At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 22 day of September 2025

PRESENT:

HON. ELLEN M. SPODEK, Justice

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KAYANN WILLIAMS, as Administrator of the Estate of VERNA MAY WILLIAMS, Deceased,

Plaintiff,

-against-

SANATH DHARMASENA, M.D., MICHAEL THOMPSON, M.D., TIRUPATI RAJU, M.D., LEONARD A. PACE, M.D., STEVE E. NOZAD, M.D., ELIE FTEHA, M.D., ALBER FTIHA, M.D., RICHARD STEINBERG, M.D., KESHWAR RAMIKISSOON, M.D., and NEW YORK COMMUNITY HOSPITAL,

Defendants.

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DECISION AND ORDER

Index No. 503779/2020

MS # 5 & 6

Papers	**Numbered**
Notice of Motion and Affidavit.....	111-125, 143-157
Answering Affidavits.....	161-182
Replying Affidavits	183-184

Defendants ELIE FTEHA, M.D., ("Dr. Fteha"), ALBER FTIHA, M.D., ("Dr. Ftiha"), and MICHAEL THOMPSON, P.A. s/h/a "MICHAEL THOMPSON, M.D.", ("PA Thompson") move pursuant to CPLR §3212 for summary judgment, dismissing the complaint against them. Defendants SANATH DHARMASENA, M.D., ("Dr. Dharmasena"), TIRUPATI RAJU, M.D., ("Dr. Raju"), and NEW YORK COMMUNITY HOSPITAL ("NYCH") move pursuant to CPLR §3212 for summary judgment regarding

the cause of action of wrongful death, dismissing the complaint against them as a matter of law. Plaintiff KAYANN WILLIAMS opposes both motions.

In 2017, Verna May Williams ("Decedent"), then 85 years old, was widowed and lived in an apartment with her daughters, Kayann Williams ("plaintiff") and Glenniece Williams, and plaintiff's husband. Def. Mot. Exh. D, pg. 18, ¶ 8. Decedent was assisted by a home health aide for approximately 10-12 hours per day, five days per week, and four hours per day on the weekends for approximately six to nine years prior to her passing on September 24, 2018. Def. Mot. Exh. D, pgs. 26, 73, 98-99, 138-139; Def. Mot. Exh. H, pg. 150; Def. Mot. Exh. I, pg. 1; Def. Mot. Exh. J, pg. 11.

Prior to her three hospitalizations on August 17, 2017, May 6, 2018, and May 31, 2018, decedent's significant medical history included: Alzheimer's disease, diabetes mellitus, high cholesterol, hypertension, GERD, hyperlipidemia, hypothyroidism, and hepatitis C. Def. Mot. Exh. H, pgs. 100, 108; Def. Mot. Exh. K, pg. 2.

In August of 2017, decedent's condition began to worsen. She presented to defendant NYCH at 10:49 a.m. on August 17, 2017, after suffering two syncopal episodes at home. The emergency room admitting note was authored by defendant Dr. Dharmasena, an Internal Medicine/ER Physician, stated "syncope acute for 1 day" with stopped breathing during the last episode at 9:00 a.m. Plt. Aff. In Opp., Exh. G, pgs. 97, 101. Dr. Dharmasena's 11:11 a.m. note documents his complete physical examination of decedent with a plan to obtain blood work, chest x-ray, troponin and D-dimer levels, thyroid panel and stat CT scans of the head and chest. Id. at pg. 102. The CT scan of the chest did not reveal any signs of pulmonary embolism ("PE") and the CT scan of the head revealed diffuse age-related cortical atrophy with no evidence of acute intracranial

hemorrhage, mass, infarction or hydrocephalus. Id. at pgs. 102, 105.

At 1:30 p.m. decedent was admitted to the telemetry floor under the service of internist defendant Dr. Ftiha in guarded condition. At 2:38 p.m. decedent was seen by defendant PA Thompson. Id. at pgs. 102-103. His examination of decedent was unremarkable and there were no focal neurological findings. Id. at pg. 103. His plan was to obtain neurology and cardiology consults to work up the episodes of syncope. Id. At 3:58 p.m. decedent was examined by Dr. Ftiha whose plan mirrored PA Thompson's.

At 5:09 p.m. decedent was seen by defendant Dr. Raju who acknowledged the prior diagnostic tests, vital signs, clinical notes and nursing notes. Id. at pg. 104.

At 10:06 p.m. decedent was seen by defendant Leonard Pace, M.D. ("Dr. Pace") for a neurology consultation. He documented that decedent passed out twice that morning at home and came to the hospital by EMS after the second episode. Id. His exam noted that decedent was confused and not oriented to place or time. After reviewing her labs, chest x-ray and CT scans, Dr. Pace's assessment was advanced Alzheimer's disease and syncope of unclear etiology. The plan was to rule out arrhythmia, seizure and transient ischemic attack ("TIA"). He ordered a Holter monitor, echocardiogram, EEG and bilateral carotid Doppler study to rule out stenosis. Id. at pgs. 104-106.

On August 18, 2017, at 12:02 p.m., decedent was seen by defendant Steve E. Nozad, M.D. ("Dr. Nozad") for a cardiology consultation. Decedent was noted to be confused and disoriented. Dr. Nozad noted the current treatment was to continue and recommended a Holter monitor and an ultrasound echocardiogram. Id.

At 1:31 p.m. decedent was seen by Dr. Fteha who noted that she was comfortable without fever. After examination, Dr. Fteha's assessment was syncope and collapse and

he noted that he agreed with Dr. Pace's plan to obtain an EEG, echocardiogram and Holter monitor. Id. at pg. 108.

On August 19, 2017, at 8:59 a.m., decedent was seen by Dr. Nozad who noted a benign physical examination and a plan to continue the current treatment plan. At 9:42 a.m. he provided a more detailed consultation report which reported that his impression was syncope with etiology to be determined and planned to perform a cardiac workup and continue following decedent. Id. at pgs. 109-110.

At 6:15 p.m. decedent was seen by Dr. Pace who noted that she was awake and alert but not oriented to place or time. Her neurological exam was within normal limits and Dr. Pace's impression was advanced Alzheimer's disease with syncope and collapse with unclear etiology and a possible vasovagal event. The plan was to rule out cardiac arrhythmia, rule out seizure or TIA, use a Holter monitor, perform an echocardiogram, an EEG and a carotid doppler scan. Id. at pg. 116.

On August 20, 2017, at 4:10 p.m., decedent was seen by Dr. Ftiha who directed continued workup with neurology and cardiology, he ordered an EEG, echocardiogram and a Holter monitor. He also noted that he discussed decedent with Dr. Pace. Id. at pg. 119. At 10:15 p.m. decedent was seen by Dr. Pace who, again, noted the syncope with unclear etiology and, again, noted the need for a carotid doppler. Id. at pg. 120.

On August 21, 2017, at 2:21 p.m., a bilateral carotid artery ultrasound doppler was performed, but not interpreted until later. Id. at pg. 135. At 6:28 p.m. decedent was seen by Dr. Fteha who recommended the continued workup as per neurology and cardiology. He also discussed decedent with Dr. Pace. Id. at pg. 123. At 7:13 p.m. Dr. Pace reviewed the echocardiogram results and chest CT scan results. The echocardiogram was a limited

study due to poor acoustical window and decedent's inability to cooperate. As a result, much could not be visualized but it did show preserved systolic function and an ejection fraction of 55%. The chest CT scan showed no evidence of a pulmonary embolism. Id. at pg. 124.

At 8:06 p.m. the carotid artery ultrasound doppler was read and interpreted by defendant Richard Steinberg, M.D. ("Dr. Steinberg"). The study revealed (1) focal plaque in the right carotid bulb and proximal right internal carotid artery causing 40-50% stenosis; (2) bilateral diffuse intimal hyperplasia; and (3) a patent left vertebral artery. Dr. Steinberg noted that the study was limited due to decedent being uncooperative and that the right vertebral artery could not be visualized or assessed. Id. at pg. 135.

On August 22, 2017, at 10:28 a.m., decedent was seen by Dr. Nozad who recommended to continue with the current treatment plan. Id. at pg. 126. At 1:14 p.m. decedent was seen by PA Thompson who noted that she was awake and generally alert. He recommended discharge. Id. at pg. 125. At 5:11 p.m. decedent was seen and examined by Dr. Fteha who agreed that she would be discharged. She was discharged home with instructions to follow up with her primary care physician in two to three days. Her discharge medications included B-Complex, Glipizide, Irbesartan, Omeprazole, Quetiapine and Repaglinide. Id. at pgs. 125, 127.

On May 6, 2018, at 9:43 p.m., decedent presented to the ER of NYCH with complaints of an acute onset of slurred speech and left facial droop that began at 8:30 p.m. and lasted five minutes. Id. at pgs. 187, 191-192. On examination, decedent was awake, alert, and conversant, but not following all commands. She had no slurred speech, facial droop, or pronator drift and the cranial nerves were intact. The impression was

CVA/TIA v. infectious v. metabolic etiology and a stroke code was called. The case was discussed with Dr. Pace who recommended Lipitor and planned to see the patient the next day. A CT scan of the head was also ordered. Id. at pgs. 191-192. The CT scan of the head was performed at 10:08 p.m. and revealed chronic atrophy, chronic ischemic changes, small bilateral chronic infarcts, no acute hemorrhage, and no fluid collection. The study was noted to be limited. Id. at pg. 206.

