SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

Justice

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TERRE BLAIR, in her Individual Capacity and as Executor of the Estate of MARVIN HAMLISCH,

Plaintiff,

- v -

NEW YORK-PRESBYTERIAN HOSPITAL, DAVID J. COHEN, M.D. and COLUMBIA UNIVERSITY,

Defendants.

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INDEX NO. 805258/2014

MOTION DATE 01/26/2021

MOTION SEQ. NO. 011

DECISION AND ORDER

The following e-filed documents, listed by NYSCEF document number 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264 ,265, 266, 267, 268, 272, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, and 288 (Motion 011)

were read on this motion to/for SUMMARY JUDGMENT/CROSS MOTION FOR THE IMPOSITION OF SANCTIONS.

In this action to recover damages for medical malpractice and wrongful death, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion and cross-moves pursuant to 22 NYCRR Part 130 for the imposition of sanctions upon the defendants on the ground that the motion is frivolous.

The motion is denied. In opposition to the defendants' prima facie showing of their entitlement to judgment as a matter of law, the plaintiff raised triable issues of fact as to whether her decedent died from medication-induced heart failure, rather than choking and airway obstruction, as alleged by the defendants, and whether the defendants' malpractice, and the decedent's concomitant heart failure, caused him to sustain both conscious pain and suffering and death. The defendants' summary judgment motion, however, cannot be characterized as having no good-faith basis in fact or in law and, hence, the cross motion is denied as well.

Well-known composer, conductor, and pianist Marvin Hamlisch died on August 6, 2012, six months after undergoing a kidney transplant performed by the defendant David J. Cohen,

M.D., at the New York and Presbyterian Hospital (NYPH), sued herein as New York-Presbyterian Hospital, and one month after being treated for back pain, dehydration, fatigue, and gastrointestinal symptoms by Cohen and others at NYPH. The plaintiff alleges that NYPH operates under the auspices of the Trustees of Columbia University in the City of New York (Columbia), sued herein as Columbia University. The plaintiff, Terre Blair, as executor of Hamlisch's estate, and in her personal capacity, commenced this medical malpractice and wrongful death action against Cohen, NYPH, and Columbia.

Hamlisch had been admitted to NYPH in February 2012, at which time Cohen performed a kidney transplant procedure upon him on February 14, 2012. The plaintiff's bill of particulars, dated October 10, 2014, alleged that, as a consequence of the administration of the medications prescribed to Hamlisch in connection with both the surgery and other pre-existing medical conditions, Hamlisch suffered from medication-induced Long QT syndrome (LQTS), a heart rhythm condition that can potentially cause fast, chaotic heartbeats that, in turn, might trigger sudden fainting, seizures, and, in some severe cases, sudden death. The plaintiff asserted that, after Hamlisch was readmitted to NYPH for observation and treatment in the summer of 2012, the defendants failed properly to monitor his heartbeat and heartrate, failed properly to interpret electrocardiograms (EKGs), and thus failed to diagnose medication-induced LQTS. She also asserted that the defendants failed to measure Hamlisch's blood magnesium levels, which are allegedly crucial to a proper diagnosis and treatment. In her bill of particulars, the plaintiff claimed that the defendants were negligent in

> "failing to appreciate the implications of the interactions and consequences of plaintiff's medications on his cardiac status and function; failing to appropriately reconcile plaintiff's medications in view of his medical and clinical status; failing to recognize the significance of plaintiff's cardiac arrhythmia; failing to recognize medication adverse effects; failing to recognize medication side effects; . . . failing to obtain appropriate and indicated medical consultations."

In the plaintiff's CPLR 3101(d) statement dated November 25, 2019, she gave notice to the defendants that she anticipated that her expert would testify that

> "the defendants departed from accepted standards of care in failing to recognize and treat the decedent's electrolyte imbalance as a result of being over medicated with immuno suppressive drugs. This expert will further testify that the defendant's electrolyte imbalance would have been easily treatable and that Mr. Hamlisch's death would have been avoided had the defendants corrected Mr. Hamlisch's electrolyte imbalance. This expert will further opine that the decedent died from cardiac complications arising from an electrolyte imbalance in addition to his debilitated condition."

The statement also indicated that the expert may further testify that "the defendant's negligence is a substantial factor in causing the decedent's injuries as set forth in the bills of particulars and in the decedent's plaintiff's subsequent treatment records."

