Min Min Than v Braha
2023 NY Slip Op 31525(U)
April 24, 2023
Supreme Court, Kings County
Docket Number: Index No. 506534/2019
Judge: Genine D. Edwards
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At an IAS Term, Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 24th day of April 2023.

PRESENT:

HON. GENINE D. EDWARDS,
Justice.

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MIN MIN THAN, as Administratrix of the Estate of KO SWE, Deceased, and MIN MIN THAN, Individually,

Plaintiffs,

-against-

JACK BRAHA, D.O.,
SULTAN S. KHAN, M.D., and
MOUNT SINAI BROOKLYN,

Defendants.

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DECISION, ORDER, AND JUDGMENT

Index No. 506534/19

Mot. Seq. No. 1-3

The following e-filed papers read herein:	NYSCEF Doc. Nos.:
Notice of Motion, Affirmations, and Exhibits Annexed..............	1-42; 52-64; 66-80
Affirmations (Affidavits) in Opposition, and Exhibits Annexed......	84-95; 96-97; 98-99
Reply Affirmations and Exhibits Annexed..............................	101-104; 106-107; 105

In this action to recover damages for medical malpractice, wrongful death, and lack of informed consent, Jack Braha, D.O. ("Dr. Braha"), Sultan S. Khan, M.D. ("Dr. Khan"), and Mount Sinai Brooklyn ("MSB"[1] and collectively with Drs. Braha and Khan, "defendants") separately moved for summary judgment dismissing all claims as against him or it (as applicable). Min Min Than ("plaintiff"), individually and as the Administratrix of the Estate of her late father, Ko Swe (the "patient"), opposes insofar as

[1] MSB was also known as Mount Sinai Beth Israel Brooklyn. MSB's records at 001. All references to MSB's records were to their full version e-filed in two parts under NYSCEF Doc. Nos. 79-80. When quoting from MSB's records, the Court spelled out all abbreviations.

defendants sought dismissal of her medical malpractice and wrongful death claims, but did not oppose dismissal of the lack of informed consent claim.[2]

Background

This action arose out of the series of events that transpired during the course of the patient's hospitalization at MSB from the late evening of Saturday, December 23, 2017 until his death in the early morning of Friday, December 29, 2017[3] (the "hospitalization"), for the upper gastrointestinal bleeding ("UGIB") from the preexisting ulcer in his duodenum (the "duodenal ulcer"). In addition to the immediately preceding episode of bloody vomitus at home, the patient, on presentation to MSB, complained of (among other conditions) gastroesophageal reflux disease for which he had been taking several types of acid suppressants at home. The patient's Hemoglobin reading of 7.9 at 00:06 hours on December 24 confirmed a prior bleeding episode from his duodenal ulcer. On admission to MSB at 02:42 hours on December 24, its emergency department ("ED") attending assigned Dr. Khan to act as the patient's attending physician supervising his overall care. Dr. Khan, in turn, involved Dr. Braha as the specialist in the field of gastroenterology because of the ED attending's suspicion that the patient, on presentation, was suffering from the UGIB.[4] Neither the patient nor his family had any input into MSB's selection of Dr. Khan or Dr. Braha, both of whom happened to have

[2] Plaintiff's Affirmation in Opposition to Defendants' Motions for Summary Judgment, dated January 13, 2023, ¶ 4 (NYSCEF Doc. Nos. 84 and 96).

[3] All date references were to the 2017 calendar year, unless otherwise indicated. For the sake of uniformity, all time references were converted to military time.

