

**O'Rourke v Epstein**

2025 NY Slip Op 34491(U)

April 25, 2025

Supreme Court, Queens County

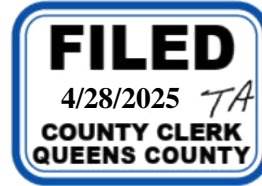
Docket Number: Index No. 707846/2020

Judge: Tracy Catapano-Fox

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This opinion is uncorrected and not selected for official publication.

Short Form Order  
SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF QUEENS



-----X  
RICHARD L. O'ROURKE, as Executor of the Estate of  
JOHN J. GUTLEBER, deceased, and FRAN  
GUTLEBER, individually,  
  
Plaintiffs,

Index No. 707846/2020  
Part MDP  
Motion Date: March 19, 2025

-against-

Calendar No. 17  
Sequence No. 2

LAURENCE EPSTEIN, STEVEN GOLDBERG,  
LEONARD LANDESBERG, MINH TRINH,  
NORTHWELL HEALTH, INC., NORTH SHORE  
UNIVERSITY HOSPITAL, NORTHWELL HEALTH  
PHYSICIAN PARTNERS, PROHEALTH CARE  
ASSOCIATES, L.L.P., NORTH SHORE  
CARDIOLOGY & INTERNAL MEDICINE, NYU  
LANGONE HEALTH SYSTEM and NYU LANGONE  
PULMONARY ASSOCIATES- NORTH SHORE,

Defendants.

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The following papers numbered EF-109 to EF-176 read on this motion by defendants LAURENCE EPSTEIN, M.D., MINH TRINH, M.D., NORTHWELL HEALTH, INC., NORTH SHORE UNIVERSITY HOSPITAL and NORTH SHORE UNIVERSITY HOSPITAL s/h/a NORTHWELL HEALTH PHYSICIAN PARTNERS for summary judgment and dismissal of plaintiffs' Complaint pursuant to CPLR §3212.

Papers  
Numbered

Notice of Motion, Affirmation, Exhibits.....EF109-EF142  
Affirmation in Opposition, Exhibits.....EF171-EF174  
Reply Affirmation.....EF176

Upon the foregoing papers, and after oral argument, it is ordered that this motion is determined as follows:

Defendants Laurence Epstein, M.D., Minh Trinh, M.D., Northwell Health, Inc., North Shore University Hospital and North Shore University Hospital s/h/a Northwell Health Physician Partners' motion for summary judgment and dismissal of plaintiffs' Complaint pursuant to CPLR §3212 is granted as to Minh Trinh, M.D., Northwell Health, Inc., North Shore University Hospital and North Shore University Hospital s/h/a Northwell Health Physician Partners, but denied as to Laurence Epstein, M.D. (*See Erkomashvili v. Volovoy*, 186 A.D.3d 799 [2d Dept. 2020].) Plaintiffs commenced this action for medical malpractice, lack of informed consent and wrongful death alleging failure to timely diagnose and treat decedent John J. Gutleber's atrio-esophageal fistula. Plaintiffs filed the Summons and Complaint on June 17, 2020 and issue was joined on August 6, 2020. It is noted decedent passed away on September 7, 2018, and the death certificate listed the cause of death as cardiopulmonary arrest as a consequence of septic shock and atrial-esophageal fistula.

Defendants move for summary judgment, arguing they did not depart from applicable standards of care nor did they cause decedent's injuries and death. They present the pleadings, decedent's medical records, parties' deposition testimony, affidavit of merit from defendant Dr. Trinh, the affirmation of Avraham Schwartz, and the expert affirmations of Dr. Christopher Liu and Dr. Mark Silberman in support of their motion. Defendants argue their care and treatment of decedent was appropriate and not a deviation from accepted standards of practice, and their actions were not the proximate cause of decedent's injuries. They further argue there is no evidence to support plaintiffs' claim for lack of informed consent, as they had conversations with decedent regarding the treatment of his atrial fibrillation and the risks and benefits of an ablation procedure. Defendants further argue all claims against Dr. Minh Trinh should be dismissed, as his care and treatment was appropriate and performed as an intern/resident under the supervision of attending physicians. They further argue all claims against defendant Northwell Health, Inc. should be dismissed, as it is a corporate entity that did not provide medical care and treatment to decedent. Defendants alternatively argue venue should be changed from Queens County to Nassau County pursuant to CPLR §510(3), as Dr. Trinh was the sole party residing in Queens County and should be dismissed from the case. Based upon the above, defendants argue summary judgment is warranted.

