Dowd v Katkovsky
2019 NY Slip Op 33388(U)
November 8, 2019
Supreme Court, Kings County
Docket Number: 506113/2017
Judge: Bernard J. Graham

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

REGAN DOWD and CHERYL DOWD,

Index No.: 506113/2017

Plaintiff,

DECISION/ORDER

-against-

DMITRY KATKOVSKY, D.O., MT. SINAI BETH ISRAEL BROOKLYN, MT. SINAI HEALTH SYSTEM,

Hon. Bernard J. Graham
Supreme Court Justice

Defendants.

Recitation, as required by CPLR 2219(a), of the papers considered on the review of this motion to: award summary judgment to the defendants, pursuant to CPLR § 3212.

Papers	**Numbered**
Notice of Motion and Affidavits Annexed.....	1-2
Order to Show cause and Affidavits Annexed.....	
Answering Affidavits.....	3
Replying Affidavits.....	4
Exhibits.....	
Other: .....(memo).....	

Upon the foregoing cited papers, the Decision/Order on this motion is as follows:

Defendants, Dmitry Katkovskiy, D.O., s/h/a Dmitriy Katkovsky, D.O, ("Dr. Katkovsky") and Beth Israel Medical Center s/h/a/ Mt. Sinai Beth Israel Brooklyn ("Beth Israel") have moved, pursuant to CPLR§ 3212(b), for summary judgment and a dismissal of plaintiffs' complaint, upon the grounds that they did not depart from accepted medical and hospital practice in the care and treatment rendered to the plaintiff, Regan Dowd, ("Mr. Dowd") and that any alleged departure was not the proximate cause of his alleged injuries. In opposition to the defendants' motion, the plaintiffs assert that summary judgment is not warranted as there are triable issues of fact as to whether the defendants Dr. Katkovsky and Beth Israel departed from accepted medical and hospital practice in the care and treatment that was rendered to Mr. Dowd, and that those departures were a substantial factor in causing the injuries that he sustained.

Background:

An action was commenced, on or about March 28, 2017, by the filing of a summons and complaint on behalf of the plaintiffs. Issue was joined, on or about April 27, 2017, by the service of the answer of the defendants. An amended answer was filed by the defendants on or about May 25, 2017.

At the time that defendants served their answer, discovery demands, which included a demand for a verified bill of particulars, were made of the plaintiffs. The plaintiffs, in their Bill of Particulars, alleged a number of claims, including that defendants delayed in performing an embolectomy as well as in transferring Mr. Dowd to a hospital where he could undergo an endovascular intervention. This alleged delay resulted in medical personnel being unable to perform an embolectomy for an embolic stroke, and Mr. Dowd was then required to undergo a craniotomy, he developed a deep vein thrombosis, sepsis, and an infarct as well as other medical issues. The co-plaintiff, Cheryl Dowd ("Ms. Dowd") has a cause of action against said defendants for loss of consortium.

A deposition was conducted of Mr. Dowd on October 23, 2017, and Ms. Dowd on November 8, 2017. Defendant Dr. Katkovsky was deposed on December 18, 2017, and Dr. George Tavoulereas, a non-party, was deposed on October 19, 2018. The Note of Issue and Certificate of Readiness was filed on behalf of the plaintiffs on or about September 10, 2018.

Facts:

On October 10, 2014 at approximately 11:39 A.M, Mr. Dowd, (53 years old) who was experiencing left sided weakness with facial droop and slurred speech, was attended to at his home by Emergency Medical Service ("E.M.S.") personnel after a family member called 911 at approximately 11:27 A.M. Thereafter, E.M.S. transported Mr. Dowd by ambulance to Beth Israel where a stroke protocol was initiated upon his arrival in the Emergency Room Department (E.D.). Dr. Katkovsky was the attending Emergency Medical physician for the plaintiff. Cardiac, respiratory and abdominal

exams were taken of Mr. Dowd, the results of which were deemed to be normal. The neurologic exam of the patient found a left-sided facial droop with slurred speech and left arm weakness. He was found to be alert, able to follow commands and to answer questions appropriately and his appearance and judgment seemed to be appropriate. Lab results were said to be normal. Chest x-rays were performed and the right lung and left upper lobe were found to be clear.

