

**Roven v Seitz**

2025 NY Slip Op 33111(U)

August 15, 2025

Supreme Court, New York County

Docket Number: Index No. 805049/2020

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY**

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

*Justice*

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JANICE ROVEN as Executor of the Estate of GLEN ROVEN, and JANICE ROVEN, Individually,  
  
Plaintiff,

**INDEX NO.** 805049/2020

**MOTION DATE** 07/23/2025

**MOTION SEQ. NO.** 001

- v -

DAVID ELLIOT SEITZ, M.D., and HOUSECALLMDNY, LLC,  
  
Defendants.

**DECISION + ORDER ON MOTION**

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The following e-filed documents, listed by NYSCEF document number (Motion 001) 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65 were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and wrongful death, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing the plaintiff's claim, set forth in the medical malpractice cause of action, that the defendants failed to obtain her decedent's fully informed consent to treatment. The motion is otherwise denied.

The crux of the plaintiff's claims against the defendants is that, on July 12, 2018 and July 13, 2018, the defendant family practitioner David Elliot Seitz, M.D., departed from good and accepted medical practice by failing timely and properly to diagnose her brother and decedent, Glen Roven, with pneumonia, thus ultimately leading to his death on July 25, 2018. She asserted that Seitz failed timely and properly to include pneumonia high up in his differential diagnosis, and failed to take account of her decedent's acute onset of symptoms and the persistence thereof. In her complaint, she specifically alleged that Seitz failed to be cognizant of

her decedent's medical history, complaints, and clinical indicators and presentations, failed to document an accurate history, and failed to order her decedent to check into a hospital emergency department for immediate treatment. She further asserted that Seitz failed timely and properly to consult with emergency medicine or infectious disease specialists, and failed properly to educate her decedent as to his symptoms. In addition, the plaintiff contended that Seitz failed properly to screen or test for pneumonia in light of the symptoms that the decedent presented, perform proper work-ups, imaging, and diagnostic laboratory testing, including analysis of blood or urine samples, or refer him in a timely fashion to others who could have performed those work-ups, imaging, and testing. She further averred that Seitz failed properly to examine her decedent, thus causing him to lose an opportunity for a cure or better outcome. The plaintiff, although she did not assert an independent cause of action alleging lack of informed consent, nonetheless asserted in her complaint that Seitz failed to obtain her decedent's informed consent by failing to provide him with adequate or sufficient information and guidelines necessary for her decedent to care for himself, or to explain any risks that may have been related to his symptoms.<sup>1</sup> In addition, the plaintiff alleged that Seitz failed timely or properly to monitor her decedent or prescribe appropriate and indicated medications. She alleged that HouseCallMDNY, LLC (House Call), which was the limited liability company under which Seitz practiced medicine, was vicariously liable for Seitz's malpractice. The plaintiff further asserted that her decedent, who was her brother and the uncle of her sons, provided services and support for his next of kin, and that her sons lost the guidance that he provided.

In her bill of particulars, the plaintiff essentially reiterated the allegations set forth in her complaint, and asserted that, as a consequence of the defendants' malpractice, her decedent

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<sup>1</sup> A cause of action to recover for lack of informed consent, although akin to an action for medical malpractice, is a distinct cause of action (*see Pagan v State of New York*, 124 Misc 2d 366, 367 [Ct Claims 1984]). Although the plaintiff did not expressly assert a cause of action to recover for lack of informed consent in her complaint, the court will deem the allegations set forth in the medical malpractice cause of action to include a cause of action sounding in lack of informed consent.

suffered from worsening Legionella pneumonia, with related respiratory distress, fever, weakness, tachycardia, dyspnea, oxygen desaturations, acute hypoxemic respiratory failure, septic shock, cardiac arrest, and an acute left middle cerebral artery stroke, all of which caused him consciously to experience pain and suffering, led to his fear and knowledge of his impending death, and, ultimately, his death itself.

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-Sturup 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 Chiamonte*, 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; 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 plaintiff's bill of particulars, relevant medical and hospital records, transcripts of the parties' deposition testimony, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified internist and infectious disease specialist Phillip J. Palmieri, M.D., who opined that Seitz did not depart from the applicable standard of care in examining and treating the plaintiff's decedent, and that nothing that Seitz did or did not do caused or contributed to the onset of the decedent's illness, the exacerbation of that illness, or his death.

Dr. Palmieri explained that, on July 12, 2018, at 9:00 p.m., Seitz, through House Call, made a single visit to the home of the decedent, who was then 61 years old. As Dr. Palmieri interpreted the chart that Seitz maintained in connection with the decedent's examination and treatment, the decedent had just returned to New York City approximately two hours earlier from a one-week trip to the island of Nevis in the Caribbean Sea. According to Dr. Palmieri, the chart indicated that the decedent reported to Seitz that, about two days into the trip, the decedent developed a bilateral frontal headache of mild-to-moderate severity, associated with a mild

intermittent cough that had produced white sputum, a nasal drip, and a scratchy throat. Seitz's note further reported that the decedent had reported that, over the next four days of the trip, the decedent's symptoms decreased somewhat, with the headache having subsided, albeit intermittently present, and the cough diminished in frequency to once or twice per hour. According to the chart, the decedent told Seitz that, during that time, he felt "warm" and "run down," but did not take his own temperature, and denied any shortness of breath, chest pain, or gastroenterological symptoms. As Seitz recorded the decedent's history, the latter reported no chronic medical problems, and reported only that he had been diagnosed with a sinus infection a few years earlier that had resolved after he took antibiotics, but that, since Amoxicillin did not work, he had been prescribed another antibiotic.