[4] Dr. Braha's deposition tr at page 55, line 24 to page 56, line 3.

been on call at the time of the patient's admission to MSB, although, in the case of Dr. Braha, he also functioned as the administrative chief of gastroenterology at MSB.[5]

Various delays in rendering medico-surgical care to the patient interspersed the course of his hospitalization since its inception. Although the standard operating procedure was for an upper endoscopy (the "endoscopy") to be performed within 24 hours of presentation to confirm (or rule out) an UGIB in an individual (like the patient here) with a high index of suspicion for peptic ulcer bleeding,[6] Dr. Braha could not commence the endoscopy until 08:50 hours[7] on December 25, or approximately 33 hours after the patient's presentation to MSB in the late evening of December 23. The reason for the delay was that the patient had not been put on the "nothing-by-mouth" order until midnight of December 25 and had been permitted to eat in the meantime.[8] The record, when viewed in a light most favorable to plaintiff (as it must be at this stage of litigation), reflected that the patient's endoscopy lasted for only five minutes from 08:50 hours to 08:55 hours, with his remaining one-hour stay in the endoscopy suite until 09:55 hours having been apparently devoted to his post-procedure assessment,[9] after which he was

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[5] Dr. Braha's deposition tr at page 26, lines 10-12; page 31, lines 5-17.

[6] As was noted in passing by plaintiff's expert internist in ¶ 51 of his/her affirmation (NYSCEF Doc. No. 86).

[7] The Court credits the independent "Amb-Surg/Endoscopy Service Procedure Record" for the start of the endoscopy at 08:50 hours over Dr. Braha's own procedure note that timed the start of the endoscopy approximately one hour earlier at 07:56 hours. *Compare* MSB's records at 057 (NYSCEF Doc. No. 79) *with* Dr. Braha's endoscopy report (NYSCEF Doc. No. 93).

[8] MSB's records at 044 (at 08:50 hours on December 24, the patient ate breakfast brought in by one of his daughters); at 044 (at 16:04 hours on December 24, the patient ate hospital lunch). Dr. Braha's deposition tr at page 61, lines 17-21 ("Q. . . . [I]f [the patient] ate recently[,] does that mean that he couldn't undergo an endoscopy? A. Right. He has a full stomach with food.").

[9] MSB's records at 057.

transferred to the recovery room.[10] The record further suggested that the endoscopy might have been truncated by the patient's "full stomach," as reflected in the "Anesthesia/Pain Management Record" which listed "full stomach" among other elements of the patient's "important medical history."[11]

During the five-minute endoscopy, Dr. Braha found a 10 mm ulcer in the patient's duodenum, with a clean base, no signs of active bleeding, and no stigmata (or signs) of a recent bleeding.[12] Dr. Braha prescribed an intravenous regimen of an acid-suppression medication for two consecutive days, recommended a follow-up endoscopy to be performed in four weeks,[13] and, subject to Dr. Khan's prior approval, anticipated the patient's discharge from MSB two days later on December 27.[14]

The events preceding (as well as those following) the December 25th endoscopy proved that Dr. Braha's post-endoscopy recommendations/suggestions were overly optimistic. The *pre-endoscopic* events that were concerning for the ongoing post-admission, pre-endoscopic *bleeding* included:

(1) the patient's fainting episode at 16:08 hours on December 24 when, shortly after his attempts at passing stool on the commode, he nearly lost consciousness and had

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[10] The Court again credits the independent "Amb-Surg/Endoscopy Service Procedure Record" for the end of the endoscopy at 08:55 hours over Dr. Braha's own procedure note with the "finalized" time of 08:55 hours. The fact that Dr. Braha finalized his report at 08:55 hours (or, more precisely, at 08:55:50 hours) did not reflect the actual duration of the endoscopy. *Compare* MSB's records at 057 (NYSCEF Doc. No. 79) *with* Dr. Braha's endoscopy report (NYSCEF Doc. No. 93).

[11] MSB's records at 061.

[12] MSB's records at 460.

[13] MSB's records at 460.