The notations of Dr. Katkovsky indicated that aspirin, normal saline, calcium, Atorvastatin and Labetalol were administered to the patient. Dr. Tavoulereas, a neurologist, who was not situated in the hospital, was consulted at approximately 12:00 P.M. with respect to Mr. Dowd's condition.

Thereafter, a CT scan of the patient's head was performed. Dr. David Liu, the attending radiologist, issued a report wherein it was his impression that this was an acute non-hemorrhagic infarct in the right middle cerebral artery ("MCA") distribution with mass effect. These findings were discussed with Dr. Katkovsky who recommended performing a CT angiogram ("CTA") [1]and prescribing Lipitor for the patient. Dr. Tavoulereas considered the possibility of transferring Mr. Dowd to a stroke team at another hospital. Since Beth Israel did not perform embolectomies, the call center at Mt. Sinai was then contacted to ascertain whether Mt. Sinai or one its other affiliated hospitals could accept the plaintiff for the possibility of performing an embolectomy. Dr. Hahn, at the stroke center at Mt. Sinai NY hospital, indicated that their stroke team would accept the patient only if the CTA demonstrated a clot. The CTA of the neck was then conducted, the results of which was that the patient had a complete occlusion involving the proximal right internal carotid artery ("ICA"). After discussing the results with Dr. Tavoulereas, Dr. Katkovsky ordered the transfer of the patient to Mt. Sinai at 1:48 P.M. The transfer note indicated that the patient was in critical but stable condition. The transfer records from Midwood Ambulance indicate that their ambulance arrived at Beth

[1] The CT Angiogram is a study that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues

Israel at 2:12 P.M., departed the hospital at 2:45 P.M. and arrived at Mt. Sinai Hospital NY at 3:30 P.M.

The notes from Mr. Sinai indicate that the plaintiff was admitted at 3:45 P.M. The notes of Dr. Achillefs Ntranos, a neurologist at Mt. Sinai, indicated that since the plaintiff first reported facial, arm and leg weakness at 8:30 A.M., he was considered to be outside the window for endovascular intervention when he arrived at the hospital. Thereafter, at Mt. Sinai, both an MRI and an MRA[2] of the head and neck were ordered and performed, the results of which was that the neck showed a right distal ICA dissection and a right hemispheric stroke. A subsequent CT scan showed hemorrhagic conversion and increased edema with mass effect. When plaintiff's condition worsened, he underwent a right-sided hemicraniectomy on October 12, 2014, for decompression of the right cerebral hemisphere, and creation of a bone flap. During the remainder of plaintiff's hospitalization, the patient developed a left leg femoral deep vein thrombosis which resulted in the placement of an IVC filter. The patient also developed aspiration pneumonia and was treated with Vancomycin and Zosyn. Mr. Dowd was later transferred to the rehabilitation department where he underwent physical, occupational, speech, and swallowing therapy before his discharge from the hospital.

Discussion:

On a motion for summary judgment seeking a dismissal of a medical malpractice cause of action, a defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or, if there was a departure, that the departure was not the proximate cause of plaintiff's alleged injuries (Williams v. Bayley Seton Hosp., 112 AD3d 917, 918, 977 NYS2d 395 [2nd Dept. 2013]; Giacinto v. Shapiro, 151 AD3d 1029,1030, 59 NYS3d 42 [2nd Dept. 2017]; Brinkley v. Nassau Health Care Corp., 120 AD3d 1287, 993 NYS2d 73 [2nd Dept. 2014]). Thus, on a motion for summary judgment, the defendant has the initial burden of establishing the absence of any

[2] Dr. Mazarin, an expert for the defendants affirmed in his report that the actual study was a CTA rather than an MRA (see page 2 of said report).

departure from good and accepted practice or that the plaintiff was not injured by any departure (see Terranova v. Finklea, 45 AD3d 572, 845 NYS2d 389 [2nd Dept. 2007]). "In order to sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (Bhim v. Dourmashkin, 123 AD3d 862, 864, 999 NYS2d 471 [2nd Dept. 2014]).

Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact (see Fritz v. Burman, 107 AD3d 936, 94, 968 NYS2d 167 [2nd Dept. 2013]; Brinkley v. Nassau Health Care Corp., 120 AD3d at 1287). The plaintiff must "lay bare her proof and produce evidence, in admissible form, sufficient to raise a triable issue of fact as to the essential elements of a medical malpractice claim, to wit, (1) a deviation or departure from accepted medical practice, [and/or] (2) evidence that such departure was a proximate cause of injury" (Sheridan v. Bieniewicz, 7 AD3d 508, 5089 [2nd Dept. 2004]; Gargiulo v. Geiss, 40 AD3d 811, 911-812 [2nd Dept. 2007]). In order to prevail on a claim for medical malpractice, "expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause" (Nicholas v. Stammer, 49 AD3d 832, 833 [2008]).

In addressing the issue of proximate cause, the Court notes that "in a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (Johnson v. Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 [2nd Dept. 2005], quoting Holton v. Sprain Brook Manor Nursing Home, 253 AD2d 852 [2nd Dept. 1998]). "A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of

a better outcome or increased the injury" (Semel v. Guzman, 84 AD3d 1054, 1055-1056 [2nd Dept. 2011], quoting Goldberg v. Horowitz, 73 AD3d 691, 694 [2nd Dept. 2010], quoting Alicea v. Liguori, 54 AD3d 784, 786 [2nd Dept. 2008]).

Here, this Court is presented with the issue as to whether the defendants deviated or departed from accepted medical and hospital practice in the care and treatment rendered to Mr. Dowd, with respect to their treatment of his stroke symptoms, and if so, whether that departure from accepted medical and hospital practice was the proximate cause of the injuries that allegedly occurred.

In support of the motion for summary judgment by the defendants and a dismissal of plaintiffs' cause of action as against the defendants, counsel offers the affirmation of two medical experts, Dr. Mark Raden, Board Certified in Diagnostic Radiology, as well as Dr. Gregory Mazarin, Board Certified in Emergency Medicine, who each opined that the defendants did not depart from accepted medical practice in the care, treatment and services rendered to Mr. Dowd, and that any alleged acts or omissions on the part of the defendants were not the proximate cause of the plaintiff's injuries.

Dr. Raden notes that when Mr. Dowd arrived at Beth Israel at 11:56 A.M., there were clear signs of a likely stroke occurring in the right side of the brain, as he had exhibited left-sided symptoms. At that time varying histories were provided to Dr. Katkovsky and the staff at Beth Israel, as to when the stroke symptomatology began, which is a key component in terms of treating an acute stroke.[3] The expert opined that performing thrombectomies on patients who are unclear as to the proximate time of the onset of the stroke has the real potential to worsen the damage to the brain.

The expert opined that Dr. Katkovsky properly relied upon the input of Dr. Tavoulereas, a consulting neurologist, as well as the doctors and staff at Mt. Sinai, in terms of treatment and determining whether to transfer Mr. Dowd to another facility to

[3] The record of Beth Israel indicates that as per the information provided by Ms. Dowd, the plaintiff was last seen in his normal state of health at 8:30 or 9:00 A.M. that day, but then began complaining of mild to moderate bilateral temporal headaches associated with mild dizziness. She reported that his incoherence with slurred speech, left sided weakness and facial droop, with numbness to the left arm did not begin until 40 minutes prior to his arrival at the hospital. Mr. Dowd provided a history of moderate weakness, numbness, dizziness, facial droop and confusion that began three hours prior to arrival, and the symptoms started upon awakening.

undergo an embolectomy which in 2014 was being performed experimentally to potentially stop the further progression of stroke symptoms and injury to the brain.

The expert opined that at the outset, Dr. Katkovsky and the Beth Israel staff performed the appropriate testing, which included a head CT, as well as a CTA, as per the recommendation of Dr. Tavoulereas. While the testing was performed in a quick and timely fashion, and the plaintiff was transferred to Mt. Sinai, the physicians and staff at Mt. Sinai NY nevertheless declined to perform the embolectomy since the timing of the procedure would have been outside the window of opportunity.

