Nisman v New York City Health & Hosp. Corp./Coney Is.
2025 NY Slip Op 33236(U)
August 27, 2025
Supreme Court, Kings County
Docket Number: Index No. 519198/2020
Judge: Consuelo Mallafre Melendez
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At an IAS Term, Part MMESP-7 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 27th day of August 2025.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS
--X
IRINA NISMAN, as Administratrix of the Estate of ALEXANDER NISMAN, Deceased, and IRINA NISMAN, Individually,

Plaintiffs,

-against-

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION/CONEY ISLAND, ANV AR BABA EV, M.D., NYU LANGONE HEALTH SYSTEM, NYU LANGONE HOSPITALS, ALEKSEY KAMENETSKY, M.D., ELENA FROLOVA, M.D., EUGENE KHAIT, M.D., HENRY HOM, M.D., KEV AL JOSHI, M.D., CHIAZOR IGBOECHI, M.D., and ADELAIDE VIGURI, D.O.,

Defendants.
--X

DECISION & ORDER

Index No. 519198/2020
Mo. Seq. 1

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.
Recitation, as required by CPLR § 2219 [[a], of the papers considered in the review:
NYSCEF #s: 47 – 49, 50 – 70, 74 – 76, 77 – 85, 86

Defendants New York City Health and Hospitals Corporation/Coney Island Hospital ("NYCHHC"), Elena Frolova, M.D. ("Dr. Frolova"), Eugene Khait, M.D. ("Dr. Khait"), Henry Hom, M.D. ("Dr. Hom"), Keval Joshi, M.D. ("Dr. Joshi"), Chiazor Igboechi, M.D. ("Dr. Igboechi"), and Adelaide Viguri, D.O. ("Dr. Viguri") move (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment to these defendants and dismissing all causes of action in Plaintiff's Complaint against them.

Plaintiff opposes the motion only as to Dr. Viguri and as to all vicarious liability claims against NYCHHC. Plaintiff does not oppose the part of the motion seeking summary judgment

for Dr. Frolova, Dr. Khait, Dr. Hom, Dr. Joshi, and Dr. Igboechi. Accordingly, the part of the motion seeking summary judgment on their behalf is **granted** without opposition.

Plaintiff Irina Nisman commenced this action on October 7, 2020, asserting claims of medical malpractice and wrongful death on behalf of Decedent, in connection to treatment and care rendered at Coney Island Hospital Center ("CIH") from July 13, 2019, through July 24, 2019. Plaintiff alleges that the CIH physicians failed to timely and properly diagnose and treat Decedent's stroke, leading to his injuries and death. Plaintiff also asserts individual claims for loss of services.

Prior to the events at issue, Decedent had an extensive medical history including renal disease with hemodialysis, osteoarthritis, diabetes mellitus, hypertension, coronary artery disease, multiple cardiac stent placements, congestive heart failure, hypoxic respiratory failure, laryngeal cancer, lung cancer, and chronic obstructive pulmonary disease.

On June 2, 2019, Decedent was admitted to CIH with a right pleural effusion with right lower lobe atelectasis and pneumonia and was prescribed a course of antibiotics (Exhibit "3" at 1, 14, 23). During the admission, on June 4, 2019, Decedent was seen by CIH cardiology and an echocardiogram was performed, which revealed a poorly performing left ventricle with an ejection fraction of 30 percent (*i.d.* at 121). The treating cardiologist recommended that Decedent obtain a life vest. The medical records from this hospitalization indicate that Decedent wanted to follow up with his private cardiologist upon discharge (*i.d.* at 39). On June 8, 2019, Decedent was discharged from CIH. Plaintiff does not claim this first CIH admission in this action.

About a month later, on July 12, 2019, Decedent underwent an outpatient cardiac catheterization at non-moving co-defendant New York University Langone Hospital ("NYU Langone").

[* 2]

At 12:02 p.m., Decedent was oriented with clear, spontaneous, logical speech. The catheterization was performed from 12:22 p.m.-1:59 p.m. At 6:11 p.m., final vitals at NYU recorded a blood pressure of 156/63, a pulse 74, and respirations 18. He was discharged home at 6:32 p.m. the same day.

Plaintiff Irina Nisman testified that following his discharge from NYU Langone, Decedent exhibited behavioral changes on the way home, including confusion, a "strange glance," and aggressive behavior (Exhibit "6" at 76). She further testified that once they arrived home, Decedent did not know where he was, and he had trouble walking, standing, and talking.

Early the next morning, on July 13, 2019, at 2:08 a.m., 911 was called for Decedent's altered mental status. Decedent arrived at the emergency department at CIH at 3:03 a.m.