[14] Dr. Braha's deposition tr at page 89, line 20 to page 90, line 3; page 83, line 23 to page 84, line 9.

to be equipped with a non-breather mask to receive his oxygen,[15] as well as carried back to his ED pod on a stretcher;[16]

(2) the stool which the patient passed (or attempted to pass) while sitting on the commode was black[17] and subsequently tested positive for occult blood;[18]

(3) the patient's hemoglobin reading as reported at 20:48 hours on December 24 was 5.3 (which was significantly lower than the reading of 7.9 approximately twenty hours earlier at 00:06 hours of the same day);[19] and

(4) in response to the intervening hemoglobin drop, the patient received "blood products"[20] in the late evening/early morning of December 24-25 preceding the endoscopy.[21]

The *post-endoscopic* events for the remainder of the endoscopy day on December 25 as well as for the entirety of the next day of December 26, were concerning for a potential post-endoscopic *re-bleeding*. Those post-endoscopic events included:

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[15] The patient had been on the 2 liters per minute oxygen by nasal cannula since admission. MSB's records at 042.

[16] MSB's records at 044. The patient was not moved from the ED to a room until 17:27 hours on December 24 (MSB's records at 042).

[17] MSB's records at 044 ("noted with stool on rectal area, black in color"). At 16:47 hours on December 24, nonparty hospitalist Dr. Batterman was made "aware of the patient's near syncopal episode while using the commode" (MSB's records at 044).

[18] MSB's records at 575.

[19] MSB's records at 547.

[20] Because the patient (throughout his hospitalization) received fresh blood plasma, packed red blood cells, and platelets, the Court was using a collective term "blood products" to encompass any/all types of products used in the transfusions.

[21] MSB's records at 092, 100-101, 105-110, 114, 117, and 128-129.

(1) the downtrend of the patient's hemoglobin from its initial post-endoscopic increase to 8.3 at 14:10 hours on December 25, to a drop to 7.6 at 09:23 hours on December 26, and to a further drop to 7.2 at 22:04 hours on December 26;[22]

(2) the radiographic finding on the patient's abdominal CT scan, reported at 14:20 hours on December 25, of a rectosigmoid fecal impaction with stercoral proctitis;[23]

(3) the notes of the patient's consulting hematologist, nonparty Dr. Blokh (at his bedside consultation at 14:55 hours on December 25), stating that: (i) the patient's condition presented a "[v]ery complicated case," (ii) he was suffering from a "severe anemia," and (iii) his blood sample (on a peripheral blood smear) contained "toxic granulations";[24]

(4) Dr. Khan's bedside-visit notation, made approximately 24 hours later, at 13:22 hours on December 26, stating that the patient was "weak [and] complaining of abdominal pain";[25]

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[22] MSB's records at 534.

[23] MSB's records at 456. "Stercoral" or "stercoraceous" means "[r]elating to or containing feces." Stedman's Medical Dictionary, entry 848910. "Proctitis" is the "[i]nflammation of the mucous membrane of the rectum." *Id.*, entry 724850.

[24] MSB's records at 551. "Toxic granulation, a rather nonspecific finding, is found in a variety of disorders including ***infections*** and metabolic derangements." CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LABORATORY EXAMINATIONS, 3rd ed., Chapter 155 - Peripheral Blood Smear (available at https://www.ncbi.nlm.nih.gov/books/NBK263/) (last accessed April 17, 2023) (emphasis added). In fact, the patient's blood culture, subsequently reported at 04:00 hours on December 27, was gram positive for "cocci chains," a form of Streptococcus bacteria. Stedman's Medical Dictionary, entry 854300; MSB's records at 050.

[25] MSB's records at 538.

