Boikai v White Plains Hosp.
2025 NY Slip Op 33832(U)
October 3, 2025
Supeme Court, New York County
Docket Number: Index No. 805399/2021
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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INDEX NO. 805399/2021

JEDEDIAH Z. BOIKAI, individually and as Administrator of the Estate of KRYSTAL V. BOIKAI, deceased,

MOTION DATE 07/23/2025 07/23/2025

Plaintiff,

MOTION SEQ. NO. 001, 002

- v -

WHITE PLAINS HOSPITAL, MONTEFIORE HEALTH SYSTEM, INC, DANIEL E. SAMMARTINO, M.D., LEORA JOEL, M.D., NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM, INC., AND NEW YORKPRESBYTERIAN HOSPITAL-COLUMBIA,

DECISION AND ORDER ON MOTION

Defendants.

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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, 85, 95, 97

were read on this motion to/for SUMMARY JUDGMENT.

The following e-filed documents, listed by NYSCEF document number (Motion 002) 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 86, 87, 88, 89, 90, 91, 92, 93, 94, 96, 98

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, wrongful death, and loss of spousal consortium, the defendants New York-Presbyterian Healthcare System, Inc., and New York-Presbyterian Hospital-Columbia (together the NYPH defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 001). The defendants White Plains Hospital (WPH), Daniel E. Sammartino, M.D., and Leora Joel, M.D. (collectively the White Plains defendants) move for the same relief as to them (MOT SEQ 002). The plaintiff expressly declines to oppose the NYPH defendants' motion, but opposes so much of the White Plains defendants' motion as sought summary judgment dismissing the complaint insofar as asserted against WPH and Sammartino.[1] The NYPH defendants' motion is granted,

[1] The court notes that, pursuant to a stipulation dated January 5, 2022, the plaintiff discontinued the action against the defendant Montefiore Health System, Inc.

and they are awarded summary judgment dismissing the complaint insofar as asserted against them. The White Plains defendants' motion is granted to the extent that they are awarded summary judgment dismissing the complaint insofar as asserted against Joel, and so much of the medical malpractice cause of action, insofar as asserted against WPH and Sammartino, as was premised upon their negligent hiring, training, supervision, retention, and credentialing of healthcare personnel. The motion is otherwise denied, as there are triable issues of fact as to whether Sammartino departed from good and accepted practice in failing to suspect, test for, or diagnose the plaintiff's decedent with colon cancer, whether WPH is vicariously liable therefor, and whether those departures caused or contributed to the spread and progression of the decedent's cancer and, ultimately, to her death.

The crux of the plaintiff's claims against the NYPH defendants is that, on May 20, 2019, during the pregnancy of his wife and decedent, Krystal V. Boikai, medical personnel in their maternal fetal medicine and emergency departments failed timely to diagnose her with colon cancer, and thus failed timely to treat her for that condition, despite her presentation with rectal bleeding, abdominal pain, and bloody diarrhea. He further asserted that they caused and permitted the cancer to progress, become worse, and metastasize to her liver and other organs and systems, ultimately causing her death on February 15, 2021. The core of his claim against WPH and Sammartino is that, between December 27, 2018 and April 27, 2020, they also failed timely to diagnose his decedent with colon cancer, as is the gist of his claim against Joel, limited to Joel's examinations and treatment between February 21, 2019 and November 11, 2019.

In his complaint, the plaintiff alleged that WPH hematologist/oncologist Sammartino examined and rendered treatment to his decedent on November 15, 2018, December 27, 2018, February 28, 2019, April 9, 2019, June 25, 2019, July 12, 2019, August 30, 2019, October 3 2019, February 24, 2020, February 27, 2020, February 28, 2020, March 4, 2020, March 11, 2020, March 25, 2020, April 10, 2020, and April 27, 2020. He asserted that Sammartino committed malpractice by failing timely to suspect, diagnose his decedent with, and treat his

decedent for colon cancer, thus causing and permitting the colon cancer to progress and metastasize to her liver and other organs and systems. He further faulted Sammartino for failing to order and/or perform appropriate and necessary laboratory tests, stool tests, examinations, colonoscopies, and imaging studies, including magnetic resonance imaging (MRI) and computed tomography (CT) scans. In addition, the plaintiff alleged that Sammartino failed properly to evaluate the abnormal results of the blood testing that he did perform on the decedent, and thus failed to recognize the decedent's anemia and to formulate a proper differential diagnosis for the etiology of that condition that included colon cancer. Moreover, the plaintiff alleged that Sammartino failed to make timely or appropriate referrals to other specialists, including gastroenterologists, and failed properly to coordinate the decedent's care with that rendered by other physicians. The plaintiff further alleged that WPH obstetrician/ gynecologist (OB/GYN) Joel examined or treated his decedent on February 21, 2019, March 21, 2019, April 11, 2019, May 9, 2019, May 30, 2019, June 27, 2019, July 17, 2019, August 6, 2019, August 13, 2019, August 20, 2019, August 28, 2019, September 3, 2019, September 16, 2019, September 19, 2019, October 24, 2019, and November 11, 2019, and was liable for the same reasons as Sammartino. He also averred that WPH failed to exercise proper supervision over its healthcare employees,[2] and should also be held liable under the doctrine of respondeat superior for the negligent acts of their agents, servants, and employees, including Sammartino and Joel. The plaintiff asserted that, as a proximate result of the negligence committed by the White Plains defendants, his decedent's colon cancer was caused to progress and spread, thus depriving her of the opportunity for a cure or better outcome, and ultimately leading to her death.

[2] The court notes that, while allegations of negligent hiring, training, supervision, and retention constitute a cause of action independent of a medical malpractice cause of action, and the plaintiff did not separately plead a such cause of action, the court will address that claim as if it had been separately pleaded (*see Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp.*, 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming allegation of "negligent credentialing" to constitute an independent cause of action]).

In connection with the claims asserted against the NYPH defendants, the plaintiff asserted in his complaint that, on May 20, 2019 at 2:18 p.m., his decedent, while she was pregnant, and during the course of her medical supervision by the WPH defendants, presented to the maternal fetal medicine, labor, and delivery department of NYPH, complaining of rectal bleeding, bloody diarrhea, and abdominal pain. He alleged that, after determining that his decedent was not yet in labor, healthcare personnel in that department discharged her, and thereupon transferred her to the NYPH emergency department at 5:04 p.m. on that date for further evaluation of her rectal bleeding, bloody diarrhea, and abdominal pain. The plaintiff alleged that his decedent, while in the emergency department, was examined by NYPH healthcare personnel, including, but not limited to, Cristina Del Toro, M.D., Gina Therese Waight, M.D., Christopher Joseph Reisig, M.D., as well as nurses and others, and that NYPH emergency department personnel discharged his decedent on May 20, 2019 at 10:11 p.m., with a diagnosis of hemorrhage of the anus and rectum, gastrointestinal bleeding, internal hemorrhoids, and anal fissure. The plaintiff averred that NYPH healthcare personnel departed from good and accepted medical practice for the same reasons as the White Plains defendants.

