SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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DOUGLAS ABELES and LORI ABELES,

Plaintiffs,

- v -

DAVID H. MILLER, M.D., and NEW YORK-PRESBYTERIAN/WEILL CORNELL MEDICAL CENTER,

Defendants.

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INDEX NO. 805029/2022

MOTION DATE 07/21/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 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 SUMMARY JUDGMENT (AFTER JOINDER).

In this action to recover damages for medical malpractice based on allegations of departures from good and accepted practice, lack of informed consent, negligent hiring, training, supervision, and retention of health-care personnel, and loss of spousal consortium, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the causes of action alleging lack of informed consent and negligent hiring, training, supervision, and retention of health-care personnel, and so much of the medical malpractice cause of action as was premised upon departures allegedly committed on July 20, 2020. The motion is otherwise denied, since there are triable issues of fact as to whether the defendants departed from good and accepted practice on April 19, 2021 through April 21, 2021, May 3, 2021, and June 10, 2021 by failing to consider whether the plaintiff Douglas Abeles (the patient) was suffering from a particular coronary defect, and by

failing timely to test him for, diagnose him with, and treat him for, that condition, and whether those failures caused or contributed to a stroke.

The crux of the plaintiffs' claims against the defendants is that they failed timely and properly to test the patient for a cardiac condition known as patent foramen ovale (PFO)---a congenital small opening in the heart that fails to close after birth---and to diagnose him with and treat him for that condition. In their complaint, the plaintiffs alleged that, on several occasions, including July 20, 2020, April 19, 2021 through April 21, 2021, May 3, 2021, and June 10, 2021, the defendants failed timely and properly to perform necessary diagnostic testing upon the patient, including, but not limited to, repeat electrocardiograms (EKGs), bubble tests, and computed tomography cardiac angiograms (CTAs), and failed timely and properly to interpret those tests that were in fact ordered and/or performed. They further alleged that the defendants failed properly and timely to analyze and compare the results of transthoracic echocardiograms (TTEs) with prior TTE findings, specifically failing to identify significant changes in left atrial enlargement. The plaintiffs asserted that, as a consequence of the defendants' failure timely and properly to perform a full cardiac work up or consult with specialists, including cardiologists, the defendants negligently failed to rule out PFO, despite the patient's signs, symptoms, and abnormal test results. They further alleged that the defendants committed malpractice by failing to recommend and order interventional treatments, including, but not limited to, PFO transcatheter repair, and by improperly discharging the patient from the defendant New York Presbyterian/Weill Cornell Medical Center (NYPH) before his condition had fully been treated. The plaintiffs alleged that, due to this malpractice, the patient sustained a stroke, peripheral vision loss, memory loss, and other conscious pain and suffering, along with mental anguish and emotional distress. In their bills of particulars, they essentially reiterated the allegations set forth in their complaint, and identified additional injuries allegedly caused by the defendants' malpractice, including depression, chest pain, arm numbness, and insomnia.

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]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish 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]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *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 this 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 [emphasis added]; *see also*

Pancila v Romanzi, 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *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).

In support of their motion, the defendants submitted the pleadings, the plaintiffs' bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmations of board-certified cardiologist, internist, cardiac disease specialist, and adult comprehensive echocardiography specialist Edward Katz, M.D., and Steven Sparr, M.D., who is a board-certified internist and neurologist, with subspecialty certifications in neurorehabilitation, vascular neurology, and neurosonology.

Dr. Katz opined that Miller did not depart from good and accepted medical practice in the timing and manner in which he examined, ordered tests for, and diagnosed the patient. He further asserted that nothing that Miller did or did not do caused or contributed to the patient's alleged injuries. Initially, Dr. Katz explained that PFO is a congenital heart defect, in which there is an open connection between the right atrium and left atrium. He asserted that a PFO is present in all individuals before birth, and averred that, in 75-80% of individuals, the PFO closes shortly after birth, while the remainder of the population retains the PFO as they grow. As he framed the issue, while a PFO is often described as a "hole" between the atria of the heart, "it is better described as a 'potential hole,' as a PFO is extremely small." Dr. Katz asserted that, as such, there may be times during the cardiac cycle when there is no open connection between the two atria and other times when there is a connection that can allow an embolus to travel from the right atrium to the left atrium, and then to the brain, and result in a stroke. He explained that, consequently, a PFO may be visible on one diagnostic study, but might not be

visible on another study, since there is not always a connection present and that, in any event, the connection is very small and may require the use of special techniques to detect it.

Furthermore, Dr. Katz opined that, with respect to signs, symptoms, and diagnosis, a PFO is usually completely asymptomatic, and often is diagnosed as an incidental finding on a diagnostic study performed for another purpose, or only after a patient has suffered a stroke. He explained that, after a patient has suffered a stroke, a standard evaluation includes an echocardiogram with bubble study, "which is considered the standard test to diagnose a PFO." Dr. Katz described a bubble study as a diagnostic test in which agitated saline solution is injected into a vein and travels to the right heart, upon which the echocardiographer observes the heart to ascertain whether there are visible bubbles moving from the right to left side of the heart through a PFO. He asserted that patients are also asked to perform a Valsalva breathing maneuver, also known as a "bear down," as this can open the connection between the atria. He concluded that a PFO is "much more challenging to observe" on a standard TTE without a bubble study and, thus, can often be missed by a clinician.

Dr. Katz opined that the care and treatment rendered to the patient on July 20, 2020 was within good and accepted standards. As he interpreted the relevant medical chart, the patient had presented to Miller's office on April 28, 2020 with complaints of lightheadedness and chest pain that were not associated with exertion, and a sensation of an unsatisfactory volume of breath. According to Dr. Katz, at that time, the patient was an endurance athlete who rode his bicycle an average of 80 miles per week, was 6'2" tall, and weighed 165 pounds, with a body mass index of 21.18. He noted that the records reflected that the patient had undergone cardiac evaluation via a treadmill stress test in 2013 that yielded normal results, as well as a CT of the coronary arteries on January 2, 2014 that revealed a calcium score of 0. As such, Dr. Katz explained that the patient's symptoms were nonspecific to any particular cardiac condition and that, consequently, Miller appropriately ordered an echocardiogram and stress test to assess the patient's symptoms. As Dr. Katz described it, at the July 20, 2020 appointment with

Miller, the patient underwent an outpatient TTE at NYPH, which was interpreted as revealing a normal left ventricle size and function, with a satisfactory ejection fraction of 69%, normal left ventricle diastolic relaxation, normal right ventricle size and function, normal valvular function, no pulmonary hypertension, and mild dilatation of the left atrium. Dr. Katz expressly opined that the TTE was of "good quality," and that Miller interpreted it appropriately so as to report normal findings, except for the mild dilatation of the left atrium. As he explained it, mild dilatation of the left atrium can be seen in the setting of certain arrythmias such as atrial fibrillation, for which the patient was then being evaluated for, and is also a common finding in individuals as they age, including in persons within the patient's age range. According to Dr. Katz, "[s]ignificantly, Mr. Abeles' July 20, 2020 TTE did not show a PFO, as it "did not reveal a connection between the right atrium and left atrium."

Inasmuch as Dr. Katz had opined that PFOs are more commonly diagnosed *after* a patient suffers a stroke, and special diagnostic testing is done as a result of the stroke, he concluded that there was no indication for special testing such as a bubble study, since the patient evinced no stroke symptoms on April 28, 2020 or July 20, 2020, which symptoms typically include speech issues, vision loss, weakness typically on one side, and vertigo. Thus, he averred that, in response to the July 20, 2020 TTE, Miller appropriately reviewed the echocardiogram results, discussed the findings with the patient, and thereafter proceeded with outpatient treadmill stress test on August 7, 2020, which was appropriately interpreted to suggest that anatomically or functionally significant coronary artery disease was unlikely. Therefore, Dr. Katz concluded that Miller appropriately appreciated, assessed, and evaluated the patient's signs, symptoms, and complaints during that period of time.

Dr. Katz additionally asserted that the care that Miller rendered to the patient from April 19, 2021 through April 21, 2021 was appropriate and in accordance with good and accepted standards of medical care. He noted that the patient had presented to the NYPH emergency department on April 19, 2021 with complaints of abdominal and back pain, along with

associated nausea and shortness of breath that had begun suddenly 90 minutes earlier. Dr. Katz concluded that, based upon the patient's complaints and symptoms, he was "appropriately assessed for aortic dissection, abdominal aortic aneurysm, pancreatitis, renal colic, and mesenteric ischemia," and that, as such, Miller and NYPH personnel timely ordered and performed appropriate tests to evaluate the patient with respect to those conditions, including an EKG, a chest CT scan, a CT scan of the patient's abdomen and pelvis, and proper blood work. He concomitantly opined that an appropriate differential diagnosis was formulated during the patient's April 19, 2021 presentation to NYPH, inasmuch as his signs, symptoms, and complaints were consistent with either a cardiac, pancreatic, or renal etiology.

As Dr. Katz summarized the relevant medical chart, the patient's April 19, 2021 blood work revealed an elevated troponin level of 420 nanograms per liter of blood (ng/L), and an elevated total bilirubin level of 2.5 milligrams per deciliter of blood (mg/dL), while his EKG revealed sinus bradycardia at a rate of 45 beats per minute, normal axis, t-wave inversions, and "slight J point appearing ST elevations in lead V2/V3." Dr. Katz reported that the CT scan of the patient's chest had been interpreted at NYPH to reveal right atrial enlargement, and a "misty" mesentery, without abdominal lymphadenopathy, while his abdominal/pelvic CT scan had been interpreted as revealing gaseous distention of the colon, with moderate rectal and colonic stool, small nonspecific subhepatic free fluid, and two small indeterminate hypodense liver lesions, as well as kidney and liver cysts that may have burst and generated pain. Consequently, Dr. Katz asserted that "both cardiac etiologies and ruptured cyst/biliary pathology/panniculitis were appropriately considered to explain his complaints of abdominal and back pain, as well as shortness of breath."

On April 20, 2021, a cardiology consultation was performed at NYPH to assess the patient's cardiac risk stratification and EKG results, which NYPH cardiologists concluded were positive for sinus bradycardia, borderline first-degree atrioventricular block, and frequent premature atrial contractions. According to Dr. Katz, the patient's cardiac history, including

his prior calcium score of 0 in 2014 and his normal stress test from 2020, were "appropriately acknowledged and appreciated." He noted that a TTE was performed on April 20, 2021 that was interpreted as depicting severe dilatation of the left atrium, normal ejection fraction of 60-65%, normal left ventricular size, no significant valvular disease, dilated right ventricle but normal right ventricular function, and severe dilatation of the right atrium. Dr. Katz opined that Miller and NYPH personnel appropriately compared the April 20, 2021 TTE findings with the findings from his July 20, 2020 TTE, "appreciated" the increased bilateral atrial dilatation on April 21, 2021, and appropriately ordered a further evaluation by the NYPH cardiology department, whose personnel acknowledged the finding of bi-atrial dilatation on the TTE, as well as an EKG telemetry strip "consistent with the Wenckebach phenomenon," a progressive elongation of the p-wave/r-wave interval on an EKG, usually due to a reversible electrical conduction block at the atrioventricular node, that causes a missed or dropped heartbeat. Upon his review of both the July 20, 2020 and April 20, 2021 TTEs, Dr. Katz concluded that the defendants' interpretation of bi-atrial dilatation was appropriate, since both atria appeared moderately dilatated.

Dr. Katz characterized the patient's April 21, 2021 physical examination as "unremarkable," and asserted that, at that time, the patient denied chest pain, dyspnea, palpitations, abdominal pain, nausea, dizziness, or orthopnea. He posited that Miller appropriately recommended that the patient follow up for "coronary risk stratification with coronary CTA, outpatient cardiac monitor, and serial echo[cardiogram]s to follow bi-atrial dilatation," particularly because the April 19, 2021 through April 21, 2021 work up at NYPH did not reveal acute findings that required immediate work up. Dr. Katz discounted the patient's elevated troponin levels during this admission as not indicative of any necrosis of heart tissue or an infarction, but "secondary to a stress response from the abdominal pathology and associated pain," and described the etiology of the initial pain episode as "unclear and noted to be possibly related to hepatic/renal cyst rupture."

Mr. Abeles' D-dimer levels were also evaluated on April 20, 2021 to rule out pulmonary embolus, and were determined to be mildly elevated. According to Dr. Katz, mild elevation of D-dimer levels are non-specific, while elevated troponin levels "were likely associated with a stress response to abdominal pathology and pain" that did not require any further intervention prior to discharge. Thus, in connection with the plaintiffs' allegations that the defendants failed timely to diagnose and treat PFO, Dr. Katz averred that the patient's complaints, signs, symptoms, evaluation, testing, and radiology imaging results "were not diagnostic of a PFO during his admission to NYPH from April 19, 2021 through April 21, 2021," since, among other things, he did not exhibit stroke symptoms that would warrant clinical suspicion of a PFO, and the April 20, 2021 TTE findings did not reveal a PFO, as PFO "has no clinical correlation to dilatation of the right ventricle." Rather, since, according to Dr. Katz, that TTE revealed bi-atrial enlargement, the defendants appropriately recommended that he be evaluated on an outpatient basis.

In addition, Dr. Katz reiterated that, inasmuch as the patient's April 20, 2021 TTE revealed a normal ejection fraction of approximately 65%, normal left ventricle size/function, normal right ventricle function, and no significant valvular disease, he concluded that the patient did not warrant any additional work up for PFO. Although he conceded that the patient evinced mildly elevated D-dimer values during his April 19, 2021 to April 21, 2021 NYPH admission, he concluded that this finding also did not warrant a workup for PFO, since, although D-dimer levels are employed to screen for venous thrombosis, a mildly elevated D-dimer level, standing alone, without clinical findings associated with a thromboembolic event, is a nonspecific finding that, coupled with the absence of stroke symptoms, did not require further follow up.

In connection with the patient's May 3, 2021 cardiac follow-up appointment with Miller, Dr. Katz interpreted the relevant chart as revealing that, as of that date, Miller reported that the patient was feeling fine and had completed a 35-mile bicycle ride. Dr. Katz opined that, at that visit, Miller appropriately appreciated the results of the patient's April 19, 2021 through April 21, 2021 blood work and radiology imaging, and that Miller expressly acknowledged the patient's

elevated troponin levels, as well as the results of his chest CT, abdominal/pelvic CT, TTE, and telemetry EKG studies. He asserted that Miller, upon acknowledging the patient's bi-atrial dilatation and his mild right ventricle dilatation, appropriately recommended a CTA of the coronary arteries. With respect to the April 2021 studies that revealed sinus bradycardia, with atrial as well as ventricular ectopy, Dr. Katz stated that Miller appropriately documented his joint review, with an electrophysiologist, of one strip from that study that had identified a second-degree arteriovenous block (type I-Wenckebach), and correctly determined that this condition represented a dropped beat as a consequence of a preceding premature ventricular contraction, that is, an abnormality in the electrical conduction of heart, which Dr. Katz concluded warranted a further workup only via Holter monitor to assess cardiac arrythmias. Dr. Katz approved of Miller's plan to obtain 24-hour Holter monitoring, consider-long term cardiac monitoring for a period of two weeks thereafter, and a consider CTA to determine cardiac risk stratification. He opined that, at that time, and in light of the absence of other thromboembolic symptoms, Miller again appropriately evaluated the patient's elevated troponin as a response to his abdominal pathology and pain, and his D-dimer level as a non-specific finding. Dr. Katz explicitly opined that the patient's complaints, signs, and symptoms, as well as his evaluation, test results, and radiology imaging, were "inconsistent with a PFO during his May 3, 2021 office visit," particularly because the April 20, 2021 TTE did not reveal a PFO, his clinical condition had improved between April 21, 2021 and May 3, 2021, and he still had not exhibited stroke symptoms that would have warranted clinical suspicion of PFO.

According to Dr. Katz, after the plaintiff presented to NYPH on June 6, 2021 with complaints of syncope, headache, and loss of peripheral vision in his right eye, he was admitted to NYPH. He noted that, on June 7, 2021, NYPH personnel interpreted a brain MRI scan as depicting a cerebrovascular accident, that is, a stroke, which they posited may have been cardioembolic in nature. He further alleged that, on June 9, 2021, a CTA was performed in a timely and appropriate manner, and noted NYPH personnel interpreted it as revealing a PFO

and mild right atrial enlargement, but no coronary artery disease. Dr. Katz averred that, on June 10, 2021, the patient timely underwent an echocardiogram with a bubble study, which was interpreted as consistent with atrial septal defect, that is, a congenital PFO, albeit with normal left ventricular function, valvular function, diastolic function, and right ventricular function, a normal ejection fraction of 67%, and no pulmonary hypertension, albeit with moderate right ventricular dilation, moderate left atrial enlargement, and severe right atrial enlargement. After a consultation with the NYPH cardiology department, NYPH personnel determined that the patient's stroke was likely cardioembolic in nature and that he would benefit from outpatient closure of his PFO. On June 11, 2021, the patient was discharged to his home with a diagnosis of stroke, and his only neurologic deficit was noted to be in his peripheral right visual field.

Dr. Katz opined that the defendants' care and treatment of the patient between June 6, 2021 to June 11, 2021 were appropriate and within good and accepted standards of care, and that the patient appropriately was assessed by the stroke team and neurology service once he presented with syncope, vision loss, and sudden dizziness. He concluded that the defendants appropriately administered the anti-blood clotting drug tPA to restore blood flow to his brain, and properly admitted the patient to the neurology intensive care unit, "where his cardiac history, including his April 2021 admission to NYPH and prior TTEs, were appreciated." Dr. Katz approved of the defendants' administration of aspirin and cholesterol-lowering statins to manage the patient's stroke, and asserted that the patient thereafter was "continuously evaluated by specialists in neurology and critical care, as well as physical therapy and occupational therapy."

Dr. Katz further concluded that the defendants' care and treatment of the patient from April 2020 to June 2021 did not cause or contribute to his alleged injuries. As he explained it,

> "[i]f a PFO is diagnosed as an incidental finding on a study performed for another purpose, the standard of care is to do nothing. Again, a PFO is a common finding present in 20-25% of the general population. PFO closure is not recommended unless and until a patient has had a stroke or evidence of paradoxical embolus elsewhere in the body. It would not be reasonable or good medical practice to close a PFO in 20-25% of the general population. Moreover, it is not the standard of care to prescribe aspirin or other anticoagulation to

> patients with a PFO unless the patient is otherwise at elevated risk for stroke, which Mr. Abeles was not, or had a stroke. The risks of either intervention to close the PFO or use of anticoagulation outweigh the risk of a stroke associated with an asymptomatic PFO in the general population."

According to Dr. Katz, since the patient did not exhibit signs or symptoms of stroke during his various presentations to Miller's office and NYPH until June 6, 2021, even had the PFO been diagnosed incidentally earlier than June 2021, "there would have been no basis for considering treatment with closure unless he suffered from a stroke," but instead, treatment should have been, and only was, rendered after the patient had a stroke. Hence, Dr. Katz concluded that the patient's "treatment course and outcome would not have changed" had PFO been diagnosed earlier than June 2021.

In his affirmation, Dr. Sparr essentially reiterated all of the facts that Dr. Katz had articulated, and concurred with all of Dr. Katz's opinions concerning whether the defendants departed from good and accepted practice, albeit from a neurological perspective. Dr. Sparr additionally agreed with Dr. Katz that the patient's alleged injuries were not caused by defendants' care or treatment, "as they pre-existed his stroke," which Dr. Sparr characterized as "mild." He stated that the medical records reflected that the patient's only neurologic deficit was a "right upper quadrant visual field cut," which he explained had "no bearing on [the patient's] ability to drive, read, or otherwise function in society, and would only affect a small portion of his peripheral vision." With respect to the patient's claim that he suffered from cognitive impairments as a result of his stroke, Dr. Sparr averred that

> "it is significant to note that his memory issues pre-existed his stroke in 2021. Notably, Mr. Abeles complained of memory related complaints in 2016, which led to outpatient neurology work up with neurologist, Dr. Alan Segal, at NYPH. In 2016, Mr. Abeles complained that his ability to process new information had declined, that he experienced poor short-term memory, and that he experienced memory loss. As such, Mr. Abeles' alleged injuries of memory loss and short term memory loss pre-existed his stroke in 2021.
>
> "Moreover, at the time of Mr. Abeles' neurologic workup in 2016, he exhibited anxiety and depression, which were thought to play a role in his memory loss and personality change. Therefore, Mr. Abeles' anxiety and depression also pre-dated his stroke in 2021. It is my opinion to a reasonable degree of medical

> certainty that Mr. Abeles' memory-related complaints reflect a pre-existing issue that continues to be linked to his depression as opposed to any neurologic sequelae as a result of his stroke. Moreover, Mr. Abeles' medical records suggest that he is doing well, able to run in Central Park, and has taken up cycling again since his stroke. As such, it is my opinion to a reasonable degree of medical certainty that Mr. Abeles had a good prognosis and will continue to do well in the future. Moreover, given the closure of his PFO, he is not at increased risk for further strokes in the future."

In opposition to the defendants' motion, the plaintiffs relied on many of the same documents that the defendants had submitted, and also submitted an attorney's affirmation, a counterstatement of material facts, the plaintiffs' marriage license and certificate, records from the patient's rehabilitation treatment at NYU Langone Hospital, and the expert affidavit of a board-certified internist, cardiovascular medicine specialist, and interventional cardiologist.

The plaintiff's expert opined that the defendants departed from applicable standards of care by failing to perform a sufficient cardiology examination and failing timely to perform cardiac CTA, thus delaying the diagnoses and treatment of a PFO. In this respect, the expert concluded that the defendants failed to appreciate the significance of the April 20, 2021 TTE, "which showed that the left and right atrium were both severely dilated, and the right ventricle was moderately dilated." Hence, the expert asserted that closure of the PFO was indicated in April 2021, and not June 2021, as the defendants contended, and that "it would have emergently occurred and prevented the June 6, 2021 stroke from occurring." The expert further alleged that the defendants' management of the patient's care, and their departures from accepted standards of care and treatment, caused and contributed to the patient's injuries.

In particular, after reciting the underlying facts of the defendants' treatment of the patient, the plaintiffs' expert noted that the April 20, 2021 TTE showed that both the left and right atria were severely dilated, and the right ventricle was moderately dilated, while the estimated ejection fraction had decreased at least 4% over the nine months since the July 20, 2020 TTE. The expert asserted that the April 20, 2021 TTE further revealed trace mitral regurgitation, trace tricuspid regurgitation, and trace pulmonic regurgitation, with no aortic regurgitation, while the

left ventricle mass index was elevated at 87.8 grams per square meter of surface area (g/m²), the right atrium volume index was elevated at 57 milliliters per square meter (mL/ m²), and the left atrium volume index was elevated at 59.7 mL/ m². Contrary to the opinions of the defendants' experts, the plaintiff's expert asserted that the defendants failed to appreciate the significance of the dilations and enlargements depicted on April 20, 2021 TTE, explaining that the enlargements of the right and left atria were significant and abnormal findings because those conditions can result in heart failure. The expert asserted that it was a departure from the applicable standard of care for the defendants to have discharged the patient from the hospital on April 21, 2021, without reaching any conclusion as to the cause of these cardiac enlargements, which he suggested may have been caused by PFO. Moreover, although the defendants' experts asserted that the defendants compared the July 20, 2020 TTE results with the April 20, 2021 TTE results, the plaintiffs' expert opined that they further departed from the standard of care by failing *properly* to compare and analyze the two results, "including but not limited to failure to identify significant changes in left atrial enlargement."

The plaintiffs' expert alleged that the defendants improperly disregarded the patient's elevated troponin levels. Upon noting that, on April 20, 2021, the patient's D-dimer tested positive and was at elevated levels 239 ng/mL, the expert faulted the defendants' failure further to work up the patient's hypercoagulability and their determination to discharge him in a "hypercoagulable state, in violation of the Standards of Care." The plaintiffs' expert expressly disagreed with the defendants' experts that the D-dimer levels did not require further workup. Rather, the expert asserted that a CTA was warranted at that time, and should have been performed prior to discharging the patient from the hospital. The expert thus characterized the defendants' failure immediately to perform a CTA and work up the patient's hypercoagulable state as a departure from good and accepted medical practice. The expert also asserted that Miller departed from good and accepted practice by failing to order a cardiac CTA during the May 3, 2021 visit, and ultimately opined that "had the cardiac CT angiogram been performed . . .

during the April 2021 admission or in May 2021, the PFO would have been discovered on that cardiac CT angiogram as early as April 2021---as is what happened ultimately happened on June 9, 2021." The expert also concluded that, "because of the PFO and Mr. Abeles's left and right atrial enlargement, PFO closure would have been indicated and urgently performed, and Mr. Abeles would not have suffered the resulting stroke on June 6, 2021."

In reply, the defendants submitted an attorney's affirmation, in which their attorney contended that the plaintiffs' expert did not refute many of the opinions rendered by the defendants' experts, and did not raise a triable issue of fact as to whether anything that the defendants did or did not do caused or contributed to the patient's stroke. She also argued that, inasmuch as a PFO would only have been an incidental finding had the defendants conducted a CTA in April or May 2021 in connection with other conditions, there is no basis for holding them liable for failing to include PFO on their differential diagnoses at those times.

The court concludes that, although the defendants made a prima facie showing of their entitlement to judgment as a matter of law in connection with the medical malpractice cause of action, the plaintiffs raised a triable issue of fact as to whether Miller and other NYPH health-care providers departed from good and accepted medical practice in failing to include PFO in their differential diagnoses beginning on April 19, 2021 and continuing through June 10, 2021, failing to test the patient for PFO beginning on April 19, 2021 in light of his complaints, symptoms, and signs, failing to diagnose him with PFO as of April 19, 2021 or April 20, 2021, and failing to treat him for PFO until after he suffered a stroke. The plaintiff's expert further raised a triable issue of fact as to whether those delays caused or contributed to the stroke, and whether earlier intervention was both indicated and would have prevented the stroke. The court rejects the defendants' contention that the plaintiffs' expert did not raise a triable issue of fact because a finding of PFO on an earlier cardiac CTA would only have been incidental to findings of other cardiac conditions that the defendants already had diagnosed without a CTA. Rather, the plaintiffs' expert expressly stated that the complaints, signs, and symptoms that the patient

presented on April 19, 2021 were sufficient for the defendants to consider, test for, and diagnose PFO. In other words, the expert did not merely speculate that, had the defendants ordered a cardiac CTA on April 19, 2021 to test for other conditions, they would have fortuitously discovered the PFO (*see, e.g., Rivera v Greenstein*, 79 AD3d 564, 568 [1st Dept 2010] ["An expert offering only conclusory assertions and mere speculation that a doctor could have discovered the condition and successfully treated the patient does not support liability"]). Nonetheless, in opposition to the defendants' prima facie showing of entitlement to judgment as a matter of law in connection with malpractice allegedly occurring on July 20, 2020, the plaintiffs' expert did not address it and, hence, the plaintiffs failed to raise a triable issue of fact. Accordingly, summary judgment must be awarded to the defendants dismissing any claim of malpractice related to examinations, treatment, and care rendered on July 20, 2020, but those branches of their motion seeking summary judgment dismissing the remainder of the medical malpractice cause of action must be denied.

"'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]). Miller was an employee of NYPH when he allegedly committed the acts complained of here. Hence, to the extent that there are triable issues of fact with respect to whether Miller committed malpractice, there are triable issues of fact as to NYPH's vicarious liability with respect to those claims. In any event, the allegations made by the plaintiffs also included claims that NYPH medical personnel other than Miller, particularly physicians in its cardiology department, also failed timely to consider, test for, diagnose, and treat PFO. Hence, to the extent that there are triable issues of fact as to whether

those physicians committed malpractice, there are triable issues of fact as to whether NYPH is vicariously liable therefor.