Dr. Youstina Michael, a non-party emergency department attending assigned to care for Decedent, examined Decedent at approximately 3:30 a.m. Decedent was found to have clear lungs and a regular heart rhythm. Decedent had no facial asymmetry, and no hemiparesis, as he was moving all four of his extremities equally. He remained confused, non-verbal, agitated, combative, and uncooperative. Dr. Youstina Michael ordered a CBC and other lab testing, including Troponin testing[1], urine and blood cultures, a head CT, and continuous cardiac monitoring. The CBC results showed Decedent had a normal white blood cell count. Shortly after, the Troponin level results came back mildly elevated at 0.139 (normal is less than 0.010). CIH emergency department providers began cardiac monitoring on Decedent; however, he remained agitated, persistently pulling out leads and making constant cardiac monitoring

[1] Troponin testing is a cardiac enzyme test that measures the levels of troponin proteins in the blood. These proteins are released into the bloodstream when the heart muscle is damaged, such as during a heart attack. The more damage to the heart muscle, the higher levels of troponin levels will be in the blood.

challenging. To calm Decedent and obtain a better read, CIH emergency department providers administered 5mg of Haldol followed by 2mg of Ativan.

A cardiac consultation was also requested and conducted. The CIH emergency department noted Decedent had a normal heart rate and rhythm, without gallop, friction rub, or murmur. EKG[2] results revealed a poor baseline, with sinus tachycardia and occasional pre-ventricular contractions and ST depressions in the anterolateral leads, an indication of a potential heart condition. At 6:35 a.m., Decedent was taken for a head CT scan, a cervical spine CT scan, and a chest x-ray. Since it was difficult to obtain good imaging due to Decedent's constant movement, a 2 mg dose of Etomidate was administered at 7:00 a.m.; mitts were also placed on Decedent's hands. The CIH emergency department physicians suggested continuous cardiac monitoring, and neurology and neurosurgery consultations.

Dr. Viguri took over from Dr. Michael as Decedent's attending physician in the emergency department at 7:11 a.m. At 7:42 a.m., the head CT report results came back inconclusive due to motion artifact. CIH emergency department health care providers could not rule out a bleed. Additionally, the chest x-ray results showed a diffuse airspace, and the CIH providers could not rule out an infection. The patient was then given a series of antibiotics, including Vancomycin, Zosyn, Ampicillin, and Ceftriaxone for possible aspiration pneumonia, pulmonary edema, and meningitis.

About an hour after, at 8:53 a.m., the patient underwent a neurology consultation at CIH. The CIH neurologist recommended MRI and MRA or a repeat head CT, along with electroencephalogram, blood pressure stabilization, and ammonia level check. Five minutes later, the patient underwent a neurosurgery consultation, where the healthcare providers recommended

[2] An electrocardiogram (EKG) is a non-invasive test that records the heart's electrical activity. This test helps physicians assess heart rate, rhythm, and identify potential issues such as heart damage.

a repeat head CT to rule out infarct as a source of the patient's altered mental status. At 9:35 a.m., the patient also underwent a nephrology consultation, where the healthcare providers recommended putting the patient in the ICU for close monitoring during hemodialysis.

At 9:50 a.m., Dr. Viguri ordered an MRI/MRA of the patient's brain without contrast as well as a repeat head CT. These tests were not yet performed when the patient went into ventricular fibrillation at 1:55 p.m. and presented no recognizable heartbeat. The emergency department health care providers called a code and immediately initiated chest compressions. Three minutes later, the patient was intubated, and health care providers administered a single shock from a defibrillator pad, which resulted in spontaneous circulation. Post cardiac arrest, the patient was fully sedated and placed on a ventilator. A head CT was performed and ruled out intracranial hemorrhage at 3:03 p.m. Dr. Viguri noted that an MRI was not obtainable, due to his placement on IV vasopressors. He was admitted to the ICU. Dr. Viguri had no further involvement with the patient.

A brain MRI was ultimately conducted on July 15, 2019, which showed an acute infarct in the right frontal region and no active bleed. The neurology consult assessed him as having had an ischemic cardiovascular accident. He was also diagnosed with hypoxic respiratory failure secondary to pulmonary edema. The neurologist recommended continued antiplatelet therapy and a stat head CT in response to any changes in neurological status.

Decedent was extubated on July 17, and his family signed a DNR order. Though he was documented to be responsive and able to follow commands at times, his cognitive status fluctuated, and he remained lethargic and unable to initiate speech or physical therapy. Decedent passed away on July 24, 2019 after a period of agonal breathing.

Plaintiff alleges that NYCHHC, through its agents and employees, deviated from good and accepted medical standards by failing to timely diagnose and properly treat Decedent's stroke. Plaintiff further alleges that this deviation was a proximate cause of Decedent's injuries, including his cardiac arrest, brain damage, and premature death.