Defendants present the affirmation of Dr. Christopher Liu in support of their motion. Dr. Liu affirmed to be a physician licensed to practice medicine in New York who is board certified in cardiovascular disease and clinical cardiac electrophysiology. He affirmed to be fully familiar with the applicable standard of care in the field of electrophysiology and diagnosis of atrio-esophageal fistula in 2018. Dr. Liu reviewed the pleadings, parties' deposition testimony and decedent's medical records in rendering opinions based upon his experience and training.

Dr. Liu opined within a reasonable degree of medical certainty that Dr. Laurence Epstein's treatment of decedent was at all times within good and accepted medical practice and did not

deviate from accepted standards of care, nor did his actions or omissions proximately caused decedent's injuries and death. Dr. Liu further opined the care and treatment rendered to decedent by defendant North Shore University Hospital (hereinafter referred to as "NSUH") was within good and accepted medical practice, did not deviate from accepted standards of care, and no negligent acts or omissions by NSUH proximately caused decedent's injuries. Dr. Liu opined the care and treatment rendered to decedent between July 2, 2018 and August 9, 2018 was in accord with good and accepted medical practice and did not contribute to decedent's injuries. He further opined within a reasonable degree of medical certainty that decedent's August 9, 2018 ablation procedure was indicated and decedent was informed of the risks, benefits and alternatives to the procedure before providing informed consent.

Dr. Liu opined Dr. Epstein's care and treatment rendered to decedent during the July 2, 2018 office visit was within the standard of care. Dr. Epstein appropriately discussed various treatment options with decedent upon his referral on July 2, 2018, including rate control with anticoagulation, rhythm control with antiarrhythmics or rhythm control with a catheter ablation. He further opined it was entirely appropriate to offer an ablation procedure to decedent for treatment of his atrial fibrillation after conservation management failed. Dr. Liu noted decedent sought another opinion with Dr. Snow, which was consistent with Dr. Epstein's recommendation for the ablation procedure. Dr. Liu opined decedent was appropriately informed of the risks, benefits and alternatives of the ablation procedure and decedent chose to proceed with the ablation procedure.

Dr. Liu opined within a reasonable degree of medical certainty that defendants' care and treatment rendered to decedent from August 9, 2018 to August 10, 2018 was at all times proper and in accord with good and accepted medical practice, and did not contribute to decedent's injuries. He opined it was within the standard of care for Dr. Epstein to have decedent undergo a transesophageal echocardiogram on August 8<sup>th</sup>, to provide imaging of the heart and surrounding structures prior to the ablation procedure. He noted the medical records indicated decedent's post-operative nosebleed may have been due to the removal of a temperature probe from decedent's nose, but opined it is a known risk of an ablation procedure and can occur in the absence of negligence.

Dr. Liu opined within a reasonable degree of medical certainty that decedent's ablation procedure was performed within the standard of care, and the ablation energy and temperatures recorded for both ablations were within normal limits and within the standard of care. He further opined Dr. Epstein's description of the ablation procedure demonstrated it was properly performed and it was within the standard of care to use a temperature probe in furtherance of reducing the risk of injury to the esophagus during the procedure. Dr. Liu opined the post-operative nosebleed was of little significance at that time as it would have been too early for a fistula to present itself then, and opined decedent was in sinus rhythm following the procedure.

