

Marshall v Bogal

2026 NY Slip Op 31359(U)

April 2, 2026

Supreme Court, New York County

Docket Number: Index No. 805034/2023

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY**

PRESENT: HON. JOHN J. KELLEY PART 56M

Justice

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JEFFREY MARSHALL and DEBORAH MARSHALL,

Plaintiffs,

- v -

MONIKA BOGAL, JEFFREY S. LEITMAN, RYAN
HOLSTEAD, PARK AVENUE MEDICAL PROFESSIONALS,
P.C., and NEW YORK CANCER & BLOOD SPECIALISTS,

Defendants.

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INDEX NO. 805034/2023

MOTION DATE 01/30/2026
01/30/2026

MOTION SEQ. NO. 001, 002

**DECISION + ORDER ON
MOTION**

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were read on this motion to/for JUDGMENT - SUMMARY.

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were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and loss of spousal consortium, the defendants New York Cancer & Blood Specialists (NYCB) and Ryan Holstead (together the NYCB defendants) move pursuant to CPLR 3212 for summary judgment dismissing the amended complaint insofar as asserted against them (MOT SEQ 001). The plaintiffs oppose that motion. The defendants Park Avenue Medical Professionals, P.C. (PAMP), and Jeffrey S. Leitman (together the PAMP defendants) separately move for summary judgment dismissing the amended complaint insofar as asserted against them (MOT SEQ 002). The plaintiffs oppose that motion as well. The defendant Monika Bogal, in papers incorrectly denominated as a cross motion, separately moves under Motion Sequence 002 for summary judgment dismissing the amended complaint

insofar as asserted against her. The plaintiffs oppose that motion as well. The NYCB defendants' motion, the PAMP defendants' motion, and Bogal's motion are each granted only to the extent that they are awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against each of them as was premised upon their alleged failures to refer the plaintiff Jeffrey Marshall (the patient) to another cardiologist for further workup and evaluation and their alleged failures to take an appropriate medical history of the patient. The motions are otherwise denied.

As set forth in their amended complaint, the gravamen of the plaintiffs' claims against the defendant oncologist Holstead is that, on June 8, 2022, in the course of his employment for NYCB, he negligently treated the patient, while the crux of the plaintiffs' claims against the defendant internist Leitman is that, on May 26, 2022, in the course of his employment with PAMP, he negligently treated the patient. The plaintiffs' claims against the defendant cardiologist Bogal, who is a shareholder in PAMP, arise from her alleged negligence during May and June 2022 in consulting with other physicians in connection with their treatment of the patient. The plaintiffs asserted in the amended complaint that this malpractice caused or contributed to the aggravation and exacerbation of the patient's bacterial endocarditis, resulting in further injuries, including a stroke and neurologic deficit.

In their respective bills of particulars as to the two NYCB defendants, the plaintiffs alleged that those defendants departed from good and accepted practice by negligently failing to refer the patient to an infectious disease specialist in a timely or emergent fashion, in failing to appreciate the significance and the potential of an infectious etiology of an enlarged spleen, and in failing to appreciate the significance of initial and repeat abnormal laboratory findings. They further faulted the NYCB defendants for failing to perform an adequate physical examination of the patient, for failing to appreciate the significance of the patient's cardiac history, and for failing to perform a proper and timely diagnostic evaluation that included infectious and "sinister" processes high in the differential diagnosis, rather than excluding them altogether from the

diagnosis. They averred that these failures led to the NYCB defendants' additional departure from good practice in allowing an infectious process to go untreated.

In their respective bills of particulars as to the two PAMP defendants, the plaintiffs alleged that those defendants departed from good and accepted practice by failing to refer the patient to a cardiologist in a timely, urgent, or emergent fashion, and in failing timely, urgently, or emergently to advise the patient that he should be examined by a cardiologist, or to refer him to a cardiologist, including Bogal, who worked for PAMP. The plaintiffs further asserted that the PAMP defendants negligently failed to recommend, to Bogal, that she should perform an examination and evaluation of the patient. As with their claims against the NYCB defendants, they faulted the PAMP defendants for negligently failing to refer the patient to an infectious disease specialist in a timely or emergent fashion, in failing to appreciate the significance and the potential of an infectious etiology of an enlarged spleen, and in failing to appreciate the significance of initial and repeat abnormal laboratory findings. In this respect, they claimed that the PAMP defendants departed from good and accepted practice in failing to recommend or perform additional appropriate diagnostic and laboratory testing. Similarly, they averred that the PAMP defendants were negligent in failing to perform an adequate physical examination of the patient, in failing to appreciate the significance of the patient's cardiac history, and in failing to perform a proper and timely diagnostic evaluation that included infectious and "sinister" processes high in the differential diagnosis, rather than excluding them from the diagnosis.

In the plaintiffs' bill of particulars addressed to Bogal, they asserted that Bogal committed malpractice by failing to recommend or schedule an in-office evaluation of the patient, in failing to take a medical history from the patient or to examine him, and in failing to recommend or perform appropriate diagnostic testing, including an echocardiogram and a blood culture. As with the other defendants, the plaintiffs alleged that Bogal departed from good and accepted practice in failing to refer the patient to an infectious disease specialist in a timely or emergent fashion, in failing to appreciate the significance and the potential of an infectious

etiology of an enlarged spleen, and in failing to appreciate the significance of initial and repeat abnormal laboratory findings, as well as in failing to perform a proper and timely diagnostic evaluation that included infectious and “sinister” processes high in the differential diagnosis, rather than excluding them altogether from the diagnosis. They contended that Bogal’s malpractice in this regard caused the patient to forego timely treatment of an infection.

