SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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JARON MANDEL, AS EXECUTOR OF THE ESTATE OF JACK MANDEL,

Plaintiff,

- v -

STUART L. KANTERMAN, M.D., MICHAEL J. SCHWARTZ, M.D., HIMANSHU PANDYA, M.D., NORTH SHORE UNIVERSITY HOSPITAL, and NORTHWELL HEALTH, INC.,

Defendants.

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INDEX NO. 805223/2021

MOTION DATE 05/01/2023

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 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, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57

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

I INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, and wrongful death, the defendants Stuart L. Kanterman, M.D., Michael J. Schwartz, M.D., North Shore University Hospital (NSUH), and Northwell Health, Inc. (collectively the North Shore defendants), move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted to the extent that the North Shore defendants are awarded summary judgment dismissing the complaint insofar as asserted against Northwell Health, Inc., and the lack of informed consent cause of action insofar as asserted against the remaining North Shore defendants. The motion is otherwise denied.

II FACTUAL BACKGROUND

The crux of the plaintiff's claim is that, during the time that his decedent, Jack Mandel, was an inpatient at NSUH from January 30, 2021 until February 4, 2021, and while his decedent

remained a patient of Kanterman and Schwartz subsequent to discharge from NSUH, the North Shore defendants failed to diagnose the presence of deep vein thrombosis in his decedent's lower extremities, and inappropriately treated clotting and blockages prophylactically, rather than therapeutically, thus causing or contributing both to conscious pain and suffering and to the death of the plaintiff's decedent on February 24, 2021.

On July 15, 2019, Kanterman, an internist, first examined the decedent in connection with a routine annual checkup. From July 15, 2019 through June 8, 2020, the decedent continued routine treatment and follow-up examinations with Kanterman for multiple conditions, including anxiety disorder, insomnia, enlarged prostate (benign prostatic hyperplasia), elevated prostate-specific antigen, hyperlipidemia, hypertension, hypogonadism, erectile dysfunction, and renal insufficiency. During that period of time, the decedent also saw specialists in nephrology, endocrinology, and urology.

On January 30, 2021, the decedent, who then was 73 years old, presented to the NSUH emergency department, complaining primarily of abdominal pain radiating to his right flank, following one episode of bowl incontinence that occurred when he took a laxative to treat constipation. At a physical examination in the emergency department, the decedent reported urinary urgency and dribbling with very scanty urine, but he denied the presence of pain, discomfort, dysuria, hematuria, fever, chest pain, shortness of breath, nausea, vomiting, or diarrhea. A computed tomography (CT) scan of the decedent's abdomen and pelvis was administered without contrast at NSUH on January 30, 2021, and revealed the existence of an enlarged prostate with irregular soft tissue at the base of the bladder, with a bladder lesion not excluded, as well as mild bilateral hydroureteronephrosis and a 5.7- centimeter (cm) indeterminate left renal mass that was suspicious for renal cell carcinoma. Results from initial laboratory blood testing, also undertaken on January 30, 2021, revealed acute kidney injury with renal insufficiency, as the decedent's blood urea nitrogen level was at 170 milligrams per deciliter (mg/dL) of blood, while the reference range was 7 to 23 mg/dL, and his creatinine level

was 16.21 mg/dL, while the reference range was 0.50 to 1.30. In addition, the decedent evinced the presence of metabolic acidosis, inasmuch as his blood pH was 7.25, while the reference range was 7.35-7.45 and his base excess reading was -13.8, while the reference range was -2.0 to 2.0, evidencing a very low level of alkaline in the blood. Further, the decedent's blood carbon dioxide level was measured at 13 milliequivalents per liter (mEq/L) of blood, while the reference range was 22 to 30 mEq/L, and his potassium blood level was measured at 6.4 mEq/L, while the reference range was 3.5 to 5.3 mEq/L, and was thus indicative of hyperkalemia.

NSUH emergency room personnel inserted an indwelling Foley catheter into the decedent, yielding an initial drainage of 800 milliliters of dark yellow urine. Additional blood was drawn for a repeat metabolic blood testing panel, and the samples were sent to NSUH's nephrology department, which engaged in a consultation later on January 30, 2021. According to NSUH's records, although a physical examination of the decedent was normal, he was admitted to NSUH with diagnoses of acute kidney failure and obstructive uropathy. The plan upon admission was for continued use of Foley catheter, intravenous fluid hydration, administration of antibiotic prophylaxis, monitoring of repeated laboratory blood testing and urine output, and a consultation with the NSUH urology department.

Also on January 30, 2021, the defendant Himanshu Pandya, M.D., an internist, took a medical history from the decedent at NSUH, and performed a physical examination, which allegedly included a risk assessment for deep vein thrombosis and pulmonary emboli, which Pandya reported to be negative. Pandya documented the decedent's physical examination to be within normal limits, including cardiovascular rate and rhythm and vascular pulses. Pandya reported that the decedent's lungs were clear to auscultation bilaterally, and that all extremities were also within normal limits, with no cyanosis, clubbing, or edema. An internal medicine progress note generated by NSUH on January 31, 2021 documented that the decedent was anxious, but presented with a normal physical examination without cough, no chest pain, clear

lungs bilaterally, regular heart rate and rhythm, and no edema in his extremities. As set forth in the NSUH chart, the administration of the anticoagulant drug heparin for deep vein thrombosis prophylaxis was ordered on that date as well, and 5,000 units of heparin thereafter were administered subcutaneously every 12 hours, that is, twice daily, from January 31, 2021 through February 3, 2021 at 6:00 p.m., when the decedent allegedly refused a dose. According to the chart, the last dose of heparin was administered to the decedent in the morning of February 4, 2021, just prior to the decedent's discharge from NSUH later that day.

