At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 1st day of December 2022.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

----------X

GENNADY FURMAN and IRINA FURMAN,

Plaintiffs,

- against -

DR. EUGENE SHTEERMAN, M.D., ADVANCED CARDIO DIAGNOSTIC, PLLC, DR. MAUREEN Z. WANG, M.D., DR. DEVINDRA DABIESINGH, M.D. and NEW YORK METHODIST HOSPITAL,

Defendants.

----------X

DECISION & ORDER
Index No: 510484/2017

The following e-filed papers read herein:	NYSCEF Doc Nos.
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations)	79-100
Opposing Affidavits (Affirmations)	104-105
Reply Affidavits (Affirmations)	106-107

Upon the foregoing papers, defendants Maureen Z. Wang, M.D. (sued herein as Dr. Maureen Z. Wang, M.D.) (Dr. Wang), Devindra S. Dabiesingh, D.O. (sued herein as Dr. Devindra Dabiesingh, M.D.) (Dr. Dabiesingh), and New York-Presbyterian Brooklyn Methodist Hospital, sued herein as New York Methodist Hospital, (collectively, moving

defendants) move (in motion [mot.] sequence [seq.] number [no.] 4), pursuant to CPLR 3211 and 3212, for an order dismissing the complaint.[1]

Background

This medical malpractice action, as it relates to moving defendants, seeks damages on the basis that moving defendants deviated from accepted medical standards and failed to accurately diagnosis plaintiff Gennady Furman's (Mr. Furman) endocarditis. The action primarily focuses on the care rendered by Drs. Wang and Dabiesingh, between March 8 to March 10, 2015, while Mr. Furman was admitted to New York-Presbyterian Brooklyn Methodist Hospital. Between January 2015 to October 2015, Mr. Furman sought treatment from multiple physicians and various medical facilities relating to symptoms he was experiencing on-and-off again, which included, among others, weight loss, fever, and the swelling of extremities. Mr. Furman first presented himself to the emergency room of Coney Island Hospital in January 2015, complaining of decreased appetite, fever, and lower back pain. While admitted, an MRI of his back and an ultrasound of his abdomen were performed. He was diagnosed with degenerative joint disease and discharged. Mr. Furman later presented himself to New York-Presbyterian Brooklyn Methodist Hospital (NYPBMH) on February 7, 2015, complaining of the same symptoms. He was admitted to NYPBMH on the same day and discharged on February 10, 2015. While admitted to

[1] Though the notice of motion also cites CPLR 3211 (7), seeking dismissal for failing to state a cause of action, the arguments comprising the motion papers are focused on summary judgment based upon the proffered evidence. Accordingly, that branch of the motion is denied as unsupported by the moving papers.

NYPBMH in February 2015, Mr. Furman received treatment including physical examinations, blood tests, and imaging. At admittance, Mr. Furman had a white blood cell count of 12.3 which decreased to 6.4. At the time of discharge, Andy Huang, M.D., a hematology consultant, (Dr. Huang) diagnosed Mr. Furman with normocytic anemia without a need for blood transfusion and directed him to follow-up in the hematology clinic two weeks after his discharge.

On February 20, 2015, Mr. Furman presented himself to the hematology clinic at NYPBMH and was again examined by Dr. Huang. Dr. Huang noted that Mr. Furman's white blood cell count was normal (9.1) and that the physical examination of Mr. Furman was within the normal limits. Mr. Furman was afebrile, but had chronic renal failure as a consequence of chronic anemia for which Procrit was recommend. Mr. Furman was discharged and directed to follow up with his primary care physician concerning the chronic back pain and have a screening colonoscopy.

