Kursky v Harvey
2023 NY Slip Op 31319(U)
April 13, 2023
Supreme Court, New York County
Docket Number: Index No. 805144/2019
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY, *Justice*	PART 56M
JULIA KURSKY, deceased, by the Executor of her Estate, DOREEN HYMAN, Plaintiff, - v - BEN-GARY HARVEY, M.D., HARSIMRAN SINGH, M.D., and NEW YORK PRESBYTERIAN WEILL CORNELL MEDICAL CENER Defendants.	INDEX NO. 805144/2019 MOTION DATE 01/23/2023 MOTION SEQ. NO. 001 **DECISION + ORDER ON MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 001) 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice, lack of informed consent, and wrongful death, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff does not oppose the motion. The motion is granted, and the complaint is dismissed.

The crux of the dispute is that the defendant pulmonologist Ben-Gary Harvey, M.D., who evaluated the plaintiff's decedent for pulmonary hypertension in advance of a possible hip replacement procedure, departed from good and accepted practice by improperly recommending that the decedent undergo a contraindicated right-heart catheterization procedure, ordering the procedure without consulting with the decedent's primary cardiologist, and failing to account for the decedent's medical history. The plaintiff also averred that the defendant Harsimran Singh, M.D., negligently performed the procedure, thus causing her decedent to develop a pulmonary aneurysm secondary to the catheterization, and that the aneurysm ultimately caused her decedent's death seven months after the procedure. The plaintiff further asserted that the defendants failed to obtain her decedent's fully informed

consent to the procedure by failing to explain all of the risks and benefits of the procedure, and the alternatives thereto. In support of their motion, the defendants submitted the pleadings, the plaintiff's bill of particulars as to each of them, the transcripts of the parties' depositions, relevant medical and hospital records, an attorney's affirmation, a memorandum of law, and the expert affirmations of board-certified internist James N. Slater, M.D., and board-certified internist and pulmonologist Alan Mensch, M.D.

Dr. Slater, who averred that he had conducted hundreds of right-heart catheterizations to evaluate patients for pulmonary hypertension, concluded that Singh, an interventional cardiologist, did not depart from good and accepted medical practice when he performed a right-heart catheterization on the plaintiff's decedent on August 29, 2017, and that his treatment was not the proximate cause of the decedent's death on March 8, 2018. Specifically, Dr. Slater asserted that, although the catheterization was performed properly, it likely caused a small pulmonary artery perforation, and that the decedent's vascular system responded by creating a pseudoaneurysm, but not a true aneurysm. He opined that Singh and the other health-care providers assisting him fully and successfully addressed any problems presented by the pseudoaneurysm by installing coils, and that the decedent died due to other conditions and comorbidities long after she underwent the procedure.

Dr. Slater first explained the purposes of a right-heart catheterization and the manner in which it should be performed, including the proper equipment that should be used, the measurements and tests that should be performed intraoperatively, and the propriety of administering medication intraoperatively to dilate blood vessels. He then described the difference between a pseudoaneurysm and a true aneurysm, explaining that

> "[a] pseudoaneurysm is a pooling of blood caused by injury to a blood vessel (usually an artery). It's also called a 'false aneurysm.' Pseudoaneurysms are often complications from medical procedures, like an angiogram or right heart catheterization. A pseudoaneurysm is localized, which means the blood leakage occurs in one specific location where the artery has been injured. If a pseudoaneurysm were to later rupture, it can cause serious complications, or even death.

> "The main difference between a pseudoaneurysm and an aneurysm is the kind of material that surrounds it. This is known as the 'wall' that contains the pseudoaneurysm or aneurysm. An aneurysm is a bulge causing a widening within your artery. That bulge still has all three layers of the artery wall (intima, media and adventitia) as its own wall. Conversely, a pseudoaneurysm includes none of the usual layers of the arterial wall. Instead the wall is made of connective tissue that forms when the artery is injured. This wall is much weaker than an aneurysm's wall. The pseudoaneurysm often has a narrow 'neck' that connects it to the artery."

He also asserted that aneurysms appear in different shapes and sizes, and are more likely than pseudoaneurysms to be wider in the middle and narrower towards the endpoints, thus bulging out on all sides of the artery. Conversely, he stated that pseudoaneurysms have an eccentric, sac-like shape, that is, they are rounder and protrude from one side of an artery, and do not make the artery wall expand outward on all sides.

Dr. Slater asserted that coils or micro coils are the preferred and most widely used agents for embolization of a pulmonary artery pseudoaneurysm. As he explained it, they act by slowing the flow of blood to the pseudoaneurysm by virtue of mechanical obstruction, thereby inducing thrombosis via their thrombogenic fibers, as well as inciting inflammatory reaction. Dr. Slater further explained that the main aim of coil embolization is the occlusion of the pseudoaneurysm and its neck, or its exclusion from circulation, either of which would protect a patient from a possible, and possibly harmful, rupture. According to Dr. Slater, the usual healing process then rebuilds the normal arterial wall.