On May 7, 2018, at 1:15 a.m., decedent was seen by Dr. Raju who noted that she was awake and confused. Id. at pg. 193. At 7:21 a.m. decedent was seen by Dr. Pace and, on exam, was found to be awake and alert but confused and not oriented to place or time. Her speech was fluent, and motor and sensation were intact. Dr. Pace's impression was TIA, metabolic encephalopathy and advanced Alzheimer's disease. He ordered a thyroid panel and a carotid doppler study. Id. at pgs. 193-197. At 11:35 a.m. decedent was seen by PA Thompson with Dr. Fteha. On exam, she was noted to be awake, grossly alert and cheerful. It was noted that the CT scan of the head did not reveal any acute infarcts. The neurology consultation was appreciated and they were awaiting the carotid doppler to be performed. Id. at pg. 198.

On May 8, 2018, at 9:39 a.m., decedent was seen by Dr. Pace who noted that the carotid doppler performed during her stay in August of 2017 revealed 50% stenosis of the right carotid artery and, again, ordered a follow-up doppler study. At 11:34 a.m. defendant Keshwar Ramkissoon, M.D. ("Dr. Ramkissoon"), a cardiologist, consulted and noted that decedent was hospitalized after sustaining a TIA at home. It was recommended that Holter monitoring continue and that aspirin, statin and metoprolol be continued. Id. at pgs. 200-201. At 3:31 p.m. decedent was seen by PA Thompson who noted her functional

statute had declined. Both Dr. Fteha and Dr. Ftiha saw the patient as well and documented that they agree with the plan to continue the workup for TIA. Id. at pg. 202.

On May 9, 2018, at 9:13 p.m., decedent was seen by Dr. Pace who noted that there were no new complaints but, again, noted that the follow-up carotid doppler was still pending. Id. at pgs. 206-207. On May 10, 2018, at 1:38 p.m., decedent was seen again by Dr. Pace who noted that she was awake and alert, but forgetful. He, again, noted that he wanted a follow-up carotid doppler performed. Id. at pg. 208. At 5:30 p.m. decedent was seen by Dr. Ftiha who noted that the carotid doppler was still pending. On May 11, 2018, at 12:13 p.m., decedent was seen by PA Thompson who noted that her functional status continued to decline and that her cognitive status was poor to fair. He also stated that the carotid doppler was pending but ordered the patient to be discharged home with instructions to take her medications, including Aspirin and Lipitor. The discharge summary was signed by Dr. Fteha. Id. at pgs. 210, 213-215.

On May 31, 2018, at 5:54 p.m., decedent presented to the ER of NYCH with complaints of altered mental state, lethargy and confusion for two days and not eating or taking her medication. She was noted to be arousable to painful stimuli. Id. at pgs. 45, 49-51. She was placed on a cardiac monitor for observation, had blood drawn, and received IV fluids and antibiotics. Id. at pg. 74. A CT scan of the head was performed at 7:02 p.m. and revealed no acute infarcts or hemorrhage. Id. at pg. 55.

On June 1, 2018, at 4:31 a.m., decedent was seen by Dr. Raju who noted that she had been more confused for the past two days. The assessment was noted as altered mental status with no plan for further treatment or testing. Id. at pg. 51. At 11:48 a.m., Dr. Fteha, after discussing decedent's history, physical examination, and diagnostic

evaluations with Dr. Dharmasena, approved the discharge of decedent. She was discharged at 2:33 p.m. with a diagnosis of dementia. Id. at pgs. 67, 87.

At 3:36 p.m., about one hour after her discharge from NYCH, decedent presented to SUNY Downstate University Hospital of Brooklyn ("SUNY") by ambulance as unresponsive with left sided facial droop and slurred speech before arrival of the ambulance. Plt. Aff. In. Opp., Exh. H, pgs. 20-22. A CT scan of the head revealed hypoattenuation right external capsule and adjacent front corona radiata concerning for recent ischemia. Id. at pgs. 47-48.

On June 5, 2018, an MRI/MRA showed Right MCA occlusion with large Right MCA territory infarct. Right internal Carotid Artery Stenosis of 50%. Impression was "Recent right MCA ischemia with mass effect and petechial hemorrhage/laminar necrosis, extensive MRA findings including occlusion right MCA". Id. at pg. 66.

On June 19, 2018, decedent was discharged to a skilled nursing facility with a discharge diagnosis of persistent dense Left Hemi-paresis, aphasia, and unable to follow commands. Id. at pg. 31.

On September 24, 2018, decedent become unresponsive while feeding and was transferred via ambulance to Kings County Hospital Emergency Department "post cardiac arrest". Def. Mot. Exh. J, pgs. 15, 17; Def. Mot. Exh. D, pg. 47. Decedent became pulse-less shortly after arrival and no cardiac motion was seen on bedside sonogram. Decedent was pronounced dead at 9:38 a.m. on September 24, 2018. Def. Mot. Exh. J, pg. 15.