Dr. Liu opined within a reasonable degree of medical certainty that the care and treatment rendered to decedent from August 10, 2018 through September 5, 2018 was in accord with good and accepted medical practice. He opined Dr. Epstein properly performed an exercise stress test on decedent on August 17, 2018, and decedent's signs of shortness of breath and fatigue were not, in and of themselves, signs and symptoms of the development of an atrio-esophageal fistula. Dr. Liu further opined decedent did not have chest pain during the exercise stress test, which demonstrates he was not suffering from an ulcer or fistula at that office visit. He noted Dr. Epstein properly had decedent undergo an interrogation of his loop recorder which revealed decedent was still in sinus rhythm after the successful ablation procedure. Dr. Liu opined within a reasonable degree of medical certainty that Dr. Epstein's care and treatment of decedent at the August 17<sup>th</sup> visit was appropriate and within the standard of care, and decedent did not exhibit any signs or symptoms of a developing atrio-esophageal fistula at that visit.

Dr. Liu opined within a reasonable degree of medical certainty that the care and treatment rendered to decedent at NSUH between September 5, 2018 and September 7, 2018 was at all times within the standard of care. He opined NSUH medical providers had no duty to contact Dr. Epstein, as decedent's complaints in the emergency room were not related to heart or rhythm issues. Dr. Liu opined the care and treatment rendered to decedent by the electrophysiology team was at all times appropriate and within the standard of care, noting while Dr. Epstein was not present in New York, he still remained in contact with the team after decedent's admission. Dr. Liu opined decedent's CT angiogram of the chest did not demonstrate evidence of an atrio-esophageal fistula, and there were no indications the electrophysiology team needed to send decedent for additional testing. Dr. Liu opined the care and treatment of the electrophysiology team was at all times appropriate and within the standard of care, as they properly attempted to ascertain and treat the source of decedent's stroke, and timely ordered a chest CT Angiogram to rule out an atrio-esophageal fistula after the thoracentesis aspirated non-purulent fluid.

Dr. Liu opined within a reasonable degree of medical certainty that the surgical repair of the atrio-esophageal fistula was a complex procedure with a very high mortality rate. He further opined even if decedent had been taken to the operating room to address an atrio-esophageal fistula in the weeks prior to his NSUH admission, there was still a high likelihood he would have passed away as a result of the repair surgery. Dr. Liu opined within a reasonable degree of medical certainty that defendants' care and treatment of decedent was in accordance with good and accepted standards of care, they did not deviate from the standard of care, and none of their actions or inactions were the proximate cause of decedent's injuries and death.

Defendants also present the affirmation of Dr. Mark Silberman in support of their motion. Dr. Silberman affirmed to be a physician licensed to practice in New York who is board certified in Emergency Medicine, Internal Medicine, Critical Care and Pulmonary Medicine. He reviewed the pleadings, deposition transcripts, and decedent's medical records in support of his opinions,

based upon the applicable standard of care and his training and experience. Dr. Silberman opined within a reasonable degree of medical certainty that NSUH staff's treatment of decedent was at all times within good and accepted medical practice and did not deviate from accepted standards of care. He further opined no negligence acts or omissions by NSUH staff were the proximate cause of decedent's injuries. Dr. Silberman further opined Dr. Trinh's treatment of decedent was within good and accepted medical practice, did not deviate from accepted standards of care, and none of his acts or omissions proximately caused decedent's injuries.

Dr. Silberman opined within a reasonable degree of medical certainty that NSUH staff rendered treatment to decedent from July 2, 2018 through September 7, 2018 that was at all times in accordance with accepted standards of medical practice and did not proximately cause or contribute to decedent's injuries. He further opined Dr. Trinh rendered treatment to decedent from July 2, 2018 through September 7, 2018 that was at all times in accordance with accepted standards of medical practice and did not proximately cause or contribute to decedent's injuries. Dr. Silberman opined NSUH staff's post-operative care and treatment was proper and in accordance with good and accepted practice, noting they appropriately and timely evaluated and treated decedent's epistaxis during admission. He opined they properly addressed decedent's complaints of a nosebleed by obtaining an otolaryngology consultation to evaluate the source of bleeding and ordering a dysphagia screen to ensure decedent was able to appropriately swallow post-operatively.