On March 8, 2015, Mr. Furman again was admitted to NYPBMH with complaints of pain and swelling of the lower extremities. At admission, he demonstrated a temperature of 99.4, a respiratory rate of 20, an oxygen saturation of 96, and blood pressure of 176/90. Cardiomegaly was revealed after a chest x-ray was performed and Mr. Furman demonstrated a brain natriuretic peptide of 8790. Mr. Furman was diagnosed with congestive heart failure due to uncontrolled hypertension and kidney disease. A transthoracic echocardiogram indicated left ventricular hypertrophy. He was prescribed intravenous Lasix. On March 9, 2015, Dr. Wang interpreted a transthoracic

echocardiogram. Dr. Wang made observations concerning Mr. Furman's left ventricle, ventricular septum, mitral valve, and left atrium. Based upon such observations, Dr. Wang concluded the circumstances were consistent with obstructive hypertrophic cardiomyopathy. The following day, on March 10, 2015, NYPBMH house staff and Dr. Dabiesingh, performed a cardiac consultation on Mr. Furman, who reported that there was no acute distress, the pain in his knees and feet had considerably subsided, and that the swelling of his legs deceased. Dr. Dabiesingh recommend that an echocardiogram be repeated in a few months when blood pressure and heartrate goals were reached and that if mitral regurgitation persisted, more invasive treatment would be considered. After a hematology consultation was performed and Mr. Furman demonstrated improved vitals and constitution, he was discharged on March 10, 2015, and directed to follow up with the hematology clinic within 17 days and the cardiology clinic within 15 days.

On March 19, 2015, Mr. Furman's primary care physician, Dr. Ada Chak (Dr. Chak), recommended that he seek an evaluation by Dr. Eugene Shteerman (Dr. Shteerman). Dr. Shteerman saw plaintiff for the first time on March 20, 2015, with a chief complaint of cardiomyopthay. Dr. Shteerman performed both a transthoracic echocardiogram and electrocardiogram, the latter showing non-specific ST-T-wave changes and the former showing focal thickness of the aortic and mitral valves, left ventricular outflow tract obstruction, and mitral valve regurgitation. Dr. Shteerman arranged for a Holter monitor, ordered exercise stress test, and prescribed Verapamil and increased Lisinopril. He recommended Mr. Furman being on a low sodium diet, focus on

weight loss, and nonstrenuous exercises. On March 27, 2015, Mr. Furman followed up with Dr. Huang, reporting lower back pain. Additionally, between March 2015 to April 2015, Mr. Furman sought treatment from his primary care physician, Dr. Chak, on five occasions.

Mr. Furman returned to Dr. Shteerman on April 8, 2015, and again on April 22, 2015. On April 8, 2015, Dr. Shteerman increased the dosage of Verapamil and renal and gastrointestinal evaluations were recommended. On April 22, 2015, Mr. Furman underwent an exercise stress test, yielding a negativing result of ischemia, but ceased after 6 minutes due to Mr. Furman's fatigue, leg pain, and requests to stop. Echocardiographic images produced from the exercise stress test were consistent with dynamic left ventricular outflow obstruction without evidence of exercised induced ischemia.

In between Mr. Furman's visits to Dr. Shteerman, on April 10, 2015, he presented to Dr. Igor Khelemsky (Dr. Khelemsky), who diagnosed Mr. Furman with severe cervical radiculopathy. On April 11, 2015, Mr. Furman presented to Dr. Zachary Brener (Dr. Brener). Dr. Brener determined that Mr. Furman had chronic kidney disease (stage III), hypertension, and hyperlipidemia. Dr. Brener recommended evaluations in hematology and gastroenterology. On April 15, 2015, Dr. Chak referred Mr. Furman to NYPBMH's emergency department after laboratory studies showed critically low hemoglobin of 7.9 and low hematocrit of 24.3. Upon admittance to NYPBMH, Mr. Furman was examined and noted that the anemia was attributable to chronic kidney disease and no intervention was recommended.

On April 27, 2015, Mr. Furman was seen by Dr. Robin Baradarian (Dr. Baradarian), a gastroenterologist. Mr. Furman complained of weight loss, associated with blood loss and anemia. Dr. Baradarian noted elevated sedimentation in Mr. Furman's blood and that he had a pallor, systolic murmur, and mild hepatosplenomegaly. Dr. Baradarian provided a differential diagnosis of autoimmune diseases and/or infection.