As the North Shore defendants described it, daily nursing notes throughout the decedent's admission documented a venous thromboembolism prevention protocol, which included passive range-of-motion exercises, active range-of-motion exercises, dorsiflexion, and plantarflexion, along with assessments for risk of bleeding, the maintenance of precautions against bleeding, the promotion of frequent ambulation, and the promotion of fluid intake. They further asserted that these daily notes also confirmed that decedent was out of bed and ambulating throughout the course of his admission to NSUH.

On February 2, 2021, a hematology/oncology consultation was performed, after which the hematology/oncology staff reported no history of malignancy or hematologic disorders, that the physical examination was within normal limits, and the results of blood testing showed improvement. Nonetheless, the hematology/oncology staff assessed the decedent as having leukocytosis, likely reactive to acute kidney injury, albeit with no evidence of myeloproliferative disorder on the CT scan, with blood iron levels consistent with chronic disease, albeit without evidence of overt bleeding. The hematology/oncology staff lodged no objection to the decedent's discharge on February 3, 2021, subject to an outpatient follow-up, including a complete blood count and eventual magnetic resonance imaging (MRI) scan to evaluate the renal mass that had been identified on CT scan.

On February 3, 2021, the decedent complained of left ankle pain, with concern for trauma. According the NSUH chart, however, a physical examination reflected the absence of

swelling, edema, erythema, and deformity, and the presence of a good range of motion in the ankle, although the chart noted that the decedent complained of pain on both dorsiflexion and plantar extension. The decedent also reported what was described as "chronic outpatient left knee pain." An X-ray of the left ankle that was performed at NSUH on February 3, 2021 was negative for acute fracture, but, according to the NSUH chart, revealed findings consistent with an old avulsion fracture of the medial malleolus and a large plantar and small dorsal calcaneal spur. The NSUH orthopedics staff discussed the X-ray with the attending physician, concluded that no intervention was warranted, and determined that the decedent could bear weight and ambulate to the extent that he could tolerate it.

A physical therapy evaluation that was undertaken on February 3, 2021 yielded a diagnosis of decreased functional mobility, albeit with an independent level of function and weight-bearing, as tolerated, on the decedent's left lower extremity. The evaluation recommended the use of a rolling walker as an assistive device and that, upon discharge, the decedent should engage in at-home physical therapy exercises two to three times per week for a duration of two weeks.

On February 4, 2021, the decedent was cleared for discharge from NSUH, upon the conclusion that his hyperkalemia had resolved. The decedent's diagnoses upon preparation for discharge were acute kidney injury, anxiety, obstructed uropathy, and anemia. The decedent was discharged from NSUH on February 4, 2021, with the Foley catheter remaining in place. He was instructed, among other things, to follow up with Kanterman on February 8, 2021 and to follow up with the defendant urologist Schwartz at the Smith Institute for Urology within one week to assess what were described as multiple comorbidities. According to the North Shore defendants, no post-discharge thromboprophylaxis was indicated; the administration of heparin thus was discontinued.

On February 8, 2021, Kanterman met with the decedent, who complained of left knee pain that had worsened during his hospitalization at NSUH. Kanterman performed a physical

examination of the decedent on that date, which he concluded was unremarkable, inasmuch as he found no acute distress, that the decedent was "well-appearing," and that his lungs were clear to auscultation, with no respiratory distress reported. Kanterman reported that a cardiac examination was normal with normal rate and regular rhythm. He further concluded that the decedent's gait was normal, that a musculoskeletal examination revealed grossly normal strength and tone, with no joint swelling, and that a vascular examination was normal, with no carotid bruits, no bruit "heard" in the abdomen, and no varicosities. While pedal pulses were present, no peripheral edema was observed, there was no palpable aorta, and no evidence of clubbing or cyanosis in the extremities. Kanterman averred that, on February 8, 2021, the decedent had no signs or symptoms of a clot, concluding that his complaint of left knee pain was orthopedic in nature, and thus referred the decedent to Northwell Orthopedics in connection with his complaint of left knee pain.

On February 11, 2021, Schwartz saw the decedent at an initial post-discharge visit to assess the nature, extent, and severity of his renal mass, urinary urgency, and acute kidney injury, and to administer a urine voiding trial. According to the North Shore defendants, the decedent's chief complaint related to the placement of the Foley catheter. On the form that the decedent filled out that day, he affirmatively reported that he had no pain, no fever, no chest pain, no nausea, no vomiting, no joint pain, no joint swelling, no limb swelling, no dizziness, no limb weakness, no difficulty walking, and no hematological disorders. Schwartz performed a physical examination of the decedent on that day as well, which Schwartz described as unremarkable, as it revealed no acute distress and no peripheral edema, that the decedent's gait and station were normal, that he evinced no respiratory distress, and demonstrated normal respiratory rhythm and effort. According to Schwartz, he also performed a catheter exchange on February 11, 2021, and observed the decedent's lower extremities in the process.

As a consequence of the February 11, 2021 appointment, Schwartz ruled out the need for a prostate biopsy, despite the decedent's elevated blood levels of prostate-specific antigen,

and recommended that the decedent undergo a transurethral prostate resection procedure, given his severe acute kidney injury, secondary to an enlarged prostate, which Schwartz believed would optimize the decedent's condition for anticipated renal surgery. Schwartz further recommended an additional work-up of the renal mass, which he concluded and documented was consistent with renal cell carcinoma, and instructed decedent to follow up with him in two weeks.

On February 24, 2021, after a concerned neighbor contacted Joshua Mandel, who was one of the decedent's sons, the neighbor entered the decedent's apartment and found the decedent lying on the floor, unresponsive and not breathing. When Joshua Mandel arrived, police officers informed him that the decedent had died. An autopsy was performed by the Nassau County Office of the Medical Examiner. The autopsy report indicated that the cause of the decedent's death was bilateral pulmonary thromboemboli due to deep vein thrombosis of the right leg, which was also reported as the cause of death on decedent's death certificate. The autopsy report also identified hypertensive and arteriosclerotic heart disease under the heading "other significant conditions."