In support of the defendants' motion, the defendants submitted an affidavit of their expert cardiologist, Dr. Steven Evans, who averred that he is familiar with the accepted standards of practice in the field of cardiology, including the development and diagnosis of cardiac rhythm abnormalities such as LQTS, as well as electrolyte abnormalities in relation to cardiac function. He affirmed that he was also familiar with the pathophysiology of cardiac arrests in comparison with respiratory arrests.

Evans asserted that the 68-year-old Hamlisch underwent a kidney transplant at NYPH on February 14, 2012, was managed medically by Cohen, and recovered well from the transplant. He noted that, by late March 2012, Hamlisch had begun to attend professional engagements, and had returned to performing at symphonies nationwide by April 2012. Evans stated that, in July 2012, Hamlisch became fatigued from his "arduous schedule," suffered from severe back pain and anemia, and was admitted to NYPH from July 23, 2012 to July 30, 2012 for a thorough evaluation by the gastroenterology, nephrology, pain management, psychiatry, endocrinology, and cardiology departments. Evans noted that Hamlisch underwent EKGs, a colonoscopy, an echocardiogram, a lab workup, an upper GI endoscopy, and physical therapy evaluations and treatment that were all negative for any significant or threatening pathology, other than a gastric ulcer and spinal stenosis. As Evans explained it, after Hamlisch underwent studies diagnosing the disc disease and anemia that caused his back pain and fatigue, the

NYPH physicians determined that there was no acute reason or underlying cardiac condition to retain him as an inpatient.

Evans went on to note that Hamlisch had a professional engagement in California that he insisted on attending on August 2, 2012, that Cohen cleared him for discharge from NYPH on July 30, 2012, and that Hamlisch flew to California on August 1, 2012 with his best friend and amanuensis, Richard Kagan. As Evans interpreted the medical records and Kagan's deposition testimony, shortly after arriving at the hotel, Hamlisch, while relaxing and apparently feeling "like his old self," began eating a peanut butter sandwich that became lodged in his airway. Evans concluded that Kagan and the EMS personnel who were called to the scene

> "confirmed that Mr. Hamlisch abruptly left the room unable to speak and collapsed with peanut butter lodged in his airway. He was unable to breathe with peanut butter blocking his airway as the EMS personnel removed a significant amount of peanut butter over approximately twenty minutes while also attempting to administer oxygen by bagging." He then experienced a spontaneous return to regular sinus cardiac rhythm, but suffered a respiratory arrest and sustained a global anoxic injury as a result of the airway blockage. Care was withdrawn on August 6th and he was pronounced dead at 8:00pm."

Based in part on his stated understanding that Hamlisch died from airway obstruction, and not heart failure arising from undiagnosed and untreated or improperly treated LQTS, Evans concluded that

> "[t]he medical records and deposition testimony establish that Dr. Cohen and NYPH did not in any way depart from the standard of care in treating Mr. Hamlisch, and that all treatment rendered was appropriate, and that none of their actions and/or inactions played a role in the cause of Mr. Hamlisch's death. It is therefore my opinion that these defendants are not liable for the alleged injuries claimed by plaintiffs."

In support of his conclusion, Evans explained that, over the years, Hamlisch had been treated by a physician other than Cohen for borderline hypertension, and was prescribed Cardizem for that condition. In addition, Evans noted that Hamlisch had suffered from local glomerulonephritis (kidney scarring), with constant low-grade hematuria, kidney stones, and a duodenal ulcer. According to Evans, Hamlisch generally had normal EKGs for many years, until 1997, when his EKG was slightly abnormal, although his annual EKGs from 1998 to 2011 were

normal, despite the fact that Hamlisch took Elavil for depression for several decades, which is known to be a risk factor in developing LQTS. Evans noted that Zoloft was later prescribed to Hamlisch to treat the same condition.

Evans further explained that, in early 2012, Hamlisch suffered from bouts of lightheadedness while conducting the Pittsburgh Symphony Orchestra, and was taken to University of Pittsburgh Medical Center (UPMC) for observation. He noted that a Dr. Hickey, the treating physician at UPMC, concluded that Hamlisch presented with

> "early vasovagal symptoms which were exacerbated by his chronic renal failure. She highly doubted any cardiac origin for the episode, as Mr. Hamlisch had recently been evaluated for a kidney transplant and cleared from a cardiac standpoint, including a negative stress test. To that end, an electrocardiogram obtained at UPMC-Mercy Hospital on January 29th revealed no evidence of arrhythmia or acute ischemia. . . . A troponin test came back negative and Dr. Hickey did not suspect an acute coronary syndrome. Mr. Hamlisch was determined to be medically stable in the ED at UPMC-Mercy Hospital. He was given a saline bolus and offered, but declined an observation admission."

