of perjury as follows:

1. I am an attorney with the firm of Wilson, Elser, Moskowitz, Edelman & Dicker LLP, attorneys of record for the defendants-appellants Christopher C. Lee, M.D. and Bronx Lebanon Hospital Center. This affirmation is submitted pursuant to 22 NYCRR 500.1(f).

[continued on next page]

--- Conclusion

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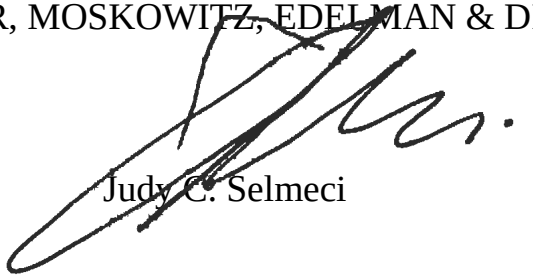

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cc: Landers & Cernigliaro, P.C.
Attn: Stanley A. Landers, Esq.
One Old Country Road, Suite 400
Carle Place, New York 11514
516.742.6000
landers10m@gmail.com

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STATE OF NEW YORK)
COUNTY OF NEW YORK) SS

James Pacheco, Being duly sworn, deposes and says that deponent is not party to the action, and is over 18 years of age.

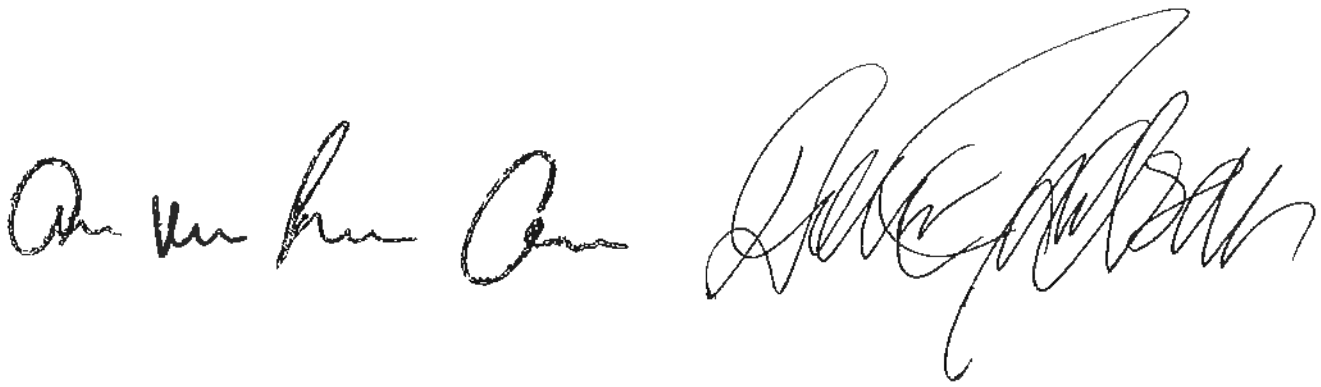
That on 5/29/2020 deponent caused to be served 1 copy(s) of the within

LETTER BRIEF

upon the attorneys at the address below, and by the following method:

By Overnight Delivery

LANDERS & CERNIGLIARO, P.C.
Attorney for Plaintiff-Appellant
One Old Country Road, Suite 400
Carle Place, NY 11514
Phone: 516-742-6000
Email: landers10m@gmail.com



Sworn to me this
Friday, May 29, 2020

Antoine Victoria Robertson Coston
Notary Public, State of New York
No.01RO6286515
Qualified in Nassau County
Commission Expires on 7/29/2021

Case Name: Mamidou Barry v. Christopher C. Lee (2)

Docket/Case No: APL-2020-00058

Index: 30461/2017E