At the July 12, 2018 appointment, Seitz measured the decedent's body temperature as 99.8 degrees Fahrenheit, his heart rate at 78 beats per minute, his respiration rate at 12 breaths per minute, and his oxygen saturation at 99%, which Dr. Palmieri characterized as normal, with his heart in sinus rhythm without murmurs. Seitz reported his examination of the decedent's lungs as reflecting that they were clear to auscultation bilaterally and anteriorly, without rales, rhonchi, or wheezing, and no cough on forced exertion. According to Seitz's chart, head, ear, nose, throat, neck, extremities and neurological examinations all were unremarkable or negative for significant findings. Dr. Palmieri averred that Seitz recommended that the defendant be tested for influenza, and undergo rapid testing for streptococcus and a purified protein derivative test for tuberculosis. He further asserted that the decedent refused the recommended tests, but would have them done a later time if the symptoms did not resolve. Dr. Palmieri reported that Seitz's assessment was that the symptoms and examination were "consistent with mild sinusitis," and that Seitz thus prescribed the antibiotic Cefitin, although Seitz further wrote in the chart that, in light of the decedent's travel to Nevis, tropical diseases such as Zika could not be excluded. As Dr. Palmieri read the chart, Seitz also recommended that the decedent undergo routine bloodwork and a Zika test the following morning, but that the decedent declined the

recommendation, pending the development of his symptoms. According to Dr. Palmieri, Seitz directed the decedent to call him in 24 hours to check in and report on the symptoms, but to call him immediately if the symptoms worsened or if new symptoms developed.

On July 13, 2018 at approximately, 6:00 p.m., the plaintiff, Jancie Roven, called Seitz from the decedent's apartment, and informed Seitz that the decedent's symptoms had changed, upon which Seitz purportedly directed the decedent to check into a hospital emergency room. According to Dr. Palmieri, Seitz never saw or spoke with the decedent after July 12, 2018,

As Dr. Palmieri explained it, the decedent checked into the emergency room at Mount Sinai West at 2:41 a.m. on July 14, 2018, and that, on July 17, 2018, the plaintiff texted Seitz to advise him that the decedent was then in that hospital's intensive care unit (ICU) on a ventilator. As he interpreted Seitz's deposition testimony, when Seitz attempted to call the plaintiff, she did not respond, and that when Seitz requested to speak to the decedent's attending physician, the plaintiff refused to provide that contact information, but instead directed Seitz to place his medical malpractice insurance carrier on notice of an impending claim.

In connection with the decedent's admission to Mount Sinai, Dr. Palmieri more specifically asserted that the decedent was triaged in emergency department at 2:47 a.m. on July 14, 2018, which he noted was seven hours after Seitz had directed him to go there. The decedent arrived at the hospital via ambulance, and complained that he had experienced headache, weakness, cough, shortness of breath on exertion, and diarrhea "while he was on vacation," along with contemporaneous complaints of intermittent headache, fatigue, cough, shortness of breath, and episodes of diarrhea for the six previous days, but denied chest pain, and was afebrile. According to the Mount Sinai West chart, the decedent nonetheless was tachycardic, with a low oxygen saturation level of 89%, and was noted to be in respiratory distress with rales, that is, a clicking, bubbling, or rattling sound in his lungs, specifically, the mid-left lung field. The Mount Sinai West chart further reported that the decedent's white blood cell count was 0.7 billion cells per liter of blood, which Dr. Palmieri characterized as "extremely

low,” although another note in the chart reported that the decedent’s headache and cough had improved after he saw Seitz on July 12, 2018 and took the Ceftin. Although Dr. Palmieri noted that the history that the decedent gave to Mount Sinai West health-care staff included a “remote” history of hairy cell leukemia, depression, and hypersensitive lung disease, he asserted that neither the decedent nor the plaintiff reported the history of hairy cell leukemia to Seitz. According to Dr. Palmieri, the decedent reported to Mount Sinai West staff that his normal white blood cell count was approximately 3.5 billion cells per liter of blood, and that he had sometimes been administered Neupogen injections when he had become acutely sick, a portion of his medical history that Dr. Palmieri states also had not been reported to Seitz.

As Dr. Palmieri interpreted the decedent’s hospital chart, while the decedent remained in the emergency department on July 14, 2018, he evinced increased difficulty in breathing and oxygen desaturation, at which juncture he was admitted to the ICU, intubated for hypoxemic respiratory failure, and placed on mechanical ventilation. The chart indicated that the decedent was being treated for acute respiratory distress secondary to pneumonia, and further indicated that he was administered the antibiotics Cefepime, Vancomycin, and Azithromycin. On July 15, 2018, the decedent developed hypotension, requiring the administration of vasopressors, and evinced worsening hypoxemia. The decedent then went into a pulseless electric activity level-3 cardiac arrest, although spontaneous circulation resumed after four minutes of cardio-pulmonary resuscitation efforts, while, subsequent to that incident, the decedent was, according to Dr. Palmieri, “persistently hypotensive and hypoxemic.” The chart further revealed that a computed tomography (CT) scan of the decedent’s head depicted “lacunar infarcts of indeterminate age.” As of that date, Legionella sputum culture and urine Legionella tests were both negative. Nonetheless, on June 24, 2018, that is, 10 days after the decedent had been admitted, a Legionella antibody test returned a positive result.

Dr. Palmieri explained that, during the course of decedent’s treatment at Mount Sinai West, emergency room and ICU physicians considered numerous etiologies to explain the

decedent's symptoms, including a recurrence of leukemia, sepsis, neutropenia, pancytopenia, that is low counts of all three types of blood cells, right lower-lobe pneumonia, HIV, hypoxic/ischemic brain injury, cardiac complications, fungal infection, adenovirus, influenza, and Chlamydomphila. He stated that, despite a suspected recurrence of hairy cell leukemia, the plaintiff directed the decedent's treating physicians to delay the performance of a bone marrow biopsy. Dr. Palmieri asserted that, on July 25, 2018, a second CT of the decedent's head depicted an acute/subacute left middle cerebral artery territory infarct that had newly developed since the most recent CT scan of July 16, 2018, albeit without any hemorrhagic component, but associated with a 1.0-centimeter midline shift, with a right-sided uncal hernia and brain parenchymal edema. The decedent died on July 25, 2018. No autopsy was performed.