The plaintiff also asserted that the beneficiaries of his decedent's estate, including himself, suffered pecuniary loss as a consequence of his decedent's death, and that he personally sustained loss of his decedent's consortium during the time that she remained alive but was suffering from colon cancer.

In his bills of particulars addressed to the White Plains defendants, the plaintiff essentially reiterated the specific allegations of departures from accepted medical practice that he set forth in his complaint. He specifically asserted that, as a consequence of the White Plains defendants' malpractice, his decedent suffering from a progression and worsening of colon cancer, with metastatic spread to liver, lungs, mediastinum, peritoneum, adnexa, and bones, tendons and ligaments, including, but not limited to, her legs, pelvis, skull, and spine, that, in turn resulted in pathologic compression fractures, a bowel obstruction from tumors,

nausea, vomiting, cramping, loss of appetite, odynophagia, anemia, weight loss, fevers, multiple infections, tachycardia, sleep disturbance, dehydration, and drug neuropathy. The plaintiff further contended that, as a consequence of the conditions caused by the White Plains defendants' malpractice, his decedent necessarily was compelled to undergo multiple surgeries and invasive procedures, including, but not limited to, a colectomy, ileostomy, cholecystectomy, embolization, and insertion of a hepatic artery infusion (HAI) pump and a peripherally inserted central catheter (PICC) for administration of chemotherapy, as well as a celiotomy and salpingo-oophorectomy, along with abscess drainage procedures and multiple biopsies. He averred that, ultimately, his decedent was unable to ambulate, and sustained jaundice, sepsis, pain, suffering, mental anguish, loss of enjoyment of life, depression, and death. In addition, the plaintiff asserted that he was dependent on his decedent's financial support, that his three minor children were dependent on the decedent's financial and parental support, and that, as a consequence of his decedent's death, he and his children were deprived of that support. The plaintiff made similar allegations in his bill of particulars addressed to the NYPH defendants.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Flanders v Goodfellow,* _____NY3d_____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; *see Haymon v Pettit*, 9 NY3d 324, 327 n

[2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). Moreover, where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment

proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover,

as noted, to satisfy the burden on a summary judgment motion, 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, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 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; *Luu v Paskowski*, 57 AD3d 856, 857 [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).

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]).

"'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]). 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]).

The court notes that 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.[3]

In support of their motion, the NYPH defendants submitted the pleadings, the plaintiff's bills of particulars, relevant medical and hospital records, the transcript of the depositions of

[3] The court further 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]).

several of the parties, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmations of board-certified OB/GYN Robert Dropkin, M.D., and board-certified emergency medicine specialist Stuart Kessler, M.D. Drs. Dropkin and Kessler explained in detail the treatment and care rendered to the plaintiff's decedent on May 20, 2019, and opined that each and every aspect of the care rendered at NYPH satisfied the applicable standard of care. They further opined that nothing that NYPH healthcare personnel did or did not do caused or contributed to the exacerbation or spread of the decedent's colon cancer or her death. The plaintiff expressly declined to oppose the NYPH defendants' motion. The court concludes that the NYPH defendants established their prima facie entitlement to judgment as a matter of law. Since the plaintiff did not oppose their motion, he failed to raise a triable issue of fact in opposition to their showing. Consequently, summary judgment must be awarded to the NYPH defendants dismissing the complaint insofar as asserted against them.

In support of their motion, the White Plains defendants relied on many of the documents that had been submitted by the NYPH defendants. They also submitted additional medical records, additional party deposition transcripts, their own statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmations of internist and board-certified OB/GYN, maternal fetal medicine specialist, and clinical geneticist Victor R. Klein, M.D., and board-certified internist and hematologist/oncologist Anna Kurzina-Solinas, M.D. Drs. Klein and Kurzina-Solinas opined that the White Plains defendants did not depart from good and accepted medical practice in their treatment of the plaintiff's decedent, and that nothing that they did or did not do caused or contributed to the exacerbation, spread, and metastasis of the decedent's colon cancer, or to her death.

In his affirmation, Dr. Klein noted that the decedent, who was 32 years old in 2019, presented to Joel on February 7, 2019 to confirm a pregnancy. Joel purportedly noted that the decedent had a 10-year history of heavy menses and iron-deficiency anemia, and that the decedent was then under Sammartino's care for her anemia. The decedent gave birth to a child

on September 4, 2019. According to Dr. Klein, between February 7, 2019 and October 23, 2019, when she met with Sammartino for a hematology follow-up visit, her blood hemoglobin and hematocrit (H/H) levels ranged from 8.5 grams per deciliter (g/dL) of hemoglobin and 28% (that is, 28 milliliters of red blood cells per 100 milliliters of blood) of hematocrit to 11 g/dL/ 34.5%, with normal H/H levels typically around 11.8 g/dL/35%. Upon reviewing the decedent's chart, Dr. Klein noted that, during this timeframe, 10 out of 15 hematocrit tests performed on the decedent were above 30%, and 7 out of 15 hemoglobin tests performed were above 10 g/dL, and that the 11 g/dL/34.5% H/H levels recorded during the decedent's October 23, 2019 visit reflected an improvement from the 8.5 g/dL/28% H/H levels recorded on September 5, 2019, which was postpartum day one. Dr. Klein explained that a normal hematocrit level in a pregnant woman is approximately 31% or 32%, and opined that, throughout most of the decedent's pregnancy, her hematocrit was stable at around 30%, which was a reasonable level for a pregnant woman with a known history of sickle cell trait and chronic anemia.

With respect to the decedent's presentation to the NYPH labor and delivery department on May 20, 2019, Dr. Klein explained that the relevant chart reflected that she complained of rectal bleeding that had started on the previous evening, accompanied by four episodes of watery diarrhea with blood, which was described in her chart as red to maroon in color, but that, by the morning of May 20, 2019, she egested "formed" bowel movements, with decreasing amounts of mixed blood. He stated that her last bowel movement in that department, which occurred at 1:00 p.m. on that date, contained mucous blood, albeit less than previous movements. The chart reflected that, although the decedent's history was positive for gastroesophageal reflux disease, with one episode of nausea and vomiting with "scant' blood, she denied having experienced palpitations, dizziness, shortness of breath, or current nausea, vomiting, or hematemesis. Dr. Klein averred that a physical examination conducted by NYPH personnel revealed a nontender, gravid abdomen, and a rectal examination showed no hemorrhoids or blood, while the decedent's blood pressure was 116/58, and the fetal heart rate

was 150 beats per minute, with moderate to minimal variability, and no concerns for the fetus's health. He noted, however, that no laboratory blood testing was performed, and that NYPH physicians formulated a differential diagnosis that included gastric infection, gastroenteritis, hemorrhoid irritation, gastrointestinal ulcer, and anal fissures. According to Dr. Klein, the decedent reported that her symptoms improved while she was being triaged. As he framed the issue, from an "OB standpoint," the decedent was cleared and discharged from the labor and delivery department at 4:24 p.m. on May 20, 2019, at which time she was ambulatory. NYPH physicians recommended that she visit the NYPH emergency department, and to follow up with Joel within one week.

The decedent did, in fact, present to the NYPH emergency department on May 20, 2019 at 8:07 p.m., reporting seven episodes of bright red, bloody bowel movements, which were intermittently diarrhea-like, complaining of gastric pain, and informing emergency department personnel that she suspected the presence of hemorrhoids. At that time, the decedent's blood pressure reportedly was stable, and she remained ambulatory. According to Dr. Klein's interpretation of the NYPH chart, bowel sounds were present in all four quadrants, and her medical history noted both sickle cell trait and iron deficiency anemia, while a physical examination revealed that her abdomen was soft, nontender, and nondistended, with no hepatosplenomegaly. The report of a rectal examination indicated the presence of an ulceration at the "10 o'clock" position, but no obvious hemorrhoids, while her H/H levels were measured at 10.3 g/dL/32.2%. Emergency department physicians diagnosed the decedent with hemorrhage of the anus and rectum that appeared to be resolving. The decedent was discharged to her home on May 20, 2019, with instructions to follow up with her primary care physician within 24 hours, and to return to the emergency department if new symptoms arose, while the instructions regarding gastrointestinal bleeding, including a discussion of "anal fissure," were included in the discharge note. According to Dr. Klein, there was no indication that any of the physicians who examined or treated the decedent at NYPH contacted Joel.

Dr. Klein further asserted that, as set forth in Joel's chart, the decedent informed Joel on May 30, 2019 of her May 20, 2019 visit to NYPH, the diagnosis of hemorrhoids, the absence of an active complaint of rectal bleeding, and the fact that she had not experienced any further episodes of bloody stools since restarting the proton-pump inhibitor Pepcid. According to that chart, the complete blood cell count testing that Joel ordered on that date revealed that the decedent had H/H levels of 9.5 g/dL/29.7%, while Joel reported having left a telephone message for the decedent that, in light of her persistent anemia, she should follow up with oncologist/hematologist Sammartino.

Dr. Klein opined that it was reasonable and within the standard of care for Joel to have declined to conduct an independent workup in connection with the decedent's previous rectal bleeding, since that condition was evaluated, diagnosed as hemorrhoids, and managed in the NYPH emergency department. He further concluded that the standard of care did not require Joel to refer the decedent for a colonoscopy, since she made no complaints of active bleeding during the May 30, 2019 visit, had no family history of colon cancer, and had a known chronic anemia that was being managed by a hematologist. Hence, Dr. Klein asserted that he did not believe that Joel was required to order any further testing or treatment in that regard. He further asserted that Joel appropriately noted the low reported H/H levels, timely informed the decedent that she had persistent anemia, and timely and properly instructed her to follow up with her hematologist for management, the latter of which Dr. Klein characterized as the "most appropriate" course of action. Dr. Klein further concluded that it also was reasonable for Joel to "assume" that the decedent, whom he described as an "educated nurse," would have provided the same history rectal bleeding to Sammartino during her June 25, 2019 consultation with him.

As Dr. Klein explained it, the decedent had been seeing Sammartino since November 15, 2018 for the management of her 10-year history of anemia, sickle cell trait, and heavy menses. He asserted that Sammartino would have been the physician most familiar with these conditions, and asserted that "[n]o obstetrician would reasonably subject a pregnant woman of

this age, who has no family history of colon cancer, a known diagnosis of chronic anemia and sickle cell trait, heavy menses, and no active bleeding, with stable H/H levels" to a colonoscopy. He further opined that, had colon cancer been diagnosed during the decedent's pregnancy, treatment nonetheless would likely have been delayed until the fetus could be delivered early, likely between 34 to 36 weeks of gestation.

Dr. Klein explained that Joel's records from the decedent's last prenatal visit, which occurred on June 28, 2019, indicated that the decedent then was at 29 weeks of gestation, and she made no complaints. He also referred to WPH's chart, which reported spontaneous vaginal delivery on September 4, 2019, with no complications, and a discharge from WPH on September 6, 2019, and reiterated that the decedent's H/H levels had improved between September 5, 2019, or one day after the delivery of her infant, and September 17, 2019, or two days before her first postpartum visit with Joel. Dr. Klein noted that, at the September 19, 2019 postpartum visit, which was the decedent's last visit with Joel, the decedent complained of a headache on the left side of her head, radiating to her neck, while her blood pressure was mildly elevated. The decedent also reported mild vaginal bleeding, but denied any bladder or bowel incontinence, epigastric pain, or right upper quadrant pain, and had no other complaints. In light of the improvement in the decedent's H/H levels two days prior to the postpartum visit, the decedent's presentation and complaints during the postpartum visit, and her ongoing care by a hematologist for her chronic anemia, Dr. Klein concluded that the standard of care did not require Joel to consider referring the decedent for additional evaluation of her known anemia or to investigate a suspected cause for the anemia or prior rectal bleeding. Dr. Klein also concluded that the care that the WPH defendants rendered to the decedent did not cause or exacerbate her injuries, let alone cause or contribute to her death.

Dr. Kurzina-Solinas explained that the decedent first presented to Sammartino on November 11, 2018, or approximately three months before she first consulted with Joel, for the evaluation and management of her anemia, and a recent depressed hemoglobin level of 7.2

g/dL. She further noted the decedent's history of sickle cell trait and heavy menses, as well as her denial, at that visit, of black stool or bleeding in her stool, although Dr. Kurzina-Solinas further noted that the decedent reported having egested one bloody stool sometime in 2017, which the decedent herself attributed to internal hemorrhoids. According to Dr. Kurzina-Solinas, the decedent made no other complaints of bleeding, although she reported craving "chalk and ice," and complained of recent shortness of breath while climbing stairs. The decedent reported to Sammartino that her half half-sister had been diagnosed with alpha thalassemia trait, and further reported that she had removed her intrauterine device on November 10, 2018. According to Dr. Kurzina-Solinas, based upon the results of the decedent's blood tests, Sammartino recommended two doses of the intravenous iron-replacement drug Injectafer and the administration of oral iron sulfate once daily, after which the decedent reported that she could not tolerate taking the oral iron supplement.

On December 27, 2018, the decedent saw Sammartino for a second visit, at which time Sammartino noted that the decedent's hemoglobin level had increased to 11.1 g/dL, while the decedent reported that she was feeling much better after treatment with Injectafer. By this time, the decedent had become pregnant, as Joel confirmed on February 7, 2019, upon learning that the decedent's last menstrual period had occurred on December 3, 2018. The decedent again returned to see Sammartino on February 28, 2019 and April 19, 2019 for monitoring of her H/H levels, among other things. According to Dr. Kurzina-Solinas, the decedent reported feeling tired, with occasional palpitations and shortness of breath, but denied any bleeding. Her H/H levels were 10.7 g/dL/32.6% at the February 28, 2019 visit, and 11 g/dL/33% at the April 9, 2019 visit. During April 2019, the decedent received three infusions of the iron-sucrose supplement Venofer.

Dr. Kurzina-Solinas opined that there was no reason for either Sammartino or Joel to order additional testing to ascertain the cause of the decedent's iron deficiency anemia, and she agreed with Dr. Klein that the standard of care was for forego a colonoscopy in a young woman

with no family history of colon cancer, known sickle cell trait, possible alpha thalassemia trait, heavy menses, no change in bowel habits, and only one report of bloody stool one year earlier that had not recurred. She further explained that the decedent experienced two pregnancies prior to November 2018, which "supported the likelihood that internal hemorrhoids were the cause of the previous episode of bloody stool." Moreover, Dr. Kurzina-Solinas asserted that the decedent's pregnancy foreclosed the possibility of a more comprehensive workup for the purpose of ascertaining the underlying cause of her anemia, inasmuch as pregnancy itself causes anemia. She stated that, even if a colonoscopy had been indicated at that time, the risks posed by anesthesia to a pregnant mother would have outweighed the benefits, especially for a patient without a clear indication for the procedure, as documented in Sammartino's chart.

After reiterating the history of the decedent's encounters with Sammartino, Joel, and NYPH, Dr. Kurzina-Solinas agreed with Dr. Klein that it was reasonable for all of the defendants not to conduct an independent workup with respect to the decedent's May 20, 2019 rectal bleeding, which she noted was evaluated, diagnosed as hemorrhoids, and managed at NYPH. She further agreed with Dr. Klein that it was reasonable for the defendants to forego the referral of the decedent for a colonoscopy, and additionally opined that is was proper to forego the referral for an endoscopy as well, in light of the decedent's age and the risks of anesthesia, since she had no complaints of active bleeding, no family history of colon cancer, but had known chronic anemia, a history of two prior pregnancies and hemorrhoids, and stable H/H levels that were at her baseline. More specifically, Dr. Kurzina-Solinas concluded that a colonoscopy would not have been within the standard of care after one episode of bloody stool during a pregnancy, and that no further testing or treatment in that regard was required of either Sammartino or Joel. In addition, Dr. Kurzina-Solinas asserted that Sammartino appropriately met with and examined the decedent on October 23, 2019, several weeks after she delivered her child, and appropriately prescribed the resumption of oral iron supplements, and that, given the improvement in her H/H levels after the delivery, as well as the decedent's presentation and

complaints, the standard of care did not require Sammartino to consider referring the decedent for additional evaluation of her known anemia or to investigate a suspected cause, including a referral for a colonoscopy, even at that juncture. She concluded that it was reasonable for Sammartino to instruct the decedent to return as needed, since continued monitoring of the decedent was not then warranted.

Dr. Kurzina-Solinas noted that, on November 30, 2019, the decedent presented to WPH, complaining of an episode of abdominal pain that was managed at that facility. She explained, however, that a CT scan taken on that date revealed liver masses, and that the decedent was instructed to follow up with her primary care doctor within one to two days, and to consult a gastroenterology specialist regarding those masses. On December 23, 2019, the decedent consulted with gastroenterologist, Robert Antonelle, M.D., who ordered a comprehensive workup, including a colonoscopy, which also revealed a mass on the decedent's colon.

The decedent returned to see Sammartino on February 24, 2020, subsequent to the colonoscopy, upon which Sammartino wrote in his chart that the decedent, for the first time, told him of her May 20, 2019 encounter at NYPH. He further wrote that the decedent informed him, for the first time, that, while she was at NYPH on May 20, 2019, its emergency department personnel had recommended an endoscopy, but she deferred such testing because she did again experience bloody stool or rectal bleeding, and she wished to avoid being anesthetized while pregnant. On February 24, 2020, Sammartino referred the decedent to a hepatobiliary surgeon for a liver biopsy, with interventional radiology, imaging, and blood laboratory testing. In addition, Sammartino wrote in his chart that if colon cancer with liver metastasis was thereupon confirmed, treatment options included either perioperative chemotherapy with a chemotherapy regimen for treatment of colorectal cancer, consisting of the folinic acid, fluorouracil, and oxaliplatin, otherwise known as FOLFOX therapy, with resection after two months, or, alternatively, upfront diversion, followed by treatment to prevent obstruction. That same day, an MRI of the decedent's abdomen revealed a lesion at the dome of the right lobe, a

lesion in segment 4A, a lesion in segments 4/5, and a new lesion in segment 2, which were consistent with metastatic disease. On February 27, 2020, the decedent returned to see Sammartino, at which time he informed her of the results of the CT and MRI scans, and recommended systemic treatment. According to Dr. Kurzina-Solinas, by April 27, 2020, the decedent had completed three out of four cycles of FOLFOX therapy, but a CT scan nonetheless revealed increased hepatic tumor burden. On May 6, 2020, the decedent was cleared for surgery, and, on May 11, 2020, she underwent a transfusion of one unit of packed red blood cells, which Dr. Kurzina-Solinas explained was the last entry in the WPH records.

In fact, relevant medical records reflected that, on May 8, 2020, the decedent presented to Memorial Sloan Kettering Cancer Center (MSKCC) for a second opinion as to the appropriate treatment for her colon cancer and liver metastasis, both of which had spread and become worse, despite the administration of chemotherapy.

Dr. Kurzina-Solinas concluded that Sammartino's treatment plan for the decedent's colon cancer, beginning with her February 24, 2020 visit, "was completely appropriate, timely, and standard." In this respect, she explained that the pathology reports indicated epidermal growth factor receptor status and KRAS gene mutation, meaning that the decedent's colon cancer could only be treated with standard FOLFOX chemotherapy, since other systemic treatments would not be effective. Inasmuch as Sammartino immediately initiated FOLFOX therapy, anticipating that it would shrink the colon tumor and liver lesions for a better surgical outcome, Dr. Kurzina-Solinas opined that he satisfied the standard of care, but that the decedent's cancer did not respond to any of the treatments that were provided to her.

Dr. Kurzina-Solinas further concluded that none of conduct described by the plaintiff caused or exacerbated the decedent's injuries.

In opposition to the White Plains defendants' motion, the plaintiff relied on many of the same documents that both the NYPH defendants and the White Plains defendants submitted, and also submitted an attorney's affirmation, a counter statement of material facts, and the

expert affirmations of board-certified internist and gastroenterologist Larry Good, M.D., and board-certified internist and oncologist/hematologist Barry Singer, M.D., both of whom opined that Sammartino departed from good and accepted medical care in failing to diagnose the decedent with, or work her up for, colon cancer, and that these departures caused or contributed to the spread of the cancer, the deprivation of an opportunity for a cure or a better outcome, and the decedent's death.

Dr. Good asserted that he was fully familiar with the standards of care applicable to diagnosis and treatment cancers of the gastrointestinal tract, including colon cancer, as well as with diagnostic modalities for the evaluation of the gastrointestinal tract and the indications for the employment of those modalities and the risks, complications and alternatives applicable to specific procedures. Specifically, he averred that he was familiar with the indications and contraindications for employing laboratory studies for the presence of fecal occult blood, colonoscopies, upper endoscopies, and imaging procedures such as ultrasound, MRI scans, and CT scans. He explicitly alleged that he had performed more than 15,000 colonoscopies, including colonoscopies on pregnant women.

After recounting the history of the decedent's examinations and treatment by Sammartino and Joel, as well as the complaints that she made to them, Dr. Good explained that, when Sammartino made his diagnosis of anemia on November 30, 2018, the latter indicated that the laboratory results were very clearcut for a diagnosis of iron-deficiency anemia, and that her heavy menses seemed symptomatic, thus formulating a differential diagnosis that included only iron deficiency due to chronic blood loss in the setting of heavy menses, but omitted gastrointestinal bleeding or colon cancer that could have caused such bleeding. Dr. Good, however, further noted that Sammartino testified at his deposition that iron-deficiency anemia can be caused by colon cancer, but that he did not consider colon cancer in his differential diagnosis, and, thus, never recommended or prescribed any tests to rule out colon cancer, such as an occult blood test such as Cologuard, a colonoscopy, or a carcioembryotic

antigen test. Dr. Good noted that Sammartino continued to evaluate and treat the decedent for iron-deficiency anemia on multiple subsequent visits after she became pregnant in December 2018, but that, when he met with the decedent on December 27, 2018, he again failed to include gastrointestinal bleeding on his differential diagnosis or to prescribe any fecal occult blood tests. He further stated that, when the decedent returned to see Sammartino on June 25, 2019, she remained anemic, with H/H levels of 9.3 g/dL/28%, and that Sammartino testified at his deposition that the cause of the decedent's anemia at that time was increased iron demand in the setting of pregnancy, despite the fact that the decedent remained anemic throughout the summer of 2019, even in the face the administration of intravenous and oral iron supplements.

Although Dr. Good conceded that, by the time that Sammartino first saw the decedent after the delivery of her child, her hemoglobin level had improved, but that she nonetheless evinced persistently low iron and iron saturation levels. Dr. Good then reiterated the decedent's presentation to the WPH emergency department on November 30, 2019, during which she complained of abdominal pain in her lower right quadrant. He asserted that her H/H levels at that time were 8.5 g/dL/27.6%, "indicating blood loss," while he restated that the findings of a CT scan that revealed a lobulated structure adjacent to the appendix, with possible calcification, measuring approximately 3.3 centimeters (cm) by 2.2 cm by 3.6 cm, along with a 5.2 cm-by-4.6 cm left hepatic mass, and an adjacent 1.1 cm left hepatic mass. Dr. Good noted, as did Dr. Kurzina-Solinas, that the decedent underwent an endoscopy/colonoscopy on February 14, 2020, after which she was diagnosed with colon cancer, with her hepatic masses subsequently found to constitute Stage IV metastatic cancer. He explained that, despite the FOLFOX treatment rendered by Sammartino, and additional treatment rendered by MSKCC personnel, she succumbed to the disease and died on February 15, 2021.

Dr. Good opined that Sammartino departed from good and accepted medical practice at the initial November 15, 2018 visit by failing to formulate a proper differential diagnosis to include gastrointestinal bleeding as a cause of the patient's iron-deficiency anemia, by making

an unwarranted assumption that heavy menses was the sole cause of the anemia, and by failing to test the patient for fecal occult blood utilizing a set of three Hemoccult cards. As he explained it, this test would have yielded positive results, necessitating further evaluation via endoscopy and colonoscopy to locate the source of the bleeding. According to Dr. Good, a colonoscopy would have diagnosed the cancerous lesion in the patient's proximal right colon, and appropriate treatment would have been instituted, but, instead, there was a delay of more than one year in making the diagnosis, which permitted the cancer to progress and metastasize to the liver, developing to a Stage IV cancer at the time of diagnosis. Dr. Good further concluded that, during the course of the decedent's pregnancy, that is, from early-to-mid December 2018 until her September 4, 2019 delivery, Sammartino made another "unwarranted assumption" that, despite multiple intravenous infusions of iron in the form of Injectafer and Venofer between November 2018 and July 2019, the decedent's continued anemia was solely due to her pregnancy, when she was, in fact, bleeding due to colon cancer. As Dr. Good framed the issue, the decedent's continued anemia, "despite multiple iron infusions was a sign of significant and continued gastrointestinal bleeding that should have been appreciated by any reasonable physician prompting a strong suspicion of a tumor in the colon." He concluded that Sammartino should have tested the decedent for the presence of occult blood in her stool during the entire course of her pregnancy, and that his failure to do so constituted a "continuing" departure from the standard of care.

Dr. Good expressly disagreed with Drs. Klein and Kurzina-Solinas that a colonoscopy was either not indicated or contraindicated in the decedent's case. Dr. Good adverted to a guideline promulgated by the American Society for Gastrointestinal Endoscopy and a peer-reviewed medical journal article, and expressly opined that

> "[c]olonoscopy would have been indicated during the second or early third trimester of pregnancy to locate the source of the bleeding and provide a basis for appropriate treatment. Significant or continued GI bleeding and/or a reasonable suspicion of a colonic mass are recognized indications for colonoscopy during pregnancy which should have been performed in this case.

> The general principles guiding endoscopy during pregnancy include deferring the procedure until the second trimester if possible, using the lowest effective dose of sedative medications, utilizing Category A or B drugs, minimizing procedure time, positioning patients in left pelvic tilt or left lateral position to avoid vena cava or aortic compression, confirming the presence of fetal heart sounds before and after the procedure, along with having obstetric support available in the event of a pregnancy related complication."

Dr. Good concluded that, "[a]ccordingly, the patient should have had a colonoscopy, both prior to and during the pregnancy after the first trimester," since this would have resulted in diagnosis and treatment of her colon cancer at a significantly earlier time than actually occurred.

With respect to the issue of proximate cause, Dr. Good opined that the negligent delay in diagnosis and treatment resulted in the progression and metastatic spread of the tumor, causing it to progress to Stage IV at the time of diagnosis, with little if any chance of cure, and, as such, was a substantial factor in causing her death.

Dr. Good explicitly disagreed with Dr. Kurzyna-Solinas's opinion that, during Sammartino's initial workup of the decedent, there was no reason for Sammartino to ascertain the cause of the decedent's anemia, and that it would not be within the standard of care to perform a colonoscopy. Rather, he opined that the standard of care clearly required further investigation of the cause of the patient's iron-deficiency anemia, initially with a Hemoccult test, followed by colonoscopy. He reiterated that, while the decedent's history of heavy menses may have been a contributing cause of her chronic anemia, for which no treatment had been indicated in the past, the failure to rule out gastrointestinal bleeding as an additional cause of the anemia when she presented to Sammartino was a clear departure from the standard of care, particularly because the decedent's craving of chalk and ice, which are symptoms of iron deficiency, as well as shortness of breath when climbing a flight of stairs, were indicative of worsening symptomatology. He further reiterated his disagreement with Dr. Kurzina-Solinas's opinion that the decedent's pregnancy foreclosed the possibility of a more comprehensive workup of her anemia, and that the risks of anesthesia would have outweighed the benefits of a colonoscopy. Dr. Good concluded that the anesthetic risks of colonoscopy are minimal if

accepted guidelines are observed, including the administration of Category B drugs, such as Propofol, for sedation.

Dr. Good explicitly agreed with the White Plains and NYPH defendants that the symptoms that the decedent presented during her May 20, 2019 emergency visit to NYPH were unlikely to have been caused by her colon cancer, because the tumor in the proximal right colon would not likely present as bright red blood from the rectum. Hence, he concluded that the diagnosis of infectious diarrhea, which ultimately resolved, was reasonable, with the other diagnoses of anal fissure and/or hemorrhoids also being possible. Dr. Good asserted that, standing alone, this incident would not necessarily have been an indication to perform a colonoscopy. Rather, he concluded that the indication for performing a colonoscopy during the decedent's pregnancy was her continued iron deficiency in the face of multiple courses of iron supplementation. Moreover, although Sammartino testified that he was not initially aware of this "isolated incident" of rectal bleeding and, thus, it was not a factor in his diagnosis or treatment, Dr. Good stated that Sammartino "certainly did not attribute the patient's continued I[ron] D[efficiency] A[nemia] to this incident but instead unreasonably persisted in the belief that the patient's IDA was due to the normal demands of pregnancy."

In his affirmation, Dr. Singer concurred with Dr. Good's opinion that Sammartino departed from accepted standards of care during his initial workup in failing to rule out gastrointestinal bleeding due to colon cancer as a cause of the patient's iron-deficiency anemia, and that. prior to initiating treatment with iron supplementation, he should have administered fecal occult blood tests that would have led to an endoscopy and colonoscopy and/or the employment of other imaging modalities to rule out gastrointestinal bleeding as a cause of her anemia. Dr. Singer asserted that, had these tests been performed, a diagnosis of colon cancer would have been made, and appropriate medical and surgical treatment would have been instituted, with a good prognosis for a cure. He averred that, instead, Sammartino's failure to rule out a colon cancer, and his negligent attribution of the decedent's anemia solely to a history

of heavy menses and, later, to her pregnancy, resulted in a delay in diagnosis of more than one year, during which time her colon cancer progressed and spread to her liver as a Stage IV cancer, and effectively deprived her of a reasonable probability of cure. Dr. Singer concluded that Sammartino's departures from accepted care continued during the decedent's pregnancy, when she continued to suffer from anemia despite multiple intravenous infusions of iron, and he continued to fail to evaluate her for a gastrointestinal source of bleeding which, according to Dr. Singer, "unquestionably existed during that time." He asserted that, had the correct diagnosis of colon cancer been made during the pregnancy, the decedent would have had the option to terminate the pregnancy and begin treatment, or to undergo surgery and chemotherapy while maintaining the pregnancy. Dr. Singer opined that Sammartino's failure timely to rule out colon cancer as a cause of the decedent's iron-deficiency anemia was a substantial factor in causing this her death.

Dr. Singer explained that a hematologist/oncologist who is presented with a new patient for evaluation of anemia has the duty to formulate a differential diagnosis of the patient's condition based upon the patient's history, complaints, signs, and symptoms, and to perform a reasonably thorough investigation with appropriate laboratory tests, diagnostic procedures and imaging studies if necessary, so as to establish the cause of the anemia. In his respect, he asserted that, while Sammartino was correct in diagnosing moderate to severe iron-deficiency anemia due to blood loss, he negligently ignored the fact that colon cancer can cause iron-deficiency anemia due to blood loss, "a fact he acknowledged in his deposition testimony."

Dr. Singer averred that asymptomatic colonic and/or gastric carcinoma may present with anemia, and that "exclusion of these conditions is mandatory" in formulating a proper differential diagnosis. He faulted Sammartino for generating only a "very short list" in connection with his differential diagnosis that included only iron deficiency due to chronic blood loss in the setting of heavy menses, while there were no other conditions identified in his differential diagnosis because, to Sammartino, it was "very clear" at that time. Dr. Singer described this approach as

> "a gross violation of the standard of care, which requires that potentially causative disease entities be included in the differential and that they be ruled out in a methodical way, especially those that are potentially serious or lethal like cancer, before settling on a more benign diagnosis."

In connection with that opinion, Dr. Singer asserted that iron deficiency, with or without anemia, is the most frequent hematological manifestation in individuals with cancer, and is especially common in patients suffering from colon cancer, with the incidence reported at approximately 60%. He stated that a history of heavy menses in a young woman and/or chronic anemia "should never be the basis for failing to properly investigate the cause" of the anemia "because it can result in a significant delay in diagnosis and treatment of cancer, as it did in this case."

As Dr. Singer paraphrased a peer-reviewed medical journal article, the strategy of treating a patient with several cycles of iron supplementation prior to proper evaluation by endoscopy and colonoscopy, "especially in young females and in patients with a prior history of anemia," results in a significant delay in etiological diagnosis of anemia. As he quoted from the article, "[i]n this sense, except in very specific situations, I[ron] D[efficiency] with or without anemia should always be investigated because it can be caused by potentially serious diseases." He noted that the decedent's history, prior to her presentation to Sammartino, reflected, at most, a mild chronic anemia, but when she presented to Sammartino, she had severe iron-deficiency anemia with symptoms of pica, such as a craving for ingesting ice and chalk, fatigue, and shortness of breath while climbing stairs, "all of which should have raised a suspicion that something more than her history of heavy menses was contributing to this marked worsening of her condition." He opined that Sammartino's subjective certainty in his diagnosis should not have been a substitute for careful investigation in accordance with the standard of care. Dr. Singer further opined that

> "[t]he minimum standard of care requires doing a fecal occult blood test (Hemoccult) which involves 3 stools and 2 'windows' for each stool. Colonic neoplasms and other gastrointestinal lesions bleed intermittently requiring several samples. If any of the six 'windows' is positive, then that is an indication to do more intensive diagnostic study to determine the source of the bleeding.

> Over 80% of colon cancers are detected by the three stool hemoccult test. In this case, the overwhelming likelihood is that the hemoccult test would have been positive, thereby necessitating further workup with colonoscopy which would have found the lesion in the proximal colon. At that point, a treatment plan including surgical resection and possible medical therapies could have been initiated depending on the findings."

Dr. Singer concluded that the delay in the diagnosis and treatment of the decedent's colon cancer, from November 15, 2018, when she was first evaluated by Sammartino, until November 30, 2019, when the CT scan at WPH revealed abnormal findings in the colon and liver that were later confirmed to be colon cancer with liver metastases, deprived her of a substantial chance of cure or of a better outcome, and was a substantial factor and proximate cause of her death. Specifically, he concluded that, in view of the fairly aggressive nature of the decedent's tumor, at the onset of this "delay" period, she likely had early-stage cancer, either Stage I or II, that was confined to the colon, but which had progressed to Stage IV by the time of diagnosis. Dr. Singer explained that long-term survival rates in various studies for early-stage, young-onset colon cancer patients are approximately 98.2% and 89.1% for Stages I and II, respectively, while Stage III colon cancer in a relatively young patient has an approximately 60%-to-75% probability of five-year overall survival. In contrast, he asserted that treatment of Stage IV colon cancer is mostly palliative, with median survival reportedly being approximately nine months, even with the best supportive care. Dr. Singer averred that the decedent's chances of long-term survival "were effectively destroyed" by Sammartino's "negligent failure" to rule out colon cancer in his initial workup before commencing iron replacement therapy.

Dr. Singer further faulted Sammartino for his "ongoing and total failure" to consider and rule out colon cancer as a cause of the patient's iron-deficiency anemia after she became pregnant, which he characterized as an additional and continuing departure from the standard of care. According to Dr. Singer,

> "[b]y the 4/9/19 visit, the patient had received IV iron supplementation with Injectafer on two occasions. Her iron saturation on that date had fallen to 10% (Ref. 25-35%). She was given intravenous Venofer (iron sucrose) on 4/19, 4/22 and [4/26/19] because her iron stores had dropped compared to the prior visit

> and she was potentially symptomatic with palpitations. Then on 6/25/19, hemoglobin was 9.3 and she was given additional doses of Venofer on 6/28, 7/1 and 7/3/19. This ongoing need for intravenous iron supplementation is far outside the norm for pregnancy alone and Dr. Sammartino's continued attribution of the patient's iron losses to pregnancy without excluding gastrointestinal bleeding as a potential contributing factor was a continuing departure from the standard of care."

He also asserted that, once the decedent became pregnant, she could still have been administered a Hemoccult test, "which would have been positive and would have prompted a further workup to determine the source of the bleeding in the gastrointestinal tract." Contrary to the opinions of Drs. Klein and Kurzina-Solinas, but in accord with Dr. Good's opinion, Dr. Singer asserted that a colonoscopy during pregnancy can be performed with appropriate anesthesia and obstetric availability, while other diagnostic modalities, including abdominal ultrasound and MRI, have no documented adverse effects on a pregnant mother or fetus.

Dr. Singer concluded that, even without terminating her pregnancy, the decedent had other options for treatment, inasmuch as chemotherapy during pregnancy, including FOLFOX therapy, is a well-established cancer treatment after the first trimester until two to three weeks prior to delivery, although he noted that targeted therapy and immunotherapy are more restricted. He stated that surgery to remove a cancerous colonic lesion is ideally performed during the early second trimester, although such surgery can be performed throughout the entire pregnancy when technically feasible, with additional obstetric considerations.

Dr. Singer explicitly disagreed with Dr. Kurzina-Solinas's opinion that a colonoscopy was not indicated because of the decedent's past history of heavy menses, one report of bloody stool in 2017, and two prior pregnancies. He asserted that internal hemorrhoids were the cause of that previous episode of bloody stool, which did not explain why the decedent was severely anemic at the time of Sammartino's November 15, 2018 examination. Dr. Singer stated that a tumor in the proximal colon, especially in its early stages, may not produce any noticeable blood in stool because the blood dries as it travels through the colon to the rectum. He explained that this was why a Hemoccult test was the indicated procedure to make an evaluation in the first

instance, prior to ordering a colonoscopy, an approach that he noted Dr. Kurzina-Solinas had failed to address. He further rejected Dr. Kurzina-Solinas's opinion that the decedent's pregnancy "foreclosed the possibility of a more comprehensive workup as to the cause of anemia because pregnancy itself causes anemia," an opinion he criticized has having "no scientific basis." In addition, he criticized Dr. Kurzina-Solinas's recitation of only some of the results of the decedent's H/H testing, while ignoring Sammartino's eight administrations of intravenous iron supplementation due to depletion of iron, and the fact that, even after significant iron supplementation, the decedent's H/H levels were "marginal at best." In this respect, he noted that the H/H ranges that are employed in clinical practice are expressed as concentrations, based on whole blood volume, while so-called "dilutional" anemia during pregnancy is caused by an increase in plasma volume, that latter of which does not affect the absolute amount of iron in the blood. Dr. Singer explained that abnormal pregnancy consumes approximately 500 to 1200 milligrams of iron, with the largest percentage thereof being utilized during the third trimester. He asserted that, although the decedent received eight iron infusions immediately before and during her pregnancy, she remained anemic. As Dr. Singer framed the issue, Sammartino was "simply masking the problem without making the proper diagnosis."