III THE PLAINTIFF'S ALLEGATIONS

In his complaint, the plaintiff asserted that the North Shore defendants negligently treated his decedent from January 30, 2021 to February 24, 2021 and that, as a consequence of that negligence, his decedent experienced conscious pain and suffering and died. He also asserted that the North Shore defendants failed to obtain his decedent's fully informed consent to certain unidentified procedures that they allegedly performed upon him. In his bills of particulars as to Kanterman and NSUH, the plaintiff alleged that those defendants departed from good and accepted practice in failing to take a proper medical history of the decedent, failing to perform a proper physical examination, failing to perform appropriate radiological and laboratory studies, and failing to appreciate the significance of and act upon the history that was elicited, the results of the examination that was conducted, and the results of the studies that

were performed. He also asserted that Kanterman and NSUH failed to recognize his decedent's risk factors for deep vein thrombosis and pulmonary embolism, failed to appreciate the significance of and act upon the signs and symptoms displayed, and complaints made, by his decedent that were consistent with deep vein thrombosis, including leg pain, leg soreness, leg swelling, leg tenderness, leg warmth, and leg skin coloration changes and, thus, failed to work up the decedent for, diagnose him with, and treat him for, deep vein thrombosis. With respect to the work-up, the plaintiff averred that Kanterman and NSUH were negligent in failing to administer a D Dimer test, duplex ultrasound, venography, and/or a magnetic resonance imaging (MRI) scan. In connection with treatment, the plaintiff asserted that Kanterman and NSUH were negligent in failing to administer blood thinners and clot dissolvers or provide filters and compression stockings.

The plaintiff also contended that Kanterman and NSUH negligently failed timely to work up his decedent for, and diagnose him with, pulmonary embolism, inasmuch as they ignored, failed to appreciate the significance of, and failed to act upon the signs and symptoms displayed, and complaints made, by the decedent that were consistent with pulmonary embolism, including shortness of breath, chest pain, cough, rapid heartbeat, sweating, fever, lightheadedness, and dizziness. With respect to the work-up for pulmonary embolism, the plaintiff alleged that Kanterman and NSUH were negligent in failing to administer a chest X-ray, ultrasound scanning, a computed tomography (CT) pulmonary angiography, a ventilation/ perfusion (V/Q) scan, and an MRI to his decedent. With respect to treatment of a pulmonary embolism, the plaintiff alleged that Kanterman and NSUH were negligent in failing to treat him in a timely fashion by administering anticoagulants or clot dissolvers, providing filters, or performing surgical clot removal. He further asserted that Kanterman and NSUH deviated from good practice in failing to call for appropriate consultations with specialists, including surgeons, thoracic surgeons, vascular surgeons, and pulmonologists. In addition, the plaintiff averred that

Kanterman and NSUH were negligent in failing properly to instruct and advise his decedent, and in failing to check in with him at sufficient intervals and frequency.

The plaintiff contended that all of these departures from good practice caused or contributed to his decedent's death from a pulmonary embolism secondary to deep vein thrombosis.

In his bills of particulars as to Northwell Health, Inc., and Schwartz, the plaintiff made the same allegations against those defendants as he made against Kanterman and NSUH.

IV THE SUMMARY JUDGMENT MOTION

In support of their motion, the North Shore defendants submitted the pleadings, the bills of particulars, transcripts of both party and nonparty witness deposition testimony, relevant medical and hospital records, the decedent's death certificate and autopsy report, the note of issue, letters testamentary that had been issued in connection with the decedent's estate, certain discovery orders, a statement of allegedly undisputed material facts, and an attorney's affirmation. They also submitted the expert affirmation of internist, hematologist, and autopsy pathologist Jacob H. Rand, M.D., as well as the affidavit of Avraham Z. Schwartz, an attorney who is the Vice President of the Medical Malpractice Program, Corporate Risk Management, for the defendant Northwell Health, Inc.

The North Shore defendants argued that none of the defendants deviated or departed from good and accepted practice, that nothing that they did or did not do caused or contributed to the decedent's death, that an alleged failure to diagnose deep vein thrombosis or pulmonary embolism cannot sustain a lack of informed consent claim in any event, and that Northwell Health, Inc., which did not and does not provide medical care or treatment, is not a proper defendant in this action.

Dr. Rand opined that neither Kanterman nor Schwartz departed from good and accepted medical practice in taking a medical history from the decedent, in examining the decedent, in considering the nature and causes of complaints that he made while he was an inpatient at

NSUH, in considering and evaluating the decedent's various risk factors for blood clotting, in working him up for any medical condition, in ordering relevant tests and scans, or in diagnosing the decedent's condition. Specifically, Dr. Rand opined that both Kanterman and Schwartz properly appreciated the decedent's risk factors for thrombosis and properly administered deep vein thrombosis prophylaxis in accordance with the standard of care. In this regard, he noted that the decedent demonstrated no signs or symptoms consistent with deep vein thrombosis or pulmonary embolism that warranted diagnostic testing, and that there was no evidence or medical basis to support a causal link between the decedent's complaints of left ankle and left knee pain and his death, which Dr. Rand asserted had been caused by bilateral pulmonary emboli due to deep vein thrombosis of the right leg.

As Dr. Rand explained it, venous thromboembolism is a common and serious blood clotting condition that includes deep vein thrombosis and pulmonary embolism. He asserted that deep vein thrombosis is a medical condition that occurs when a blood clot forms in a deep vein, typically in the lower leg, thigh, or pelvis, while pulmonary embolism is a serious complication of deep vein thrombosis, which occurs when a blood clot, or part of it, travels through the venous bloodstream to the pulmonary arteries that feed the lungs, causing blockage. Dr. Rand noted that, while anyone can develop deep vein thrombosis and pulmonary embolism, there are certain factors that may increase the risk of developing those conditions, including a prior injury to a vein caused by fracture or major surgery, decreased blood flow arising from confinement to bed in connection with a medical condition or surgery, limited movement, paralysis, and certain chronic illnesses, such as heart disease and cancer, as well as other risk factors such as previous deep vein thrombosis and pulmonary embolism, family history of deep vein thrombosis and pulmonary embolism, and a history of clotting disorders.

