Paul v Mukherji
2025 NY Slip Op 34432(U)
November 19, 2025
Supreme Court, Kings County
Docket Number: Index No. 519679/2016
Judge: Consuelo Mallafre Melendez

At an IAS Term, Part 15 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 19th day of November 2025.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

----------X

SONIA PAUL, as Administrator of the Goods, Chattels and Credits which were of JOHN PAUL, and SONIA PAUL, Individually,

Plaintiffs,

-against-

RAJAT K. MUKHERJI, M.D., KARTAVYA RAJPAL, as Administrator of the Estate of SANJEEV RAJPAL, M.D. (deceased), HUA LI, M.D., NAY AUNG, M.D., KYI KYI HTEIN, M.D., FRANTZ LOUIS M.D. and KINGSBROOK JEWISH MEDICAL CENTER,

Defendants.

----------X

DECISION & ORDER

Index No. 519679/2016
Mo. Seq. 3

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.
Recitation, as required by CPLR §2219 [a], of the papers considered in the review:

NYSCEF #s: 122 – 124, 125 – 136, 151 – 162, 165

Defendant Rajat K. Mukherji, M.D. ("Dr. Mukherji") moves for an Order, pursuant to CPLR 3212, granting summary judgment or partial summary judgment in his favor (Seq. No. 3).

Plaintiff opposes the motion.

Plaintiff commenced this action on November 7, 2016, asserting claims of medical malpractice and wrongful death against Dr. Mukherji and others, in connection with diagnosis and treatment of a pleural effusion (fluid in the lungs). Plaintiff also asserts individual claims for loss of services.

Decedent presented to Kingsbrook Jewish Medical Center on December 3, 2014 with complaints of right abdominal pain and a cough lasting two weeks. He was 52 years old and had a medical history including diabetes and stage 3 chronic kidney disease.

A chest x-ray indicated a right pleural effusion, and Decedent was admitted for further evaluation. The attending physician, Dr. Reddy, ordered consults for infectious disease and pulmonology at 7:11 p.m. Dr. Reddy testified that she spoke with pulmonology consult Dr. Mukherji about the case that afternoon by telephone, and he told her he would make a decision about whether to perform thoracentesis after seeing the patient (Dr. Reddy tr at 63).

On December 4, 2014, a resident noted "f/u pulm. Dr. Mukherji for possible thoracentesis" at 12:41 p.m. Dr. Mukherji first examined Decedent at approximately 4:20 p.m. that day, and he assessed him with a "moderate" right pleural effusion of unclear etiology. Dr. Mukherji ordered a thoracentesis, which would be performed the following day. A chest CT scan, ordered by an internal medicine resident, was performed at approximately 7:30 p.m. with reported findings of "large right pleural effusion" that "nearly collapses the right lung, most notably on the right lower lobe."

On December 5, Decedent left the unit for the scheduled thoracentesis at 11:15 a.m. The procedure was not completed because he went into cardiac arrest at 11:28 a.m. After approximately 13 minutes of resuscitation efforts, his pulse returned but he remained unresponsive and on a ventilator.

A thoracentesis was later performed at 1:59 p.m., obtaining 208 mL of yellow fluid. A second thoracentesis was performed on December 10, obtaining 70 mL of amber fluid. Decedent never regained consciousness following his cardiac arrest, and he passed away on April 21, 2015.

Plaintiff alleges that Dr. Mukherji departed from the standard of care by failing to timely evaluate Decedent, order and review a "stat" CT scan, and arrange for an urgent thoracentesis.

Plaintiff alleges that these departures proximately caused Decedent's cardiac arrest and death, because a timely thoracentesis would have relieved the compression in his lungs.

In evaluating a motion for summary judgment in a medical malpractice action, the Court applies the burden shifting process summarized by the Second Department: "[A] defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or that the plaintiff was not injured by any such departure" (*Rosenzweig v Hadpawat,* 229 AD3d 650, 652 [2d Dept 2024]). "In order to sustain this prima facie burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (*Martinez v Orange Regional Med. Ctr.,* 203 AD3d 910, 912 [2d Dept 2022]). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." (*Rosenzweig* at 652 [2d Dept 2024] [internal quotation marks and citations omitted].) However, "expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact" (*Barnaman v Bishop Hucles Episcopal Nursing Home*, 213 AD3d 896, 898-899 [2d Dept 2023]).

In support of his motion, Dr. Mukherji submits an expert affirmation from Umesh Gidwani, M.D. ("Dr. Gidwani"), a licensed physician board certified in pulmonary diseases, critical care medicine, and palliative care medicine.

Dr. Gidwani opines that Dr. Mukherji complied with the standard of care at all times while evaluating and treating Decedent as a pulmonology specialist. First, he states that Dr. Mukherji's physical examination of Decedent on December 4 was timely conducted within 24

hours of the consult request. Upon examination and review of "the available laboratory data and imaging," Dr. Gidwani opines that "the patient was stable, with no signs of respiratory or cardiac distress" and his vital signs were within normal/baseline limits.