On May 21, 2015, Mr. Furman underwent a bone marrow biopsy, which yielded negative results for lymphoma and acute leukemia. Mr. Furman later underwent an MRI of the abdomen and pelvis on June 5, 2015, ordered by Dr. Baradarian. The MRI revealed splenomegaly, hydronephrosis, and hydroureter.

On June 10, 2015, Mr. Furman again appeared before Dr. Shteerman with complaints of heart palpitations, weakness, fatigue, low labile blood pressure, and weight loss. Dr. Shteerman prescribed Metoprolol and Simvastatin, and discontinued Lipitor. The following day, June 11, 2015, Mr. Furman had another follow-up appointment with Dr. Baradarian and reported lower abdominal pain. Dr. Baradarian advised Mr. Furman to seek emergency medical treatment.

On June 14, 2015, Mr. Furman presented at New York Presbyterian/Weill Cornell's emergency department with complaints of anemia, weight loss, fatigue, and extreme weakness. Blood cultures were taken, and a transthoracic echocardiogram and PET scan were performed. The blood cultures were positive for streptococcus and the echocardiogram demonstrated left ventricular hypertrophy and aortic valve and mitral valve vegetation. Based upon these findings, Mr. Furman was diagnosed with

streptococcus gallolyticus endocarditis. He was placed on ceftriaxone and gentamycin to resolve the diagnosis.

On June 23, 2015, a transesophageal echocardiogram was performed, revealing additional vegetation and more aortic regurgitation. On July 1, 2015, Dr. Arash Salemi, M.D. (Dr. Salemi) performed replacements of aortic and mitral valves on Mr. Furman. Finally, on October 15, 2015, Mr. Furman underwent further procedures to close a mitral perivalvular leak.

Thereafter, on May 26, 2017, Mr. Furman commenced the instant action asserting claims sounding in medical malpractice against all defendants. Co-plaintiff Irina Furman (Mrs. Furman) asserts a derivative cause of action for loss of consortium and companionship. Subsequently, moving defendants served a joint answer asserting general denials and various affirmative defenses. Discovery took place, resulting in, among other exchanges, Mr. Furman providing verified bill of particulars as to each moving defendant. Mr. Furman specifically alleges that the moving defendants were negligent and departed from the accepted standards of practice by only performing an transthoracic echocardiogram, misinterpreting the transthoracic echocardiogram, failing to perform a transesophageal echocardiogram, which resulted in improper diagnosis and treatment of mitral and aortic valve endocarditis when he presented himself to their care in March 2015. As a consequence of this negligence and delay in care, Mr. Furman maintains he suffered additional deterioration, requiring invasive surgeries, and suffered pain, fatigue,

hypotension, and decreased life expectancy. Moving defendants now seek an order awarding them summary judgment, dismissing the action.

The Parties' Positions

Supporting their position, moving defendants, present, among other deposition testimonies, the transcripts of Mr. Furman, Dr. Dabiesingh, and Dr. Wang. They also proffer the medical records from several treating facilities and physicians Mr. Furman visited during the relevant period, including NYPBMH. Additionally, moving defendants present the expert affirmation of Dr. Stavros Mountantonakis, M.D. (Dr. Mountantonakis), a board-certified internist, cardiologist, and cardiac electrophysiologist. Fundamentally, the moving defendants' position is that Mr. Furman received appropriate medical treatment from Drs. Wang and Dabiesingh, which met the requisite standard of care during Mr. Furman's admission to NYPBMH between March 8, 2015 to March 10, 2015. They argue that there was no deviation from accepted standards of medical practice in Drs. Wang and Dabiesingh's treatment of Mr. Furman, specifically that the performance of only a transthoracic echocardiogram was appropriate, the interpretation of the echocardiogram was correct, and that the conclusion and diagnosis that Mr. Mr. Furman was experiencing obstructive hypertrophic cardiomyopathy aligned with the symptoms. Critically, they assert that Dr. Mountantonakis' expert affidavit establishes that moving defendants' treatment of Mr. Furman was appropriate and aligned with accepted medical standards and further, Mr. Furman's symptoms, diagnostics, and physical examinations in March 2015 did not suggest nor were characteristic of acute infective endocarditis.