Dr. Rand referred to a set of "comprehensive guidelines" promulgated by the American Society of Hematology (ASH) for hematologists and other clinicians with respect to the prevention and management of deep vein thrombosis and pulmonary embolism. He averred

that ASH guidelines state that it is generally accepted in standard medical practice that no one isolated risk factor is controlling, but, rather, that the risk factors should be appreciated in the aggregate, based upon the employment of clinical judgment in considering the patient's overall clinical condition. According to Dr. Rand, the presence of certain risk factors will dictate the preventative measures required by the standard of care. In this regard, he opined that, generally, in an in-patient hospital setting where a patient has decreased mobility, deep vein thrombosis prophylaxis via anticoagulants may be administered to prevent the condition. Dr. Rand asserted that standard in-patient prophylaxis is generally achieved with the administration of 5,000 units of unfractionated heparin two times per day, along with encouragement of the patient to sit up, stand, ambulate, use his or her own muscles to cause joint movement, known as active range-of-motion, and/or have a therapist or health care provider use force to cause joint movement, known as passive range-of-motion.

Dr. Rand asserted that both ASH and the United States Centers for Disease Control and Prevention have reported that deep vein thrombosis and pulmonary embolism may be clinically silent with no symptomology, and that this conclusion is accepted by practitioners. He nonetheless opined that the most common signs and symptoms of deep vein thrombosis include swelling, pain, tenderness, and redness of the skin, while the most common signs and symptoms of pulmonary embolism include difficulty breathing, tachycardia, chest pain or discomfort, low blood pressure, lightheadedness, and fainting. Where a patient displays signs and/or symptoms suspicious for deep vein thrombosis, Dr. Rand suggested that diagnostic tests may be conducted, including a D-dimer blood test, which he explained measures the presence of a protein in the blood that is released when a blot breaks or dissolves in the body, a contrast venography, which he characterized as the most accurate test for diagnosing blood clots, but has the disadvantage of being an invasive X-ray procedure that uses injectable contrast material to visualize the deep veins on imaging that may itself irritate the veins and cause inflammation, and a duplex ultrasonography, which he described as the standard imaging test

for diagnosing deep vein thrombosis, that uses sound waves to visualize the blood flow in the veins. He stated that, although MRI and CT scans are imaging tests that provide visualization of the veins and clots, they are not generally used to diagnose deep vein thrombosis. Dr. Rand averred that, if a patient displays signs and/or symptoms suspicious for pulmonary embolism, the appropriate diagnostic tests are a computed tomographic angiography (CTPA), which provides X-ray imaging of the blood vessels in the lungs using contrast, and which he described as the standard imaging test to diagnose pulmonary embolism, a V/Q scan, which uses a radioactive substance to depict oxygen and blood flow in the lungs, a pulmonary angiography, which he characterized as the most accurate test to diagnose pulmonary embolism, but has the disadvantage of being an invasive procedure involving catheterization, and an MRI.

Dr. Rand opined, however, that none of the diagnostic tests that he identified is indicated in the setting of a low- or average-risk patient such as the decedent, who did not present any signs or symptoms of deep vein thrombosis and pulmonary embolism. In this regard, he concluded that Kanterman and Schwartz, as well as all other NSUH medical personnel, properly appreciated the decedent's risk factors for deep vein thrombosis, and administered proper deep vein thrombosis prophylaxis in accordance with the standard of care, that is, 5,000 units of the anticoagulant heparin two times per day. Dr. Rand explained that, over the course of the decedent's admission to NSUH from January 30, 2021 to February 4, 2021, the decedent's risk factors for deep vein thrombosis and pulmonary embolism, including his various comorbidities such as hypertension, hyperlipidemia, benign prostatic hyperplasia, elevated prostate-specific antigen, renal insufficiency, acute kidney injury, and obstructive uropathy, "did not in any manner correlate with an increased risk for development of thrombosis such that chronic anticoagulation therapy was indicated." He stated that, although chronic, or long-term, anticoagulation therapy might have been indicated in high-risk patients with a history of thromboembolic events or an inability to ambulate, that was not the case with the decedent, who, according to Dr. Rand, had presented to NSUH with an average in-patient risk of

thrombosis and no history of hematological disorder or prior clot or hemorrhage, thus yielding an appropriate negative risk assessment for deep vein thrombosis and pulmonary embolism at the inception of his admission to NSUH. Accordingly, Dr. Rand opined that standard pharmacological deep vein thrombosis prophylaxis, consisting of unfractionated heparin at a dose of 5,000 units twice daily, was properly administered.

Dr. Rand further concluded that the daily nursing notes generated at NSUH documented proper venous thromboembolism prevention, which included both passive and active range-of-motion exercises, dorsiflexion, and plantarflexion, with bleeding risk assessment, bleeding precautions maintained, the promotion of both ambulation and fluid intake, as well as daily ambulation exercises. He additionally noted that, although the decedent's autopsy reported the presence of arteriosclerotic disease, that condition had not previously been diagnosed, and there was no evidence of it during the decedent's admission to NSUH. Dr. Rand opined, however, that even if arteriosclerotic disease had been diagnosed and appreciated during the decedent's admission to NSUH, the administration of prophylactic doses of heparin, rather than therapeutic doses, would have been indicated in any event, and that the proper treatment would have remained the same as the treatment that was in fact provided.

Dr. Rand went on to assert that, while renal malignancy was not diagnosed during the decedent's admission to NSUH, his renal mass was highly suspicious for cancer. He noted that, while malignancy in general increases a patient's risk for thrombosis, no malignancy was confirmed in the decedent's case and, thus, even prophylactic anticoagulation would not be indicated on the basis of malignancy alone. Dr. Rand opined that,

> "[n]evertheless, given the 5-day duration of decedent's hospital course with the potential for decreased mobility, along with decedent's risk factors in the aggregate, it was within the standard of care for NSUH to administer standard DVT prophylaxis of unfractionated heparin at 5,000 units twice daily with the last dose administered on the date of discharge."

He further concluded, that upon discharge from NSUH, the decedent was ambulatory, with an

independent level of function and, thus, “no post-discharge thromboprophylaxis was indicated when considering all of the risk factors in the aggregate. “

In his affirmation, Dr. Rand asserted that the decedent evinced no signs or symptoms of deep vein thrombosis and pulmonary embolism during his admission to NSUH, or at post-discharge follow-up visits with Kanterman and Schwartz. In this regard, Dr. Rand asserted that the decedent’s only complaint with regard to his lower extremities during his admission to NSUH was made on February 3, 2021, when he complained of generalized left ankle pain with concern for trauma. According to Dr. Rand, a physical examination revealed no swelling, no edema, no erythema, and no deformity, and the decedent presented a good range-of-motion. He further asserted that a left ankle X-ray performed on February 3, 2021 was negative for acute fracture, after which the decedent’s ankle condition was reviewed by an orthopedist in NSUH’s orthopedics department, who concluded that no intervention was indicated, particularly because the decedent was able to bear weight and ambulate to the extent that it could be tolerated. Hence, Dr. Rand concluded that the decedent’s generalized complaints of left ankle pain and the subsequent examination and diagnostic studies revealed a pathology consistent with a prior injury that was orthopedic in nature, with no vascular abnormalities, and thus reflected a condition that was not consistent with deep vein thrombosis.

In addition, Dr. Rand concluded that the decedent presented no signs or symptoms of pulmonary embolism during his admission to NSUH, as the hospital’s charts reflected that multiple physical examinations were within normal limits, including cardiovascular rate and rhythm and vascular pulses, and that the decedent was without cough, without fever, had no chest pain, denied shortness of breath, his lungs were clear to auscultation bilaterally, and all extremities were normal, with no presence of cyanosis, clubbing, or edema.

Dr. Rand noted however, that, on February 8, 2021, the decedent was seen by Kanterman for a follow-up visit, at which the decedent complained of left knee pain, reporting that this pain had worsened during his hospitalization at NSUH. He further noted that the

NSUH hospital chart documented decedent's left knee pain as "chronic outpatient left knee pain," and that Kanterman, at his deposition, testified that, on February 8, 2021, the decedent had no signs or symptoms of a clot and that his complaint of left knee pain constituted an orthopedic problem. Based on the hospital chart and Kanterman's testimony, Dr. Rand concluded that the decedent's complaint of left knee pain on February 8, 2021 was reasonably attributable to chronic pain, was musculoskeletal in nature, and was not suspicions for deep vein thrombosis or pulmonary embolism. Dr. Rand thus further concluded that Kanterman, after appropriately conducting a physical examination that was negative for any concerning condition, properly referred the decedent to an orthopedist.

With respect to the decedent's February 11, 2021 appointment with Schwartz, Dr. Rand concluded that the decedent presented no signs or symptoms consistent with deep vein thrombosis or pulmonary embolism, as the appropriately conducted physical examination was Unremarkable, and the decedent affirmatively denied any concerning signs or symptoms.

While Dr. Rand conceded that, on February 24, 2021, the decedent died from bilateral pulmonary thromboemboli due to deep vein thrombosis of the right leg, he noted that the decedent's only complaints with regard to his lower extremities concerned his left ankle and his left knee, which pain Dr. Rand reiterated was orthopedic in nature and suggested no vascular abnormalities and, thus, not consistent with deep vein thrombosis. As Dr. Rand explained it,

> "a DVT of the right leg resulting in a PE would have originated in the veins of the right leg, which directly contradicts any alleged correlation between the decedent's complaints of left knee pain and left ankle pain and the DVT of the right leg that caused the fatal PE in this case."

He thus concluded that there was "no evidence or medical basis to support a causal link between the decedent's complaints of left ankle and left knee pain and his death caused by bilateral PE due to DVT of the right leg." In addition, Dr. Rand opined that "any attempt to estimate the timing of the fatal DVT/PE in this case would be unsupported by the available clinical data." In this regard, he explained that although it was possible that the decedent had

been thrombosing without symptoms in the veins of the right leg for one day, a few days, or longer before suffering the pulmonary embolism, it was just as possible that the fatal pulmonary embolism was a singular catastrophic thrombus or a cascade of smaller thrombi.

In his affidavit, Avraham Z. Schwartz alleged that Northwell Health, Inc., does not provide any medical, hospital, or therapeutic care to any patient, but is merely the corporate parent of NSUH. He further alleged that Northwell Health, Inc., did not employ any of the individual physicians named as defendants in this action.

In opposition to the North Shore defendants' motion, the plaintiff relied on the same submissions they did, and also submitted an attorney's affirmation and the expert affirmation of a board-certified internist, with a subspecialty in pulmonology. In summary, the plaintiff's expert opined that, inasmuch as the decedent presented with numerous risk factors for deep vein thrombosis and pulmonary embolism, the North Shore defendants should have begun appropriate diagnostic testing for those conditions immediately after he made complaints of left-leg pain and that, had they done so, they would have discovered the thrombosis soon enough to administer therapeutic doses of the anticoagulant heparin that would have "busted" any clots and prevented the development of the pulmonary embolism that caused the decedent's death.

The plaintiff's expert described the decedent's repeated complaints to his sons about continuing left leg pain and his inability to ambulate during his hospitalization, and complaints of bilateral leg pain and inability to ambulate after his discharge, as well as complaints of swelling and redness in his left leg below the knee. As the expert recounted it, according to the deposition testimony of Michael Stallone, a friend of the decedent's who had accompanied the decedent to his follow-up visit with Schwartz, and was in the examination room with him at that appointment, Schwartz did not examine the decedent's legs, despite the fact that the decedent informed Schwartz that he had severe pain in his left leg, and could not bend or move it.