Dr. Palmieri opined that all of Seitz's conduct, including his recording of the decedent's history, his documentation, examination, evaluation, assessment, and recommendations were at all times within the applicable standard of care. He described Seitz's evaluation as including a "thorough" physical examination and a "comprehensive" review of systems. He asserted that Seitz's note meticulously documented his examination, which set forth each of the decedent's subjective complaints, the reported prior medical history, and each observation that Seitz made, while Seitz's examination included checking the decedent's vital signs, blood pressure in both arms, respiration rate, temperature, and oxygen saturation levels. He further asserted that the examination properly included evaluations of the decedent's head, ears, eyes, nose, mouth, and throat, which Seitz appropriately performed using an otoscope, tongue depressor, and an ophthalmoscope, and accurately observed a moderate reddening of the decedent's nostrils with white/yellow mucus, and streaking in the posterior pharynx, which was indicative of nasal drip, along with normal tympanic membranes bilaterally. Dr. Palmieri asserted that Seitz, as part of the proper examination, pressed on the maxillary area of the decedent's head, and properly observed that the decedent complained of mild discomfort upon palpation of both frontal sinuses and maxillary sinuses bilaterally. He averred that Seitz properly performed an examination of

the decedent's heart with a stethoscope to listen for the rate and rhythm, and appropriately determined that there were no murmurs, rubs, or gallops. Dr. Palmieri described Seitz's examination as including a thorough pulmonary/lung examination with a stethoscope, inasmuch as Seitz moved that device from left to right on the decedent's back five to six times while listening to the latter's breathing, and placed the stethoscope on the decedent's chest to evaluate the middle lobe of the patient's lung, an examination that resulted in the observation of no rales, no bronchi, and no wheezing. He noted that Seitz also attempted to solicit a cough using a forced expiration technique, which did not result in a cough, and that Seitz also conducted an appropriate neurological examination, a physical examination of the extremities, and a detailed review and consideration of the patient's subjective symptoms.

As Dr. Palmieri explained it, the decedent's statements to Seitz that his headache had subsided, and that his cough had diminished, were inconsistent with a diagnosis of pneumonia because the symptoms of pneumonia do not typically subside spontaneously, and that, rather, that report was more compatible with a slowly resolving infection such as mild sinusitis. He also stated that, if the decedent had been experiencing a frequent cough, the forced exertion tests performed by Seitz, which Dr. Palmieri described in detail, would have revealed it. Dr. Palmieri also agreed with Seitz's explanation, at his deposition, that the absence of rales suggested the absence of pneumonia, while the absence of bronchi suggested the absence of bronchitis.

Dr. Palmieri further asserted that although a patient's visits for specific complaints, such as those articulated by the decedent here, merely call for a focused examination, Seitz nonetheless performed a comprehensive medical examination, including a comprehensive and thorough chest and lung examination, which he reiterated were clear to auscultation bilaterally, posteriorly, and anteriorly.

Dr. Palmieri described the history that Seitz took of the decedent, his recording thereof, and the documentation of his examination as thorough and complete, and that the symptoms and responses to testing that Seitz observed in the decedent supported Seitz's conclusion that

a diagnosis of mild sinusitis was reasonable. As he framed the issue, the decedent's complaints related only to a sinus condition, and that the decedent reported no complaints or history that should have suggested pneumonia, let alone Legionella pneumonia, but that Seitz did, in fact, consider pneumonia in formulating his differential diagnosis. Dr. Palmieri agreed with Seitz's deposition testimony that pneumonia was properly ruled out because it was then summer, and because the decedent did not report muscle aches that typically accompany the condition. He further asserted that a diagnosis of pneumonia was unsupported by the decedent's oxygen saturation respirations and by Seitz's pulmonary/lung examination, which he described as "normal and unremarkable."

According to Dr. Palmieri, the decedent's failure to report any chronic medical problems to Seitz, despite a history of hairy cell leukemia and the administration Neupogen injections due to a low white blood cell count, did not provide Seitz with information that likely would have led him to refer the decedent immediately to a higher level of care. In any event, Dr. Palmieri averred that the decedent presented to Seitz with no symptoms of pneumonia on July 12, 2018, and that a productive cough that was diminishing since its onset several days earlier was not a persistent or a progressive cough that would expect to be seen with pneumonia. He opined that the presence of clear lungs and normal oxygen saturation, along with the absence of rales, cyanosis, dyspnea on exertion, fever, progressive or unimproved headache, myalgias, night sweats, abdominal pain, diarrhea, shortness of breath, confusion, obtundation, seizures, or other relevant findings to suggest in any way that the patient would decompensate, meant that the exclusion pneumonia as a diagnosis at that time was proper and appropriate. Hence, Dr. Palmieri averred that a chest x-ray or immediate emergency room treatment was not indicated.

Dr. Palmieri concluded that Seitz's prescription of Ceftin was perfectly appropriate as an antibiotic to treat the decedent's sinus infection, particularly because the decedent had reported a history of sinusitis for which Amoxicillin was ineffective, and that he most likely had been successfully treated with Ceftin, that this drug was a logical and reasonable antibiotic for

sinusitis, and that Seitz's prescription met the standard of care. He stated that, "[s]ince there was nothing in the patient's history or examination which raised a suspicion for Legionella pneumonia, no Macrolide or Quinolone was prescribed." In addition, he approved of Seitz's recommendation that the decedent check back within 24 hours to report how he was feeling and to call immediately if symptoms worsen or new symptoms developed. Moreover, Dr. Palmieri stated that, although the plaintiff called Seitz on July 13, 2018 to report that the decedent's "fever has subsided" and that he did not have any shortness of breath since beginning on the Ceftin, and also reported that the decedent had developed weakness in his legs and felt more run down than previously, neither of these complaints had been reported to Seitz on July 12, 2018 and that, in any event, neither of these new complains was consistent with a diagnosis of pneumonia, let alone Legionella pneumonia. He asserted that, nonetheless, it was unclear to Seitz at that time as to whether the weakness was due to the decedent's fatigue but that, in any event, Seitz appropriately considered that it was something more serious, such as Guillen-Barre syndrome, and properly recommended that the decedent report to the nearest emergency department for evaluation.