Dr. Wang testified that she serves as faculty at NYPBMH. Among other responsibilities and duties, she interprets transthoracic echocardiograms. She averred that during the course of Mr. Furman's admission to NYPBMH, her sole connection to his care and treatment was interpreting his transthoracic echocardiogram. She maintains that her interpretation was accurate and consistent with the medical standards and that the results of the imaging study did not suggest nor require further imaging such as a transesophageal echocardiogram. Among other findings in her report, Dr. Wang testified that there was moderate calcification on the mitral valve. She testified that based upon her interpretation of Mr. Furman's transthoracic echocardiogram, the image indicated congestive heart failure and edema. Her report specifically and expressly states that the features she observed were "consistent with obstructive hypertrophic cardiomyopathy" (NY St Cts Elec Filing [NYSCEF] Doc No. 94, affirmation of moving defendant's counsel in support of motion, exhibit K at 205).

Dr. Dabiesingh testified that in March 2015, he was concluding, though still in, his cardiology fellowship at NYPBMH, under the supervision of attending physician Dr. Terrence Sacchi. He attested that he saw Mr. Furman after another physician, Dr. Islam, requested a cardiac consultation in connection with Mr. Furman's edema and hypertrophic cardiomyopathy. At the time Dr. Dabiesingh observed Mr. Furman, the transthoracic echocardiogram and Dr. Wang's interpretation of the echocardiogram had already been completed. Dr. Dabiesingh testified that by the time he performed his cardiac consultation, Mr. Furman's symptoms had largely resolved, principally that the swelling of his lower

extremities had dissipated. Dr. Dabiesingh testified that the consultation revealed a heart murmur located at the left sternal border and throughout the precordium. He further observed dynamic aortic radius, mitral regurgitation, and systolic anterior motion. He explained that based upon his entire evaluation and the symptoms Mr. Furman exhibited, his condition did not align with infectious endocarditis, but rather consistent with hypertrophic cardiomyopathy. While Dr. Dabiesingh directed that Mr. Furman seek future echocardiograms in several months, he testified that based upon his examination and the reports, he did not order a transesophageal echocardiogram to be performed on Mr. Furman.

Dr. Mountantonakis opines that Drs. Wang and Dabiesingh met the accepted medical standards of care and that any alleged deviation from the standard of care were not the proximate causes of Mr. Furman's alleged injuries. He presents that when Mr. Furman was admitted to NYPBMH, he exhibited lower extremity leg swelling and chest radiography showed pulmonary vascular congestion and cardiomegaly. He opines that during Mr. Furman's admission between March 8 to March 10, 2015, his symptoms were not suggestive of infective endocarditis. Particularly, Mr. Furman did not have a fever, no signs of septic emboli, and there was no laboratory evidence indicating an active systemic infection. Additionally, Dr. Mountantonakis submits that Mr. Furman's blood pressure was not low, which is typical of systemic infections like acute endocarditis, but rather was elevated. Further, "[t]he finding of mitral regurgitation in the setting of congestive heart failure was explained in the setting of hypertrophic obstructive cardiomyopathy and there