Despite the efforts to move the patient to another facility, Dr. Raden opined that the plaintiff was never a candidate for an embolectomy. In providing his reasoning, the expert explained that where there is a typical stroke, a vessel in the brain leading to a vascular territory is blocked. However, here, the entire ICA of the plaintiff was blocked which is the vessel that supplies the entire right sided brain circulation. The blockage of the right ICA was caused by a dissection which would prevent any Interventional or Vascular Radiologist from performing an embolectomy and would not allow catheters to reach the vessel in the brain which is blocked. Further, the clot in the plaintiff's brain was in the "M3" segment of the right MCA, which is considered too deep or remote in the plaintiff's vasculature to be retrieved by an embolectomy. The expert opined that embolectomies are not performed for M3 clots.

Dr. Raden opined that embolectomies have significant risks. Any time a vessel is opened to provide blood to a damaged brain, there is significant likelihood of intracranial bleeding.

The expert stated that the findings of radiologist David Liu following the first CT scan, which indicated that there was a large right-hemispheric stroke in the right MCA, further supports his argument, since a large MCA stroke is a mitigating factor against a successful embolectomy. A futile attempt at thrombectomy could only cause further damage.

The expert stated that in 2014 while some academic medical centers were performing embolectomies/thrombectomies, the procedure was still considered

experimental, and the standard of care did not require performing such a procedure on any patient. Studies were still ongoing as of 2014 to determine the overall long-term benefit of performing embolectomies/thrombectomies in patients who had a stroke caused by a clot.

Finally, Dr. Raden opined that it is speculative to claim that Mr. Dowd would not have needed the subsequent interventions that he underwent, would not have had the same complications, and would not have achieved the same amount of recovery, had an embolectomy been attempted and was successful in removing the clot.

Defendant's second expert, Dr. Mazarin, opined that both Dr. Katkovsky and the staff of Beth Israel followed the standard of care that existed in 2014 in both their diagnosis and treatment of the stroke of Mr. Dowd. Dr. Mazarin also expressed the opinion that Dr. Katkovsky properly relied upon the opinion of Dr. Tavoulereas, as well as other physicians at Mr. Sinai with respect to his treatment and determination to transfer the patient to another hospital.

Defendants maintain that there is a complete absence of proof that embolectomies were being commonly performed or were actually performed at any of the hospitals suggested by the plaintiffs that Mr. Dowd should have been transferred to.

The defendants in moving for summary judgment and a dismissal of the plaintiffs' causes of action, maintain that they have met their burden of establishing both the absence of any departure and that any alleged departure was not the proximate cause of Mr. Dowd's alleged injuries as they fully performed their duties as medical professionals.

This Court finds upon review of the defendants' submission that the defendants have met their prima facie burden of establishing that they neither departed from good and accepted medical and hospital practice nor that Mr. Dowd had been injured as a result of any alleged departure, and the burden shifted to the plaintiffs to establish the existence of a triable issue of fact.

Plaintiffs' opposition to defendants' motion to dismiss:

In opposing the defendants' motion for summary judgment, the plaintiffs offer the expert affirmation of two doctors, one whose resume includes having completed two radiological residencies and is a current practitioner at a teaching hospital in the New York Metropolitan area, and a second expert who is Board Certified by the American Board of Internal Medicine and Endocrinology, who each opined that the defendants departed from good and accepted medical and hospital practice and that the departures were a substantial factor in causing injury to Mr. Dowd.

The expert opined that the standard of care in 2014 in treating a patient suffering from an ischemic stroke of the type suffered by Mr. Dowd, was to undergo an embolectomy to minimize the effects of the stroke and to perform the procedure within six hours from the onset of stroke symptoms. The medical history of Mr. Dowd appears to indicate that the onset of symptoms occurred at either 8:30 A.M. or 9:00 A.M., with the window of opportunity to perform the embolectomy having closed at 2:30 or 3:00 P.M. Thus, the expert opined that there was sufficient opportunity by the defendants to properly treat Mr. Dowd within the six-hour window if he had been transferred promptly. In making this assessment, the expert considered that the CT of the head was ordered at 12:03 P.M., with the results which revealed the presence of an ischemic stroke, reported at 12:17 P.M. It should have required immediate transfer to a facility closer to Beth Israel where neuro-interventional procedures such as embolectomies were performed. (The expert alleges that in 2014, NYU Lutheran and Maimonides, which were both located in Brooklyn, were offering this treatment). Mr. Dowd should have been transferred based upon his needs and not upon the protocol of the hospital, which attempts to keep patients "in network". The expert maintains that embolectomies were not experimental procedures but rather procedures that were routinely performed by facilities that were equipped to do them.