As Dr. Palmieri framed the issue,

"[t]here were no signs or symptoms at any time during Dr. Seitz's home visit or during the phone call with the patient and the patient's sister the following evening that suggested legionella pneumonia. Legionnaires pneumonia almost always manifests initially with a fever. A mild headache (such as the one the patient complained of), and a resolving cough would not be indicative of Legionnaires' disease.

"Further, common signs and symptoms associated with bacterial pneumonia are chills, fever, decreased pulse oximetry and rales on physical examination. None of these signs or symptoms were [sic] present during Dr. Seitz[s] examination of the patient."

Dr. Palmieri further alleged that, even if Seitz did depart from the standard of care, any such departure did not proximately cause the decedent's injuries and death. As he explained it, Legionella pneumonia is diagnosed by a sputum culture or urine antigen test and that, although a sputum culture was performed at Mount Sinai West several days after the decedent's July 14,

2018 admission, the culture was negative. Dr. Palmieri explained that, since there was a possibility that the sputum culture was negative due to the recent administration of antibiotics, including Azithromycin, a urine antigen test also was performed, and also was negative, “thus confirming that there was no legionella bacteria to be found,” since, if Legionella had been present, it would have been found in the urine.

Dr. Palmieri concluded that “[t]he diagnosis of legionella pneumonia made at Mt. Sinai West was improperly made on the basis of a single positive antibody test.” He asserted that it was “well known” that Legionella antibody tests frequently produce false positives, and that an antibody test “in no way proves” that decedent had contracted Legionella pneumonia. In this respect, he asserted that the decedent suffered from chronic neutropenia due to hairy cell leukemia at the time that he was admitted to Mount Sinai West on July 14, 2018, at which time his complete blood cell count indicated agranulocytosis, since his total white blood cell count was 0.7 billion cells per liter of blood and total neutrophil count was 300 per microliters of blood. Dr. Palmieri asserted that agranulocytosis would have caused a “poor outcome for a patient with any type of pneumonia,” although he did not explain what type of outcome would have been “poorer” than acute respiratory failure and death, and how the condition of a patient who did have pneumonia would have developed differently than the decedent’s condition actually did.

Ultimately, Dr. Palmieri opined that the decedent suffered from a severe cerebrovascular accident, that is, a stroke, and cardiac arrest while at Mount Sinai West, that the stroke caused the decedent’s death, and that neither pneumonia nor Legionella bacteria had anything to do with the stroke. According to Dr. Palmieri, the results of a July 18, 2018 cell flow cytometry study performed at the hospital indicated that the decedent’s history of hairy cell leukemia was a substantial factor in the outcome, since it demonstrated the presence of “[a] monoclonal B cell population with coexpression of CD25 and DBA.44 (by immune stains on cytosine slide) consistent with recurrent/residual Hairy Cell Leukemia,” despite the decedent’s “failure to report the condition to the emergency department medical staff prior to being intubated and sedated.”

Dr. Palmieri concluded the presence of these cells demonstrated that the decedent was severely immunocompromised, contrary to a note generated by emergency room physician Ryan Tansek, M.D., that the decedent was “negative for immunocompromised state.” Consequently, Dr. Palmieri opined that the decedent “developed pneumonia subsequent to his examination with Dr. Seitz, and that he decompensated rapidly prior to being intubated and passing away from an unrelated condition on July 25, 2018.”

In opposition to the motion, the plaintiff relied on many of the same documents that the defendants submitted, and also submitted an attorney’s affirmation, a response to the defendants’ material statement of undisputed facts, the plaintiff’s affidavit concerning her search for documents requested by the defendants during discovery, the deposition transcript of nonparty witness Christopher Beckman, and the expert affirmation of board-certified medical examiner, internist, pulmonary disease specialist, and chest physician Wilfredo Talavera, M.D., who opined that the defendants “breached the standards of care for medical care and treatment of plaintiff’s decedent, Glen Roven, which directly caused and contributed to Glen Roven’s untimely diagnosed and untimely treated pneumonia disease progression, and the medical complications that flowed therefrom resulting in his premature death.”

Specifically, Dr. Talavera concluded that Seitz departed from good and accepted practice when, on July 12, 2018, he failed to include pneumonia high on his differential diagnoses of the decedent, despite the decedent’s report of an acute onset of symptoms two days into his trip to Nevis and his request that Seitz make a house call only two hours after his return from Nevis, along with the decedent’s low-grade fever of 99.8 degrees F., and his complaints of an intermittent productive cough at that time of “once or twice per hour,” feeling “run-down” and “warm,” and an “intermittent headache.” He faulted Seitz for failing to rule out pneumonia during that visit by failing to recommend and direct that the decedent immediately present to a local emergency department for a work up, including blood and urine testing and a chest x-ray, “which would have led to the timely diagnosis of pneumonia and proper treatment

with broad spectrum antibiotic therapy.” Dr. Talavera also contended that, on July 12, 2018, Seitz misdiagnosed the decedent with mild sinusitis, and failed timely and properly to prescribe broad-spectrum coverage antibiotics, such as Vancomycin and Azithromycin, given the “index of suspicion of pneumonia indicated” by the decedent’s complaints and presentation. He alleged this misdiagnosis delayed testing and treatment that could have been performed and rendered on July 12, 2018 or July 13, 2018, and caused and contributed to the decedent’s loss of an opportunity to prevent the worsening of the pneumonic disease progression, and the complications that immediately flowed therefrom, as well as a cure. Dr. Talavera described the complications as acute respiratory distress, severe sepsis, hypoxemic respiratory failure requiring mechanical ventilation, hypotension requiring vasopressors and worsening hypoxemia, pulseless electrical activity causing cardiac arrest, septic shock due to Legionella pneumonia, and, ultimately, an acute and massive cerebral artery stroke, all of which caused and contributed to the decedent’s premature death on July 25, 2018.