In evaluating a summary judgment motion in a medical malpractice case, the Court applies the burden shifting process as summarized by the Second Department: "[A] defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or that the plaintiff was not injured by any such departure. Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." (*Rosenzweig v Hadpawat,* 229 AD3d 650, 652 [2d Dept 2024] [internal quotation marks and citations omitted].) However, "expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact" (*Barnaman v. Bishop Hucles Episcopal Nursing Home,* 213 AD3d 896, 898-899 [2d Dept 2023]).

In support of the motion, NYCHHC submits an expert affirmation from Mark S. Silberman, M.D. ("Dr. Silberman"), a licensed physician board certified in Internal Medicine, Pulmonary Medicine, Critical Care Medicine, and Emergency Medicine. Dr. Silberman completed a residency in Internal Medicine at New York Presbyterian Hospital/Columbia University Medical Center in 1987. He also completed a fellowship in Pulmonary and Critical Care Medicine at New York Presbyterian Hospital/Columbia University Medical Center in 1990.

Dr. Silberman is affiliated with several metropolitan area hospitals. He has approximately forty (40) years of medical experience.

Dr. Silberman opines that the care provided in the emergency department at CIH on July 13, 2019, and specifically by attending physician Dr. Viguri from approximately 7:11 a.m. until his admission to the ICU that afternoon, met the standard of care. Dr. Silverman opines that it was within the standard of care to not administer tPA treatment and that the treatment of Decedent's ischemic stroke was not emergent, because he was never a candidate for time sensitive therapy with tPA or other surgical intervention.

Dr. Silberman notes that based on the medical records and the testimony of Decedent's wife, Decedent initially developed a change in his mental status the prior evening (July 12) sometime between 5:00 p.m. or 7:00 p.m. Dr. Silberman opines that by the time Decedent arrived at CIH at 3:03 a.m., the four-and-a-half-hour window to administer tPA had closed, and therefore it was not a departure from the standard of care to not administer this treatment.

Notwithstanding the timing issue, he notes that Decedent's presentation and symptoms included altered mental status, confusion, and non-verbal state, but he did not exhibit aphasia or facial asymmetry or droop. The expert opines that hemorrhagic or ischemic stroke was appropriately considered in the differential diagnosis, in addition to other possible causes. However, the expert opines that a clear diagnosis of an ischemic stroke was not possible, because Decedent did not present with a focal neurological deficit, which would have indicated a high likelihood of that type of stroke.

Dr. Silberman further opines that before considering tPA[3] (tissue plasminogen activator) administration for acute ischemic strokes, a head CT must be performed to rule out a brain hemorrhage. He opines that the administration of tPA to Decedent while he has a potentially active brain hemorrhage carries a high risk of devastating hemorrhage, permanent brain injury, and death. Dr. Silberman opines that since Decedent's head CT had a motion artifact at 7:42 a.m. which made it difficult to interpret, raising a question of possible intracerebral hemorrhage. Administering tPA to Decedent in the presence of a hemorrhage is contraindicated. Therefore, he opines Dr. Viguri did not depart from the standard of care by not treating Decedent's condition with tPA.

Dr. Silberman also opines that Decedent was not a candidate for other surgical intervention, including catheter thrombectomy[4]. He opines that such a procedure may only be performed to treat a stroke when it was caused by a large vessel occlusion. He opines that because Decedent did not have a large vessel occlusion, he was never a candidate for any time-sensitive stroke intervention.

Dr. Silberman opines that the evaluation and treatment of Decedent's cardiac condition rendered in the emergency department at CIH was proper and met the standard of emergency and critical care. He opines that upon Decedent's arrival at CIH, the medical providers knew about his history of coronary artery disease and that he had undergone cardiac catheterization the day prior. Dr. Silberman opines that, given Decedent's symptoms, including hypertension and altered mental status, CIH providers appropriately conducted an EKG, which revealed ST depressions in

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[3] Tissue plasminogen activators, commonly known as tPA, is a medication used in the early treatment of ischemic strokes. It works by dissolving blood clots that block blood flow to the brain and restores circulation of oxygen and nutrients to the brain.
[4] Catheter thrombectomy is a minimally invasive procedure used to remove blood clots from blood vessels using a catheter.

the lateral leads. As such, Dr. Silberman opines that the CIH providers' subsequent order for cardiac monitoring, Troponin testing, and a request for a cardiology consultation was appropriate.

Dr. Silberman further opines that despite Decedent making it difficult to sustain cardiac monitoring by pulling off his cardiac leads, likely an effect of his altered mental status, agitation, and combativeness, CIH providers in the emergency department did everything they could to facilitate cardiac monitoring. Defendant's expert opines that it was appropriate for the emergency department providers to administer various medications such as Haldol, Ativan, and Etomidate to address Decedent's agitation. He also opines that it was appropriate for the emergency department providers to place mitts on Decedent's hands to help prevent him from pulling off the monitoring leads. Defendant's expert opines that deeper sedation was not possible as it could have resulted in airway compromise and respiratory depression. Therefore, Dr. Silberman opines that the standard of care was met by serial dosing of sedation, while monitoring Decedent's clinical response.

Furthermore, Dr. Silberman opines that when Decedent went into ventricular fibrillation cardiac arrest at 1:55 p.m., CIH providers properly monitored Decedent's cardiac condition, leading to early recognition, and timely and effective treatment of ventricular fibrillation. Dr. Silberman opines that the CIH emergency department medical providers resuscitated Decedent immediately, and spontaneous circulation was achieved by 1:59 p.m., in just four minutes. He opines that the CIH providers did not need to use medications, as a single defibrillation shock was successful. Dr. Silberman opines that the fact that Decedent was resuscitated so quickly with a single defibrillation shock confirms that early recognition and timely treatment of ventricular fibrillation occurred.

Additionally, Dr. Silberman opines that there was nothing further that the CIH emergency department providers should have done to prevent Decedent's cardiac arrest. He opines that following the cardiology consultation, the treatment plan appropriately focused on serial monitoring of Decedent's cardiac enzymes and continuous cardiac monitoring. Dr. Silberman notes, in reviewing the medical records, that Decedent's Troponin level prior to the cardiac arrest was only mildly elevated at 0.139, which was consistent with his usual baseline, and is expected in patients with end-stage renal disease on hemodialysis. Therefore, Dr. Silberman opines that Decedent's mildly elevated Troponin level did not suggest a need for urgent cardiac intervention.

Finally, Dr. Silberman opines that following Decedent's cardiac arrest and resuscitation, the CIH emergency department providers appropriately intubated him, sedated him, and placed him on mechanical ventilation. He opines that the CIH emergency department providers then appropriately transferred Decedent to the ICU.

The movant also submits an expert affirmation from Steven R. Levine, M.D. ("Dr. Levine"), a licensed physician board certified in Neurology and sub-certified in Vascular Neurology. Dr. Levine completed a residency in Neurology at the University of Michigan Medical Center in 1985. He also completed a fellowship in Cerebrovascular Diseases & Stroke at the Henry Ford Hospital/NIH Center for Stroke Research in 1987. Dr. Levine is currently affiliated with SUNY Downstate Health Sciences University. He has approximately twenty (20) years of medical experience.

As to Plaintiff's claims that defendants failed to timely or properly consider, diagnose, manage, and treat hemorrhaging, stroke, cerebral ischemia and ischemic stroke, Dr. Levine opines that Plaintiff's allegations "have no merit." Dr. Levine notes, based on Dr. Youstina Michael's medical charts, that a stroke was properly considered as a differential diagnosis on

Decedent's arrival and evaluation in the emergency department at CIH on July 13, 2019, as evidenced by the appropriate ordering of a head CT scan. Additionally, he opines that a neurology consult was timely ordered and provided.

Dr. Levine opines that tPA was contraindicated throughout the time Decedent was being treated by the emergency department health care providers at CIH. Based on the medical records and history from the family, Dr. Levine notes that well over 4.5 hours had passed since Decedent's last known normal in the patient's car ride home. Thus, he opines that tPA was entirely contraindicated by the time Decedent arrived at CIH.

As to Plaintiff's claims that defendants failed to timely or properly consider, diagnose, manage, and treat hemorrhaging, stroke, cerebral ischemia and ischemic stroke, Dr. Levine opines that Plaintiff's allegations "have no merit." Dr. Levine notes, based on Dr. Youstina Michael's medical charts, that a stroke was properly considered as a differential diagnosis on Decedent's arrival and evaluation in the emergency department at CIH on July 13, 2019, as evidenced by the appropriate ordering of a head CT scan. Additionally, he opines that a neurology consult was timely ordered and provided.

Dr. Levine opines that tPA was contraindicated throughout the time Decedent was being treated by the emergency department health care providers at CIH. Based on the medical records and history from the family, Dr. Levine notes that well over 4.5 hours had passed since Decedent's last known normal in the patient's car ride home from NYU Langone. Thus, he opines that tPA was entirely contraindicated by the time Decedent arrived at CIH.

Additionally, Dr. Levine opines that Decedent was not a candidate for tPA based on his initial CT scan results, as the 6:35 a.m. CT scan was inconclusive due to motion artifact and could not rule out a brain bleed. He notes that the absence of an active bleed or hemorrhage was

only determined in a repeat CT scan after Decedent's cardiac arrest. Defendant's neurology expert opines that an active brain bleed or hemorrhage is a strict contraindication for use of tPA, which could cause more harm than benefit to the patient.

Further Dr. Levine states that, prior to considering the administration of tPA for a stroke, the clinical presentation must clearly point to an acute ischemic stroke by demonstrating signs of a focal neurological deficit, such as hemiparesis, facial droop, or aphasia. He notes that Decedent's clinical presentation did not suggest an ischemic stroke as a likely diagnosis because Decedent did not exhibit several of the most crucial focal neurological deficits, most notably hemiparesis. He opines that in addition to the timing of the onset of Decedent's symptoms , because Decedent did not exhibit clear ischemic stroke indicators, and a brain bleed could not be ruled out, the alleged failure to administer tPA was not a departure from the standard of care due to the risk of hemorrhage.

On the issue of proximate causation, Dr. Levine opines that the window to administer tPA is four and a half hours, beginning with a patient's "last known normal behavior." He notes that Decedent's family reported to the health care providers at CIH that Decedent had an altered mental status after discharge following the cardiac catheterization at NYU Langone, during the car ride home between 5:00 p.m. and 7:00 p.m. the previous evening. Decedent did not present to CIH until 3:03 a.m. on July 13, 2019, at least eight hours later. Therefore, Dr. Levine opines that tPA was not only contraindicated, but the alleged failure to administer tPA was not a proximate cause of Decedent's injuries or death, since Decedent was already outside the four-and-a-half-hour window when he arrived at CIH, and this treatment would not have been effective regardless of when his stroke was diagnosed.

Further, Dr. Levine notes that ischemic stroke can be treated surgically by interventional radiology. However, that procedure may only be used in cases where there is a large vessel occlusion. That was not the case here, as Decedent had a small, acute infarct in the right cortical region. Surgical intervention was never a treatment option in this case. Therefore, he opines that the procedure was not appropriate and could not have improved the patient's condition.

Dr. Levine opines that because Decedent was never a candidate for time sensitive therapy with tPA or surgical intervention, the diagnosis and treatment of his stroke was not emergent. Thus, he opines that the timing of the head CT, MRI, or any imaging or repeat imaging did not and could not in any way change Decedent's outcome. Dr. Levine opines that by the time Decedent arrived at CIH at 3:03 a.m., all that could have been done for him, even if a stroke had been diagnosed immediately, was to monitor, wait for the stroke to conclude, and start therapy afterward. The expert supports this opinion by noting that the brain MRI revealed a small, acute infarct in the right frontal region. He opines that this was a very small and clinically insignificant stroke, and no treatment such as thrombectomy was indicated or warranted. Defendant's neurology expert opines that the timing of all the radiology testing was appropriate, and that earlier radiology testing at CIH would not have impacted in any way Decedent's outcome.

Finally, the movants submit an expert affirmation from Stanley J. Schneller, M.D. ("Dr. Shneller"), a licensed physician board certified in internal medicine and cardiovascular disease.

Dr. Schneller primarily addresses claims against the cardiologist Dr. Khait, whose motion for summary judgment was not opposed. However, to the extent that the expert addresses the cardiology treatment Decedent received while in the emergency department, the expert opines in relevant part that appropriate cardiac monitoring was instituted, and "the CIH health care providers in the ED [emergency department] did everything that could be done to obtain a clear

and constant cardiac read" in light of Decedent's agitation and combativeness. The expert opines that they used restraints and appropriate medications "to calm and stabilize him for a better cardiac read," and that "more aggressive sedation" was not appropriate within the standard of care due to the risk of respiratory compromise.

He further opines that the emergency department physicians reacted "immediately" when he went into ventricular fibrillation, and resuscitation and spontaneous circulation was achieved within four minutes. He opines that "no brain injury was caused by the cardiac arrest," and the fact his ejection fraction increased from 20% to 50-55% by July 16 demonstrates that the response to his cardiac arrest was effective.

Based on these submissions, the movants have established prima facie entitlement to summary judgment on behalf of NYCHHC and Dr. Viguri. They have proffered expert opinions that the actions of emergency department health care providers, including the attending physician Dr. Viguri, to diagnose Decedent's ischemic stroke and to monitor his cardiac condition were appropriate and within the standard of care. The experts opine that radiological imaging was timely ordered, but the result of the head CT scan was inconclusive, and it was first necessary to treat his agitation and combativeness, then administer IV vasopressors, before an MRI or other images could be obtained.

Defendants' experts also establish that Decedent was not a candidate for tPA, because a brain bleed was not ruled out by his symptoms or the CT scan, and he was outside the four-and-a-half-hour window for that treatment to be effective. The experts further opine that surgical intervention was not required by the standard of care, and it was not appropriate in Decedent's case due to his small, acute infarct rather than large vessel occlusion. The cardiology expert also opines that Dr. Viguri and the emergency department physicians at CIH initiated and sustained

cardiac monitoring within the standard of care, despite Decedent requiring sedation and restraints.

The movants further establish prima facie, through the affirmations of their emergency medicine, neurology, and cardiology experts, that no acts or omissions of Dr. Viguri and NYCHHC were a proximate cause of Decedent's injuries or death. These experts opine that no treatment for his ischemic stroke would have changed his outcome, as the window to effectively administer tPA had closed by the time he presented to CIH. The experts also opine that the emergency department could not have prevented his cardiac arrest, and the fact he was resuscitated with a single shock within minutes of his ventricular fibrillation demonstrates that there was no delay in responding and restoring his normal heart rhythm and pulse.

As the movants have established their entitlement to summary judgment, the burden shifts to Plaintiff to raise issues of fact as to the standard of care and proximate causation.

In opposition, Plaintiff submits an expert affirmation from a licensed physician [name of expert redacted], board certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine. A signed, unredacted copy of the affirmation was presented to the Court for *in camera* inspection. This expert was, at the time of the treatment at issue, and continues to be a clinical professor of Medicine at two New York-area medical schools. The expert states they have "cared for, managed, and treated thousands of patients who have suffered from different types of strokes," and that they have over 45 years of experience practicing internal medicine with a specific focus in pulmonary and critical care.

Plaintiff's expert opines that NYCHHC and its medical care providers, who were responsible for overseeing the care and treatment of Decedent, deviated from good and accepted medical care by failing to "treat a possible stroke as an emergency." This expert opines that when

a patient is admitted to the hospital, the institution is responsible for the overall care of that patient, including the providers' awareness of symptoms consistent with emergency conditions, such as strokes. The expert also opines that when a patient presents to the emergency department with symptoms consistent with a potential stroke, it is of the utmost importance to diagnose the cause of the symptoms as quickly as possible. Additionally, this expert opines that even if tPA could not be administered, Decedent's condition was still a medical emergency that required "immediate attention."

Plaintiff's expert states that NYCHHC's providers deviated from the standard of care by failing to establish a differential diagnosis for Decedent. This expert opines that a differential diagnosis was necessary to systematically identify the most likely cause of Decedent's symptoms, when multiple conditions could be responsible, allowing for a more targeted and effective planning and treatment. The expert further opines, based on a vague question and answer from Dr. Viguri's deposition testimony, that there was no differential diagnosis when she assumed care of Decedent (Exhibit "J" at 76-77). The expert states that the emergency department doctor on duty was aware that Decedent was admitted to CIH with an altered mental state, confusion, inability to follow commands, unexplained agitation, unstable gait, and a loss of balance and coordination. This expert opines that these are all signs of a stroke and despite this knowledge, NYCHHC's emergency department provider made no attempts to establish a differential diagnosis for Decedent.

Plaintiff's expert further opines that in the differential diagnosis for Decedent, the emergency department doctor should have implemented a "worst first" approach by considering Decedent's medical history and prioritizing the most serious and life-threatening conditions first. This expert contends that this method ensures that emergency medical conditions are promptly

confirmed or ruled out. Plaintiff's expert opines that given Decedent had undergone a cardiac catheterization the day prior and his symptoms upon arrival at CIH, a stroke should have been at the top of the list for possible diagnoses and confirmed or ruled out immediately. However, Dr. Viguri testified that this is "not necessarily" the case when there is a "more likely" diagnosis (Exhibit "J" at 40). Plaintiff's expert opines that this is inconsistent with the standard of care required by emergency department physicians.

Plaintiff's expert further opines that Dr. Viguri and the CIH emergency department deviated from the standard of care by failing to conduct a head CT as quickly as possible. This expert opines that good and accepted practice required diagnosing the condition causing the patient's confusion, agitation, loss of balance and coordination, inability to follow commands and an altered mental state, among other symptoms, in an expedited fashion. Additionally, based on Dr. Viguri's deposition testimony, the expert states that when a patient presents to the hospital with the symptoms of a stroke, including those mentioned above, the attending emergency department doctor's customary practice is to conduct a head CT within ten minutes of the patient's arrival. (Exhibit "J" at 41). As such, this expert opines that it would have been appropriate for NYCHHC to perform diagnostic imaging within ten (10) minutes of Decedent's arrival to the emergency room. The expert notes that the first head CT scan, which did not rule out a brain bleed due to motion artifact, was conducted approximately three hours after his arrival to CIH.

Plaintiff's expert further opines that when the head CT came back inconclusive, Dr. Viguri failed to ensure that Decedent received an MRI as quickly as possible. This expert opines that when imaging is inconclusive, the standard of care is for emergency doctors to conduct further imaging studies "as soon as possible."

Plaintiff's expert states that he disagrees with the opinion of Defendant's internal medicine, critical care medicine, and emergency medicine expert Dr. Silberman that appropriate radiologist imaging was recommended and performed. Plaintiff's expert notes that a "stat" MRI/MRA was recommended by the neurosurgeon Dr. Arif at 8:53 a.m., but that Dr. Viguri did not place the order for the MRI, in accordance with Dr. Arif's recommendation, until 9:50 a.m., following the patient's neurology and nephrology consults. The expert opines that Dr. Viguri "failed to ensure that Mr. Nisman received an MRI of his brain as quickly as possible."

Plaintiff's expert further opines that for every minute NYCHHC, and its agents and employers failed to properly diagnose Decedent's stroke, Decedent's brain deteriorated, and his brain damage got worse. This expert opines that since Decedent was outside of the four-and-a-half-hour window in which tPA could be administered, NYCHHC providers should have used supportive treatments to reduce brain damage, including direct fibrinolysis, administration of supplemental oxygen, administration of anticoagulants or antiplatelets, and administration of medications to manage the patient's blood pressure.

As to proximate causation, Plaintiff's expert opines that NYCHHC's deviations from good and accepted medical practice by failing to timely diagnose Decedent's stroke were substantial contributing factors in causing Decedent's injuries and premature death. The expert opines that patients with signs and symptoms of a stroke should be imaged within ten minutes of arrival in the emergency department, and that although there was a neurosurgery recommendation to order a stat MRI/MRA, Decedent only had one inconclusive head CT between his admission to CIH at 3:03 a.m. and his cardiac arrest at 1:55 p.m. Plaintiff's expert opines that the delay in diagnosis and treatment of Decedent's stroke directly contributed to Decedent's cardiac arrest, due to ventricular arrhythmia caused by the stroke's effects on his

nervous system. The expert also opines that the delay in diagnosis and treatment led to his brain damage and ultimate death.

Based on evaluation of these submissions, the Court finds Plaintiff's expert is conclusory, unsupported by the record, and fails to raise a triable issue of fact sufficient to defeat summary judgment. Plaintiff's expert renders opinions which are not supported by the record and fail to rebut the opinions of the movant's experts that from the time of Decedent's initial presentation at 3:03 a.m. in the emergency department, no time-sensitive treatment for his ischemic stroke would have been possible or effective. While the expert opines that the CIH physicians failed to timely diagnose and treat his stroke as an "emergency," the expert does not address the complications in obtaining a conclusive head CT scan and MRI, and further does not address the contraindication of administering tPA or surgical intervention. Thus, they do not raise a genuine, triable issue of fact that any departures from the standard of care deprived him of any viable treatment options for his ischemic stroke.

Specifically, Plaintiff's expert opines that NYCHHC's providers failed to timely perform a CT scan or MRI. However, the expert does not address the fact that radiological imaging was initially complicated by the patient's agitated state and constant motion. Although a head CT scan was ordered, it could not rule out a brain bleed due to motion artifact. An MRI was recommended and the expert states generally that Dr. Viguri failed to "ensure" it was timely performed, but the expert does not address the evidence in the record that the MRI was not possible due to the patient's instability. Plaintiff's expert does not address the opinion of Dr. Silberman that it was within the standard of care to attempt to control his agitation before further radiological studies were obtained. The expert only states in a conclusory manner that they failed

to obtain these images "timely" or "immediately," without articulating the appropriate standard of care under these circumstances.

The opinions of Plaintiff's expert that a differential diagnosis was not properly formulated is also speculative and not supported by the record. As stated above, the expert does not address the complications (including the need to administer sedatives and inability to control the patient's movement) which hindered their ability to obtain a conclusive CT scan and MRI to rule out a brain bleed or ischemic stroke, even though those tests were ordered.

Moreover, the expert's statement that Dr. Viguri and the CIH emergency department providers "made no attempts to establish a differential diagnosis for Decedent" is contradicted by the record. Plaintiff bases this opinion on an equivocal answer from Dr. Viguri's deposition testimony as to whether a differential diagnosis was "in place" when she took over as attending physician, but the CIH records demonstrate a stroke was considered, despite the absence of focal neurological deficits, and a neurology consult and head CT were ordered.

Furthermore, on the issue of proximate causation, Plaintiff's expert fails to opine in detail how the timing of the head CT or MRI affected the patient's outcome. The movant's neurology expert Dr. Levine opines that the "timing of the head CT, MRI, or any other repeat imaging did not . . . change Decedent's outcome in any way," because by the time he arrived at CIH at 3:03 a.m., it had been eight hours after the onset of his symptoms. He opines that "from a neurological perspective, all that could have been done for him, even if a stroke had been diagnosed immediately, was to monitor, wait for the stroke to conclude, and start therapy afterward." Plaintiff's internal medicine physician does not lay a proper foundation to rebut these opinions from a neurology specialist. Notwithstanding their qualifications, Plaintiff's expert only states in

a general and speculative manner that every minute of delayed diagnosis worsened Decedent's outcome.

Despite the expert's general statements that a delay in stroke diagnosis leads to loss of brain cells "for every minute that the brain is deprived of oxygen and nutrients," Plaintiff's expert does not sufficiently counter the movant's experts that no available treatment would have improved the patient's outcome in light of his ischemic stroke and small, acute infarct. Plaintiff's expert concedes that when the patient arrived at the CIH emergency department, he was already outside of the window in which tPA can be administered. However, the expert states that CIH emergency department providers should have administered treatments including "fibrinolysis, supplemental oxygen, anticoagulants, and antiplatelets." As argued by the movants in reply, Plaintiff does not expand on these potential treatments, how they differed from those that were administered or contraindicated, and how they could have altered the patient's outcome. The expert does not define "fibrinolysis" or distinguish it from tPA. The expert also does not provide any detailed reasoning to counter the opinions of the movant's neurology and cardiology experts, who stated that anticoagulant and antiplatelet therapy could not have been administered in the emergency department until an active brain bleed was ruled out.

Finally, Plaintiff's expert opines generally that the delay in diagnosis of the stroke directly led to the patient's cardiac arrest, but the expert does not address the opinions of the movants' cardiology expert that the ventricular fibrillation/cardiac arrest was timely and effectively treated and that it did not contribute to the patient's brain damage or ultimate death.

For these reasons, the Court finds Plaintiff's expert affirmation is conclusory, unsupported by the record, and fails to provide detailed reasoning and citations to the facts to counter the movants' emergency medicine, neurology, and cardiology expert submissions.

Plaintiff has therefore not raised a triable issue of fact as to specific departures from the standard of care by Dr. Viguri and the CIH emergency department. Plaintiff's expert also fails to raise an issue of fact to defeat the prima facie showing that the alleged departures did not proximately cause the patient's cardiac arrest, brain deterioration, or death. The motion for summary judgment on behalf of Dr. Viguri is therefore granted, and any vicarious liability claims against NYCHHC on behalf of Dr. Viguri and other CIH emergency department physicians are dismissed.

With respect to the other named physicians employed by NYCHHC, Plaintiff states in their opposition papers that they do not oppose summary judgment on behalf of Dr. Frolova (ICU nephrologist), Dr. Khait (cardiologist), Dr. Hom (internal medicine), Dr. Joshi (infectious disease specialist), or Dr. Igboechi (resident), all of whom treated Decedent after he was transferred from the emergency department to the medical ICU. Summary judgment is therefore granted to these defendants without opposition.

Plaintiff states they oppose the motion as to NYCHHC's vicarious liability or "these doctors' malpractice, as set forth in plaintiffs' expert affirmation." However, Plaintiff's expert offers no opinions as to any of these physicians. The expert addresses only the claims regarding Dr. Viguri and the CIH emergency department on July 13, 2019. Accordingly, summary judgment is granted to NYCHHC as to their vicarious liability for Dr. Frolova, Dr. Khait, Dr. Hom, Dr. Joshi, and Dr. Igboechi.

A cause of action for wrongful death requires underlying misconduct which caused Decedent's death. In light of the Court's decision on the medical malpractice claims, summary judgment is also granted to all movants on the wrongful death claim.

Lastly, as Decedent's underlying causes of action sounding in medical malpractice against

the moving defendants are dismissed, the derivative claims of Plaintiff for loss of services against Dr. Viguri and NYCHHC cannot survive independently and are also dismissed (*see Klein v Metropolitan Child Services, Inc.,* 100 AD3d 708, 711 [2d Dept 2012]).

Accordingly, it is hereby:

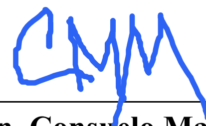
ORDERED that the motion (Seq. No. 1) of Defendants Dr. Viguri, Dr. Frolova, Dr. Khait, Dr. Hom, Dr. Joshi, Dr. Igboechi, and NYCHHC/Coney Island Hospital for an Order, pursuant to CPLR 3212, granting summary judgment in their favor and dismissing Plaintiff's complaint against them, is **GRANTED** in its entirety; and it is further

ORDERED that counsel for the remaining parties shall appear for a Settlement Conference on September 30, 2025 at 12:00pm, in person at 360 Adams St., Brooklyn, New York, Courtroom 561.

The Clerk shall enter judgment in favor of ELENA FROVOLA, M.D., EUGENE KHAIT, M.D., HENRY HOM, M.D., KEVAL JOSHI, M.D., CHIAZOR IGBOECHI, M.D., ADELAIDE VIGURI, D.O. and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION/CONEY ISLAND HOSPITAL.

This constitutes the decision and order of this Court.[5]

ENTER.



Hon. Consuelo Mallafre Melendez
J.S.C.

[5] This decision was drafted with the assistance of legal intern Charli Gunzburg, Brooklyn Law School.