The expert further opined that at 12:46 P.M. when the determination was made to transfer Mr. Dowd if a CTA revealed that an embolectomy was warranted, steps should have been taken to have an ambulance ready and waiting to transfer the patient upon the

completion of the CTA. However, a transfer order was not put in place until 1:48 P.M. The expert also alleges that there were delays in performing and reporting the results of the CTA to Dr. Tavoulereas who was clearly part of the decision-making process.

Plaintiff's expert addressed the statement of Dr. Raden who had opined that Mr. Dowd was never going to be a candidate for an embolectomy because he had a dissection of the right internal carotid artery. However, the CTA revealed that Mr. Dowd had an occlusion of the artery, which is not synonymous with "destruction of a segment" of the artery. The expert further opined that since this was an acute stroke, the clot would still have been fresh and soft, and the standard of care was to use a catheter to dislodge the clot which would have been a smaller risk as compared to allowing the patient to suffer the consequences of the larger stroke he experienced. Since the blood supplied by the ICA was larger than the blood supply provided by the small clot in the MCA, it was necessary to open the ICA with either a balloon or a stent and open a new path for the blood to flow. Once this was accomplished, it may not have been necessary to complete the embolectomy with respect to the MCA since the larger vessel supplying blood to the brain would now be open which would minimize the damage caused by the stroke. The expert further opined that the opening of the ICA at the beginning of the embolectomy would have either enabled access to the MCA clot, or it would have made access to the MCA clot less important because the majority of the blood flow to the brain would have been restored from the ICA. As a result, the restoration of this blood flow would have prevented or reduced the injuries/damages sustained by Mr. Dowd which included left sided hemiparesis, cognitive impairment, impairment in his ability to read, sepsis, neurological deficits, left sided weakness, limited ability to ambulate, as well as loss of future earning capacity and loss of enjoyment of life.

Plaintiff's second expert, who expressed many of the same opinions as the first expert, opined that the defendants deviated from the normal course of medical and hospital conduct when the CTA of the head and neck with contrast was not ordered by Dr. Katkovsky until 12:55 P.M., despite his knowledge of the CT results at 12:17 P.M. Additionally, Dr. Tavoulereas, the neurologist, was not notified of these findings until

1:30 P.M., despite the fact that plaintiff's neurointerventional radiology expert states that this test should have only taken a few minutes.

In addition, this expert opined that there was no evidence that the stroke began when the plaintiff woke up in the morning nor that it may have occurred during the overnight period. There is no reason to believe that 8:30 A.M. should be the time used to determine the window of opportunity for successful treatment of Mr. Dowd's stroke since he did not experience facial droop and clumsiness that early in the morning and his headache was only mild in nature. This expert further opined that even if 8:30 A.M. was accurate, there was still sufficient opportunity to treat the plaintiff within the six-hour window if he had been transferred promptly to a facility closer to Beth Israel where neuro-interventional procedures such as embolectomies were performed.

This Court finds that the plaintiff has raised triable issues of fact with the submission of two expert affirmations which offered detailed opinions as to the treatment rendered to Mr. Dowd which conflicts with defendants' expert opinions, sufficient to warrant denial of summary judgment and a dismissal of the causes of action pertaining to claims of malpractice as to the defendants (see Contreras v. Adeyemi, 102 AD3d 720, 721, 958 NYS2d 430 [2nd Dept. 2013]); Shahid v. NYC Health & Hosps. Corp., 47 AD3d 798, 850 NYS2d 521 [2nd Dept. 2008]).