Dr. Talavera also alleged that Seitz departed from good practice by failing properly to document his telephone conversations with the plaintiff and the decedent on July 13, 2018, which “credibly indicate[d]” that Seitz’s history, examination, assessment, diagnosis, and instructions to the decedent on both July 12, 2018 and July 13, 2018 were improper and inadequate, and that his medical notes were suspect and not contemporaneously, timely, properly, or accurately made.

Dr. Talavera reiterated most of the factual history of the decedent’s medical conditions, Seitz’s medical examination and testing, and the course of the decedent’s examinations, testing, and treatment at Mount Sinai West that Dr. Palmieri had described. Dr. Talavera, however, added some other facts that Dr. Palmieri did not mention. Thus, for instance, Dr. Talavera quoted from an entry made in the decedent’s Mount Sinai West chart by an emergency room physician at 3:05 a.m. on July 14, 2018, that the decedent presented with “weakness. Reports 6 days of intermittent headache, cough, . . . feels whole body weak . . . Reports diarrhea

coming out when he coughs a lot,”<sup>2</sup> that the decedent was “in respiratory distress. L mid lung field with crackles/wheeze,” and that the assessment and plan was “*most likely pneumonia* given cough, S[hortness] O[f] B[reath], weakness, hypoxia, wheeze/crackles to L[eft] mid lung. Possible myocarditis. Will pursue sepsis protocol, chest x-ray, reassess, admit (emphasis added).” Dr. Talavera noted that the physician ordered a chest x-ray at that time, which was performed immediately, and that, at 4:39 a.m., a radiologist discussed the x-ray findings with that physician, noting in the chart the presence of “right middle lobe airspace opacification with small right pleural effusion . . . Impression: *right middle lobe pneumonia*, small right pleural effusion may be parapneumonic (emphasis added).” Hence, Dr. Talavera concluded that, contrary to Dr. Palmieri’s contention, less than two hours after the decedent’s arrival at Mount Sinai West, or approximately 32 hours after Seitz had examined him, the decedent had been diagnosed with pneumonia in his right middle lung, with a suspicion of fluid buildup in the pleural space that occurs when a patient is suffering from an infection such as pneumonia.

As Dr. Talavera interpreted the Mount Sinai West chart, the decedent’s condition quickly deteriorated shortly after his admission, and that, by 4:25 a.m. on July 14, 2018, the chart documented “breathing worsening,” that he was placed on a “non-rebreather” oxygen mask, and then a BiPAP ventilator for support, but nonetheless experienced oxygen desaturations and tachycardia. While the decedent was still in the emergency, physicians administered the broad-

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<sup>2</sup> In connection with these complaints, Dr. Talavera asserted that he considered “credible” the deposition testimony of the plaintiff and Beckman with respect to the severity of the decedent’s illness, particularly in light of the text messages that the decedent sent to the plaintiff during the mid-afternoon of July 12, 2018, in which he described himself as being “really sick,” experiencing a “spastic cough which goes on for two minutes . . . like heaving [his] guts out,” “needing rest,” feeling unable “to function,” having “bad fever,” not having the “strength to talk,” and applying a cold compress to “take down the fever.” As Dr. Talavera framed it, the decedent’s own words, along with the hospital emergency department chart, “contradict and discredit what Dr. Seitz documented in his handwritten medical notes on 7/12/18 and 7/13/18 and his testimony at deposition,” in which he claimed that the decedent “did not cough once during his encounter on 7/12/18,” and that the decedent’s symptoms were “decreased, improving, and only mild.” He asserted that the text messages and hospital chart were “credible and significant” since they were generated contemporaneously with the decedent’s complaints and symptoms, were all made prior to his grave and sudden decline, and, thus, were made prior to any threat by the plaintiff to Seitz that Seitz should contact his medical malpractice insurance carrier.

spectrum antibiotics Ceftriaxone and Azithromycin for pneumonia, to which Cefepime and Vancomycin were later added after he was diagnosed with leukopenia, that is, a low white blood cell count. The chart reflected that the decedent was admitted to the ICU at 6:12 a.m. on July 14, 2018 for “pneumonia due to organism,” “severe sepsis,” and acute hypoxic respiratory failure. Dr. Talavera noted that a chest x-ray taken in the ICU reflected a worsening pneumonic process involving both the right and left lungs, after which the decedent was intubated in the ICU because his condition was not improving. As Dr. Talavera interpreted the chart, the decedent experienced a “cascade of complications,” and was unable to survive “owing to his acute respiratory distress syndrome due to multifocal pneumonia that had been undiagnosed and untreated since July 12, 2018,” when Seitz examined him.

Dr. Talavera recapitulated and summarized the “Discharge Summary of Deceased Patient” note in the hospital chart, which he noted had documented that, while in the ICU, the decedent continued to experience hypoxemia, that is, a low level of blood oxygen. As he explained it, pneumonia can prevent oxygen from being added to the blood and prevent carbon dioxide from being removed, due to the presence of fluid in the lungs that interfere with the exchange of gases. He further asserted that the decedent developed hypotension requiring vasopressors, which also was caused by the pneumonia and the response of the decedent’s body to the infection. Dr. Talavera noted, as did Dr. Palmieri, that the decedent went into cardiac arrest, and that he was successfully resuscitated, but that the cardiac arrest resulted in a diffuse anoxic brain injury, all of which Dr. Talavera concluded had been caused by his progressive pneumonia, since progressive sepsis, shock, respiratory failure, and cardiac arrest are all known complications of pneumonia. He further stated that the decedent’s mental status did not improve from the time of his admission on July 14, 2018 through July 25, 2018, during which period he remained critically ill and had developed a fever. According to Dr. Talavera, while a possible recurrence of hairy cell leukemia was initially suspected, physicians at Mount Sinai West documented that the plaintiff deferred a biopsy for her brother because he had

experienced pain during previous biopsies. He further asserted that the administration of antibiotics and other medications nevertheless improved his neutropenia, and that that hematologist/oncologist with whom ICU physicians consulted did not recommend a bone marrow biopsy, inasmuch as it would not have changed the management plan for decedent, who then was in critical condition by virtue of the infectious disease process.