Discussion

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure

from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. Brinkley v. Nassau Health Care Corp., 120 A.D.3d 1287 (2d Dept. 2014); Stukas v Streiter, 83 AD3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986); Brinkley v. Nassau Health Care Corp., supra; Fritz v. Burman, 107 A.D.3d 936, 940 (2d Dept. 2013); Lingfei Sun v. City of New York, 99 AD3d 673, 675 (2d Dept. 2012); Bezerman v. Bailine, 95 AD3d 1153, 1154 (2d Dept. 2012); Stukas v. Streiter, at 24. A plaintiff will succeed in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused the plaintiff's injury. Contreras v Adeyemi, 102 AD3d 720, 721 (2d Dept. 2013); Gillespie v New York Hosp. Queens, 96 A.D.3d 901, 902 (2d Dept. 2012); Semel v Guzman, 84 AD3d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. Stukas, at 24. "When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition" Schwartz v Partridge, 179 AD3d 963, 964 (2d Dept 2020) (internal citations omitted).

After oral argument and a review of the papers, the Court finds that the defendants have sustained their burden of showing that they did not depart from good and accepted

medical standards with regards to Dr. Fteha, Dr. Ftiha and PA Thompson, as well as Dr. Dharmasena, Dr. Raju and NYCH for the third admission. The burden then shifted to plaintiff to provide evidence to the court that the defendants did in fact deviate from the accepted standards of medical care, raising a triable issue of fact. The Court finds that plaintiff has sustained their burden by raising triable issues of fact in opposition to defendants' motion for summary judgment. "Summary judgment may not be awarded in a medical malpractice action where the parties adduce conflicting opinions of medical experts." *McKenzie v. Clarke*, 77 A.D.3d 637, 638 (2d Dept. 2010); *see Adjetey v. New York City Health & Hosps. Corp.*, 63 A.D.3d 865 (2d Dept. 2009). Defendant's expert Brian Feingold, M.D. and Stanley Tuhrim, M.D. disagree with plaintiff's Vascular and Internal Medicine experts as to whether the good and accepted medical standards, during all three of decedent's admissions to NYCH, were adhered to. Plaintiff's experts believe Dr. Fteha, Dr. Ftiha, PA Thompson, Dr. Dharmasena, Dr. Raju, and NYCH performed outside the good and accepted medical standards in failing to timely diagnose and appropriately treat decedent's carotid artery stenosis and impending stroke as well as whether such departures were the proximate cause of the decedent's injuries. Plt. Aff. In. Opp., Exh. A, pg. 3; Plt. Aff. In. Opp., Exh. B, pgs. 2-3. Alternatively, defendant's experts believe the care provided during all three of decedent's admissions to NYCH on August, 17, 2017, May 6, 2018, and May 31, 2018, by the moving defendants conformed to the accepted standards of medical care. Def. Mot. Exh. A, pg. 4; Def. Mot. Exh. B, pg. 4.

These disagreements are evidenced by plaintiff's experts, who stated in their affirmations "...it is my opinion [] that Williams' TIA, stroke, pain and suffering and untimely death were all avoidable. It is my further opinion that the above deviations were the cause

of Williams' injuries and death." Plt. Aff. In. Opp., Exh. A, pg. 4. For example, defendant's experts affirm that an MRI, an MRA and CT Angiogram were "ordered and "performed" during decedent's August 17, 2017 admission. However, this claim is unequivocally contradicted by the medical records and plaintiff's experts who, based upon their review of the medical records, believe these three studies were never ordered or performed as there is no mention of them being considered, ordered or performed within the medical records for this specific admission or any other admission. Plt. Aff. In. Opp., Exh. A, pg. 8, ¶ 15. Furthermore, defendants' expert, Dr. Feingold, states "This degree of stenosis did not warrant any treatment or intervention." Def. Mot. Exh. A, pg. 8, ¶ 17. Plaintiff's experts "wholeheartedly disagree with this statement and opinion." They add "Anti-platelet medications are proven to reduce the risk of formation of blood clots and help prevent heart attacks and strokes. It is my opinion [] that Williams was at an increased risk of stroke and/or TIA and required anti-platelet medication." Plt. Aff. In. Opp., Exh. A, pg. 8, ¶ 16. These are both conflicting opinions of medical experts which preclude summary judgment.

In conclusion, defendants' Sanath Dharmasena, M.D., Michael Thompson, M.D., Tirupati Raju, M.D., Elie Fteha, M.D., Alber Ftiha, M.D., and New York Community Hospital's motions are denied.

This constitutes the decision and order of the Court.

ENTER,

JSC HON. ELLEN M. SPODEK