(5) a nursing observation six hours later, at 20:15 hours on December 26, that the patient was lethargic with small emesis of bright red blood;[26]

(6) the admission of the patient with "active bleeding and hypotension" (and appearing "very pale and very lethargic[,] barely moving and . . . non-verbal") to the ICU two hours later at 00:08 hours on December 27;[27]

(7) a cardio-pulmonary arrest due to a hypovolemic shock, with the patient turning "totally unresponsive and pulseless" ten minutes later at 00:18 hours on December 27;[28] and

(8) revival of the patient by the code team seven minutes later at 00:25 hours on December 27.[29]

Once the patient was revived and placed in resuscitation in the ICU, the sole treatment modality (of the three generally available treatment modalities[30]) for his then-diagnosed post-endoscopic re-bleeding was an emergency surgery to sew over his duodenal ulcer. A repeat endoscopy, or, alternatively, a radiologic intervention to embolize the underlying bleeding vessel, were both contraindicated because of the serious concern for the duodenal ulcer's perforation which, in advance of the repeat

[26] MSB's records at 052.

[27] MSB's records at 155.

[28] MSB's records at 155 and 146.

[29] MSB's records at 155.

[30] A typically used trio of treatment modalities for a bleeding duodenal ulcer were an endoscopy, arterial embolization, and surgery.

endoscopy or the radiologic intervention, could not be ruled out by a CT scan because of the ongoing resuscitation as well as the patient's general instability.[31]

In the course of his resuscitation and in preparation for surgery, the patient underwent numerous blood-product transfusions which continued intraoperatively. From 11:05 hours to 14:30 hours on December 27, the patient underwent an exploratory laparotomy, an over-seal of the duodenal ulcer, and a jejunostomy – an extremely taxing surgery for the 79-year-old man with multiple preexisting comorbidities, exacerbated by the preceding massive blood losses.[32] Despite the "heroic efforts"[33] on the part of the ICU personnel to save the patient's life, he died from cardiac arrest in the early morning on December 29.[34]

On March 25, 2019, plaintiff commenced this action. In April and May 2019, each defendant interposed his (or its) answer, as applicable. On June 23, 2022, plaintiff filed a note of issue and certificate of readiness. Thereafter, each defendant timely moved for summary judgment. On February 10, 2023, the Court heard oral argument on the motions, reserving decision. Additional facts are stated when relevant to the discussion below.

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[31] Dr. Braha's deposition tr at page 97, lines 3-8; page 104, lines 14-18; page 105, lines 21-23; page 118, line 13 to page 119, line 6; page 120, lines 10-14; page 122, lines 12-16; page 122, line 23 to page 123, line 12; page 127, lines 9-14; page 128, lines 20-22; page 132, lines 11-25.

[32] MSB's records at 070 and 086.

[33] Dr. Braha's deposition tr at page 118, lines 11-12.

[34] MSB's records at 054.

Discussion[35]

On their separate motions for summary judgment, defendants established their prima facie entitlement to judgment as a matter of law with respect to the causes of action sounding in medical malpractice and wrongful death. Defendants did so through the submission of: (1) in the case of Dr. Braha, a detailed opening affirmation of his expert gastroenterologist (Michael Frank, M.D.) ("Dr. Braha's expert") (NYSCEF Doc. No. 32); (2) in the case of Dr. Khan, a succinct affirmation of his expert internist (Sanford Goldberg, M.D.) (NYSCEF Doc. No. 54); and (3) in the case of MSB, the detailed affirmations of its expert intensivist (Amit Uppal, M.D.) and its expert internist (Brian Feingold, M.D.) (NYSCEF Doc. Nos. 70 and 71, respectively). *See e.g. Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 508 N.Y.S.2d 923 (1986); *Feinberg v. Feit*, 23 A.D.3d 517, 806 N.Y.S.2d 661 (2d Dept., 2005).

In opposition to defendants' prima facie showing, plaintiffs' experts failed to raise a triable issue of fact as to any of the defendants. As the threshold matter, plaintiffs' two experts – one, an internist; the other, a surgeon – lacked "the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered [was] reliable" in the specialized fields of gastroenterology and interventional radiology. *See Behar v. Coren*, 21 A.D.3d 1045, 803 N.Y.S.2d 629 (2d Dept., 2005) (internal quotation marks omitted), *lv. denied* 6 N.Y.3d 705, 812 N.Y.S.2d 34 (2006); *see*

[35] For the sake of brevity, the recitation of the well-established summary judgment standards in medical malpractice cases was omitted. *See e.g. Coffey v. Mansouri*, 209 A.D.3d 714, 176 N.Y.S.3d 641 (2d Dept., 2022).

also Galluccio v. Grossman, 161 A.D.3d 1049, 78 N.Y.S.3d 196 (2d Dept.. 2018); *Mustello v. Berg*, 44 A.D.3d 1018, 845 N.Y.S.2d 86 (2d Dept., 2007), *lv. denied* 10 N.Y.3d 711, 860 N.Y.S.2d 483 (2008).

The absence of qualified expert submissions in the fields of gastroenterology and interventional radiology deprived plaintiffs' opposition of probative value on three key points. First, plaintiffs' experts were unable (nor did they attempt): (1) to challenge Dr. Braha's endoscopy finding of the clean-base, stigmata-free ulcer, which finding was based on the visual cues alone as they were subjectively interpreted by Dr. Braha; (2) to assess the intra-procedure quality indicators of the patient's five-minute-long endoscopy; and (3) to evaluate the Dr. Braha's competence in his preparation for, and in his performance of, the patient's endoscopy. Second, plaintiffs' experts were unable (nor did they attempt) to challenge Dr. Braha's expert's submission of the "Clinical Guideline on Management of Patients with Ulcer Bleeding" issued by the American College of Gastroenterology (the "practice guideline").[36] The practice guideline, which was issued in 2012 and was in effect at the time of the patient's endoscopy in 2017, "strongly"[37] recommended that: (1) the "[e]ndoscopic therapy should *not* be provided to patients who have an ulcer with a *clean base*"; and (2) the "[p]atients with ulcers that have . . . *clean bases* can receive standard [acid-suppression] therapy (*e.g.*, oral [acid suppressant] once

[36] The practice guideline, which was e-filed under NYSCEF Doc. No. 41, was published at Laine L., Jensen D.M., *Management Of Patients With Ulcer Bleeding*, AM. J. GASTROENTEROL., 2012;107:345-360.

[37] According to the practice guideline (at page 2), "[t]he strength of a recommendation is graded as strong when the desirable effects of an intervention clearly outweigh the undesirable effects."

daily)," as was the case here.[38] The practice guideline concluded, based on a study of 2,994 patients, that the average risk of rebleeding following the finding of a *clean-base, stigmata-free* ulcer at the index endoscopy (as was the case here) was only 5%.[39] Third and finally, plaintiffs' experts were unable (nor did they attempt) to challenge Dr. Braha's opinion (at page 105, lines 21-23 of his deposition testimony) that neither the repeat endoscopy nor the interventional radiology could have been utilized to stop the re-bleeding until and unless perforation of the ulcer was first ruled out by a CT scan – the necessary condition precedent that could not have been fulfilled in the patient's case because of his ongoing resuscitation.[40] According to Dr. Braha's unchallenged opinion (at page 116, lines 22-25 of his deposition testimony), the patient "ultimately never reached a point of hemodynami[c] stability to go for a [CT] Scan or to be . . . qualified to undergo an endoscopy."

There were further deficiencies in plaintiffs' experts' opinions. The first of the two opinions of plaintiffs' expert surgeon – and that expert rendered only two opinions,

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[38] Practice guideline's recommendations Nos. 15 and 21 at pages 3 and 4, respectively (emphasis added).

[39] Practice guideline at page 5.

[40] As Dr. Braha explained (at page 105, lines 4-17 of his deposition transcript):

> "When we're dealing with a patient with GI bleed[,] there are multiple things that we can consider doing for them. Most of which require that the patient is first resuscitated. That the patient has a protected airway if they're vomiting. So these are things that we're thinking of doing which [were] possible IR [interventional radiology and possible] endoscopy[,] but we were awaiting [CT scan] imaging because we were highly concerned about [the ulcer's] perforation where those two things [*i.e.*, endoscopy and interventional radiology] would be contraindicated[,] and we wanted imaging to see if we could[,] and at the time he needed to be resuscitated. He was not stable."

both in ¶¶ 35-36 of his/her affidavit[41] – that defendants failed "to timely transfer the patient to a facility with Interventional Radiology services available in light of the known risks of re-bleeding," ignored Dr. Braha's justifiable (and unchallenged) high index of suspicion that the patient's ulcer could have perforated after the endoscopy. The other opinion of plaintiffs' expert surgeon (also in ¶¶ 35-36 of his/her affidavit) that surgery to sew over the duodenal ulcer should have been started at (or shortly after) 20:12 hours on December 26 when consultation was requested from house surgeon Elliot Goodman, M.D. ("Dr. Goodman"), glossed over the undisputed fact that the patient was hemodynamically unstable at the time – in fact, he became even more unstable following his cardio-pulmonary arrest at 00:18 hours on December 27 – and required extensive, night-long resuscitation to prepare him for surgery in the morning of December 27.

The opinions of plaintiffs' other expert – those of her expert internist – fared no better. In addition to echoing the aforementioned opinions of plaintiffs' expert surgeon, her expert internist (in ¶¶ 40-41 of his/her affirmation) opined that the patient should have been admitted to the ICU upon discharge from the recovery room following the completion of the endoscopy, instead of being discharged to a regular (non-telemetry) floor. In so contending, plaintiffs' expert internist posited (in ¶ 41 of his/her affirmation) that "[i]t is *likely* that *had* the patient been admitted to the ICU following his endoscopy, *earlier* consultations with interventional radiology and/or surgical team *could* have been accomplished for *earlier* interventions, including a repeat endoscopy, and before his

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[41] Although titled as "affirmation," the opinion of plaintiffs' out-of-state expert surgeon was notarized, thus turning it into an affidavit (NYSCEF Doc. No. 87).

conditio[n] deteriorated to the extent it did on the night of December 26, 2017" (emphasis added). To accept plaintiffs' expert internist's contention would require this Court to engage in a multi-level series of speculations consisting of the following inferential leaps: First, *if* the patient had been admitted to the ICU from the recovery room following the endoscopy, the intensivists would have involved either Dr. Braha (for a repeat endoscopy) or Dr. Goodman (for surgery) sometime earlier, even though (according to the practice guideline) the patient at that time would not have been a candidate either for a repeat endoscopy or for surgery. Second, *if* the intensivists had involved Dr. Braha sometime earlier before the night of December 26, he would have proceeded with a repeat endoscopy – the inference that flew in the face of Dr. Braha's unequivocal deposition testimony that he would (and could) *not* have performed a repeat endoscopy without a prior CT scan clearance for lack of ulcer perforation. Third, *if* the intensivists had involved Dr. Goodman sometime earlier before 20:12 hours on December 26, he would have taken the patient to the operating table *without* resuscitating the patient in the interim – another unfounded inference. Fourth and irrespective of the foregoing, *if* the intensivists (and/or Dr. Goodman) requested sometime after the endoscopy a transfer of the patient to an outside interventional radiology service, the latter would have accepted the patient *without* waiting for him to be stabilized, with such hypothetical acceptance predicated on yet another unfounded assumption that the non-stabilized patient would have been able to tolerate the inter-hospital transfer. The Court declines to credit a string of assumptions and speculations of plaintiffs' expert internist. *See Kiernan v. Arevalo-Valencia*, 184 AD3d 727, 126 N.Y.S.3d 205 (2d Dept., 2020); *Capobianco v. Marchese*,

125 A.D.3d 914, 4 N.Y.S.3d 127 (2d Dept., 2015); *Shahid v. New York City Health & Hosps. Corp.*, 47 A.D.3d 800, 850 N.Y.S.2d 519 (2d Dept., 2008), *partially overruled on other grounds by Stukas v. Streiter*, 83 A.D.3d 18, 918 N.Y.S.2d 176 (2d Dept., 2011).

As noted, the patient had a clean-base, stigmata-free ulcer on the index endoscopy, which finding (according to the practice guideline) required no more than a two-day in-hospital administration of an acid suppressant. The development of a known complication – here, a post-endoscopic re-bleeding of the patient's duodenal ulcer – was not malpractice on the record before the Court. *See Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287, 993 N.Y.S.2d 73 (2d Dept., 2014); *Matos v. Schwartz*, 104 A.D.3d 650, 960 N.Y.S.2d 209 (2d Dept., 2013). In sum, there were no conflicting expert opinions that warrants a jury determination regarding the causes of action alleging medical malpractice and wrongful death as against any defendant. *See Tsitrin v. New York Community Hosp.*, 154 A.D.3d 994, 62 N.Y.S.3d 506 (2d Dept., 2017).

Although the patient's death was unfortunate, "a bad result does not, ipso facto, support a claim for medical malpractice." *Saliaris v. D'Emilia*, 143 A.D.2d 996, 533 N.Y.S.2d 607 (2d Dept., 1988) (internal quotation marks omitted). Inasmuch as defendants' respective experts demonstrated, prima facie, their entitlement to summary judgment as a matter of law, whereas plaintiffs failed to shoulder their burden via expert testimony in opposition, this Court is constrained by the parties' respective expert submissions to accept defendants' experts' positions. *See Ostrov v. Rozbruch*, 91 A.D.3d 147, 936 N.Y.S.2d 31 (1st Dept., 2012) ("Supplemental affirmations . . . should not be

utilized as a matter of course to correct deficiencies in a party's . . . answering papers.").[42]

Plaintiff's remaining contentions were considered, but this Court finds they are unfounded.

Conclusion

Upon the foregoing and after oral argument, it is

ORDERED that the respective branches of defendants' motions for summary judgment dismissing plaintiff's lack of informed consent claim as against them are *granted without opposition*; and it is further

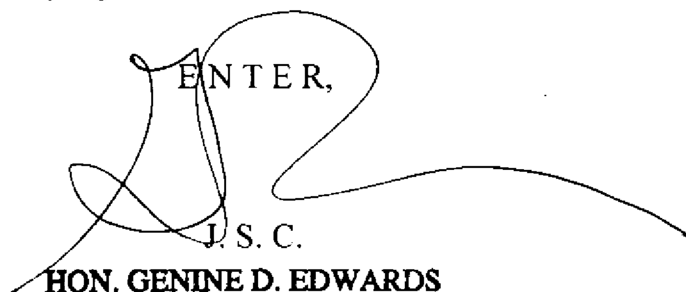
ORDERED that the remaining respective branches of defendants' motions for summary judgment dismissing plaintiff's medical malpractice and wrongful death claims as against them are *granted*, and the complaint is *dismissed* in its entirety as against all defendants without costs or disbursements; and it is further

ORDERED that Dr. Braha's counsel is directed to electronically serve a copy of this decision, order, and judgment with notice of entry on the other parties' respective counsel and to electronically file an affidavit of said service with the Kings County Clerk; and it is further

[42] The First Judicial Department's holding in *Ostrov v. Rozbruch* is binding on this Court in the absence (as was the instance here) of a contrary ruling from the Court of Appeals or the Second Judicial Department. *See Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 476 N.Y.S.2d 918 (2d Dept., 1984).

ORDERED that the parties' next appearance for an Alternate Dispute Resolution conference in the ADR Medical Malpractice Part on July 18, 2023, at 11:30 a.m. is canceled.

This constitutes the decision, order, and judgment of this Court.



E N T E R,

J. S. C.
HON. GENINE D. EDWARDS