Dr. Talavera reiterated the entry in the decedent's chart that indicated that, despite the fact that antibiotic coverage had been maintained throughout his ICU admission, the July 24, 2018 antibody test for Legionella pneumonia came back positive, and that he suffered a massive cerebral artery stroke on July 25, 2018. As he described it, respiratory infections like pneumonia are known to increase risk of stroke in the days after an infection. He further asserted that, although a neurosurgeon had been consulted on June 25, 2018, surgery was deemed to present too high a risk and likely was futile, while the decedent's prognosis was grave in any event. He explained that the plaintiff elected to continue the decedent on palliative management, the latter was extubated at 1:30 p.m. on July 25, 2018, and died at 1:56 p.m. on that date. The hospital chart memorialized the "final diagnosis" of the decedent as "acute hypoxemic respiratory failure, septic shock secondary to Legionella pneumonia; acute left middle cerebral Artery stroke," and Dr. Talavera opined that there was no evidence in the chart or otherwise indicating that the final diagnosis was not accurate or complete.

Dr. Talavera expressly disagreed with Dr. Palmieri that the July 24, 2018 antibody test for Legionella generated a false positive result. As he characterized it, Dr. Palmieri offered no explanation, let alone proof, that the result was a false positive, and that there was nothing in the medical records or elsewhere to support Dr. Palmieri's opinion that it was a false positive. He also explicitly disagreed with Dr. Palmieri's opinion that the decedent "developed pneumonia subsequent to his examination with Dr. Seitz, and that he decompensated rapidly prior to being intubated and passing away from an unrelated condition on July 25, 2018." In this respect, Dr. Talavera asserted that Dr. Palmieri offered

“no explanation, let alone proof, of when or how Glen Roven suddenly developed pneumonia only after 7/12/18 and this statement is contradicted by the Mount Sinai medical chart that well documents that Glen Roven had signs and symptoms of pneumonia, i.e. productive cough, weakness, fever, and fatigue, while he was in the Caribbean for a week before he presented to the hospital, including on 7/12/18 when he encountered Dr. Seitz. Dr. Palmieri does not state what ‘unrelated condition’ caused the death of Glen Roven.”

Dr. Talavera explained that, “significantly,” Dr. Palmieri never opined that the decedent’s remote history of hairy cell leukemia, hairy cells present on flow cytometry, low white blood cell count, or alleged immunocompromised condition caused the pneumonia that was diagnosed on July 14, 2018, and diagnosed as Legionella pneumonia on July 24, 2018, or any condition and medical complication that the decedent experienced from the time of his Caribbean vacation until the time of his death, including his acute respiratory distress, severe sepsis, hypoxemic respiratory failure requiring mechanical ventilation, hypotension requiring vasopressors, worsening hypoxemia, pulseless electrical activity causing cardiac arrest, septic shock, pneumonia, acute and massive cerebral artery stroke, and his death on July 25, 2018. He characterized Dr. Palmieri’s suggestions in this regard as “red herrings” since the decedent’s complaints, symptoms, and medical charts presented a “straightforward set of facts” that fully documented the untimely diagnosis and treatment of the decedent’s pneumonia.

Dr. Talavera asserted that, even if he were to assume that Seitz’s deposition testimony and the records of his encounters with the decedent and the plaintiff on July 12, 2018 and July 13, 2018 were entirely true, he nevertheless would conclude that Seitz departed from the applicable standard of care, thus causing the worsening course of the pneumonia and the decedent’s death. In this respect, he stated that Seitz completely ignored the decedent’s complaints of feeling “run down” and feverish, and of experiencing a productive cough that had been occurring once or twice per hour as of July 12, 2018, and that Seitz should have been highly suspicious that the decedent was then suffering from pneumonia in light of the fact that the decedent was then 61 years old and, thus, was at higher risk for pneumonia than younger patient, along with the acute onset of those symptoms one week earlier, and the one-week

duration and persistence of those symptoms without resolution. As he framed the issue, inasmuch as Seitz admitted at his deposition that the decedent's complaint of a continuing cough prompted Seitz to consider tuberculosis in his differential diagnosis, Seitz also was required by the standard of care to have included pneumonia high up in his differential diagnosis, and ruled it in or out. Dr. Talavera further asserted that the low-grade fever that the decedent was experiencing at the time of Seitz's examination, coupled with the complaints of a productive cough, were consistent with pneumonia, and should have compelled Seitz to order an immediate chest x-ray to rule in or out a pneumonic infectious process in the lungs. According to Dr. Talavera, merely because Seitz found that all of the decedent's other vital signs were normal, and that the examination of the lungs did not detect rales, crackling, or wheezing, "did not rule out an index of suspicion of pneumonia, contrary to what Dr. Palmieri suggests, given [the decedent's] other complaints, presentations, their duration, his age, and history of traveling abroad." As Dr. Talavera phrased it,

"[a]s conceded by Dr. Seitz himself at deposition, standard of care required that for any suspicion of pneumonia, the patient must be immediately referred to the emergency room to rule in or ruled out a pneumonic infectious process by work up, including a chest x-ray. . . . Dr. Seitz, based upon his own notes and testimony, breached the standard of care in failing to immediately refer Glen to the emergency room on 7/12/18 for work up, including chest x-ray, for suspicion/differential diagnosis of pneumonia."