In connection with Dr. Kurzina-Solinas's discussion of the decedent's visit to the NYPH emergency department on May 20, 2019, he concluded that it was unlikely that her bloody stools and diarrhea were related to her right proximal colon tumor which, "unlike a tumor in the rectum, typically would not likely present with" those symptoms. Hence, he concluded that NYPH's diagnosis of possible infectious diarrhea and/or hemorrhoids or anal fissure was reasonable, and that the decedent's "apparent decision to defer colonoscopy" also was reasonable. Dr. Singer asserted that his opinions were not influenced by the fact that Sammartino apparently was not informed of the NYPH visit.

Both Drs. Good and Singer agreed that Joel properly deferred the management of the decedent's case to Sammartino, and Dr. Singer agreed with Dr. Klein that the responsibility for

ascertaining the etiology of the decedent's anemia fell to Sammartino. Dr. Singer also accepted Dr. Klein's opinion that, assuming that the correct diagnosis had been made during the decedent's pregnancy, treatment for the cancer could probably have been delayed until the fetus could be delivered at between 34 and 36 weeks of gestation, which Dr. Singer conceded was one of several options that would have been available. He nonetheless opined that, due to Sammartino's negligence, the decedent was deprived of an opportunity to make that decision.

In reply, the White Plains defendants submitted an attorney's affirmation, in which counsel argued that the plaintiff's experts did not address their prima facie showing that Joel did not commit any malpractice, and did not identify any malpractice on behalf of WPH itself apart from its alleged vicarious liability for Sammartino's conduct. Counsel further argued that the plaintiff failed to raise triable issues of fact because his experts' opionions constituted "generalized statements," that were "conclusory, speculative, [and] lack[ed] support from the record," thus "failing to establish a genuine issue of material fact, including with regard to proximate cause of decedent's death."

The court concludes that the White Plains defendants established, prima facie, that they did not depart from good and accepted practice, and that nothing that they did or did not do caused or contributed to the progression of the decedent's cancer or her death. Since the plaintiff did not address the opinions of the White Plains defendants' experts with respect to Joel's alleged malpractice, he did not raise a triable issue of fact in opposition thereto, and summary judgment must be awarded to Joel dismissing the complaint insofar as asserted against her. Nonetheless, the court concludes that the opinions of the plaintiff's experts were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the plaintiff's decedent (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to whether Sammartino committed malpractice in failing timely to suspect, test for, diagnose, or treat the decedent's colon cancer. It is well settled that a battle of experts, such as presented

here, raises credibility issues which must be resolved by a fact finder and which preclude summary judgment (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 25). The plaintiff also raised triable issues of fact as to whether that malpractice caused or contributed to the progression of the decedent's cancer and her death. Of course, a wrongful death cause of action may be premised upon medical malpractice (*see Roques v Noble*, 73 AD3d at 207). The White Plains defendants failed to establish, prima facie, that the beneficiaries of the decedent's estate did not sustain pecuniary loss. The court also concludes that, based on the plaintiff's deposition testimony, there are triable issues of fact as to whether he was deprived of the consortium of the decedent while she remained alive. Since there are triable issues of fact as to whether Sammartino's malpractice proximately caused the decedent's injuries and death, the court must deny those branches of the White Plains defendants' motion seeking summary judgment dismissing the wrongful death and loss of consortium causes of action insofar as asserted against Sammartino.

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2d Dept 2018]). Sammartino was an employee of WPH during the time that he examined, tested, diagnosed, and treated the decedent. Hence, to the extent that there are triable issues of fact as to whether Sammartino may be held liable for malpractice, wrongful death, and loss of consortium, there are triable issues of fact as to WPH's vicarious liability with respect to those causes of action.

The White Plains defendants demonstrated that all healthcare employees working for them were properly trained. Since the plaintiff, in his opposition papers, adduced no facts with

respect to whether the White Plains defendants knew or should have known of the propensity of any employee to commit acts of malpractice, that branch of their motion seeking summary judgment dismissing that claim against them must be granted.

In light of the foregoing, it is,

ORDERED that the motion of the defendants New York-Presbyterian Healthcare System, Inc., and New York-Presbyterian Hospital-Columbia for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 001) is granted, without opposition, and the complaint is dismissed insofar as asserted against the defendants New York-Presbyterian Healthcare System, Inc., and New York-Presbyterian Hospital-Columbia; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendants New York-Presbyterian Healthcare System, Inc., and New York-Presbyterian Hospital-Columbia; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendants New York-Presbyterian Healthcare System, Inc., and New York-Presbyterian Hospital-Columbia; and it is further,

ORDERED that the motion of the defendants White Plains Hospital, Daniel E. Sammartino, M.D., and Leora Joel, M.D., for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 002) is granted only to the extent that summary judgment is awarded to Leora Joel, M.D., dismissing the complaint insofar as asserted against her and dismissing so much of the medical malpractice cause of action as was premised on alleged negligent hiring, training, supervision, retention, and credentialing of healthcare personnel insofar as asserted against White Plains Hospital and Daniel E. Sammartino, M.D., the complaint is dismissed insofar as asserted against Leora Joel, M.D., and so much of the medical malpractice cause of action as was premised on alleged negligent hiring, training,

supervision, retention, and credentialing of healthcare personnel is dismissed insofar as asserted against White Plains Hospital and Daniel E. Sammartino, M.D.; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendant Leora Joel, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant Leora Joel, M.D.; and it further,

ORDERED that, on the court's own motion, the attorneys for all of the remaining parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on October 30, 2025, at 11:30 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

10/3/2025
DATE

JOHN J. KELLEY, J.S.C.

MOTION 001:		**CASE DISPOSED**			[X]	**NON-FINAL DISPOSITION**		
	[X]	**GRANTED**	[ ]	**DENIED**	[ ]	**GRANTED IN PART**	[ ]	**OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**			[ ]	**SUBMIT ORDER**		
CHECK IF APPROPRIATE:	[ ]	**INCLUDES TRANSFER/REASSIGN**			[ ]	**FIDUCIARY APPOINTMENT**	[ ]	**REFERENCE**
MOTION 002:	[ ]	**CASE DISPOSED**			[X]	**NON-FINAL DISPOSITION**		
	[ ]	**GRANTED**	[ ]	**DENIED**	[X]	**GRANTED IN PART**	[ ]	**OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**			[ ]	**SUBMIT ORDER**		
CHECK IF APPROPRIATE:	[ ]	**INCLUDES TRANSFER/REASSIGN**			[ ]	**FIDUCIARY APPOINTMENT**	[ ]	**REFERENCE**