As reported by Evans, after Hamlisch underwent the kidney transplant in February 2012, during which he was prescribed amiodarone, an anti-arrhythmia drug, he was under the care of Dr. Cohen, but maintained his regular performance and travel schedule. Evans further reported that laboratory and cardiac tests remained normal over the several following months, although Hamlisch continued to complain of lightheadedness, dizziness, and back pain. Evans also indicated that Hamlisch's wife reported to Cohen a few weeks prior to his death that his heart was "racing." As Evans recounted it, a gastroenterologist who examined Hamlisch in late July 2012 concluded that, in light of the fact that Hamlisch tested positive for blood in his stool, he was suffering from dehydration and a possible recurrent non-steroidal anti-inflammatory drug (NSAID)-induced gastrointestinal bleed caused by taking ibuprofen. The gastroenterologist instructed Hamlisch to present to NYPH for admission.

According to Evans, a July 24, 2012 endoscopy revealed that Hamlisch was suffering from a duodenal ulcer. He further attested that a July 29, 2012 EKG indicated normal sinus rhythm, albeit with "nonspecific T wave inversions." Evans asserted that, by July 31, 2012, after

Hamlisch had been prescribed the muscle relaxant Flexeril and the anxiolytic Valium, his gastrointestinal symptoms had resolved. Evans recounted that Hamlisch was discharged from NYPH, and continued to take Elavil for depression and the immunosuppressant tacrolimus in connection with his recent organ transplant.

Evans stated that, while Hamlisch was staying in a hotel in Southern California on August 1, 2012, he "fainted while eating a peanut butter sandwich," and was taken to a hospital near the hotel for intubation, but never regained consciousness. Evans noted that, after Hamlisch was transferred to UCLA Medical Center, he died on August 6, 2012.

Evans concluded that, from the perspective of cardiac health, there was no reason not to discharge Hamlisch from NYPH on July 31, 2012, as non-specific T-wave abnormalities are very common. He opined that such abnormalities

> "can occur with hyperventilation, anxiety, positional changes, and cardiomyopathy. Isolated nonspecific T wave abnormalities can be indicative of an underlying cardiac issue, which is why Dr. Sherman appropriately ordered an echocardiogram and troponin testing for further evaluation. There was also a repeat EKG to evaluate cardiac function when Mr. Hamlisch's amitriptyline (Elavil) dosage was increased, which was appropriate and thorough medical management. That EKG, as noted above, reported a normal QTc of 404 milliseconds. The troponin returned as normal on July 30th at 0.02 µg/ml and the echocardiogram showed only mild left ventricular hypertrophy. It is my opinion, within a reasonable degree of medical certainty, that there was no indication to perform further cardiac testing or to keep Mr. Hamlisch admitted to the Hospital on the basis of these normal findings."

Evans further concluded that Hamlisch

> "did not have medication-induced LQTS leading to cardiac arrest and death. It is important to understand the potential causes, symptomology, and diagnosis of LQTS. As noted above, the QT interval represents the time from the electrical stimulation (depolarization) of the heart's ventricles to their recharging (repolarization). It closely approximates the time from the beginning of the ventricles' contraction until the end of relaxation. LQTS can be characterized by seizures, syncope and heart palpitations, and can cause sudden cardiac arrest."

Nor, concluded Evans, did Hamlisch suffer from genetic LQTS. He further opined that any amiodarone given to Hamlisch to address cardiac arrhythmias could not have caused LQTS under the circumstances presented. As Evans explained it,

> "[d]iagnosis of medication-induced LQTS requires a 60 millisecond increase over the patient's existing baseline QT interval. In determining whether Mr. Hamlisch had a medication-induced LQTS while on amiodarone, I have measured the QT interval on a February 18, 2012 EKG, several hours before amiodarone was started to identify his baseline QT interval. I have determined that the baseline QTc was 440 milliseconds. This means that Mr. Hamlisch would have medication-induced LQTS when he was on a medication that increased his QTc interval above 500 milliseconds.
>
> "To be clear, there is absolutely no evidence that Mr. Hamlisch ever developed medication-induced LQTS that could have caused a sudden cardiac arrest. While Mr. Hamlisch was taking several medications that are known to have a potential risk of LQTS, there is no evidence that this in fact occurred. Importantly, Mr. Hamlisch was on amitriptyline (Elavil) as early as 1994, and occasionally had low magnesium, and over the course of the next 18 years he had a multitude of EKGs, all of which revealed normal sinus rhythm."

Evans nonetheless noted that Hamlisch did indeed sustain a "somewhat prolonged QT interval" on one occasion prior to August 1, 2012. As Evans described it, Hamlisch "was reported to have a somewhat prolonged QT interval . . . in the immediate post-transplant period in February 2012 due to both the presence of atrial fibrillation, which can falsely elevate the computerized EKG interpretation, and the amiodarone he was taking." He explained, however, that Hamlisch's QT intervals at the time varied between 464 milliseconds and 495 milliseconds, which "does not meet the threshold for medication-induced LQTS as all measured QT intervals were below 500 milliseconds." Evans further explained that atrial fibrillation can make it "challenging for the computer to determine when the T wave returns to the baseline, and as such, can falsely elevate the length of the QT interval."

Thus, although Evans conceded that amiodarone "is known to prolong the QT interval," and that the prolonged QT interval that Hamlisch exhibited while on that medication "was expected," the administration of amiodarone could not cause sudden cardiac arrest because it is not proarrhythmic, and the QT prolongation in February 2012 was thus irrelevant as to an assessment of whether Hamlisch exhibited LQTS in July 2012. Evans further stated that, similarly, the other QTc measurements in February 2012 that were between 460 and 492 milliseconds, "though somewhat prolonged, do not fall within the definition of a 60 millisecond

prolongation, and even if they did, they could also not have caused sudden cardiac arrest at that time or at any other time," particularly in July or August 2012, when the medication had already been discontinued.

Evans further opined that it was appropriate to discontinue giving Hamlisch the drug Elavil while he was on amiodarone immediately subsequent to the kidney transplant operation, as that would have assured that his heart remained in sinus rhythm.

The defendants' other expert, nephrologist Roy Bloom, M.D., essentially echoed Evans's conclusions. Bloom further opined that the post-operative care referable to the kidney transplant procedure was appropriate, and did not implicate any issue with Hamlisch's heart rate, heartbeat, or other cardiac issues. Evans and Bloom concurred that Cohen appropriately managed Hamlisch's blood magnesium levels during the time that Hamlisch was under his care, and gave appropriate permission for him to fly to California with a companion.

In opposition, the plaintiff submitted the affidavit of an internist/nephrologist, who asserted that the defendants

> "deviated from accepted standards of care in prescribing Mr. Hamlisch a combination of drugs after February 2012—in particular, colchicine, amiodarone, and tacrolimus—without careful monitoring of their side effects and drug-drug interactions. The Defendants also deviated from accepted standards of care in failing to consult with a transplant pharmacist or refer Mr. Hamlisch to a transplant pharmacist to review and discuss Mr. Hamlisch's medication combinations in the post-kidney transplant setting, as required by the Organ Procurement and Transplant Network (OPTN) Bylaws. The Defendants also deviated from accepted standards of care in failing to heed, appreciate, and appropriately and timely respond to multiple interactions and side effects of his medications that led to Mr. Hamlisch's signs and symptoms of tacrolimus (Prograf®) toxicity and colchicine (Colcrys®) toxicity after his kidney transplant and untoward side effects of his mycophenolic acid (Myfortic®) and esomeprazole (Nexium®) therapy. These signs and symptoms include tremors, insomnia, low white blood cell count, exacerbation of diabetes, exacerbation of hyperuricemia and gout, headaches, diarrhea and other gastrointestinal symptoms, prolonged hypomagnesemia, muscle weakness, prolonged QT interval, neck and back pain, and increasingly severe fatigue."

The plaintiff's retained nephrologist went on to conclude that

> "the tacrolimus toxicity and the colchicine toxicity that Mr. Hamlisch suffered in 2012 significantly increased his risk for suffering a cardiac dysrhythmia, including

> cardiac arrest, which is how he died. It is my opinion to a reasonable degree of medical certainty that these departures were substantial factors leading to Mr. Hamlisch's death."

The nephrologist explained that Hamlisch had an onset of atrial fibrillation in the course of his February 2012 kidney transplant surgery, and that the diagnosis of that condition, and the concomitant prescription of amiodarone to treat it, necessitated a higher level of medical monitoring for heart arrhythmias. In addition, he noted that, during and immediately after surgery, Hamlisch's blood work showed excessively low levels of phosphorus and magnesium. As the expert explained it, "[a]s the transplant nephrologist, Dr. Cohen was responsible for monitoring Mr. Hamlisch's overall health as well as the status of his kidney transplant and effects of immunosuppression upon Mr. Hamlisch." The nephrologist opined that, during the months between the February 2012 surgery and the July 2012 readmission, Hamlisch's tacrolimus blood levels were excessive, as were levels of colchicine, which had been prescribed to Hamlisch to treat his pre-existing condition of gout. The plaintiff's expert nephrologist concluded that, during that period of time, Hamlisch repeatedly presented Cohen and others at NYPH with symptoms of fatigue, tremor, gastrointestinal problems, weakness, back and neck pain, nausea, respiratory problems, and loss of appetite and, crucially, a "racing heart."

The expert nephrologist noted that, upon Hamlisch's July 2012 readmission to NYPH, Hamlisch also presented with repeatedly low magnesium and phosphorus levels for more than 10 days, and a low white blood cell count, with a high level of tacrolimus in his blood. The expert pointed to a note written by one of the NYPH physicians treating Hamlisch, a Dr. Sherman, indicating that Hamlisch suffered from "[e]xertional dyspnea likely due to anemia, deconditioning nonspecific EKG changes, *possibly due to electrolyte abnormalities*" (emphasis added). The expert asserted that

> "Dr. Cohen and the other providers at New York Presbyterian Medical Center/Columbia University failed to appropriately monitor and manage Mr. Hamlisch's medication regimen after his kidney transplant resulting in, among other things, tacrolimus toxicity, colchicine toxicity, and the sequelae thereof. These departures were substantial factors leading to Mr. Hamlisch's death."

Specifically, he concluded that, where a transplant physician prescribes a nonsteroidal immunosuppresant such as tacrolimus, he or she must assure that the patient does not develop tacrolimus toxicity, which manifests as "magnesium wasting" in the kidneys, tremors, fatigue, weakness, headaches, insomnia, gout, nausea, decreased appetite, electrolyte disturbances, increased serum creatinine, exacerbation of diabetes, and mental status changes. The plaintiff's expert described tacrolimus as a proarrhythmic drug, and opined that tacrolimus toxicity increases the risk of cardiac arrhythmia. As he explained it, tacrolimus is metabolized by the CYP3A4 enzyme and also inhibits P-glycoprotein and, thus, it may have an impact upon the metabolism and transport of other drugs such as colchicine, which was administered to Hamlisch in the months following the transplant operation. He also asserted that

> "amiodarone is an antiarrhythmic medication and P-glycoprotein (P-gp) inhibitor. Like tacrolimus, amiodarone prolongs the QT interval *and the risk is additive when the two drugs are combined*. *Due to the extremely long half-life of amiodarone, a drug interaction with tacrolimus is possible for days to weeks after discontinuation of amiodarone*,"

and that "amiodarone increases colchicine levels" (emphasis added). The expert asserted that, inasmuch as Hamlisch had been prescribed colchicine for the treatment of his gout, his colchicine levels rose into in the toxic range due to its drug interactions with both tacrolimus and amiodarone, regardless of how soon after the surgery the amiodarone was discontinued.

The nephrologist thus concluded that,

> "[a]s such, it is a deviation from accepted standards of care to prescribe a patient with impaired renal function colchicine if that patient is already taking a P-gp inhibitor like tacrolimus or amiodarone. In this case, Mr. Hamlisch was prescribed all three. Signs and symptoms of colchicine toxicity include gastrointestinal symptoms such as nausea, vomiting, diarrhea, and abdominal pain, leukopenia (low white blood count), elevation of liver enzymes, muscle weakness, electrolyte imbalance, and neuropathy. Colchicine toxicity is life-threatening because it increases the likelihood of cardiac arrest."

The expert placed the alleged colchicine toxicity in context by explaining that one of the factors leading to cardiac arrest is the loss of magnesium and electrolytes caused by three drugs prescribed to Hamlisch. As he explained it,

> "[l]ow magnesium occurs in two settings: renal losses of magnesium and gastrointestinal losses of magnesium. In this case, it is likely that a combination of renal magnesium losses from the high tacrolimus levels as well as gastrointestinal magnesium losses from long-term concomitant use of esomeprazole as well as from the diarrhea caused by the colchicine and mycophenolic acid caused the long term persistent low magnesium levels. If hypomagnesemia persists, it can affect the heart's ability to beat and will lead to what is called "sudden cardiac death," particularly in the setting of other cardiac risk factors and medications."

The expert thus asserted that Cohen deviated from good practice in maintaining Hamlisch on high doses of the anti-rejection drug tacrolimus and mycophenolic acid despite a March 2012 renal biopsy that showed no rejection of the donor kidney, and that the drug regimen prescribed by Cohen caused Hamlisch to suffer from leukopenia and anemia at the time of his July 2012 readmission. According to the nephrologist, it was also a deviation to prescribe colchicine to continue to treat Hamlisch's gout, as it is contraindicated for patients who have taken amiodarone and, at the very least, required careful monitoring for a patient who is on tacrolimus, lest it lead to heart failure. He further asserted that it was a deviation to discharge Hamlisch from NYPH on July 30, 2012 in light of his complaints and blood tests.

The plaintiff also submitted the affirmation of a forensic pathologist, who reviewed the autopsy records and the transcripts of Kagan's and the EMTs' depositions, and concluded that

> "Mr. Hamlisch did not choke to death on peanut butter as Defendants assert. Dr. Palma Diaz, the pathologist who conducted the autopsy, concluded that Mr. Hamlisch's death was due to a cardiac arrhythmia due to natural heart disease, and that 'The reported poor health during the 2 weeks prior to this event, may have also played a contributing role.' He found no evidence that peanut butter had obstructed Mr. Hamlisch's ability to breathe, had been aspirated into his lungs or had caused or contributed to his death.
>
> "Mr. Hamlisch's sudden loss of consciousness and collapse is typically caused when a cardiac arrhythmia develops and leads to a cardiac arrest. A respiratory arrest due to airway occlusion *occurs after many minutes of obvious struggling to breathe which did not occur before Mr. Hamlisch lost consciousness and collapsed*"

(emphasis added). In fact, at his deposition, Kagan did not describe Hamlisch as having exhibited any behavior that typically would accompany choking or the obstruction of a person's airway.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr*., 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc*., 180 AD2d 579, 580 [1st Dept 1992]).

Once the movant meets his burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

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

Koulermos v A.O. Smith Water Prods., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

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

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

Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant’s prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant’s favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Where the expert’s “ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment” (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Consequently, where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24 *Cruz v St. Barnabas Hospital,* 50 AD3d 382 [1st Dept 2008]).

There is a sharp factual dispute as to the cause of Hamlisch's death. The expert opinion of the plaintiff's retained pathologist is supported by the facts otherwise developed by the parties' submissions. There is also a sharp factual dispute as to whether the simultaneous prescription and administration of amiodarone, tacrolimus, and colchicine to Hamlisch, and the consequent buildup of those drugs in Hamlisch's blood over several months, without a medical response to the bloodwork results from Cohen and the NYPH physicians treating Hamlisch in July 2012, both significantly decreased Hamlisch's blood levels of magnesium and other electrolytes, and increased the likelihood of heart arrhythmia or heart failure. In addition, there are triable issues of fact as to whether these acts and omissions were a substantial contributing factor to Hamlisch's heart stoppage and death. The court further notes that the defendants, in their motion, did not fully or adequately address the plaintiff's allegations that Cohen departed from good and accepted standards of medical care in failing to consult with a transplant pharmacist or refer Hamlisch to a transplant pharmacist to review and discuss the reactions and indications of the medications that he had been prescribed.

Hence, the defendants' motion for summary judgment must be denied.

There is nonetheless no basis for the imposition of sanctions upon the defendants. 22 NYCRR 130-1.1(c)(1) provides that, "[f]or purposes of this Part, conduct is frivolous if . . . it is completely without merit in law and cannot be supported by a reasonable argument for an extension, modification or reversal of existing law." The court concludes that, notwithstanding its denial of the defendants' summary judgment motion, their submission of the motion did not constitute frivolous conduct that would warrant the imposition of a sanction (*see Rudansky v Giorgio Armani, S.p.A.*, 306 AD2d 174, 174 [1st Dept 2003]). Litigation conduct need not be characterized as frivolous within the meaning of the relevant court rule merely because the argument underlying the conduct is ultimately determined to be without merit (*see Nassau County v Incorporated Vil. of Roslyn*, 218 AD2d 688, 690 [2d Dept 1995]).

Accordingly, it is

ORDERED that the defendants' motion for summary judgment dismissing the complaint is denied; and it is further,

ORDERED that the plaintiff's cross motion for the imposition of sanctions upon the defendants is denied.

This constitutes the Decision and Order of the court.

3/5/2021
DATE

JOHN J. KELLEY, J.S.C.

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