The court notes that, although the affidavit of the plaintiffs' expert was sworn to and executed in Connecticut, it was not accompanied by the certificate of conformity required by CPLR 2309. A certificate of conformity is a written instrument, pursuant to which a person qualified by the laws of the state in which an affidavit or affirmation is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit or affirmation has indeed been drafted, executed, and notarized in conformity with the laws of that state. The absence of the certificate of conformity, however, does not require the court to disregard or reject that affidavit, as the failure to include a certificate of conformity is a mere irregularity that may be cured by the submission of the proper certificate nunc pro tunc (*see Khurdayan v Kassir*, 223 AD3d 590, 591 [1st Dept 2024]; *Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]). Consequently, the court directs the plaintiffs to serve and file the necessary certificate of conformity on or before September 30, 2025.[1]

As a derivative claim, the loss of consortium cause of action asserted by Lori Abeles, as the patient's wife, remains viable to the extent that the patient's medical malpractice cause of

[1] The court notes that CPLR 2106, Part 1, was amended, effective January 1, 2024, to authorize the use of an affirmation in lieu of an affidavit by "*any person* wherever made," as long as the statement set forth therein had been "affirmed by that person to be true under the penalties of perjury" (L 2023, ch 559) (emphasis added). Nonetheless, that amendment did not impliedly repeal the requirement of CPLR 2309(c) that a certificate of conformity must accompany an affirmation otherwise permitted to be executed outside of the State of New York (*see Murphy v Metrikin*, 2021 NY Misc. LEXIS 48875, *2 [Sup Ct, N.Y. County, Jun. 21, 2021] [Kelley, J.]; *cf. U.S. Bank N.A. v Langner*, 168 AD3d 1021, 1023 [2d Dept 2019] [despite the 2014 amendment to CPLR 2106(b) permitting a person outside of the United States to employ an affirmation in lieu of an affidavit, "an affirmation from a person physically located outside the geographic boundaries of the United States must comply with the additional formalities of CPLR 2309(c), and must, in substance, affirm that the statement is true under the penalties of perjury under the laws of New York"]).

action remains viable (*see Robinson v Northwell Health, Inc*., 2021 NY Slip Op 33146[U], *8. 2021 NY Misc LEXIS 8552, *16-17 [Sup Ct, Queens County, Dec. 6, 2021]; *see generally Clarke v City of New York*, 82 AD3d 1143, 1144 [2d Dept 2011]; *Kaisman v Hernandez*, 61 AD3d 565, 566 [1st Dept 2009]).

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]). "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). In other words, to sustain a lack of informed consent cause of action premised upon the failure to diagnose a condition, a patient must establish, at a minimum, that he or she underwent "a diagnostic procedure that invaded the integrity of plaintiff's body" (*Ford v Lee*, 203 AD3d 456, 458 [1st Dept 2022]). The defendants established, prima facie, that the lack of informed consent cause of action was not viable under the circumstances presented here, since the plaintiffs asserted only that the defendants failed timely to consider, test for, and diagnose PFO, and did not allege that any procedure or diagnostic test that was performed invaded the patient's bodily integrity, let alone

that it caused injury. In opposition to the defendants' prima facie showing in this regard, the plaintiffs failed to raise a triable issue of fact and, hence, summary judgment must be awarded to the defendants dismissing the lack of informed consent cause of action.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). Since the plaintiffs adduced no facts with respect to whether the defendants knew or should have known of the propensity of their physicians to commit acts of malpractice, that branch of the defendants' motion seeking summary judgment dismissing that cause of action must be granted.

Accordingly, it is,

ORDERED that the defendants' motion is granted to the extent that they are awarded summary judgment dismissing the causes of action alleging lack of informed consent and negligent hiring, training, supervision, and retention of health-care personnel, and dismissing so much of the medical malpractice cause of action as was premised upon departures allegedly committed on July 20, 2020, those causes of action and that claim are dismissed, and the motion is otherwise denied; and it is further,

ORDERED that that, on the court's own motion, the attorneys for all of the remaining 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 August 14, 2025, at 2:15 p.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.

7/21/2025
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