Dr. Silberman opined NSUH staff's care and treatment of decedent in the emergency department was appropriate and in accordance with good and accepted practice and did not contribute to decedent's injuries. He opined NSUH staff appropriately evaluated decedent upon presentation with symptoms of possible sepsis and appropriately reached out to Dr. Goldberg and Dr. Landesberg to discuss decedent's presentation. Dr. Silberman opined Dr. Landesberg properly initiated a workup for complications of pneumonia and recommended further evaluation, consultations and diagnostic studies to evaluate the possibility of a complicated left parapneumonic effusion and/or empyema. He opined the emergency room staff obtained appropriate consults, ordered appropriate testing, and developed an appropriate treatment plan within the standard of care. Dr. Silberman further opined there was no reason for emergency room providers to suspect decedent was suffering from an atrio-esophageal fistula, as there were no complaints suggestive of gastrointestinal bleedings and no symptoms suggestive of air emboli. He further opined NSUH staff did not have to reach out to Dr. Epstein, as decedent did not present to the hospital with complaints related to cardiac arrhythmia. Dr. Silberman further opined NSUH staff properly ordered a CT angiogram on September 5, 2018, which did not demonstrate an atrio-esophageal fistula.

Dr. Silberman opined the decision to perform a thoracentesis drainage procedure on September 6, 2018 was indicated and within the standard of care, as decedent had an infection and

developed stroke symptoms such that septic emboli were high on the differential diagnosis. He further opined the care and treatment rendered to decedent in the medical intensive care unit (MICU) following the thoracentesis was appropriate and within the standard of care, as CT surgery was timely consulted and decedent was appropriately determined not to be a candidate for intervention. He further opined NSUH staff's care and treatment of decedent in MICU was at all times appropriate and within the standard of care, and did not contribute to decedent's injuries.

Dr. Silberman opined Dr. Trinh's evaluation and assessment of decedent was appropriate and within the standard of care. He noted Dr. Trinh was a first year resident and his progress notes and discharge note were co-signed by attending intensivist Dr. Sean Dhar. He opined Dr. Trinh was a resident under the supervision of an attending physician and Dr. Trinh performed appropriate assessments of decedent and entered appropriate orders. Dr. Silberman further opined the directions from the attending did not so greatly deviate from normal practice that Dr. Trinh should have intervened in decedent's care and treatment, as MICU staff's care for decedent was appropriate and within the standard of care.

Defendants submitted an affidavit of merit from Dr. Trinh, in which he affirmed to being a physician licensed to practice medicine in Washington. He affirmed he worked at NSUH during his first year internship/residency and participated in decedent's care on September 6, 2018 through September 7, 2018 during his training. Dr. Trinh affirmed his participation was under the supervision of attending physicians in the medical intensive care unit and all of his actions were under the direction and supervision of attending physicians. He further affirmed that while he had resided in Queens County, he moved to Washington in July 2024 and no longer has a domicile in New York.

Defendants also argue that all claims against defendant Northwell Health, Inc. must be dismissed, as it is a parent corporation that does not provide medical care and treatment to patients. They present the affirmation of Avraham Schwartz, Vice President of Risk Management from Northwell Health to demonstrate it does not provide medical care, nor did it provide medical care to decedent and therefore owes no duty to decedent. Based upon the above, defendants argue summary judgment is warranted. They further argue if summary judgment is granted only as to Dr. Trinh, then venue should be changed to Nassau County as no other parties have connections to Queens County.