was no strong indication based upon the transthoracic echocardiogram to recommend a [transesophageal echocardiogram] during that hospitalization" (NYSCEF Doc No. 82, affirmation of moving defendant's counsel in support of motion, exhibit A, affirmation of Dr. Mountantonakis ¶ 55). He avers that Dr. Wang's interpretation of the transthoracic echocardiogram was accurate and that the conclusions Dr. Wang reached did not warrant a transesophageal echocardiogram. Additionally, he states that "failing to order a [transesophageal echocardiogram] was not a deviation from clinical practice" (*id.* at ¶ 58). Dr. Mountantonakis further opines that Dr. Dabiesingh acted appropriately, in accordance with acceptable standards of medical care, and that during the consultation there was no indication of infective endocarditis. Dr. Mountantonakis insists that it was reasonable not to order a transesophageal echocardiogram as Mr. Furman's condition was improving and his symptoms were dissipating in response to the treatment he was receiving. He opines that Mr. Furman's failure to comply with Dr. Dabiesingh's directives to follow up with the cardiology clinic and undergo future echocardiograms was the proximate cause of Mr. Furman's injuries.

Based upon the foregoing, moving defendants assert that they have demonstrated their entitlement to summary judgment dismissing the action. They maintain that Dr. Mountantonakis' expert affidavit establishes that Mr. Furman received appropriate care by Drs. Wang and Dabiesingh, which met the requisite standard of care. Alternatively, they argue that Mr. Furman's claim necessarily fails, as even assuming arguendo there was a departure from the requisite standard of care by failing to order a transesophageal

echocardiogram, such deviation was not the proximate cause of Mr. Furman's injuries. They contend that the proximate cause of Mr. Furman's injuries was his failure to follow up with the cardiology clinic and undergo additional echocardiograms at future dates.

Additionally, moving defendants posit that Mr. Furman's claim, to the extent its predicated on the theory of lack of informed consent, as stated in the respective bill of particulars, must be dismissed. They present that none of the evidence demonstrates a cognizable cause of action for lack of informed consent, principally there is no evidence demonstrating that Mr. Furman was unaware of the risks associated with his treatment or that his decisions to undergo any certain treatments would have been impacted by being made aware of any risks or alternatives. Moving defendants also argue that Mr. Furman's claim as to NYPBMH seeking damages for vicarious liability and negligent hiring and supervision, must be dismissed as NYPBMH lacks authority or control over Drs. Wang and Dabiesingh. Finally, moving defendants present that as the underlying cause of action against each requires dismissal, Mrs. Furman's derivative claim must be dismissed by operation of law.

In opposition, plaintiffs argue that Mr. Furman's medical history and symptoms at the time of his presentation to NYPBMH on March 8, 2015, and throughout his admission, were suggestive of bacterial endocarditis, warranting a transesophageal echocardiogram. Plaintiffs' assert that Drs. Dabiesingh and Wang departed from the accepted standard of care by failing to consider endocarditis, failing to perform a proper work up, misinterpreting the transthoracic echocardiogram, and failing to direct the taking of a

transesophageal echocardiogram. Supporting these contentions, plaintiffs proffer their expert physician affidavit. The physician opines that moving defendants' failure to timely diagnosis and treat Mr. Furman's endocarditis caused destruction of his aortic and mitral valves, requiring multiple surgeries and other sequelae. The physician further presents that in February 2015, Mr. Furman presented to NYPBMH with complaints of fever, chills, fatigue, weight loss and decreased appetite – all symptoms and signs suggestive of endocarditis. Based upon the physician's review of medical records, the physician states that when Mr. Furman was admitted to NYPBMH on March 8, 2015, he exhibited an elevated white blood count, low-grade fever, weakness, malaise, and onset of congestive heart failure. The physician asserts that Mr. Furman's presenting condition and recent prior admission, warranted a differential diagnosis which included endocarditis and appropriate testing to rule out the disease. The physician opines that Dr. Wang misinterpreted the transthoracic echocardiogram. Specifically, the physician notes that the transthoracic echocardiogram revealed signs of vegetation of the heart valves, which Dr. Wang mistakenly identified as node rate calcification of the anterior leaflet of the mitral valve and severe mitral valve regurgitation. The physician provides that the presence of vegetation on the mitral valve should have led to Dr. Wang directing a transesophageal echocardiogram; further, the physician opines that even absent Dr. Wang's misinterpretation, the impressions and findings Dr. Wang reached should have resulted in the performance of a transesophageal echocardiogram, which would have led to the proper diagnosis of endocarditis and prevented irreversible heart damage requiring valve

replacement surgery. Concerning Dr. Dabiesingh, the physician maintains that his failure to review Mr. Furman's medical records before performing the cardiac consultation and failing to consider endocarditis when he was aware of Mr. Furman's heart murmur both deviated from the accepted medical standards. The physician concludes as follows:

> "In sum, Dr. Dabiesingh and Dr. Wang departed from accepted standards of care under the circumstances for their failure to consider endocarditis and cause a proper workup for this condition to be performed. As a result, his condition was allowed to progress and become worse, leading to and causing the injuries as set forth above; in negligently failing to timely recognize, appreciate and be cognizant of the signs and symptoms of endocarditis including fevers, fatigue and malaise; in misinterpreting an abnormal TTE dated March 9, 2015; in failing to recommend and perform proper and timely testing, including blood cultures and a timely TEE to diagnose and or rule out endocarditis as the cause of the plaintiff's signs symptoms and complaints; in failing to timely treat endocarditis so as to avoid the development and progression of endocarditis leading to irreversible mitral and aortic valve damage; All of these departures were substantial factors in Mr. Furman suffering the injuries complained of" (NYSCEF Doc No. 105, affirmation of plaintiff's counsel in opposition, exhibit A, affirmation of expert physician ¶ 12).

Accordingly, plaintiffs insist questions of fact exist preventing accelerated judgment in moving defendants' favor.

In reply, moving defendants note technical defects in plaintiffs' opposition papers. Substantively, moving defendants insist plaintiffs' expert evidence fails to raise triable issues of fact as the expert opinion is conclusory and speculative, not based upon material and relevant facts, and fails to establish that any departure was the proximate cause of Mr. Furman's injuries. Moreover, moving defendants argue that plaintiffs' physician's opinion

is based upon limited and selective review of Mr. Furman's medical records, failing to address substantial portions of Mr. Furman's medical treatments. Additionally, moving defendants argue that certain statements provided in the plaintiffs' medical expert's opinion are a mischaracterization of the record or fail to capture the complete record. Further, they present that the plaintiffs' expert evidence fails to specifically present how either Drs. Wang or Dabiesingh's conduct deviated from accepted medical standards and how such deviation during Mr. Furman's March 2015 admittance to NYPBMH were the proximate cause of his injuries resulting in the diagnosis of streptococcus gallolyticus endocarditis in June 2015. Similarly, moving defendants argue that as plaintiffs' physician failed to specifically address the assertions presented by Dr. Mountantonakis. Finally, moving defendants again argue that the claims predicated on lack of inform consent, vicarious liability, negligent hiring and supervision, and Mr. Furman's derivative claim must fail and be dismissed.

Discussion

On a motion for summary judgment the court's function is issue finding, not issue determination (*see Trio Asbestos Removal Corp. v Gabriel & Sciacca Certified Pub. Accountants, LLP*, 164 AD3d 864, 865 [2d Dept 2018] [internal citations omitted]). "Summary judgment is a drastic remedy not to be used if there is any doubt that a triable issue of fact exists" (*Cunningham v Gen. Elec. Credit Corp.*, 96 AD2d 502, 502 [2d Dept 1983]). "A party moving for summary judgment must demonstrate that 'the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in

directing judgment' in the moving party's favor" (*Jacobsen v New York City Health & Hosps. Corp.*, 22 NY3d 824, 833 [2014], quoting CPLR 3212 [b]). "[T]he proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986] [internal citations omitted]). Once the movant sets forth a prima facie case, the burden of going forward shifts to the opponent of the motion to produce evidentiary proof in admissible form sufficient to establish the existence of a material issue of fact (*see Zuckerman v City of New York*, 49 NY2d 557, 557 [1980]).