Dr. Gidwani opines that although the chest x-ray was "suggestive of a moderate to large pleural effusion," there were no signs of hemodynamic instability or cardiac stress. He states Decedent had normal ejection fraction and "no evidence of right ventricular collapse, tamponade, or mediastinal shift" in his echocardiogram. The expert also notes that "the patient's respiratory status remained stable" up until the time of his cardiac arrest, and his oxygen saturation was 96%. He opines that although Decedent had decreased breath sounds from his right lung, his left lung was functioning normally and "fully capable of compensating for any reduced output from the lower right lung." The expert therefore opines the patient's clinical picture did not require an emergent or "stat" thoracentesis.

The expert further opines that delaying the thoracentesis procedure until the following day was reasonable and within the standard of care. He opines that thoracentesis carries risks such as pneumothorax, a potentially life-threatening complication, and "hospitals are better staffed and equipped to respond to this condition during the day rather than at night." He further opines that thoracentesis for "therapeutic" reasons is only indicated when a patient is "significantly short of breath or hemodynamically unstable," which was not the case for Decedent. Instead, the procedure was ordered primarily as a diagnostic tool to "determine the underling etiology of the effusion," and therefore "the benefits of performing the test the following morning" rather than on December 4 outweighed any risk of delay in the expert's opinion. The expert opines that Dr. Mukherji properly ordered the thoracentesis on a non-emergent basis.

On the issue of proximate causation, Dr. Gidwani opines that the "small to moderate" pleural effusion was not the cause of Decedent's cardiac arrest. He bases his opinion on the fact the thoracentesis ultimately retrieved less than 300 mL of fluid and left "a small residual effusion." He opines that a large pleural effusion would have measured over 1000 ccs (1L) of fluid. He states that imaging studies such as x-rays and CT scans "tend to overestimate the actual quantity of pleural effusion," to explain the radiological images suggesting a "large" pleural effusion. He further opines that when "pleural effusion contributes to cardiac arrest, the decline is typically gradual, with progressive respiratory compromise and hemodynamic instability." He opines that in Decedent's case, the cardiac arrest was sudden and likely caused by arrhythmia from Decedent's underlying diabetes and/or chronic kidney disease.

Based on these submissions, Dr. Mukherji's expert has established prima facie that he appropriately and timely examined Decedent in his role as a pulmonology specialist. He also establishes it was within the standard of care to order the thoracentesis for the following morning, rather than on an urgent or "stat" basis. Additionally, the expert establishes prima facie that Decedent's sudden cardiac arrest was not the result of the pleural effusion, and therefore no alleged delay in pulmonology evaluation or thoracentesis was a proximate cause of Decedent's injuries or death. Accordingly, the burden shifts to Plaintiff to raise an issue of fact.

In opposition, Plaintiff submits an expert affirmation from a licensed physician [name of expert redacted], board certified in internal medicine. The Court was presented with a signed, unredacted copy of the affirmation for *in camera* inspection. Although not board certified in pulmonary medicine, the expert sets forth his qualifications to opine on the issues of this case, including relevant background and education in pulmonology and experience treating patients with pneumonia and pleural effusion "including consultations, examinations, review of lab

values, the ordering and reviewing of chest x-rays and CT scans . . . and ordering appropriate consultations and treatment, including thoracentesis." The Court finds the expert has laid a proper foundation to opine on the applicable standard of care and proximate causation in this case.

Plaintiff's expert opines that Dr. Mukherji departed from the standard of care by failing to timely evaluate Decedent and properly obtain, review, and act upon his CT scan results. The expert also opines Dr. Mukherji failed to recommend/order the thoracentesis on an urgent basis.

Plaintiff's expert notes that according to the testimony of attending physician Dr. Reddy, Dr. Mukherji was contacted by telephone about the patient's case on December 3 at 4:30 p.m. or earlier, although the official order for the consult does not appear in the record until 7:00 p.m. Dr. Mukherji did not see the patient until December 4 at 4:20 p.m. and waited an additional day to schedule the thoracentesis. The expert opines this combined delay in his evaluation and treatment constituted a departure from the standard of care.

In contrast to the movant's expert, Plaintiff's expert opines that the standard of care for a "chronically ill" patient with Decedent's many comorbidities required emergently ordering a thoracentesis and drain fluid from the lungs. The expert opines that based on the chest x-ray findings – which showed "a very large pleural effusion with lower right lung opacification" – Dr. Mukherji should have seen the patient sooner than within 24 hours, obtained and reviewed a chest CT scan, and "begun the process for an emergent thoracentesis." The expert states that thoracentesis "should be performed when the cause of effusion is not known and/or the volume of the fluid present is causing symptoms," as was the case for Decedent.

The expert further opines that the CT scan which was eventually performed at 7:30 p.m. on December 4 "unequivocally" indicated the urgent need for thoracentesis. Based on his review

of the radiological report and images, Plaintiff's expert opines that the pleural effusion was "so large it nearly completely collapsed the right lung," and 90% of the right lung was not functioning. In these circumstances, the expert opines that "an urgent thoracentesis was required to help relieve the degree of lung collapse and prevent more invasive damage." Plaintiff's expert opines that Dr. Mukherji failed to timely review this CT scan and order the stat thoracentesis accordingly. The expert also disagrees with Dr. Gidwani's opinion that thoracentesis was delayed until the morning due to the risk of pneumothorax, opining that thoracentesis is a "minimally invasive procedure" and the benefits far outweighed the "less than 1%" risk of complication.

Plaintiff's expert counters Dr. Gidwani's statements that the effusion was "small to moderate" based on the 208 mL removed. The expert states that based on the medical record, the thoracentesis did not remove all the pockets of fluid, and a post-thoracentesis x-ray and CT scan showed that the fluid had "decreased" but was still present.

Finally, Plaintiff's expert opines that Decedent's cardiac arrest more likely than not could have been prevented if the thoracentesis was performed on December 4, rather than delayed until the following morning. The expert opines that a timely thoracentesis would be both diagnostic and therapeutic, as draining fluid would relieve the symptoms of his compressed lung and reduce his risk of cardiac arrest.

Plaintiff's expert counters the movant's expert opinion that Decedent's vital signs were stable and therefore did not indicate any risk of cardiac arrest. In the opinion of Plaintiff's expert, Decedent's "category 3" pleural effusion (occupying "more than half of the hemothorax" based on the CT scan) combined with his chronic conditions and overall clinical picture placed him at

high risk of sudden cardiac arrest. Even in a hemodynamically stable patient, the expert opines sudden cardiac arrest is a known complication of category 3 pleural effusion.

Based on the submissions, the Court finds Plaintiff's expert has raised genuine issues of fact as to whether Dr. Mukherji departed from the standard of care, including by failing to timely examine the patient, obtain and review CT scan results, and order a "stat" thoracentesis rather than schedule the procedure for the following morning.

Plaintiff's expert also raises issues of fact as to proximate causation, countering the movant's expert in detail with regard to the size of the pleural effusion, whether it was a substantial factor in Decedent's sudden cardiac arrest, and whether earlier thoracentesis would have therefore prevented his cardiac arrest and subsequent injuries and death. "When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution" (*Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022], citing *Russell v. Garafalo,* 189 A.D.3d 1100, 1102 [2d Dept. 2020]).

Plaintiff does not oppose the part of the motion seeking to dismiss any claims against Dr. Mukherji in the bill of particulars related to diagnosis and treatment of pneumonia, sepsis, or management of the patient's cardiac or renal condition. Therefore, summary judgment is **granted to the extent** of dismissing those claims without opposition, and the motion is otherwise **denied.**

In reply, Defendant argues that Dr. Mukherji owed no duty to the patient as a pulmonology consult with respect to the timing of the chest CT scan, which was ordered by the attending physician and resident. While the scope of a physician's duty is generally a question of law, the Court finds the argument on this claim was improperly raised for the first time in reply (*see Lee v Law Offices of Kim & Bae, P.C.,* 161 AD3d 964, 965-966 [2d Dept 2018]). In their

initial papers, the movant argued that the scope of Dr. Mukherji's treatment was limited to Decedent's pulmonary condition and that he did not undertake a "general role" over his treatment and care. However, the movant did not establish, *prima facie*, that Dr. Mukherji did not have any duty as a pulmonologist to recommend, order, and/or follow up on the performance of the patient's chest CT scan and its results, which directly related to his pulmonary condition.

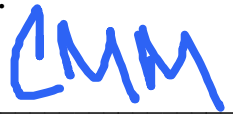
Defendant also argues for the first time in reply that it was the attending physician's duty to call for an interventional radiologist to perform the IR-guided thoracentesis. Assuming the court were to consider this issue, there is support in the medical record and Dr. Mukherji's testimony that the order and scheduling of the thoracentesis procedure was directed by him, although it would ultimately be performed by an interventional radiologist and the defendant's expert opined on the standard of care with respect to the timing of the thoracentesis. Thus, the movant did not meet their burden of establishing as a matter of law that Dr. Mukherji assumed no duty as to this claim.

Accordingly, it is hereby:

ORDERED that Dr. Mukherji's motion (Seq. No. 3) for an Order, pursuant to CPLR 3212, granting summary judgment in his favor, is **granted to the extent** of dismissing any claims in Plaintiff's bill of particulars for treatment of pneumonia, sepsis, or management of the patient's cardiac or renal condition, and the motion is otherwise **denied.**

This constitutes the decision and order of this Court.

ENTER.



Hon. Consuelo Mallafre Melendez
J.S.C.