Plaintiffs oppose defendants' motion, arguing defendants failed to present a prima facie case, and there are issues of fact that warrant denial of the motion. Plaintiffs present the pleadings, parties' deposition testimony, medical records and two expert affirmations in support of the opposition. Plaintiffs argue defendants failed to present a prima facie entitlement to summary judgment, as they failed to acknowledge NSUH radiologist Dr. Nikhil Goyal overlooked critical CT scan findings that should have raised concerns for a fistula. They further argue plaintiff's

cardiology and electrophysiology experts present conflicting opinions that warrant denial of defendants' summary judgment motion. Plaintiffs further argue defendants present no evidence to justify a transfer of venue to Nassau County and their motion to change venue should be denied.

Plaintiffs present an affirmation from a physician licensed in Georgia and board certified in internal medicine, cardiovascular disease and clinical cardiac electrophysiology. Plaintiffs' expert reviewed the pleadings, parties' deposition testimony, decedent's medical records and the affirmations of Dr. Christopher Liu, Dr. Harvey Goldberg and Dr. Mark Silberman. Plaintiffs' expert rendered opinions based upon the expert's experience and training. The expert affirmed to be familiar with the applicable standard of care in 2018 and opined Dr. Lawrence Epstein departed from the standard of care in failing to consider the possibility decedent developed a post-ablation atrio-esophageal fistula. Plaintiffs' expert opined Dr. Epstein and Dr. Goldberg failed to order appropriate diagnostic studies following decedent's catheter ablation on August 9, 2018, and the failure to consider that critical diagnosis directly contributed to the fistula being undiagnosed until decedent had a massive stroke and cardiac arrest that ultimately caused his death.

Plaintiffs' expert opined Dr. Epstein departed from the standard of care by failing to consider the diagnosis of an atrio-esophageal fistula during the post-operative period and instead assumed decedent's recurrent symptoms were solely due to aspiration pneumonia. The expert further opined this departure led to a failure to diagnose the fistula in a timely fashion until after decedent had a stroke and cardiac arrest and resulted in his death.

Plaintiffs' expert opined most atrio-esophageal fistulas develop during the first six weeks after atrial fibrillation catheter ablation, with average onset of symptoms at three weeks post-procedure. The expert opined decedent had numerous red flags that should have alerted Dr. Epstein to consider atrio-esophageal fistula. Plaintiffs' expert opined Dr. Epstein departed from the standard of care by failing to document the temperature readings from the esophageal temperature probe placed during decedent's catheter ablation procedure. The expert opined the standard of care required the electrophysiologist to stop ablating in an area when a temperature rise is detected to prevent potential esophageal injury and to document the probe's temperature readings in the patient's medical chart. The expert noted the medical records contains no documentation of the esophageal temperatures during the procedure, and opined the lack of documentation made it impossible to determine whether Dr. Epstein was actively monitoring the probe or utilizing the information it provided, and is inconsistent with the standard of care.

Plaintiffs' expert disagreed with defendants' expert Dr. Harvey Goldberg, and opined normal hemoglobin and hematocrit levels on September 1, 2018 did not rule out a serious underlying condition or active bleeding. The expert notes decedent's levels were essentially unchanged during the hospital admission when decedent was diagnosed with an atrio-esophageal fistula, and normal levels do not obviate the need for appropriate investigation.

Plaintiffs' expert opined Dr. Epstein failed to consider or rule out an atrio-esophageal fistula on September 5, 2018 despite clear indications that warranted its inclusion in a differential diagnosis. The expert opined decedent's sudden recurrence of high fever on September 5<sup>th</sup>, accompanied by gastrointestinal bleeding and persistent symptoms despite antibiotics was a red flag for an atrio-esophageal fistula in a patient four weeks post-procedure. Plaintiffs' expert further opined even if Dr. Epstein was unaware of the GI bleed, Dr. Epstein was aware that decedent had recently experienced extreme fatigue, shortness of breath and recurrent fever. The expert further opined after being informed of decedent's fever, Dr. Epstein focused on a pulmonary vein stenosis and instead should have also included atrio-esophageal fistula in his differential diagnosis, as decedent's symptoms were far more consistent with atrio-esophageal fistula than pulmonary vein stenosis. Plaintiffs' expert further opined Dr. Epstein's failure to recognize the possibility of an atrio-esophageal fistula and notify the emergency medicine team delayed diagnosis and treatment, and constituted a departure from the standard of care.