In explaining the basis for his opinion that Seitz misdiagnosed the decedent with mild sinusitis, Dr. Talavera asserted that, based upon Seitz's own notes and testimony, which reported and confirmed redness of the decedent's nares, streaking in the posterior pharynx, and mild discomfort on palpation of frontal sinuses and maxillary sinuses, a diagnosis of sinusitis was not indicated, nor did those complaints support Seitz's determination that the prescription of a narrow spectrum antibiotic solely to treat those symptoms was proper. He stated that the decedent's complaints of feeling run down and feverish, and the presence of a productive cough for more than one week, were inconsistent with sinusitis, since sinusitis generally presents with thick, discolored mucus from the nose, mucus down the back of the throat, blocked or stuffy

nose, reduced sense of smell and taste, and pain, tenderness, and swelling around the eyes, cheeks, nose, or forehead. Dr. Talavera asserted that antihistamines, pain relievers, over-the-counter decongestants, and nasal sprays, whether corticosteroid or saline-based, or the antibiotic Ceftin, are the proper treatments for “mild sinusitis”

Dr. Talavera asserted that, had Seitz properly formed a differential diagnosis of pneumonia on July 12, 2018 and July 13, 2018, and properly instructed the decedent immediately to present to an emergency room, the pneumonia would have been timely diagnosed on a chest x-ray and properly would have been treated with the very broad-spectrum antibiotics that ultimately were administered, albeit too late, early in the morning of July 14, 2018. He asserted that a timely diagnosis and treatment on July 12, 2018 or July 13, 2018 “would more likely than not have altogether prevented [the decedent’s] pneumonic disease progression causing acute respiratory distress, his worsening conditions, and all of the medical complications that flowed therefrom, starting on 7/14/18 until and causing his death on 7/25/18.” Dr. Talavera thus concluded that the decedent was indeed very sick with a pneumonic process on July 12, 2018. He further stated that it was “likely” that Seitz’s notes were “suspect and were not timely, properly, contemporaneously, and/or accurately made, all contrary to the standards of care.” He characterized Seitz’s testimony that the decedent’s complaints were decreased and mild, and that the decedent was improving, as simply “not credible” in light of the fact that the decedent requested a house-call physician to examine him after 9:00 p.m. after he just had returned from traveling abroad, as this would indicate that he was, indeed, acutely ill.

In reply, the defendants submitted an attorney’s affirmation, in which counsel argued that Dr. Talavera was not qualified to render an opinion as to the accuracy of some of the diagnostic testing performed at Mount Sinai West, and that his opinions were speculative and conclusory in any event.

The court concludes that, although Dr. Palmieri’s opinions bordered on the speculative, particularly with respect to his conclusion that the diagnosis of Legionella pneumonia was based

on a false positive test result, and that his opinions were contradicted, in part, by the Mount Sinai West chart, the defendants nonetheless established their prima facie entitlement to judgment as a matter of law. The court further concludes, however, that in opposition to the defendants' showing, the plaintiff raised triable issues of fact as to whether Seitz departed from good practice in failing to place pneumonia high in his differential diagnosis, failing to send the decedent directly to an emergency room for a chest x-ray to rule in or out pneumonia, misdiagnosing the decedent with mild sinusitis, and delaying the decedent's chance for a cure or better outcome, and whether these departures allowed the decedent's pneumonia to worsen, and ultimately caused his death. The court, in the exercise of its discretion (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]), concludes that Dr. Talavera was, in fact, qualified by training, education, and experience to render all of the opinions set forth in his affirmation (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247, 1248 [4th Dept 2008]; *Julien v Physician's Hosp.*, 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp.*, 161 AD2d 352, 355 [1st Dept 1990]). Hence, the court denies that branch of the defendants' motion seeking summary judgment dismissing so much of the medical malpractice cause of action as was premised upon alleged departures from good and accepted practice.

Where a physician working for his or her own professional corporation or limited liability company renders medical care to a patient "within the scope of his or her employment" for that corporation of company, the corporation or company may be held vicariously liable for the negligence of the physician (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]; *Yaniv v Taub*, 256 AD2d 273, 274 [1st Dept 1998]; *Connell v Hayden*, 83 AD2d 30, 46 [2d Dept 1981]; Business Corporation Law § 1505[a][i]; Limited Liability Company Law § 1205[a]; see also *Galpern v De Vos & Co., PLLC*, 10-CV-1952 (CBA) (JMA), 2011 US Dist LEXIS 117095 \*39, 2011 WL 4597491, \* [ED NY, Sep. 30, 2011] [Limited Liability Company Law is simply a

reflection of the common-law rule that a member of a professional limited liability company is liable for those torts of the company in which he or she is a participant]). Inasmuch as House Call was Seitz's limited liability company, it may be held vicariously liable for Seitz's conduct to the extent he is found to have committed malpractice. Hence, to the extent that summary judgment is being denied to Seitz, summary judgment also must be denied to House Call.

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]). 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]). “The mere fact that the plaintiff signed a consent form does not establish the defendants’ prima facie entitlement to judgment as a matter of law” (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy his or her burden of demonstrating his or her prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (see *Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

In any event, “[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that ‘involve[s] invasion or disruption of the integrity of the body’” (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007],

quoting Public Health Law § 2805-d[2][b]; see *Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Here, the plaintiff asserted that Seitz failed to consider, test for, diagnose, and ultimately treat the decedent's pneumonia. These failures to diagnose and treat did not involve an invasion or disruption of bodily integrity, but only the alleged delay in initiating proper treatment. Hence, to the extent that the plaintiff purported to assert, as part of her medical malpractice cause of action, that the defendants are liable to her for failing to obtain fully informed consent from her decedent, the defendants must be awarded summary judgment dismissing that claim.

