SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. KATHY J. KING **PART** 06

Justice

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RONALD ROTH,

Plaintiff,

- v -

ANTHONY VELASQUEZ, and NEWYORK-PRESBYTERIAN/COLUMBIA UNIVERSITY MEDICAL CENTER

Defendants.

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INDEX NO. 805197/2018

MOTION DATE 04/08/2024

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81 were read on this motion to/for JUDGMENT - SUMMARY.

Upon the foregoing papers, Defendants Anthony Velasquez M.D. ("Dr. Velasquez") and The New York and Presbyterian Hospital s/h/a New York-Presbyterian/Columbia University ("NYPH") seek an order, pursuant to CPLR 3212, dismissing all claims, against Defendants Dr. Velasquez and NYPH, with prejudice and directing the Clerk to enter judgment in their favor.

Plaintiff opposes the motion.

On November 10, 2015, Plaintiff, Ronald Roth, presented to New York-Presbyterian/Columbia University Medical Center with symptoms of shortness of breath and right flank pain. Plaintiff was discharged on later that day in the evening. Approximately six weeks later, on December 22, 2015, the Plaintiff returned to the Emergency Room with significantly different symptoms, including persistent shortness of breath and dyspnea on exertion. Imaging at that time confirmed the presence of acute PE. Plaintiff commenced the within action, and alleges negligence and malpractice based on Defendants failure to diagnose and treat a pulmonary embolism ("PE") during his November 10, 2015 presentation at the NYPH Emergency Room.

The plaintiff contends that this failure led to significant harm, including delayed diagnosis and treatment of the PE, which exacerbated his condition.

To obtain summary judgment, a physician must present expert testimony that either establishes their compliance with accepted medical standards or negates causation between their treatment and the plaintiff's claimed injuries, thereby directly challenging the plaintiff's allegations (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d 15 [1st Dept 2009]; *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]). A physician seeking summary judgment must provide detailed expert opinions, firmly grounded in the case record, that specifically refute the plaintiff's particular claims. Failure to meet this burden, even in the absence of the plaintiff's counterevidence, necessitates denial of the motion (*see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Joyner-Pack v. Sykes*, 54 AD3d 727 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]; *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]).

In support of the motion, Defendants' submit the expert affirmations of: Andrew Wollowitz, M.D. **("**Dr. Wollowitz**")**, a board certified Emergency Medicine physician; Amit Uppal, M.D. **("**Dr. Uppal**")**, a board certified Pulmonologist, Internist and Critical Care physician; Edward S. Katz, M.D., FACC, FACP, FASE **("**Dr. Katz**"),** a board certified Internist**,** Cardiologist, and Adult Comprehensive Echocardiography physician; and Stephen Machnicki, M.D., FACR, FCCP ("Dr. Machnicki"), a board certified Diagnostic Radiologist, all of whom opine, to a reasonable degree of medical certainty, that all of the care and treatment rendered to Plaintiff was

at all times in conformance with standards of medical care, and that none of the deviations alleged by Plaintiff proximately caused the injuries claimed.

The medical records show that Plaintiff arrived at NYPH Emergency Room by ambulance on November 10, 2015, and was triaged at 2:42 a.m. Per triage, EMS reported right ribcage pain with shortness of breath. Plaintiff was initially evaluated by Dr. Suguitan, an Emergency Room resident. The records also show that the shortness of breath had resolved by the resident's evaluation and that Plaintiff subsequently presented to Dr. Velasquez at around 6:20 a.m. Plaintiff's history as noted by Dr. Velasquez included a recent septoplasty, and several days of sharp, intermittent, severe right flank pain, however, Dr. Velasquez found no clear relationship between the pain and breathing or movement.

In this regard, Dr. Wollowitz opined that right flank pain is neither anatomically consistent with PE, nor did the septoplasty procedure raise a concern for a PE diagnosis. Dr. Wollowitz opines that based on the history, clinical presentation, and physical examination of Plaintiff, there was no indication that additional testing, like a CT pulmonary angiogram ("CTPA") was needed since Plaintiff's pain was improving and he had developed no additional symptoms. He noted that such additional testing had risks that would have been inappropriate and subject the Plaintiff to unnecessary radiation and contrast dye exposure, especially given his low risk for PE and negative D-dimer test. Dr. Wollowitz indicated that Dr. Velasquez's shift ended at 8:00 am, and that the day team took over Plaintiff's care, and ordered appropriate diagnostic tests, including a CT scan and EKG. All tests were negative except for an EKG which indicated an incomplete right bundle branch block. According to Dr. Wollowitz, this is a common finding in healthy patients that can simply be seen with age. It is neither indicative of PE, nor does it indicate the need for any further work-up for PE in a low-risk patient such as the Plaintiff who had a negative D-dimer test result.

Dr. Wollowitz concludes that Plaintiff was appropriately discharged from NYPH Emergency room on November 10th, after the D-dimer test returned negative.

Similarly, Dr. Uppal opined that Plaintiff did not have any signs/symptoms of PE when he presented to the Emergency Room on November 10, 2015. Additionally, he notes that a negative D-dimer test clinically ruled out PE on November 10th. He explains that as a result a CTPA was not indicated to further evaluate for PE. Dr. Uppal agrees with Dr. Wollowitz that a CTPA is not a benign test, and that it would have been improper to unnecessarily expose Plaintiff to the risks of radiation and contrast dye with the study given his low risk and negative D-dimer test result. Dr. Uppal noted that when Plaintiff returned to the NYPH on December 22, 2015, his presentation was significantly different and he exhibited the classic symptoms of PE, including persistent shortness of breath and dyspnea on exertion. Further, the D-dimer test and CTPA performed on December 22nd returned positive, in comparison to the negative results in November. According to Dr. Uppal, these results indicated that in November, Plaintiff did not have PE. After receiving anticoagulants in late December 2015, the Plaintiff quickly recovered, returning to exercise by February 2016 and showed no respiratory limitations by June 2016.

Dr. Katz, Defendants' third expert, opined that while the November 10th 2015 EKG showed an incomplete right bundle branch block, this is considered a mild abnormality and a common EKG finding in normal hearts. He further opines that it is frequently found in the general healthy population and is not diagnostic of PE in a patient. He explains that while the Plaintiff's December 22, 2015 EKG did not show any evidence of an incomplete right bundle branch block, it could be the result of a mild differential impulse conduction to the left and right ventricle that is transient.

Like Dr. Uppal, Dr. Katz notes that Plaintiff was functioning well from a cardiovascular perspective after diagnosis and treatment of PE in December 2015, and there does not appear to

be any major cardiac damage secondary to the PE. He notes that Plaintiff's stress test results also supports that he does not have any particular respiratory limitations.

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]).

In concurring with the three experts of Defendants, Dr. Machnicki opined, that neither the chest x-ray nor CT of the abdomen/pelvis performed in the Emergency Room on November 10th showed any evidence of PE. By contrast, he explained that the December 22nd chest x-ray, showing smaller blood vessels in the right lung, and indicative of acute PE differed significantly from the November 10th chest x-ray, which showed no such findings.

The Court finds that the expert affirmations of Defendants four experts have established prima facie entitlement to summary judgment. Specifically, Dr. Wollowitz and Dr. Uppal both find that Dr. Velasquez performed the necessary work-up on Plaintiff which was still on-going at the time the day team took over at the end of his shift, and that, as such, Dr. Velasquez was no longer responsible for Plaintiff's care. Collectively, Defendants' four experts opined that the hospital staff conducted the necessary diagnostic testing, and timely and properly discharged Plaintiff on November 10, 2015, and the PE diagnosed the December 22nd was acute.

Once the proponent of a summary judgment motion makes a showing of entitlement to dismissal by tendering evidence sufficient to demonstrate the absence of material issues of fact,

the burden shifts to the non-moving party "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*see Alvarez*, 508 NYS2d at 925; *see also Menzel v. Plotnick*, 202 AD2d 558 [2d Dept 1994]; *Salamone v. Rehman*, 178 AD2d 638 [2d Dept 1991]).

Here, in opposition, the Plaintiff raises triable issues of fact through the affirmation of David A. Mayer, M.D. ("Dr. Mayer"), D.A.B.S., F.I.C.S., a board certified Surgeon with experience in diagnosing patients with PE which include, inter alia, whether: 1) the failure to perform a CTPA on November 10, 2015, constituted a significant deviation from the standard of care; 2) Plaintiff presented with classic symptoms of PE on November 10, 2015, including sudden onset pleuritic chest pain, shortness of breath, and recent surgery, a known risk factor for PE; 3) the symptoms observed on December 22nd were consistent with a chronic PE that was present but not diagnosed on November 10th; 4) the medical records indicate that further treatment and care rendered at NYPH after Dr. Velasquez's shift were not sufficient to rule out PE; 5)the failure to perform a CTPA or other appropriate diagnostic tests, despite the Plaintiff's symptoms and risk factors, constitutes a deviation from accepted medical practice; 6) reliance on a negative D-dimer test was appropriate, given the Plaintiff's clinical presentation and risk factors; 7) the failure to recommend appropriate evaluation with imaging - CTPA and echocardiogram - led to a delayed diagnosis of PE in Mr. Roth during his ER visit on November 10, 2015; and 8) such delay resulted in pulmonary infarction and subsequent complications, including cavitation of a large, peripheral, wedge-shaped opacity in the right upper lobe, consistent with infarction.

As to Plaintiff's medical malpractice cause of action, it is well settled that summary judgment is inappropriate when parties present conflicting medical expert opinions, as these create credibility issues that must be decided by a jury (*see Cummings v Brooklyn Hosp. Ctr.*,

147 AD3d 902, 904 [2d Dept 2017], quoting *DiGeronimo v Fuchs*, 101 AD3d 933 [2d Dept 2012] [internal quotation marks omitted]; *see also Elmes v Yelon*, 140 AD3d 1009 [2d Dept 2016]; *Leto v Feld*, 131 AD3d 590 [2d Dept 2015]). A jury is responsible for resolving credibility issues arising from conflicting expert opinions (*see Stucchio v Bikvan*, 155 AD3d 666, 667[2017]). Applying the same reasoning to the Plaintiff's negligence cause of action, the Court finds that, "conduct may be deemed malpractice, rather than negligence, when it 'constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physicians'" (Scott v Uljanov, 74 NY2d 673, 675 [1989], quoting Bleiler v bodnar, 65 NY2d 65 [1985]]).

As to Plaintiff's claim sounding in vicarious liability, the Court notes that since triable issues of fact exist as to the care and treatment by Dr. Velasquez, an employee of NYPH, and whether such treatment proximately caused Plaintiff's alleged injuries, dismissal is not warranted against NYPH under the doctrine of respondeat superior (*see Sessa v Peconic Bay Medical Center*, 200 AD3d 1085 [2d Dept 2021]; *Klippel v Rubinstein*, 300 AD2d 448 [2d Dept 2002]; *Rivera v County of Suffolk*, 290 AD2d 430 [2d Dept 2002]; *Mduba v Benedictine Hosp.*, 52 AD2d 450 [3d Dept 1976]).

Based on the foregoing, it is hereby

ORDERED, that the Defendants' motion is denied in its entirety; and it is further

ORDERED, that the Plaintiff is directed to serve a copy of this order upon the Defendants by first class regular mail to their last known address within twenty (20) days of entry of this order; and it is further

ORDERED, that the parties are directed to appear for an in-person settlement conference on Tuesday July 22, at 11:30 am, in court room 351.

3/27/2025
DATE

KATHY J. KING, J.S.C.

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