Plaintiffs' expert disagreed with defendants' expert Dr. Harvey Goldberg's opinion that the fistula was not present during Dr. Steven Goldberg's treatment of decedent or when decedent presented to the emergency room on September 5, 2018. The expert opined fistulas develop over time, and decedent's clinical course demonstrated the progression of an undiagnosed and untreated atrio-esophageal fistula. Plaintiffs' expert noted decedent's blood culture on September 5<sup>th</sup> was positive for gram-negative rods, which is consistent with the present of a fistula at the time of presentment to the emergency room and not consistent with developing between September 5<sup>th</sup> and September 6<sup>th</sup>. The expert opined there was no justification for failing to consider or rule out an atrio-esophageal fistula in decedent based upon his symptoms within a month of undergoing a catheter-based atrial fibrillation ablation. Plaintiffs' expert further opined Dr. Epstein's failure to consider this life-threatening condition and order appropriate imaging was a departure from the standard of care, and prevented timely intervention and proximately caused decedent's injuries and death.

Plaintiffs also presented the affirmation of a physician licensed in New York and board certified in Diagnostic Radiology. Plaintiffs' expert affirmed to being familiar with the standard of radiological care in 2018 and rendered opinions based upon the expert's experience, education and a review of the pleadings, deposition testimony and medical records. Plaintiffs' expert reviewed decedent's CT angiogram performed on September 5, 2018, and confirmed the presence of mediastinal air. The expert opined mediastinal air represents an emergent medical concern and the standard of care requires it must be identified and immediately conveyed to the referring doctor. Plaintiffs' expert further opined radiologist Dr. Nikal Goyal departed from the standard of care in failing to identify and convey to the referring doctor the presence of free mediastinal air, resulting in a delay in the eventual diagnosis of an atrio-esophageal fistula. The expert further opined Dr. Goyal was not provided with an appropriate clinical history which contributed to decedent's

misdiagnosis. Plaintiffs' expert further opined had Dr. Goyal been given an appropriate and thorough clinical history, including information about the recent catheter ablation and possible atrio-esophageal fistula, Dr. Goyal would have spent more time and attention focused on CT findings associated with complications from esophageal rupture, including the presence of free mediastinal air. Plaintiffs' expert further opined Dr. Goyal would have been substantially more likely to identify the mediastinal air, recognize its significance and report it, and the failure to provide an adequate clinical history to Dr. Goyal was a substantial contributing factor in the missed diagnosis on September 5, 2018. Based upon the above, plaintiffs argue there are conflicting expert opinions that warrant denial of the motion.

Pursuant to CPLR §3212, a motion for summary judgment "shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party." (*Smith v. City of New York*, 210 A.D.3d 53, 68 [2d Dept. 2022].) The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact. (*Morejon v. New York City Tr. Auth.*, 216 A.D.3d 134, 136 [2d Dept. 2023].) If there is any doubt as to the existence of a triable issue of fact, the motion must be denied. (*Id.*) The failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposition papers. (*Winegrad v. N.Y. Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 [1985]; *see also Antonyuk v. Brightwater Towers Condo Homeowners' Assn., Inc.*, 147 A.D.3d 711, 712 [2d Dept. 2017].) In determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party, and all reasonable inferences must be resolved in favor of the nonmoving party. (*Matter of New York City Asbestos Litig.*, 33 N.Y.3d 20, 25 [2019].) Additionally, the court's function in determining a motion for summary judgment is not to resolve issues of fact or determine matters of credibility, but merely to determine whether such issues exist. (*Reyes v. S. Nicolio & Sons Realty Corp.*, 212 A.D.3d 851, 852-853 [2d Dept. 2023].) Once the moving party has demonstrated a prima facie entitlement to summary judgment, the burden then shifts to the non-moving party to demonstrate the existence of material issues of fact. (*See generally Coscia v. Mosca*, 203 A.D.3d 695 [2d Dept. 2022].)