"The elements of a medical malpractice cause of action are a deviation or departure 'from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries' (*DiLorenzo v Zaso*, 148 AD3d 1111, 1112 [2d Dept 2017], quoting *Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]). "Although, generally, a hospital cannot be held vicariously liable for the negligence of a private attending physician, concurrent liability will be imposed where, inter alia, a hospital's employees commit independent acts of negligence" (*Rosenstack v Wong*, 106 AD3d 804, 805 [2d Dept 2013]). "Therefore, when hospital employees, such as resident physicians and nurses, have participated in the treatment of a patient, the hospital may not be held vicariously liable for resulting injuries where the hospital employees have merely carried out the private attending physician's orders" (*Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2d Dept 2018]). "Thus, in order to establish its entitlement to judgment as a

matter of law defeating a claim of vicarious liability, a hospital must demonstrate that the physician alleged to have committed the malpractice was an independent contractor and not a hospital employee, and that the exception to the general rule did not apply (*Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d 948, 949-50 [2d Dept 2020]).

"In moving for summary judgment dismissing a cause of action alleging medical malpractice, a defendant [doctor] must establish, prima facie, that there was no departure or deviation from the accepted standard of care or that such departure or deviation was not a proximate cause of any injury to the plaintiff" (*Attia v Klebanov*, 192 AD3d 650, 651 [2d Dept 2021]). "In pursuance of its prima facie burden of proof, the moving defendant is required to address the factual allegations set forth in the plaintiffs' bill of particulars with reference to the moving defendant's alleged acts of negligence and the injuries suffered with competent medical proof" (*DiLorenzo*, 148 AD3d at 1112). "To establish a cause of action to recover damages for malpractice based on lack of informed consent, a plaintiff must prove '(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury'" (*Figueroa-Burgos v Bieniewicz*, 135 AD3d 810, 811 [2d Dept 2016], quoting *Spano v Bertocci*, 299 AD2d 335, 337-339 [2d Dept 2002]). The third element is construed to mean

that the actual procedure performed for which there was no informed consent must have been a proximate cause of the injury (*Trabal v Queens Surgi-Ctr.*, 8 AD3d 555, 556-557 [2d Dept 2004]).

"'Where a defendant makes a prima facie showing on both elements [of a medical malpractice claim], the burden shifts to the plaintiff to rebut the defendant's showing by raising a triable issue of fact as to both the departure element and the causation element'" (*Blau v Benodin*, 190 AD3d 922 [2d Dept 2021], quoting *Gilmore v Mihail*, 174 AD3d 686, 687 [2d Dept 2019]). The rebutting expert evidence must not be speculative, conclusory, or unsupported by the record (*see Elstein v Hammer*, 192 AD3d 1075 [2d Dept 2021]; *Wagner v Parker*, 172 AD3d 954, 955 [2d Dept 2019]; *Choida v Schirripa*, 188 AD3d 978, 979 [2d Dept 2020]). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record" (*Tsitrin v New York Community Hosp.*, 154 AD3d 994, 996 [2d Dept 2017]). Ultimately, where the plaintiff presents sufficient expert evidence rebutting the prima facie showing, summary judgment must be denied and the trier of fact must determine issues of credibility (*see Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]).

Here, moving defendants have demonstrated entitlement to partial summary judgment to the extent Mr. Furman's claim is predicated on the lack of informed consent. However, questions of fact preclude the granting of accelerated judgment dismissing the action in all other respects. First turning to plaintiffs' claims to the extent they are

predicated on lack of informed consent, moving defendants demonstrated through the testimony of Mr. Furman and Drs. Wang and Dabiesingh, along with proffered medical records, their prima facie case that the necessary elements of a medical malpractice claim based upon lack of informed consent are not present in the instant action. The evidence reveals that there were no treatments or procedures undertaken on Mr. Furman by moving defendants which led to his injuries, as required to establish a cause of action predicated on lack of informed consent (*see Trabal*, 8 AD3d at 556-557). In opposition, plaintiffs fail to present evidence raising a triable issue of fact or even address those arguments raised by moving defendants. Accordingly, to the extent plaintiffs' causes of action are predicated on the theory of lack of informed consent, summary judgment is granted to moving defendants dismissing those branches of the complaint.

Addressing the remainder of plaintiffs' action, Mr. Furman's essential allegations against the moving defendants are that they deviated from accepted medical standards by failing to adequately diagnose and treat him for mitral and aortic valve endocarditis in between March 8 and March 10, 2015. The negligent conduct attributable to Dr. Wang, which plaintiffs maintain constitutes medical malpractice, was failing to properly interpret the transthoracic echocardiogram and failing to direct the taking of a transesophageal echocardiogram. The alleged negligent conduct attributable to Dr. Dabiesingh was failing to review Mr. Furman's medical history and failing to consider endocarditis after his consultation revealed a heart murmur. Finally, by virtue of Drs. Wang and Dabiesingh's

employment with NYPBMH, plaintiffs maintain NYPBMH is liable for the negligent conduct of its employees.

Defeating these allegations, moving defendants present the expert affirmation of Dr. Mountantonakis. Dr. Mountantonakis averred that based upon his review of the relevant medical records and his expertise in the field, that moving defendants' conduct did not deviate from acceptable medical standards. Dr. Mountantonakis submitted that Mr. Furman did not present to NYPBMH with symptoms consistent with endocarditis, that Dr. Wang interpreted the transthoracic echocardiogram accurately, and based upon the conclusion reached from it, that she properly did not direct the taking of a transesophageal echocardiogram. Similarly, Dr. Mountantonakis opines that Dr. Dabiesingh properly performed his cardiac consultation and there were no indications that Mr. Furman was suffering from infective endocarditis. Moving defendants accordingly met their prima facie burden demonstrating dismissal of the plaintiffs' action against Drs. Wang and Dabiesingh, and by operation of law, as against NYPBMH.

However, in opposition, plaintiffs defeated moving defendants' prima facie case, raising triable issues of fact with the presentation of their expert physician's affidavit. Rebutting Dr. Mountantonakis, plaintiffs' expert physician opines that based upon his/her review of Mr. Furman's medical records, Drs. Wang and Dabiesingh deviated from accepted medical practices resulting in Mr. Furman's injuries. Plaintiff's expert physician maintains that the moving defendants should have directed the taking of a transesophageal echocardiogram to determine if Mr. Furman was suffering from endocarditis.

Additionally, the expert physician opined that Mr. Furman's presenting symptoms were consistent with endocarditis and that the treating physicians failed to consider this as a potential diagnosis. Further, the expert physician asserts that Dr. Wang failed to properly interpret the transthoracic cardiogram and Dr. Dabiesingh failed to review Mr. Furman's medical history and recognize a heart murmur as a symptom of endocarditis.

Thus, the instant action is the "'prototypical battle of the experts'" (*Owens v Ascencio*, - AD3d -, 2022 NY Slip Op 06133 [2d Dept Nov. 2, 2022], quoting *Rivera v City of New York*, 80 AD3d 595, 596 [2d Dept 2011]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, since conflicting expert opinions raise credibility issues which are to be resolved by the factfinder" (*Kovacic v Griffin*, 170 AD3d 1143, 1144 [2d Dept 2019] [internal quotation marks and citations omitted]).

Conclusion

Accordingly, it is

ORDERED that moving defendants' motion for summary judgment is granted to the extent that plaintiffs' action insofar as it's predicated on the theory of lack of informed consent is hereby dismissed; and it is further,

ORDERED that the moving defendants' motion for summary judgment is denied in all other respects.

To the extent not specifically addressed herein, the parties' remaining contentions have been considered and found to be either meritless and/or moot.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.

HON. BERNARD J. GRAHAM