Dr. Slater opined that Singh's technical performance of the procedure was "textbook," and "entirely pursuant to the standard of care." As he explained it, once Singh noted that the decedent began coughing at the time of, or shortly after, the insertion of a Swan Ganz Catheter, and then coughed up blood, Singh became concerned that a pulmonary artery perforation had occurred. As Dr. Slater characterized it, Singh immediately and appropriately called in the proper specialists for assistance, had a pulmonologist perform a bronchoscopy, increased the amount of oxygen that the decedent was receiving, and had the decedent intubated. According

to Dr. Slater, all of the health-care providers who assisted Singh acted appropriately to stabilize the decedent. He further opined that Singh was correct in his assessment that the decedent experienced a bleed in her pulmonary artery, likely from the Swan-Ganz catheter, which he characterized as an acknowledged but minimal risk of a right-heart catheterization procedure.

Dr. Slater concluded, however, that the decedent did not have the typical large pulmonary artery perforation that sometimes occurs in right-heart catheterization procedures because, had she sustained an extensive or large pulmonary artery perforation, she would not likely have survived the procedure itself, despite everyone's best efforts. In light of the fact that the decedent survived for seven months after the procedure, he reasoned that the decedent suffered a partial or minute tear of the artery, likely caused when the angiography balloon was inflated. Dr. Slater concluded that Singh was able to stabilize the tear, while interventional radiologists were able to repair the pseudoaneurysm with a coil, which he described as the rough equivalent of a patch. Dr. Slater thus averred that

> "there certainly was no long-term injury to the patient from the perforation, the development of a pseudoaneurysm or the . . . coiling procedure. This is evidenced by the fact that she survived long after having the coiling procedure (approximately 7 months) which patched the pulmonary artery defect, and the fact that she had an inpatient rehabilitation admission, after which she was discharged to home."

Rather, in Dr. Slater's estimation, the overall poor medical condition of the 81-year-old decedent "was already catching up to her in August 2017," and "her demise was nearing given her advanced age and significant comorbidities, including COPD, atrial fibrillation, Parkinson's disease, and severe pulmonary hypertension." As he phrased it, those medical issues "had long been affecting the quality of her life and her life expectancy, as evidenced by the fact that she required supplemental oxygen, had fallen on several occasions and had already required one hip surgery in 2015, all prior to the procedure performed by Dr. Singh." According to Dr. Slater, these issues, along with others unrelated to the procedure, caused the decedent's death in March 2018, rather than anything that occurred before, during, or after the right-heart

catheterization that Singh performed on August 29, 2017. He expressly and unambiguously opined that the treatment that Singh rendered to the decedent on August 29, 2017 did not cause or contribute to her death on March 8, 2018.

Dr. Slater expressly rejected the plaintiff's allegation that Singh negligently caused a pulmonary aneurysm secondary to the catheterization, concluding that, at worst, Singh caused a small perforation that, in turn, developed a pseudoaneurysm that was addressed by the remedial coiling procedure that protected the decedent against a rupture and concomitant further bleeding. He stated that the decedent's "body, in and of itself, developed the pseudoaneurysm, which did not cause her any pain or further medical issue once it was coiled." Dr. Slater also rebutted the plaintiff's allegation that Singh negligently failed to take into account the decedent's medical history or the conditions that she presented to him. Rather, he concluded that it was the decedent's "extensive medical history, and current/presenting severe pulmonary hypertension, that appropriately resulted in the right heart catheterization" in the first instance, "in the hope of optimizing her condition."

As to the plaintiff's allegation that Singh failed to obtain her decedent's fully informed consent to the procedure because he did not warn her of the risk of developing an aneurysm, Dr. Slater asserted that an aneurysm is not an expected risk of a right-heart catheterization, that it thus would not be necessary for a physician to warn of an aneurysm, and that the decedent did not experience an aneurysm in any event, but rather a pseudoaneurysm. He further opined that "Singh's preoperative note is one of the best the I have ever personally seen in regard to the patient being aware of the risks and complications of the procedure. He was careful and thorough, and provided all reasonable possibilities."

Dr. Mensch opined that the defendant pulmonologist Harvey, who had seen the decedent on August 24, 2017 for a preoperative evaluation, did not depart from good and accepted medical practice, did not cause or contribute to the decedent's injuries or death, and obtained the decedent's fully informed consent to the procedure. He explained that, inasmuch

as the decedent was in the process of being evaluated for a possible left hip replacement procedure, she had been referred to Harvey to assess her degree of pulmonary hypotension, as well as to ascertain whether any medications would be appropriate to treat that condition.