In moving for summary judgment in a medical malpractice action, the defendant must establish a prima facie case that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby, and the plaintiff in opposition must submit evidentiary facts or materials to demonstrate the existence of a triable issue of fact. (*Stukas v. Streiter*, 83 A.D.3d 18, 24 [2d Dept. 2011].) In presenting opposition to raise a triable issue of fact, the plaintiff is required to provide an affidavit of merit by a medical expert, and the failure to submit an affidavit by a medical expert competent to attest to the meritorious nature of the plaintiff's claims requires dismissal of the Complaint. (*Id.* at 28.) Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. (*Buch v. Tenner*,

204 A.D.3d 635, 638 [2d Dept. 2022].) In general, a hospital may be vicariously liable for the negligence or malpractice of its employees acting within the scope of employment under the doctrine of *respondeat superior*. (See *Valerio v. Liberty Behavioral Mgt. Corp.*, 188 A.D.3d 948 [2d Dept. 2020].)

In an action to recover damages for wrongful death, the decedent's personal representative must establish that the defendant's wrongful act, neglect or default caused the decedent's death. (*Eberts v. Makarczuk*, 52 A.D.3d 772, 772-773 [2d Dept. 2008].)

To establish a cause of action to recover damages based upon lack of informed consent, a plaintiff must prove "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury." (*Gilmore v. Mihail*, 174 A.D.3d 686, 688 [2d Dept. 2019].)

In general, a hospital may be vicariously liable for the negligence or malpractice of its employees acting within the scope of employment under the doctrine of *respondeat superior*. (*Valerio v. Liberty Behavioral Mgt. Corp.*, 188 A.D.3d 948 [2d Dept. 2020].) However, a parent corporation will not be held liable for the torts or obligations of a subsidiary unless it can be shown that the parent exercised complete dominion and control over the subsidiary. (*Potash v. Port Auth.*, 279 A.D.2d 562, 562 [2d Dept. 2001].) A medical resident cannot be held liable for malpractice for assisting a doctor during a medical procedure, if the resident does not exercise any independent medical judgment and so long as the supervising doctor's directions did not greatly deviate from normal practice that the resident should be liable for failure to intervene. (*Quille v. New York City Health & Hosp. Corp.*, 152 A.D.3d 808, 809 [2d Dept. 2017].)

Defendants established a prima facie entitlement to summary judgment for Dr. Trinh through the medical records, deposition testimony, affidavit of merit and expert affirmations. (See *Soto v. Andaz*, 8 A.D.3d 470 [2d Dept. 2004].) Defendants established Dr. Trinh rendered care and treatment to decedent in his capacity as a first-year resident/intern who was supervised by attending physicians and exercised no independent judgment. Plaintiffs did not oppose this portion of defendants' motion, and therefore summary judgment is warranted as to Dr. Minh Trinh.

Defendants also established a prima facie entitlement to summary judgment as to plaintiffs' claims for lack of informed consent through the deposition testimony, medical records and expert affirmations. As plaintiffs did not oppose this portion of the motion, summary judgment is warranted as to plaintiffs' claims for lack of informed consent.

Defendants established a prima facie entitlement to summary judgment as to Northwell Health, Inc., through the medical records and affidavit of Avraham Schwartz. They established Northwell is a parent corporation that does not provide medical care and treatment to patients. Plaintiffs failed to raise a triable issue of fact in dispute, as plaintiffs failed to demonstrate a duty owed by defendant Northwell, or that it provided medical care and treatment to decedent. Therefore, summary judgment is warranted as to defendant Northwell Health, Inc.

Defendants established a prima facie entitlement to summary judgment through production of the documentary evidence and affirmations of Dr. Liu and Dr. Silberman, that they rendered care and treatment in accordance with good and accepted standards of care and did not proximately cause or contribute to decedent's injuries and death. They established Dr. Epstein rendered appropriate care and treatment to decedent during the catheter ablation procedure and subsequently on July 2, 2018, August 17, 2018 and August 20, 2018 through September 7, 2018 and none of his actions or inactions proximately caused decedent's injuries. Defendants established NSUH staff appropriately cared and treated decedent upon admission, performed appropriate evaluations, communicated with Dr. Epstein and Dr. Goldberg, and appropriately ordered further testing and consultations, and none of their actions or inactions were the proximate cause of decedent's injuries. They further established through the above evidence that there were no delays in obtaining an electrophysiology consultation during decedent's hospital admission, the care provided in the MICU was appropriate and within the standard of care, and NSUH providers appropriately performed a thoracentesis on September 6, 2018. Defendants further established none of their actions or inactions proximately caused decedent's injuries and death. Based upon the foregoing, defendants demonstrated a prima facie entitlement to summary judgment.

Plaintiffs failed to raise triable issues of fact with regard to NSUH staff, who appropriately and properly treated decedent during admission. Plaintiffs' experts presented conclusory and vague opinions and failed to articulate the standard of care applicable to NSUH staff that was not met in providing treatment to decedent. They failed to raise issues of fact as to departures by NSUH staff both during emergency admission and in MICU, and failed to demonstrate any negligent actions or inactions were a proximate cause of decedent's injuries. They further failed to present sufficient evidence that Dr. Nikhil Goyal overlooked critical CT scan findings that should have raised concerns for a fistula, as plaintiffs' expert opinions are vague, conclusory, and insufficient to demonstrate any negligent acts that proximately caused decedent's injuries and death.

However, plaintiffs raised triable issues of fact with regard to whether Dr. Epstein departed from the standard of care in failing to consider an atrio-esophageal fistula in the differential diagnosis on September 5, 2018, and whether this departure was a proximate cause of decedent's injuries and death. Defendants' argument that plaintiffs' expert is not qualified to render opinions is without merit. Defendants' argument that plaintiffs' expert opinions were outside the Bill of


Particulars is without merit. Plaintiffs' expert sufficiently addressed defendants' experts' opinions and raised issues of fact as to whether defendants departed from the standard of care in failing to diagnose and treat decedent for an atrio-esophageal fistula on and after September 5, 2018. Plaintiffs' expert sufficiently raised issues of fact whether decedent's symptoms on September 5, 2018 warranted further investigation as to whether decedent had a post-ablation atrio-esophageal fistula, and whether Dr. Epstein departed from the applicable standard of care in treating decedent that proximately caused decedent's injuries and death. As the parties presented conflicting medical expert opinions that can only be resolved by a jury, summary judgment is not warranted. (*See Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902 [2d Dept. 2017].) However, plaintiffs' experts failed to raise issues of fact as to whether Dr. Epstein properly monitored decedent's temperature and utilized the temperature probe during the ablation procedure, and those claims are dismissed.

Defendants' motion to change venue is denied, as defendants failed to demonstrate compliance with CPLR §510(3) and CPLR §511, either by serving a proper Notice to Change Venue or by presenting evidence of prospective witnesses who would be inconvenienced if venue was not changed.

Accordingly, defendants Laurence Epstein, M.D., Minh Trinh, M.D., Northwell Health, Inc., North Shore University Hospital and North Shore University Hospital s/h/a Northwell Health Physician Partners' motion for summary judgment and dismissal of plaintiffs' Complaint pursuant to CPLR §3212 is granted as to Minh Trinh, M.D., Northwell Health, Inc. and North Shore University Hospital and North Shore University Hospital s/h/a Northwell Health Physician Partners, but denied as to Laurence Epstein, M.D. The parties are directed to appear for a pretrial conference on Wednesday, July 16, 2025 at 9:30am in Courtroom 48.

This constitutes the decision and Order of the Court.

Dated: April 25, 2025



Hon. Tracy Catapano-Fox, J.S.C.