The court notes that the plaintiff's expert asserted that Dr. Rand, in his affirmation, reported that the decedent had only complained of right leg pain and that thrombosis was only

detected in the left leg at the decedent's autopsy; the expert, however, mischaracterized Dr. Rand's statement, as it actually reported that the decedent had only complained of left leg pain, which Dr. Rand opined was inconsistent with the right-leg thrombosis that killed the decedent. In other words, the plaintiff's expert reversed Dr. Rand's description of which leg primarily presented with pain and in which leg the thrombosis was detected after the decedent's death.

Nonetheless, the plaintiff's expert apparently meant to show that, contrary to Dr. Rand's assertion that the decedent had only complained of pain in the left leg, the decedent actually had complained of pain in his right leg as well, where the thrombosis ultimately was detected. The expert thus asserted that, on February 12, 2021, or one day after the decedent's follow-up visit with Schwartz,

> "Physical Therapist Brian Ferrell, . . . clearly reported that Mr. Mandel complained of pain located in the right lower extremity. Also, bilateral lower extremity pain was described by several of Mr. Mandel's sons. Not only is pain in the RLE documented, but finding some residual thrombus in the veins of the LLE and not in the RLE does not mean that thrombus had not formed in both lower extremities."

Noting that Dr. Rand himself had explained that blood clots could travel throughout the circulatory system, the plaintiff's expert asserted that

> "if all the thrombi formed in the right lower extremity had embolized, one would not expect to find residual thrombus in the veins of that extremity. Not infrequently, at autopsy, no clot is demonstrated in either lower extremity, while diagnostic studies had shown evidence of significant thrombus in one or both lower extremities in the living patient. In such a case, all the thrombi had embolized, resulting in the patient's death."

The plaintiff's expert thus rejected Dr. Rand's conclusion that the decedent's repeated complaints of left leg pain were orthopedic in nature, and asserted that the thrombosis found in the right leg upon autopsy had embolized and traveled to the left leg as well prior to the decedent's death, thus accounting for that pain.

The expert agreed with Dr. Rand that the presence of only one risk factor for deep vein thrombosis and pulmonary embolism would probably not require further diagnostic investigation, and that "it is the overall clinical condition of Mr. Mandel" that the North Shore defendants were

required to consider. The expert parted ways with Dr. Rand, however, inasmuch as he concluded that the decedent's comorbidities and risk factors "required that he be studied with a Doppler ultrasound examination as soon as possible, and continuously, following his development of pain in his left lower extremity on February 3, 2021."

The plaintiff's expert identified numerous risk factors that he or she believed the North Shore defendants should have appreciated and which they should have acted upon to determine whether the decedent was suffering from deep vein thrombosis and pulmonary embolism. These included (a) probable renal cell carcinoma, which was confirmed at the autopsy, (b) inactivity, (c) a hospital admission of more than three days' duration, (d) advanced age, since the incidence of deep vein thrombosis and pulmonary embolism show a manifold increase from patients aged 40-49 to patients aged 70-79, (e) possible trauma to left leg and ankle, as evidenced by the decedent's continuous complaints of left leg pain, for which he was treated with lidocaine patches during his admission to NSUH, (f) chronic renal disease, evidence by increased blood levels of creatinine, which present a four-fold increase in the risk of deep vein thrombosis and pulmonary embolism (g) being slightly overweight, (h) being male rather than female, (i) hypertension, (j) type II diabetes, (k) increased risk of deep vein thrombosis and pulmonary embolism during winter months, as compared with the remainder of the year, (l) slightly elevated platelet count. The expert concluded that

> "Mr. Mandel was at significantly increased risk for the development of VTE during and following his admission to North Shore in 2021. Not objectively evaluating him for DVT while he remained relatively inactive, and moreover while he complained of lower extremity pain, was substandard care. This was a significant contributing factor to his developing a fatal PE."

The expert thus strongly disagreed with Dr. Rand's assessment that the decedent was a low- or average-risk patient with "the absence of any signs or symptoms," but instead characterized the decedent as a "moderately-high or high-risk patient with pain, swelling and difficulty ambulating."

The plaintiff's expert agreed with Dr. Rand that a venous thromboembolism can be clinically silent, and that this characteristic of the condition constitutes "a strong reason that the index of clinical suspicion must remain high." The expert continued that

> "[r]ecognizing when patients are at increased risk has led to the development of protocols to administer pharmacologic and/or physical prophylactic measures. These protocols include the regular routine recording of clinical VTE status assessments in hospitalized patients, including assessment at the time of discharge. The protocol at North Shore was inadequate in that it could be satisfied by saying that the assessment at discharge required no further attention, even when this entry was made by the attending physician about two days before the discharge occurred."

According to the plaintiff's expert, Dr. Rand was incorrect when he opined that contrast venography, CT, and MRI would have been reasonable diagnostic modalities for the decedent, as they involved administration of potentially nephrotoxic contrast materials, which was contraindicated by his renal failure. Rather, the expert opined that duplex venous (Doppler) ultrasound was "clearly the test that was needed as soon as Mr. Mandel developed extremity pain that limited his ability to walk. This test is non-invasive, relatively inexpensive, can be safely repeated serially and can even be done at bedside." The expert further explained that if a venous Doppler ultrasound test were positive for deep vein thrombosis, "therapeutic treatment would be instituted immediately with the goal of avoiding embolization, even if that process had begun." The expert continued that, "[i]f there were reason to suspect PE and the above study was negative for DVT, specific diagnostic testing for PE would be indicated. That is because even extensive thrombi in the veins (usually from the lower extremities) may have already embolized."

While the expert agreed with Dr. Rand that computerized tomographic pulmonary angiography (CTPA) is the usual imaging technique to demonstrate the presence of pulmonary embolism, and that contrast pulmonary angiography is the most accurate, the expert explained that both tests require contrast, and should have been avoided because of the decedent's renal condition. The expert thus asserted that, had documentation of pulmonary embolism been

necessary, V/Q nuclear lung scans would have been the procedure of choice, as the decedent likely would have tolerated them. The plaintiff's expert, however, averred that tests for the presence of pulmonary embolism would not have been necessary in the first instance had the diagnosis of deep vein thrombosis been made in a timely manner, since treatment of the two conditions is virtually identical. The expert asserted that, in either case, "a minimum of about six months of therapeutic anticoagulation would be indicated."

The plaintiff's expert took exception to Dr. Rand's description of the decedent's ability to ambulate following his discharge from NSUH. The expert noted that, immediately from the date of discharge, the decedent complained of leg pain and inability to ambulate, and that home-care nursing notes bore out the presence of those conditions. In addition, the expert faulted both Kanterman and Schwartz for their failure adequately or property to assess the decedent's gait, ambulation, and leg pain, all of which the expert concluded could have been addressed by proper diagnostic testing and anticoagulant treatment after discharge.

The plaintiff's expert opined that

> "[d]efendants administered DVT prophylaxis following [decedent's] admission to North Shore, but this was insufficient once he began complaining of pain in his LLE. At that time, the standard of care required a careful physical examination and an immediate diagnostic duplex Doppler ultrasound of the lower extremities as heparin prophylaxis continued. More likely than not, this test would have confirmed DVT. At that time, a therapeutic dose anticoagulation would have been required. In my opinion, expert consultation with a pulmonologist would be indicated to recommend an additional evaluation and treatment plan."

The expert ultimately concluded that the North Shore defendants departed from the appropriate standard of care by failing to appreciate the likelihood of deep vein thrombosis based on the decedent's complaints, by failing immediately to order a diagnostic duplex Doppler ultrasound scan, and failing thereupon immediately to treat deep vein thrombosis therapeutically rather than prophylactically. The plaintiff's expert opined that, as a proximate result of these departures, the decedent suffered from severe pain in his legs and the inability to ambulate for

the remaining several weeks of his life, and ultimately died as a consequence of those departures.

In reply, the North Shore defendants submitted an attorney's affirmation, in which their attorney noted that the lack of informed consent claim had already formally been withdrawn, that Northwell Health, Inc., could not be held liable, and that the plaintiff's expert relied on medical records that had not been submitted either with the moving or opposition papers, specifically NSUH home-care records. The attorney further characterized the plaintiff's expert's opinion as convoluted, speculative, and conclusory. The plaintiff submitted an attorney's sur-reply affirmation as a vehicle for the submission of the NSUH home-care records. Although the CPLR does not specifically provide for a sur-reply (*see Diane Serra, Inc. v Charmer Indus*., 190 Misc 2d 386, 391 [Sup Ct, N.Y. County 2002]), the court exercises its discretion and considers the sur-reply and the additional home-care records, since there would be no prejudice to the North Shore defendants if the records are considered, inasmuch as they generated and already possessed those records (*see Gross v Neiman*, 147 AD3d 505, 507 [1st Dept 2017]).

V SUMMARY JUDGMENT STANDARDS

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]).

1. LIABILITY OF CORPORATE PARENT

By submitting the affidavit of Avraham Z. Schwartz, the North Shore defendants established, prima facie, that Northwell Health, Inc., does not provide medical or hospital care to any patient, and thus did not provide care or treatment to the decedent. It demonstrated that it is merely a business entity that is the corporate parent of NSUH and, thus, cannot be held liable for medical malpractice. In opposition to that showing, the plaintiff failed to raise a triable issue of fact. Hence, that branch of the North Shore defendants' motion seeking summary judgment dismissing the complaint insofar as asserted against Northwell Health, Inc., must be granted (*see Robinson v Northwell Health, Inc*. 2021 NY Slip Op 33147[U], *3, 2021 NY Misc LEXIS 8555, *4-5 [Sup Ct, Queens County, Dec. 6, 2021]; *see also Vallone v Vulcano,* 2022 NY Slip Op 32099[U], *16, 2022 NY Misc LEXIS 11310, *29-30 [Sup Ct, N.Y. County, Jun. 30, 2022] [Kelley, J.] [applying same analysis to support summary dismissal of medical malpractice complaint against Mount Sinai Medical Systems, Inc., the corporate parent of Mount Sinai

Hospital]; *Garcia v Global Prop. Servs., Inc.,* 2018 NY Slip Op 30957[U], *6-7, 23 2018 NY Misc. LEXIS 1870, *9-10, 34 [Sup Ct, Bronx County, Apr. 3, 2018] [same]).

2. MEDICAL MALPRACTICE BASED ON DEPARTURES FROM GOOD AND ACCEPTED PRACTICE

"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]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

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, as noted, 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/or 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 North Shore defendants made a prima facie showing that Kanterman, Schwartz, and NSUH did not depart from good and accepted practice in evaluating the decedent for deep vein thrombosis and pulmonary embolism, and in treating him prophylactically. They further demonstrated, prima facie, that any failure to diagnose deep vein thrombosis or pulmonary embolism was not the cause of the decedent's left leg pain and subsequent death, inasmuch as they demonstrated that the decedent died from right-leg thrombosis. The plaintiff, however, raised triable issues of fact, via his expert's affirmation, with respect to whether Kanterman, Schwartz, or other NSUH medical specialists and personnel who examined and spoke with the decedent fully appreciated his risk factors for deep vein thrombosis and pulmonary embolism, seasonably and properly responded to his complaints of left leg pain on an emergent basis, ordered diagnostic testing that could rule in or out deep vein thrombosis, and thereupon treated those conditions therapeutically rather than prophylactically. He further raised a triable issue of fact as to whether those departures caused or contributed to the decedent's injuries and death, irrespective of whether the decedent primarily complained of pain in his left leg despite the fact that thrombosis was found in his right leg after autopsy.

Hence, that branch of the North Shore defendants' motion seeking summary judgment dismissing the medical malpractice cause of action against Kanterman, Schwartz, and NSUH must be denied. Moreover, NSUH also may be held liable to the extent that Kanterman and Schwartz, as its employees, are found to be negligent. "'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986];

Dupree v Westchester County Health Care Corp., 164 AD3d 1211, 1213 [2d Dept 2018]). Since Kanterman and Schwartz were employed by NSUH, and the court has concluded that there are triable issues of fact both as to whether Kanterman and Schwartz committed malpractice that caused or contributed to the decedent's injuries and death, that branch of the motion seeking summary judgment dismissing the complaint against NSUH also must be denied to the extent that NSUH's liability is premised upon Kanterman's or Schwartz's malpractice.

3. LACK OF INFORMED CONSENT

The elements of a cause of action to recover 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]).

Nonetheless, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or

administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]).

The North Shore defendants established, prima facie, their entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action, and the plaintiff's expert did not raise a triable issue of fact in connection with whether any diagnostic procedure involved the invasion or disruption of the decedent's bodily integrity. In any event, the North Shore defendants have alleged that the plaintiff formally withdrew his claim to recover for lack of informed consent, and the plaintiff has not contradicted that allegation. Hence, summary judgment must be awarded to Kanterman, Schwartz, and NSUH dismissing the lack of informed consent cause of action insofar as asserted against them.

4. WRONGFUL DEATH

"'In a wrongful death action, an award of damages is limited to the fair and just compensation for the pecuniary injuries resulting from the decedent's death to the persons for whose benefit the action is brought'" (*Leger v Chasky*, 55 AD3d 564, 565 [2d Dept 2008], quoting *Plotkin v New York City Health & Hosps. Corp.*, 221 AD2d 425, 426 [2d Dept 1995]; *see* EPTL 5-4.3 [a]). EPTL 11-3.2(b) provides that, in addition to a wrongful death cause of action,

> "[n]o cause of action for injury to person or property is lost because of the death of the person in whose favor the cause of action existed. For any injury an action may be brought or continued by the personal representative of the decedent,"

thus permitting the representative of the estate to prosecute a so-called "survival action" to recover for the conscious pain and suffering or other compensable damages caused by the defendant and sustained by a decedent while the decedent remained alive. The court notes that a survival claim for conscious pain and suffering that is prosecuted pursuant to EPTL 11-3.2(b) belongs to the estate, and not to the distributees of the estate, while wrongful death claims to recover pecuniary loss "belong" to the distributees (*Cragg v Allstate Indem. Corp.,* 17 NY3d 118, 121 [2011]; *see Heslin v County of Greene*, 14 NY3d 67, 76-77 [2010]).

> "There are four elements of compensable loss encompassed by the general term pecuniary loss: (1) decedent's loss of earnings; (2) loss of services each survivor may have received from decedent; (3) loss of parental guidance from decedent; and (4) the possibility of inheritance from decedent"

(*Huthmacher v Dunlop Tire Corp*., 309 AD2d 1175, 1176 [4th Dept 2003] [citations omitted]).

Although a wrongful death claim seeking to recover pecuniary loss to a decedent's estate belongs to the distributees of the estate, it may only be *prosecuted* by a duly appointed representative of the estate.

> "A personal representative who has received letters of administration [or testamentary] of a decedent's estate *is the only party who is authorized to commence* a survival action to recover damages for personal injuries sustained by the decedent or a wrongful death action to recover damages sustained by the decedent's distributees on account of his or her death"

(*Shelley v South Shore Healthcare*, 123 AD3d 797, 797 [2d Dept 2014] [emphasis added*]; see Gulledge v Jefferson County*, 172 AD3d 1666, 1667 [3d Dept 2019]; *Ambroise v United Parcel Serv. of Am*., 143 AD3d 929, 932 [2d Dept 2016]; *Jordan v Metropolitan Jewish Hospice*, 122 AD3d 682, 683 [2d Dept 2014]; *Mingone v State of New York*, 100 AD2d 897, 899 [2d Dept 1984]; EPTL 1-2.13, 5-4.1 [1]; 11-3.2 [b]). The plaintiff, as the duly appointed representative of the decedent's estate, thus has standing and capacity to prosecute a wrongful death claim, as well as the medical malpractice survival action to recover for the patient's conscious pain and suffering.

This court has determined that Kanterman, Schwartz, and NSUH are not entitled to summary judgment dismissing, insofar as asserted against them, the cause of action alleging departures from good practice, and that there are triable issue of fact as to whether their departures from good and accepted practice caused or contributed to the decedent's death. Inasmuch as Kanterman, Schwartz, and NSUH have failed to establish, prima facie, that the beneficiaries of the decedent's estate did not sustain pecuniary loss by virtue of his death, Kanterman, Schwartz, and NSUH are not entitled to summary judgment dismissing the wrongful death cause of action insofar as asserted against them.

VI CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendants Stuart L. Kanterman, M.D., Michael J. Schwartz, M.D., North Shore University Hospital, and Northwell Health, Inc., is granted to the extent that they are awarded summary judgment dismissing the complaint insofar as asserted against Northwell Health, Inc., and dismissing the lack of informed consent cause of action insofar as asserted against Stuart L. Kanterman, M.D., Michael J. Schwartz, M.D., and North Shore University Hospital, the complaint is dismissed insofar as asserted against Northwell Health, Inc., the lack of informed consent cause of action is dismissed insofar as asserted against Stuart L. Kanterman, M.D., Michael J. Schwartz, M.D., and North Shore University Hospital, and the motion is otherwise denied; and it is further,

ORDERED that the action is severed against Northwell Health, Inc.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against Northwell Health, Inc.; and it is further,

ORDERED that all remaining parties shall appear for a pretrial settlement conference before the court on November 9, 2023, at 10:00 a.m.

This constitutes the Decision and Order of the court.

9/29/2023
DATE

JOHN J. KELLEY, J.S.C.

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