In reaching this determination the Court considered that the cogent arguments offered by both parties on several issues conflicted with one another. The defendants argued that Dr. Katkovsky and the staff of Beth Israel performed appropriate testing and made the proper consultations with other physicians with respect to the condition of Mr. Dowd. They further argued that the overall time period of one hour and fifty-two minutes from the time of Mr. Dowd's arrival in the emergency room through his transfer to Mt. Sinai which included the initial evaluation; the ordering and performance of the head CT and awaiting its results; the discussion with a consulting neurologist; the subsequent recommendation for Mr. Dowd to undergo a CTA to determine whether the patient had an identifiable clot; contacting Mt. Sinai with respect to the transfer of the patient to that facility; the performance and interpretation of the CTA; the determination by Mt. Sinai to

accept the patient; and arranging for an ambulatory service to transport the patient, were well within the standard of care.

This Court further took into consideration the argument of defendants' experts' that in 2014 embolectomies were still considered to be experimental and that they considered the argument of plaintiffs' expert that other Brooklyn hospitals were performing this procedure as being entirely speculative.

Additionally, this Court considered the experts argument that Mr. Dowd was not a candidate for an embolectomy since the entire right ICA was blocked. It was argued that this blockage would prevent a radiologist or qualified physician from performing an embolectomy and would not allow catheters to reach the vessel in the brain which was blocked. This clot which was situated in the M3 segment of the right MCA was considered too deep in the plaintiff's vasculature for an embolectomy to be effective.

These arguments and defenses were rejected by the plaintiffs who offered two expert opinions as to the alleged negligence of the defendants and the departures that occurred.

The plaintiffs' experts opined that an embolectomy was the appropriate treatment that should have been performed upon Mr. Dowd and would have reduced Mr. Dowd's injuries if performed within a six-hour window after the commencement of initial stroke symptoms. The plaintiffs maintain that while defendants expert, Dr. Raden, asserts that Mr. Dowd was not a candidate for an embolectomy because a physician would have had difficulty in passing the catheter through the ICA to reach the brain, he failed to establish that it was impossible to perform this procedure or stated what the standard of care was for treating patients with a right ICA dissection. It was argued that the opinion of Dr. Raden is in conflict with that of Dr. Tavoulereas, who was able to review the CTA of Mr. Dowd and made the determination to transfer the patient in order to undergo an embolectomy.

The plaintiffs' experts further opined that the defendants deviated from the standard of care by the unnecessary delays that occurred between the time that he was admitted into the emergency room until the time that he was transported to Mt. Sinai

hospital by private ambulance which resulted in the hospital not being able to perform the procedure. The plaintiffs maintain that the determination only to transfer Mr. Dowd to a hospital within its network does not meet the standard of care and in the absence of definitive proof that the defendant met this standard, (which standard has not been set forth), summary judgment would not be an appropriate remedy.

Additionally, this Court considered the contention of plaintiffs' expert who opined that opening the ICA with either a balloon or a stent would have opened a new path for blood flow and either enabled access to the MCA clot or it would have made access to the MCA clot less important because the majority of the blood flow to the brain would have been restored from the ICA. The expert further opined that the restoration of the blood flow could have prevented or reduced the injuries sustained by Mr. Dowd.

It is well settled that where parties to a medical malpractice action offer conflicting expert opinions on the issue of malpractice and causation, issues of credibility require resolution by the factfinder (see Loaiza v. Lam, 107 AD3d 951, 953 [2013]; Omane v. Sambaziotis, 150 AD3d 1126, 1129 [2nd Dept. 2017]); Dandrea v. Hertz, 23 AD3d 332, 333 [2005]). Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical opinions (see Elmes v. Yelon, 140 AD3d 1009, 1011 [2nd Dept. 2016], (Feinberg v. Feit, 23 AD3d 517, 519 [2nd Dept. 2005]; Shields v. Baktidy, 11 AD3d 671, 672 [2nd Dept. 2014]).

Conclusion:

The motion by the defendants, Dmitry Katkovsky, D.O., and Mt. Sinai Beth Israel, for summary judgment and a dismissal of plaintiffs' complaint, pursuant to CPLR§ 3212,

is denied.

This shall constitute the decision and order of this Court.

Dated: November 8 ,2019
Brooklyn, New York

ENTER

Hon. Bernard J. Graham, Justice
Supreme Court, Kings County

HON. BERNARD J. GRAHAM

KINGS COUNTY CLERK
FILED
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