“In a wrongful death action, an award of damages is limited to the fair and just compensation for the pecuniary injuries resulting from the decedent's death to the persons for whose benefit the action is brought” (*Leger v Chasky*, 55 AD3d 564, 565 [2d Dept 2008], quoting *Plotkin v New York City Health & Hosps. Corp.*, 221 AD2d 425, 426 [2d Dept 1995]; see EPTL 5-4.3 [a]). In addition, a surviving spouse may prosecute a derivative cause of action for loss of consortium, albeit one that is limited to the period of time during which the decedent was alive, and suffering from injuries caused by a defendant (see *Liff v Schildkrout*, 49 NY2d 622, 632 [1980]). As relevant here, a claim for loss of consortium may only be maintained by a surviving spouse (see *Buckley v National Freight*, 90 NY2d 210, 214-216 [1997]; *De Angelis v Lutheran Med. Ctr.*, 84 AD2d 17, 20-21 [2d Dept 1981] [New York does not recognize child's right to recover for loss of parent's consortium]; *Arnold v Blitz*, 2025 NY Misc LEXIS 1674, \*17 [Sup Ct, N.Y. County, Mar. 17, 2025] [Kelley, J.]; *Gaviola ex rel. Estate of Gaviola v City of New York*, 2024 NY Slip Op 33161[U], \*3, 2024 NY Misc LEXIS 6691, \*6 [Sup Ct, N.Y. County, Sep. 10, 2024]; *Powell v City of New York*, 6 Misc 3d 1033[A], 2005 NY Slip Op 50282[U], \*2-4, n 4, 2005 NY Misc LEXIS 388, \*5, n 4 [Sup Ct, N.Y. County, Mar. 1, 2005]; *Brissett v City of New York*, 82 Misc 3d 1247[A]; 2024 NY Slip Op 50555[U], \*4, 2024 NY Misc LEXIS 2173, \*13 [Sup Ct, Kings County, May 10, 2024]). Hence, neither the plaintiff, as the decedent's sister, nor the decedent's nephews, may recover for loss of the decedent's consortium.

Nonetheless, EPTL 11-3.2(b) provides that, in addition to a wrongful death cause of action,

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

thus permitting the representative of the estate to prosecute a so-called “survival action” to recover for the conscious pain and suffering caused by the defendants and sustained by the decedent while the decedent remained alive. This item of recovery, however, is subsumed in the medical malpractice cause of action, and is not properly asserted as part of the wrongful death cause of action. The court notes that a survival claim for conscious pain and suffering that is prosecuted pursuant to EPTL 11-3.2(b) “belongs” to the estate, and not to the distributees of the estate, while wrongful death claims to recover pecuniary loss “belong” to the distributees (*Cragg v Allstate Indem. Corp.*, 17 NY3d 118, 121 [2011]; see *Heslin v County of Greene*, 14 NY3d 67, 76-77 [2010]).

In connection with the wrongful death cause of action,

“[t]here 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]).

Thus, “[t]he loss of parental nurture and care, as well as physical, moral, and intellectual training, is a proper component of pecuniary injury and may be considered by the jury in determining damages” (*Leger v Chasky*, 55 AD3d at 565; see *Zygmunt v Berkowitz*, 301 AD2d 593, 594 [2d Dept 2003]; *Plotkin v New York City Health & Hosps. Corp.*, 221 AD2d at 426).

Consequently, the executor of a decedent's estate has authority to pursue a loss of parental or grandparental guidance claim for the benefit of decedent's children or grandchildren, whether the executor is not the decedent's child or grandchild (see *Frometa v Mar-Can Transp. Co.*, 72 Misc 3d 316, 325-326 [Sup Ct, Bronx County 2021]) or whether the executor is also the

decedent's child or grandchild (*see Gonzalez v New York City Hous. Auth.*, 77 NY2d 663, 668-669 [1991]; *cf. Estevez v Tam*, 148 AD3d 779 [2d Dept 2017] [affirming judgment based upon jury verdict rejecting the parental guidance claim]). In light of the foregoing,

“as the decedent's distributee[ ], his . . . child[ ] may recover damages for pecuniary loss, which includes loss of income and financial support, and loss of parental guidance . . . , [but] only a personal representative who has received letters of administration of a decedent's estate is authorized to commence a wrongful death action to recover damages sustained by the decedent's distributees on account of his or her death”

(*Ambrose v United Parcel Serv. of Am.*, 143 AD3d at 932). Nonetheless, the parties have cited, and research has revealed, no authority for the proposition that the representative of a decedent's estate may recover for a niece or nephew's loss of the guidance of his or her uncle.<sup>3</sup>

In their motion, however, the defendants did not address the issue of whether the plaintiff, her two sons, or any other of the decedent's unidentified siblings, nieces, or nephews lost the possibility of claiming an inheritance from the decedent based on the termination of his ability to increase the value of his estate due to his death. Hence, they failed to make a prima facie showing of entitlement to judgment as a matter of law in connection with the wrongful death cause of action. Inasmuch as the court is denying the defendants' summary judgment in connection with the claims of departure from accepted practice upon which the wrongful death cause of action is premised, it must deny that branch of the defendants' motion seeking summary judgment dismissing the wrongful death cause of action.

Accordingly, it is,

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<sup>3</sup> Although the decedent here had executed a will, EPTL 4-1.1(a)(5) provides that, where a decedent dies intestate, and, as the decedent did here, was survived only by the “[i]ssue of parents, and no spouse, issue or parent,” the “whole” of the estate is inherited by “the issue of the parents, by representation.” Hence, only the plaintiff herself and any other sibling of the decedent would otherwise be entitled to inherit a portion of the estate, unless such other sibling has died. As such, the decedent's nieces and nephews are not entitled to inherit a portion of the decedent's estate, unless the parent of a child who was related to the decedent also has died, or the decedent made provision for them in his will.

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing any claim alleging lack of informed consent, that claim is dismissed, and the motion is otherwise denied; and it is further,

ORDERED 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 11:00 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.

8/15/2025

DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:

CASE DISPOSED

GRANTED

SETTLE ORDER

INCLUDES TRANSFER/REASSIGN

DENIED

NON-FINAL DISPOSITION

GRANTED IN PART

SUBMIT ORDER

FIDUCIARY APPOINTMENT

OTHER

REFERENCE

APPLICATION:

CHECK IF APPROPRIATE: