Katiraeifar v New York-Presbyterian
2025 NY Slip Op 32851(U)
August 12, 2025
Supreme Court, New York County
Docket Number: Index No. 162653/2015
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

Justice

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INDEX NO. 162653/2015

MASOUD KATIRAEIFAR, Pro Se, executor of the Estate of KAM KATIRAEI, also known as KARIM KATIRAEIFAR, Deceased,

MOTION DATE 07/23/2025

Plaintiff,

MOTION SEQ. NO. 003

- v -

NEW YORK-PRESBYTERIAN, THE UNIVERSITY HOSPITAL OF COLUMBIA AND CORNELL, RICHARD ROE, M.D. 1-5, and JANE DOE, RN 6-10 (names being fictitious and unknown, doctors and nurses who cared for plaintiff's decedent during his June 2013 hospitalization),

DECISION AND ORDER ON MOTION

Defendants.

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The following e-filed documents, listed by NYSCEF document number (Motion 003) 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and wrongful death, the defendant New York-Presbyterian, The University Hospital of Columbia and Cornell (NYPH), moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against it. The plaintiff opposes the motion. The motion is granted to the extent that NYPH is awarded summary judgment dismissing the wrongful death cause of action insofar as asserted against it, that cause of action is dismissed, and the motion is otherwise denied.

The crux of the plaintiff's claim is that his decedent, Kam Katiraei, also known as Karim Katiraeifar, was an inpatient at NYPH from June 14, 2013 through July 2, 2013 for the treatment of a neurological condition, and that NYPH healthcare staff caused his decedent to be deprived of oxygen, thus leading to significant injuries and, ultimately, his death on March 11, 2014. Specifically, the plaintiff alleged that NYPH failed properly to diagnose his decedent with anoxia and properly to monitor his condition as it deteriorated. In his bill of particulars, the plaintiff

alleged that NYPH departed from good and accepted practice by failing properly to ventilate his decedent, both during his stay in the NYPH emergency room and, "more particularly during the transport from the Emergency Room to the hospital for in-patient admission." He further alleged that NYPH committed malpractice by failing to become aware of his decedent's respiratory requirements, including mechanical ventilation in light of his history of amyotrophic lateral sclerosis (ALS) and pneumonia, and that it inadequately maintained oxygen delivery during the decedent's treatment in, and transfer from, NYPH's emergency room to an inpatient floor on the morning of June 14, 2013. The plaintiff expressly averred that he did "not have an issue with the manner of the resuscitation of [his] decedent by personnel on the floor following the iatrogenic episode causing anoxia on June 14, 2013." The plaintiff alleged that, as a result of NYPH's alleged departures from accepted practice, his decedent suffered from anoxia, severe respiratory distress, the inability to pursue his career, and, ultimately, death.

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 Flanders v Goodfellow,* _____NY3d_____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *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]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that 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 the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *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]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). Moreover, 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 Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally 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 Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

In support of its motion, NYPH submitted the pleadings, the plaintiff's bill of particulars, transcripts of the parties' deposition testimony, relevant medical records, an attorney's affirmation, and the expert affirmation of board-certified internist and pulmonologist David Kamelhar, M.D., who opined that NYPH's personnel did not depart from good and accepted practice in their treatment of the plaintiff's decedent, and that nothing that they did or did not do caused or contributed to the injuries that the plaintiff contends that his decedent sustained.

Dr. Kamelhar asserted that he was familiar with the evaluation of patients with chronic lung infections, including pneumonia, the impact of fibrosis on patients' respiratory health, objective criteria to evaluate a hypoxic event, and the prognosis for ventilator-dependent patients. Based on his review of medical records, he asserted that decedent, who was 63 years old when he presented to the NYPH emergency room, was diagnosed with ALS in 1978 when he was 28 years old, but nonetheless lived with this fatal and progressive disease until 2014. According to Dr. Kamelhar, the decedent became paralyzed in all four limbs by the mid-1980s, became ventilator-dependent in 1989, was fed via gastronomy tube, and had arranged for 24-hour-per day home care, although his ocular movements were spared. Dr. Kamelhar reported that the decedent was nonverbal and communicated through an elaborate series of ocular movements and letter boards. As relevant here, Dr. Kamelhar averred that the decedent experienced frequent episodes of ventilator-acquired pneumonia that required evaluation in a hospital emergency room.

Dr. Kamelhar interpreted the plaintiff's complaint, bill of particulars, and deposition testimony as alleging that NYPH took his decedent off of a ventilator, which was plugged into an

electrical outlet, in order to transfer him from the emergency room to an inpatient floor, and that, during the transfer, the decedent was oxygenated only with a manual resuscitator known as an Ambu bag or bag-valve-mask (BVM), which the plaintiff claimed constituted a departure from the standard of care that caused his decedent to decompensate. Dr. Kamelhar expressly disagreed with these allegations, and rejected the plaintiff's allegations that the decedent never recovered to his baseline and that the allegedly improper transfer caused the decedent's death nine months later on March 11, 2014, characterizing them as contrary to the medical records and the plaintiff's own sworn statements,

Dr. Kamelhar explained that ALS is a disease characterized by progressive degeneration of nerve cells in the brain and spinal cord, which first affects the voluntary control of a patient's muscles in the limbs and then progresses to adversely affecting speech and swallowing. He asserted that the disease also adversely affects the muscles involved in breathing and, thus, is known to cause respiratory problems, which he described as being among the most serious complications of this disease, and that patients often require mechanical ventilation through a ventilator to help them breathe. Dr. Kamelhar averred that ALS is a fatal disease with no known cure, and that, typically, patients with ALS have a life expectancy of three to five years after their diagnosis. He explained that, due to the advanced nature of the decedent's disease, there was no opportunity for him to participate in experimental treatment. He asserted that, by 2012, the decedent was suffering from a chronic pseudomonas pulmonary infection, was confined to a bed or a wheelchair, and, as consequence of such confinement and muscular dysfunction, was at high risk for fluid retention, joint contractures, and aspiration pneumonia. According to Dr. Kamelhar, the decedent presented to NYPH on numerous occasions through 2013 for the treatment of gastrointestinal issues, percutaneous endoscopic gastronomy changes, and respiratory events. He specifically referenced a November 18, 2012 event, where the decedent, who had a history of multiple methicillin-resistant Staphylococcus aureus (MSSA) pneumonia, presented with complaints of shortness of

breath, tachypnea, and tracheal secretions, without an apparent trigger. According to Dr. Kamelhar's review of the chart, a sputum culture grew MSSA and pseudomonas, upon which the decedent was treated with appropriate antibiotics and discharged to his home on December 1, 2012. Dr. Kamelhar asserted that, following this occurrence, the decedent's sister-in-law, internist Nina Safa, M.D., coordinated his medical care, and that, in February 2013, she requested approval for additional nebulizer treatments for congestion because that medical condition "can clearly expose him to more infections and hospitalizations."

In connection with the decedent's June 14, 2013 presentation to NYPH, Dr. Kamelhar asserted that emergency medical services (EMS) was called at 2:07 a.m. due to the decedent's complaints of difficulty breathing, and that the decedent's private nurse informed EMS personnel that the decedent had been experiencing respiratory discomfort for several hours before she called. At that time, the decedent was on a ventilator and nebulizer therapy, and was placed on his portable ventilator, with a battery unit, for transfer to from his home to NYPH. Dr. Kamelhar averred that there was no documented change in the decedent's mental status during or following the transfer to NYPH, that, upon his arrival at NYPH, he had a temperature of 100 degrees Fahrenheit, and was assessed by emergency room resident Shane Peterson, M.D., and attending physician Joseph Underwood, M.D. According to Dr. Kamelhar, a physical examination reflected that the decedent was experiencing shortness of breath, and that rhonchi were heard on both sides. Dr. Kamelhar asserted that, at that point, NYPH personnel swapped out the decedent's home ventilator for a hospital ventilator, after which Dr. Peterson assessed the decedent with ventilator-associated pneumonia, placed orders for blood laboratory studies, pathogen cultures, an electrocardiogram, a chest x-ray, and intravenous antibiotics, and concluded that the decedent be admitted to NYPH as an inpatient. Dr. Underwood reportedly agreed with the assessment and plan, and added that NYPH personnel would consult with the decedent's private pulmonologist and a critical care physician.

As Dr. Kamelhar interpreted the NYPH chart, NYPH critical care specialist Matthew Czaja, M.D., evaluated the decedent in the emergency room, and reported that the decedent recently had been experiencing more frequent pneumonias than in the past. The decedent himself described his shortness of breath at that juncture as "moderate," and requested to have his respiratory rate increased from his home ventilator setting of 28 breaths per minute, with a positive end-expiratory pressure of 5 centimeters of water, and a fraction of inspired oxygen at 100%, after which NYPH personnel increased the respiratory rate to 30 breaths per minute. NYPH records reflect that a respiratory therapist was at the decedent's bedside at that time, while a chest x-ray revealed the presence of bilateral opacities, after which the decedent was started on a regimen of the antibiotics Vancomycin, Zosyn and Tobramycin. Drs. Peterson and Underwood consulted with Dr. Czaja to determine if the decedent could safely be admitted to an inpatient floor. According to Dr. Kamelhar, the decedent did not need frequent suctioning at that time, and did not evince increased secretions, while he remained on his baseline ventilator settings, had good oxygen saturation, and appeared comfortable. Dr. Czaja spoke with the decedent's pulmonologist, Roger Maxfield, M.D., who expressed his opinion that the decedent was being overventilated, and may have been experiencing barotrauma that caused bronchiectasis and more frequent pneumonias. Dr. Maxfield agreed to follow the decedent's case and attempt to decrease the respiratory rate and peak pressures, after which Dr. Czaja agreed to admit the decedent to an inpatient floor at NYPH. According to Dr. Kamelhar, nurse Marie Gay documented the patient's vital signs at 8:52 a.m. on June 14, 2013, and participated in transferring the decedent from the emergency room to an inpatient floor.

Dr. Kamelhar referred to Gay's deposition testimony, in which she asserted that NYPH policy required that a nurse, support staff technician, and respiratory therapist must accompany a patient who presents to the emergency department on a ventilator and is transferred to an inpatient floor for admission. As he summarized Gay's testimony, the equipment involved in the transfer must include an Ambu bag, cardiac monitor, and two oxygen tanks, and that, although

NYPH provided no portable ventilators, any such transfers were not effectuated with a patient's personal home ventilator. She further testified that NYPH personnel would not document the transfer unless there was some significant event that occurred in the course of the transfer. Dr. Kamelhar recounted that nurse Richelle Lobite received the decedent on the inpatient floor at approximately 9:30 a.m. on June 14, 2013, and that the decedent arrived there with two NYPH nurses, a respiratory therapist, and his two private nurses. According to Dr. Kamelhar, the decedent's vital signs "would have been monitored," during the transport, while Lobite testified that she was not aware of any complications during the transport, and Gay's documentation reflected that the transfer was uneventful. Gay testified that, had there been any decompensation, color change, or respiratory distress during the transfer, she "would have documented" it, and explained that, during the transfer, she was able to visualize a pulse oximeter and the cardiac monitor, so that, had the decedent's vital signs become concerning, she "would have" noticed this and documented any abnormal findings

According to Dr. Kamelhar, shortly after the decedent's arrival on the inpatient floor, the decedent indicated to his private nurse that he was having difficulty breathing, and the monitors began to indicate worsening oxygenation. Dr. Kamelhar stated that, although a respiratory therapist hooked up the decedent to the hospital's ventilator, the decedent was unable to maintain adequate oxygenation, and the therapist called for a rapid response. The decedent's oxygenation level nonetheless dropped "up to 70%" despite bagging, the use of nebulizers, and suctioning. Dr. Kamelhar noted that the decedent was then administered fluids, albuterol, and intravenous Lasix, and was provided with continuous bagging. He asserted that aggressive suctioning removed thick secretions, while an immediate chest x-ray depicted a complete "whiteout" bilaterally with air bronchograms, worsening pneumonia, mucus impaction, and flash pulmonary edema. As Dr. Kamelhar described it, by 10:00 a.m., the decedent appeared to be more responsive, was able to have eye communication with his private nurse, and could follow simple instructions, while his nurse reported that he was not in pain but still felt short of breath.

Dr. Kamelhar interpreted the NYPH chart as indicating that resident gastroenterologist Jorge Suarez, M.D., had explained to the decedent that a bedside chest x-ray showed bilateral opacification of the lungs, and that the possible etiologies for the desaturation were worsening infection, mucus plugging, or worsening pulmonary edema. At 11:35 a.m. on June 14, 2013, the decedent was transferred to the NYPH medical intensive care unit, accompanied by one of his private duty nurses, Bettie Verwey. As Dr. Kamelhar characterized Verwey's deposition testimony, both in this action and in a probate proceeding referable to the decedent's estate, she averred that, after the decedent's oxygen saturation returned to normal, he opened his eyes and regained consciousness, and continued thereafter to communicate with her via eye movements, although she explained that his eye muscles were getting weaker over time due to the progression of his ALS. He similarly characterized the deposition testimony of Joyce Sael-Linjoco, another of the decedent's private duty nurses, as well as that of the plaintiff himself, who also testified that his decedent showed no significant changes in his mental status after June 14, 2013, and that his decedent continued communicating with Verwey and him through a series of eye blinks.

According to Dr. Kamelhar, NYPH pulmonologist David Chong, M.D., performed a bronchoscopy upon the decedent during the afternoon of June 14, 2013, which revealed that purulent secretions were welling up from the left lower lobe, and that small amounts of thin white secretions and mucous plugs were present in the secondary and tertiary airways throughout the bronchial tree. He asserted that the chart reported considerable inflammation, which he opined was probably due to chemical pneumonitis/aspiration and pneumonia. Dr. Kamelhar asserted that the decedent was thereupon placed on the protocol for treating acute respiratory distress syndrome (ARDS). Dr. Maxfield examined the patient later that afternoon and reported that the decedent had regained his baseline mental status.

Upon his review of the NYPH chart, Dr. Kamelhar explained that NYPH staff performed an echocardiogram upon the decedent on June 16, 2013, which revealed that the decedent

suffered from right ventricular systolic dysfunction and an increase in right ventricle size, and that, consequently, the decedent was weaned off of blood-pressure increasing pressors by June 18, 2013. According to Dr. Kamelhar, the decedent was communicating well with his private nurses. On June 20, 2013, the NYPH chart reported that NYPH neurologist Hiroshi Mitsumoto, M.D., communicated with the decedent, and that NYPH staff continuously monitored the decedent with an electroencephalogram (EEG) from June 18, 2013 to June 20, 2013, which reportedly revealed generalized "slowing." The decedent then was evaluated by NYPH neurologist, Khosro Farhad, M.D., whose assessment was that the EEG findings were most likely due to toxic metabolic encephalopathy, but that the decedent was recovering, with improved mental status. According to the chart, the decedent remained hospitalized for two more weeks due to concern for ongoing septic shock. On June 28, 2013, blood cultures grew a multidrug resistant strain of Klebsiella, which NYPH treated with the antibiotics Tigecycline, Polymixin, and Rifampin. The decedent was discharged to his home on July 2, 2013

Dr. Kamelhar asserted that, from July 2013 to February 2014, the decedent remained at his home, "essentially at his baseline health," and that he completed the course of antibiotics that had been prescribed to him upon his discharge from NYPH, with the addition of Gentamicin nebulizer treatments. He asserted that, in autumn 2013, the decedent developed shortness of breath, and that an x-ray taken at that time was consistent with his chronic fibrothorax. He averred that Dr. Maxfield recommended intensifying home respiratory therapy and suctioning.

As Dr. Kamelhar explained it, on February 6, 2014 at 1:30 a.m., the decedent returned to NYPH with hypoxia that apparently was caused by a power outage at his home at 11:00 p.m. on February 5, 2014, which caused the decedent's ventilator to stop working. Upon his arrival at NYPH, the decedent's oxygen saturation level was in the 60-percent range for approximately five minutes, as hospital staff attempted to obtain an oxygen tank. According to Dr. Kamelhar, "[s]ince then, Mr. Katiraeifar's mental status had changed. He was not as communicative and had not blinked or tracked with his eyes since the loss of oxygen. He was admitted to the

hospital for further management." He averred that a chest x-ray taken at that time was consistent with bronchopneumonia, after which the decedent was evaluated by NYPH infectious disease specialist, Brian Scully, M.D., who assessed the decedent with sepsis secondary to extensive pneumonia and likely multidrug resistant Klebsiella, and recommended treatment with Meropenem, Tigecycline, Polymixin, and Rifampin. On February 14, 2014, Dr. Maxfield wrote in the chart that the decedent's "[f]amily reports that his intellect returned to baseline after 6-7/13 admission," and further wrote that the decedent suffered from cystic lung disease and bronchiectasis due to long term positive pressure ventilation, repeated pneumonias, and bronchitis, as well as pulmonary hypertension due to chronic lung disease. The decedent was discharged from NYPH to his home on February 15, 2014 to continue antibiotics.

On February 20, 2014, the decedent experienced what Dr. Kamelhar described as an "apparent aspiration" after his ventilator malfunctioned at home while he was being turned after the rate of his tube feeding administration had been increased. According to Dr. Kamelhar, the decedent temporarily desaturated at the time of the aspiration, and then desaturated again in the afternoon, with his oxygen saturation rate decreasing to the 70-percent range, upon which the decedent's private nurses discontinued ventilation and employed an Ambu bag. He asserted that these nurses were able temporarily to increase the decedent's oxygen saturation level to greater than 90%, but that every time they reconnected the ventilator, the decedent again desaturated. As Dr. Kamelhar described it, when the decedent's saturation fell to 60%, they called for an ambulance.

The decedent thereafter was again brought to the NYPH emergency room, at which time the chart reported that he was "obtunded," that is, he evinced dulled sensitivity to stimuli, and was unable to communicate. The chart further reflected that he required ventilation with 100% oxygen and an Ambu-bag to maintain oxygen saturations above 90%, and described him as "in extremis." NYPH formulated a plan to admit him to the intensive care unit, based on a concern for aspiration or recurrence of ventilator-associated pneumonia. As Dr. Kamelhar described it,

the decedent remained in critical condition with multiorgan system failure, and, on March 8, 2014, a "do not resuscitate" order was given. On March 10, 2014, Dr. Chong reported that the decedent was critical and had a poor prognosis, while Dr. Maxfield wrote in a note that, with cascading multiorgan failure, there was no hope for survival. The decedent died on March 11, 2014, with the cause of death reported as cardiac arrest secondary to sepsis, which was, in turn secondary to ALS.

Dr. Kamelhar explained that, when a patient has intact neurological function, he or she can adequately cough out foreign objects to avoid choking or aspiration, but that the decedent's neurological function was impaired by his ALS, and, consequently, his relative risk of pneumonia was certainly higher than person who did not suffer from that malady. He further noted that the decedent also suffered from fibrothorax, or a chronic stiffness in his lungs, that made him more difficult to ventilate. Dr. Kamelhar explicitly opined that, even in light of these ailments, it was appropriate and within the standard of care for NYPH personnel to have swapped out the decedent's home ventilator for a hospital ventilator upon his June 14, 2013 emergency room visit, since hospital-grade ventilators are often more advanced than personal ventilators and that, when a patient such as the decedent presents with shortness of breath, it is important to rule out any dysfunction with the personal ventilator that could be causing any respiratory distress. Moreover, he asserted that hospital personnel need to be familiar with the ventilator being used for the patient, thus making it the standard of care to utilize the hospital's own equipment in ventilating an admitted patient.

Dr. Kamelhar also concluded that Dr. Peterson satisfied the applicable standard of care in the emergency room by examining the decedent, requesting an intensive care unit consultation, and ordering the administration of intravenous antibiotics and fluids, which, according to Dr. Kamelhar, demonstrated that emergency room personnel appreciated that the decedent likely had an infection. He further opined that Dr. Czaja satisfied the standard of care by examining the decedent and reporting that the decedent did not need frequent suctioning

and did not evince increased secretions, but that, rather, the decedent was at his baseline ventilator settings, had good oxygen saturation, and appeared comfortable. Dr. Kamelhar also approved of Dr. Czaja's determination to speak with Dr. Maxfield, who would be following the decedent in the hospital, as well as Dr. Czaja's determination that the decedent could be admitted to an inpatient floor. Hence, Dr. Kamelhar opined that the decedent was adequately evaluated before being admitted to NYPH and transferred to the inpatient floor. He also explicitly concluded that NYPH's transfer protocol was appropriate and within the standard of care, inasmuch as it involved the disconnection of the hospital's mechanical ventilator, which plugs into an electrical outlet, and its temporary replacement with an Ambu bag, supplemented by a cardiac monitor, pulse oximeter, and extra oxygen tanks, and the patient's accompaniment by nurse or physician, respiratory therapist, and technician. Dr. Kamelhar additionally explained that a mechanical ventilator cannot be used for a transfer, since it requires constant electricity, and there were no portable ventilators available at NYPH's emergency room. Moreover, he noted that there were no complications involved in the decedent's transfer, and that, had there been any, the nurse who transferred him would have documented them.

Dr. Kamelhar was of the opinion that NYPH personnel satisfied the standard of care after the decedent first arrived on the inpatient floor, since they immediately recognized that the decedent was having trouble breathing, and called for a rapid response, consisting of aggressive suctioning, nebulizer treatments, administration of fluids, and further oxygen support, and they successfully improved the decedent's oxygen saturation level. Moreover, inasmuch as the initial chest x-ray taken in the emergency room revealed increased diffuse patchy opacities in haziness, especially in the right mid-lung zone, and a repeat chest x-ray on the inpatient floor revealed that a near complete whiteout of the lungs had developed bilaterally, Dr. Kamelhar concluded that NYPH personnel correctly included severe edema and acute respiratory distress syndrome in their differential diagnosis, along with massive pneumonia. As he explained it, a total whiteout of the lungs is most often caused by cardiogenic or noncardiogenic pulmonary

edema or extensive pneumonia. He asserted that cardiogenic pulmonary edema is caused by left ventricular heart failure, while the decedent experienced right ventricular failure, not left; he stated that noncardiogenic pulmonary edema is caused by damage and inflammation to the lung tissue, typically with acute respiratory distress syndrome and septic shock. Dr. Kamelhar thus concluded that the total whiteout of the lungs that NYPH staff had observed on the second chest x-ray was caused by noncardiogenic pulmonary edema, acute respiratory distress syndrome, and septic shock from extensive pneumonia. He also stated that the bronchoscopy findings, consisting of aggressive pneumonia bilaterally, with the left side worse than the right, causing an acute development of mucus plugs, also explained why the decedent experienced an inability to maintain his oxygen saturation shortly after arriving on the floor. As Dr. Kamelhar explained it, mucus plugs make in impossible to ventilate a patient, causing a variation in blood pressure and oxygen saturation, which, in turn, causes mental status changes. In this respect, he noted that, although the decedent initially was in severe shock, he ultimately became more alert, and interacted with others once he had been treated with antibiotics and fluids.

Dr. Kamelhar asserted that the June 18, 2013 through June 20, 2013 EEG, which showed generalized slowing, caused the decedent to experience a diminution in his mental acuity due to toxic metabolic encephalopathy, which, in turn, caused by aggressive pneumonia and resulting sepsis, and that the loss of acuity was not due to a hypoxic event caused by any failure to employ mechanical ventilation during the decedent's June 14, 2013 transfer from the emergency room to the inpatient floor. In this respect, he explained that the decedent returned to his baseline level of function, and was able to communicate with his nurse through blinking, while the decedent ultimately was safely discharged to his home on July 2, 2013, and remained at home under the care of his private nurses and on antibiotic treatment for several months.

Dr. Kamelhar went on to state that,

> "[c]ontrary to plaintiff's claims, there is no evidence that Mr. Katiraeifar had a permanent anoxic injury. To the contrary, he was repeatedly documented to return to his baseline mental status and remained able to communicate with his

> private nurses until only several days before his passing in March 2014. The plaintiff himself has averred that his brother was of sound mind and had full mental capabilities, despite his claim of an anoxic injury. There is simply no dispute that Mr. Katiraeifar did not sustain a permanent anoxic injury in this case secondary to the transfer on June 14, 2013."

Dr. Kamelhar ultimately asserted that the decedent's death in March 2014 was the result of his fatal, progressive ALS, which caused him to be ventilator-dependent, and resulted in repeated respiratory infections, reiterating that "none of the actions and/or inactions of NYPH proximately caused Mr. Katiraeifar's death, which was the natural and unavoidable result of his ALS."

With respect to the issue of whether any conduct by NYPH personnel caused the decedent's cognitive and neuromotor decline in the months following the decedent's June 14, 2013 to July 2, 2013 admission to NYPH, Dr. Kamelhar noted the decedent made changes to his will after the discharge to his home on July 2, 2013, that the plaintiff himself had testified in a contested New Jersey probate proceeding that the decedent was "fully conscious of and managed his personal affairs until just a few days before his death," and further testified that the decedent was then competent to make the changes to his will that favored the plaintiff. As Dr. Kamelhar explained it, psychiatrist Vivian Shnaidman, M.D., filed a report dated August 22, 2019 in the probate proceeding. As he summarized that report, Dr. Shnaidman

> "noted that the plaintiff's siblings all claimed that Mr. Katiraeifar displayed a change in mental status following his 'June 2013' presentation to NYPH following a power outage at home when he lost electricity for his ventilator, which resulted in an anoxic injury. Dr. Shnaidman noted that the siblings mixed up the dates, as the event they described actually occurred in February 2014, as established from the medical records above. The plaintiff's sister, Parvin, also testified that Mr. Katiraeifar was able to dictate two letters in October and December 2013 using his eye movements and computer software. Dr. Shnaidman further noted that the medical records following June 14, 2013 confirm that Mr. Katiraeifar's mental status had returned to baseline. Likewise, Dr. Safa's outpatient records did not note any concerns about Mr. Katiraeifar's competency. Dr. Shnaidman's opinion, . . . was that Mr. Katiraeifar did not lack the capacity to make gifts to his family following the June 2013 admission to NYPH."

In opposition to NYPH's motion, the plaintiff relied on many of the same submissions that NYPH relied upon, and also submitted an attorney's affirmation, and the expert affirmations

of board-certified internist, pulmonologist, and critical care specialist Joel Silverman, M.D., and neuro-ophthalmologist and board-certified neurologist Beatrice C. Engstrand, M.D.

Dr. Silverman opined that "an employee or employees of NYPH herein departed from the standard of care regarding the intra-hospital transport of this ventilator dependent patient during the transfer of Mr. Katiraeifar from the Emergency Room to the floor room 7GS on June 14, 2013," a conclusion that he based on "the likely causes of the respiratory event and the observable respiratory consequences" that occurred during and immediately after the transfer. He averred that the decedent was clearly in respiratory distress upon his arrival on the inpatient floor, and concluded that the inconsistency of the ventilatory support via Ambu bagging caused the decedent's respiratory deterioration. In this respect, Dr. Silverman referred to private nurse Verwey's testimony, in which she averred that NYPH personnel "were using the Ambu bag but just in a very intermittent fashion. They would give him a couple of breaths and then stop and then keep going as they were moving rapidly." He quoted her as stating that "[t]here was a long wait for the elevator. . . . They would give him a couple of breaths like that and then start rushing and pushing the gurney trying to get to the floor." Dr. Silverman further adverted to Verwey's testimony that, during the transport process,

> "at the time when we were going through the hall they were doing the Ambu just like a few puffs of breath and then they were rushing. They were focusing on pushing the stretcher through the hallways. They had to wait for elevators. Elevators were very crowded but they were giving him just a few puffs. As they were rushing through the hall they were not giving him steady oxygen to my remembrance."

Dr. Silverman also referenced the deposition testimony of the decedent's private nurse Sael-Linjoco, who asserted that she was immediately behind the decedent's mobile bed as he was being transferred. At her deposition, Sael-Linjoco testified that she heard the pulse oximeter beeping, indicating a decline in the decedent's oxygenation level, and stated in this regard that "the saturation was dropping but I cannot see how---how far did oxygen saturation drop but as soon as they---they heard about that the respiratory therapy was bagging him."

Dr. Silverman explained that NYPH nurse Lobite authored a chart entry at 9:30 a.m. on June 14, 2013, which stated: "[a]s per ED report patient is stable with 100[%] O2 sat[uration] on vent[ilator]. Upon transfer to bed patient appears diaphoretic, hypothermic, hands are cold, and his face slightly reddened with no eye communication as per his private nurse," while he further recounted the entry as indicating that

> "O2 saturation was 88%. Patient was suctioned and bagged then placed on vent but noted with no improvement on respiratory status. O2 sat running 88 to 89% . . . R[apid] R[esponse] T[eam] activated. A[rterial] B[lood] G[as analysis] ordered. Chest x-ray done at the bedside. Patient continuously bagged. 4 Albuterols inhalation was given. No improvement on O2 sat. Patient O2 continuously dropping to 70% despite bagging him."

At her deposition, Lobite conceded that the decedent had decompensated upon arrival.

With respect to the June 14, 2013 chest x-ray that reflected the bilateral opacification of the decedent's lungs, while Dr. Silverman noted that the possible etiologies set forth in the NYPH chart included worsening infection, mucus plugging, or worsening pulmonary edema, he asserted that "[t]hese findings could also have developed as a result of insufficient Ambuing as described by Nurse Verwey with resultant hypoventilation and atelectasis." In this regard, Dr. Silverman opined that the diagnosis of acute aspiration pneumonitis was "insufficient as the sole explanation for his abrupt deterioration based upon the fact that the patient's respiratory status, chest x-ray, and ABG which had abruptly worsened, all improved within a short period of time (six hours)." He thus expressly concluded that the transport team employees departed from the standard of care during the intrahospital transport of the ventilator-dependent decedent "by providing inadequate ventilation by using an Ambu bag in an inconsistent and inefficient manner." He expressly disagreed with the explanation set forth in the NYPH chart and the opinion of Dr. Kamelhar that the exclusive diagnostic consideration was that the decedent sustained a chemical pneumonitis/aspiration event during transport. He asserted that, instead, hypoventilation resulting from suboptimal use of the Ambu bag could explain the decedent's condition, particularly because the improvement noted on the follow-up chest x-ray supported

his hypothesis, as such a result would not have been expected if it initially were caused by worsening infection and aspiration. As he explained it, chemical pneumonitis and massive aspiration without vomiting would lead to a progressive worsening of a patient's condition and would not have led to reversal of a complete "whiteout" on a chest x-ray within a few hours. As Dr. Silverman phrased it,

> "[t]he sequence of improvement does not comport with severe aspiration pneumonitis as a stand-alone explanation. While micro aspiration during transport remains a contributing possibility, that explanation is not consistent with the rapid radiologic resolution and the improvement in the blood gases after more vigorous Ambuing and placement on a ventilator."

Dr. Engstrand reiterated the history of the decedent's condition, his initial presentation to NYPH, and the evaluation, transfer, and treatment of the decedent by NYPH personnel. She specifically noted that, from 9:50 a.m. to 11:05 a.m. on June 14, 2013, the decedent's oxygen saturation level ranged from 65% to 89%, while the EEG conducted on June 19, 2013 reported findings that were "abnormal . . . moderate diffuse slowing a nonspecific indication of generalized/multifocal cerebral dysfunction worse on left." She also noted that, at the plaintiff's deposition, he described the decedent, as of June 2013, as communicating with the movement of his head and eyes, and that he was able to blink, but not enough to communicate via a computer because he lacked the ability to generate a certain rhythm of blinks to be able to create words and letters, but could only move his eyebrows and nod. According to the plaintiff, the decedent never regained the ability to use the computer to communicate. Dr. Engstrand further referred to the deposition testimony of one of the decedent's other brothers, Amin Katiraeifar, who averred that the decedent was a very able person who employed an infrared computer system to communicate, but that the decedent's involvement as an employee at Gumix International, Inc., a manufacturer and distributor of natural water-soluble gums used in foods, pharmaceuticals, nutraceuticals, and cosmetics, was "nonexistent" after his hospitalization in June 2013, in light of a dramatic decline in the decedent's neurological abilities. In addition, Dr. Engstrand summarized the testimony of yet another of the decedent's

brothers, Sean Katiraeifar, who testified that the decedent lost his ability actively to employ assistive word-generation software that would help in communication.

Dr. Engstrand opined that the decedent suffered from hypoxia during his transport from the NYPH emergency department to the inpatient floor. She asserted that the hypoxia caused the decedent's brain to experience the adverse effects of glutamate toxicity. As Dr. Engstrand explained it, brain cells have variable vulnerability to hypoxia, and that the hypoxia sustained by the decedent during the transport process affected his cerebrum, especially his striatum, which she characterized as "a most vulnerable area of the brain to hypoxia." She further concluded that the hypoxia adversely affected his muscle control and the use of his eyes, thus making him incapable of sustaining the blinking rhythm that he needed to use software to generate his communication. Dr. Engstrand thus explicitly opined that this hypoxic damage to the decedent's brain decreased his ability to communicate.

As Dr. Engstrand went on to explain, even with ALS and long-term ventilator dependence, the decedent enjoyed an adequate quality of life, inasmuch as he earned a master's degree, worked full time, and communicated with others. She asserted that the decedent's frustration with his inability to use his computer to communicate with others in an adequate fashion rendered "the remaining time of his life . . . wrought with despair," thus severely impacting and impairing the quality of his life.

In reply, NYPH submitted an attorney's affirmation, in which counsel reiterated the testimony of NYPH nurse Gay, and the conclusions set forth in Dr. Kamelhar's opinion. She further noted that Gay had testified that the transfer of the decedent to the inpatient floor was uncomplicated and that, had she observed any decompensation, color change, or respiratory distress during the transfer, she "would have" documented these conditions, and had the pulse oximeter and cardiac monitor reflected any irregularities, she "would have" noticed this and documented any abnormal findings. Counsel further argued that Dr. Silverman, in his expert affirmation, failed to offer any explanation as to how the Ambu bag ventilation that NYPH

provided was "inadequate," and did not address what the standard of care was in employing an Ambu bag, or what would be considered adequate ventilation. She further argued that the plaintiff's experts did not render any opinion as to whether the hypoxia that the decedent sustained on June 14, 2013 caused or contributed to his death on March 11, 2014.

The court concludes that NYPH established its prima facie entitlement to judgment as a matter of law in connection with both the medical malpractice and wrongful death causes of action. The plaintiff, however, raised triable issues of fact, with his experts' affirmations, as to whether NYPH departed from good and accepted practice in the manner in which they transported the decedent from the emergency room to an inpatient floor on June 14, 2013, particularly the manner in which NYPH staff employed an Ambu bag, whether NYPH personnel noticed the decedent's rapid deoxygenation during the transport, and whether, had they properly noticed it, they should have employed the Ambu bag in a more appropriate fashion, or expedited the transport process so that the decedent could more quickly be reconnected to a ventilator. The plaintiff further raised triable issues of fact as to whether these alleged departures caused or contributed to the decedent's declining mental and neuromotor conditions, thus causing him to be completely unable to communicate via computer for the remainder of his life. Consequently, that branch of NYPH's motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against it must be denied.

The plaintiff, however, failed to raise triable issues of fact as to whether NYPH's alleged departures from accepted practice caused or contributed to his death nine months after the subject occurrence. Although the plaintiff argued that he did not have to "eliminate every other possible cause of the decedent's death" (*Cavlin v New York Med. Group, P.C.,* 286 AD2d 469, 470 [2d Dept 2001]), but only had to show that "'it was probable that some diminution in the chance of survival had occurred'" (*id.*, quoting *Jump v Facelle*, 275 AD2d 345, 346 [2d Dept 2000]), neither Dr. Silverman nor Dr. Engstrand attributed the decedent's death to the June 14, 2013 incident, or the resultant hypoxia, and neither refuted the reported cause of death as

cardiac arrest secondary to sepsis, which was, in turn secondary to ALS. Moreover, "'[i]n 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]). In addition, wrongful death claims to recover pecuniary loss "belong" to the distributees of a decedent's estate (*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]). The plaintiff adduced no evidence that either he or his brothers would be affected by the loss of the decedent's earnings, since they did not allege that he supported them. Nor did he demonstrate that the decedent provided services to him or his brothers, and, as adults, he did not establish that they suffered from loss of parental guidance. In addition, he did not explicate whether he or his brothers anticipated inheriting any future increase in the assets of the decedent's estate that the decedent would not have expended for his own benefit had he survived beyond March 2014. Hence, NYPH must be awarded summary judgment dismissing the wrongful death cause of action insofar as asserted against it.

With respect to the defendants denominated as "Richard Roe, M.D. 1-5, and Jane Doe, RN 6-10," the plaintiff made no showing of any efforts that he made to identify these fictitious defendants. Although the plaintiff identified the NYPH nurses involved in transporting the decedent from the emergency room to the inpatient floor, the plaintiff, over the 10-year history of this action, never sought to amend the caption and the complaint to substitute any of those nurses as party defendants. Consequently, the plaintiff is precluded from relying on CPLR 1024

to maintain this action against those fictitious parties (*see generally Fountain v Ocean View II Assocs., L.P.*, 266 AD2d 339 [2d Dept 1999]), and the complaint must be dismissed as against them.

Accordingly, it is,

ORDERED, that the motion of the defendant New York-Presbyterian, The University Hospital of Columbia and Cornell, for summary judgment dismissing the complaint insofar as asserted against it is granted only to the extent that it is awarded summary judgment dismissing the wrongful death cause of action insofar as asserted against it, that cause of action is dismissed insofar as asserted against it, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the complaint is dismissed insofar as asserted against the fictitious defendants Richard Roe, M.D. 1-5, and Jane Doe, RN 6-10; and it is further,

ORDERED that that, on the court's own motion, the attorneys for all of the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on September 16, 2025, at 10:30 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court

8/12/2025
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