Dr. Mensch opined that the right-heart catheterization was not contraindicated, but was indeed appropriate, since the decedent had multiple co-morbidities, including a history of smoking 1½ packs of cigarettes per day for 30 years, underlying Parkinson's disease, systemic hypertension, pulmonary hypertension, and congestive heart failure, for which had been seen at New York University Medical Center in November and December 2016, coronary artery disease requiring the placement of three stents, and chronic obstructive pulmonary disease, requiring her to be on oxygen supplementation for more than two years. Dr. Mensch also noted that, shortly before her appointment with Harvey, she underwent a pulmonary function test that was consistent with reduced pulmonary capacity, and an echocardiogram that revealed decreased right ventricular function and impaired relaxation of the left ventricular area of the heart, consistent with heart failure with preserved ejection fraction. As Dr. Mensch explained it, Harvey, after examining the decedent and taking her history, recommended that she undergo the right-heart catheterization procedure, so that Harvey could comment on the patient's ability, in light of her hypertension, to withstand the hip replacement surgery.

Upon reviewing the decedent's medical records, Dr. Mensch concluded that the decedent had severe Group 2, 3, and possibly 4 pulmonary hypertension, thus warranting a complete preoperative evaluation. Dr. Mensch concluded that Harvey's assessments and recommendation all fell within the standard of care. Specifically, he asserted that Harvey's recommendation that the decedent undergo a right-heart catheterization procedure "was appropriate in order to measure the degree of pulmonary hypertension and investigate therapeutic interventions per the standard of care."

Dr. Mensch opined that

> "Given the severe degree of Ms. Kursky's pulmonary hypertension and the impending procedure, Dr. Harvey was absolutely correct in his deposition testimony that it was essential for her to be medically optimized for the procedure, which required the performance of a right heart catheterization. Evelyn Horn, M.D., one of Ms. Kursky's primary treating cardiologists, confirmed that Dr. Harvey was within his scope and authority to order this test. Additionally, his office records reflect that the . . . primary cardiologists' office was advised by Dr. Harvey's office staff of the procedure being scheduled---it is my opinion, with a reasonable degree of medical certainty, that this is sufficient contact by Dr. Harvey to that practice, and that the [claim that the] medical providers were not appropriately advised by their office staff is not his deficiency."

He further asserted that there was no basis for the plaintiff's allegation that Harvey negligently caused an aneurysm, since Harvey merely recommended that the decedent undergo the procedure, and referred her to Singh for that purpose, and because she did not sustain an aneurysm in any event. Dr. Mensch also expressly rejected the plaintiff's contention that Harvey failed to explain the risks of the procedure, or that he failed to take into account the decedent's medical history when formulating his recommendations.

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 or her 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]). Moreover, 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 contains "[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).

The elements of a cause of action for lack of informed consent are

> "(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"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

Dr. Slater's affirmation established, prima facie, that Singh did not depart from good and accepted medical practice in performing the right-heart catheterization procedure upon the decedent, that the small pulmonary artery perforation did not cause a true aneurysm, that the pseudoaneurysm that did develop was fully and successfully treated intraoperatively, and that the pseudoaneurysm did not cause or contribute to the decedent's death seven months after the procedure. His affirmation further demonstrated, prima facie, that the informed consent obtained by Singh was qualitatively sufficient. Dr. Mensch's affirmation established, prima facie, that Harvey did not depart from good and accepted medical practice in diagnosing the decedent with various pulmonary conditions or in recommending that she undergo the right-heart catheterization procedure to determine whether she would be able to withstand a potential hip replacement procedure. In addition, Dr. Mensch's affirmation established, prima facie, that the informed consent obtained by Harvey was qualitatively sufficient.

Inasmuch as the plaintiff elected not to oppose the defendants' motion, she has failed to raise a triable issue of fact, and both Singh and Harvey must be awarded summary judgment dismissing the complaint insofar as asserted against them. Since the claims asserted against

the defendant New York Presbyterian Weill Cornell Medical Center were premised solely on its purported vicarious liability for the negligence of Singh and Harvey, and the complaint is being dismissing against those physicians, the defendants must also be awarded summary judgment dismissing the complaint against New York Presbyterian Weill Cornell Medical Center.

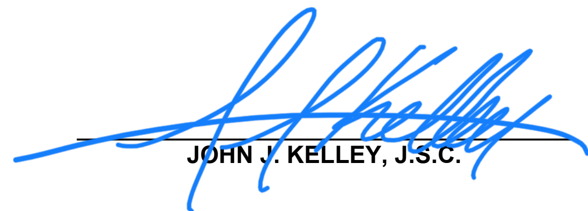
Accordingly, it is

ORDERED that the defendants' motion is granted, the defendants are awarded summary judgment dismissing the complaint insofar as asserted against each of them, and the complaint is dismissed insofar as asserted against all of the defendants; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint as against all of the defendants.

This constitutes the Decision and Order of the court.

4/13/2023
DATE



JOHN J. KELLEY, J.S.C.

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