In all five of their bills of particulars, the plaintiffs contended that, as a consequence of the several defendants’ malpractice, the patient suffered from bacteremia and the aggravation and exacerbation of bacterial endocarditis affecting, among other things, his mitral valve, specifically causing “vegetation” to develop on the mitral valve and severe mitral regurgitation. They asserted that the patient thus was compelled to undergo mitral valve replacement surgery that employed a bovine valve, necessitating the placement of a peripherally inserted central catheter, and causing him to sustain a mycotic aneurysm of the middle cerebral artery, and an acute embolic, ischemic, and cardiogenic stroke, involving a right parietal hemorrhage. The plaintiffs also asserted that, in order for the patient to be properly treated for these conditions, he was hospitalized from June 25, 2022 through July 21, 2022, from August 19, 2022 through August 21, 2022, from August 21, 2022 through September 4, 2022, and from September 4, 2022 through September 13, 2022, with rehabilitation services provided from July 21, 2022 through August 12, 2022 and from September 4, 2022 through September 13, 2022. In addition, the plaintiffs alleged that, consequently, the patient underwent intervention in the nature of coil embolization which, along with all of the other medical conditions that the plaintiffs described, left him with recurrent left-sided weakness/hemiparesis, aphasia, altered mental status, facial droop, dysarthria, sensory deficits, left-sided “extinction,” left upper extremity drift, perseveration, discitis/osteomyelitis at the L4/L5 level of his spine, as well as recurrent tonic-clonic seizure activity and non-convulsive status epilepticus that requires him to take anti-seizure medication. They further claimed that, after the procedures and conditions that the patient sustained, there were changes on imaging of the structure of his brain.

In the first instance, Bogal's application was not a proper cross motion because it did not seek relief against a moving party; instead, her application was, in effect, a separate motion seeking relief against a nonmoving party (see CPLR 2215; *Asiedu v Lieberman*, 142 AD3d 858, 858 [1st Dept 2016]; *Kershaw v Hospital for Special Surgery*, 114 AD3d 75, 88 [1st Dept 2013]; *Guzetti v City of New York*, 32 AD3d 234 [1st Dept 2006]; *Gaines v Shell-Mar Foods, Inc.*, 21 AD3d 986 [2d Dept 2005]; *Sheehan v Marshall*, 9 AD3d 403, 404 [2d Dept 2004]; *Mango v Long Is. Jewish-Hillside Med. Ctr.*, 123 AD3d 843, 844 [2d Dept 1986]; *Lucheux v William Macklowe Co., LLC*, 2017 NY Slip Op 31044[U], 2017 NY Misc LEXIS 187 [Sup Ct, N.Y. County, May 11, 2017]). CPLR 2214(b) requires such a separate motion to be made on at least eight days' notice. The mislabeling of a motion as a cross motion, however, may be treated as a "technical" defect to be disregarded, particularly where the nonmoving party does not object, and the consideration of the application results in no prejudice to the nonmoving party (see *Sheehan v Marshall*, 9 AD3d at 404), and where, as here, the party making the separate motion made its application more than eight days prior to the return date, thus giving the plaintiffs ample opportunity to be heard on the merits (see *Daramboukas v Samlidis*, 84 AD3d 719, 721 [2d Dept 2011]; *Matter of Jordan v City of New York*, 38 AD3d 336, 338 [1st Dept 2007]; *Della-Mura v White Plains Hosp. Med. Ctr.*, 2022 NY Slip Op 31085[U], *3, 2022 NY Misc LEXIS 1697, *3-4 [Sup Ct, N.Y. County, Mar. 31, 2022] [Kelley, J.]). Thus, Bogal's "cross motion" may be considered as a properly noticed separate motion (see *Matter of Jordan v City of New York*, 38 AD3d at 338).

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*, 44 NY3d 57, 62-63 [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-Sturup 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]; see generally *Kristie M. v Mercy Hosp. of Buffalo*, 240 AD3d 1228 [4th Dept 2025]; *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]; *Jones v Ricciardelli*, 40 AD3d 935, 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]; see also *Kristal R. v Nichter*, 115 AD3d 409, 411-412 [1st Dept 2014]; *Bacani v Rosenberg*, 74 AD3d 500, 501-502 [1st Dept 2010]). 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).

In support of their motion, the NYCB defendants submitted the pleadings, relevant bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, a memorandum of law, an attorney's affirmation, and the affirmation of board-certified internist and medical oncologist Michael Grossbard, M.D. In support of their motion, the PAMP defendants relied on and submitted many of the same documents that the NYCB defendants had submitted, and they also submitted the bills of particulars addressed to them, additional medical and hospital records, an attorney's affirmation, a statement of allegedly undisputed material facts, and the affirmations of board-certified internist Brian Feingold, M.D., and board-certified internist and infectious disease specialist Alan A. Pollock, M.D. In support of her motion, Bogal relied on the submissions of her codefendants, including Dr. Pollock's affirmation, and she separately submitted the bills of particulars addressed to her, an attorney's affirmation, and a statement of allegedly undisputed material facts.

In his affirmation, Dr. Grossbard opined that the NYCB defendants did not depart from good and accepted practice, and that nothing that they did or did not do caused or contributed to any of the injuries that the plaintiffs claim were suffered by the patient. He first reviewed the patient's medical history, noting that family-medicine practitioner Leitman had been the patient's primary care physician for several years prior to 2022, and had diagnosed and/or treated the patient for hypertension, mitral valve prolapse, mitral valve regurgitation, heart palpitations, tachycardia, atrial fibrillation, and a heart murmur associated with the mitral valve prolapse. According to Dr. Grossbard's review of the patient's records, as of 2022, the patient was taking a blood thinner, a statin to reduce cholesterol, and blood pressure medications. In connection with the patient's cardiovascular conditions, Dr. Grossbard further noted that Bogal was treating the patient during the same period of time. As Dr. Grossbard described it, the patient was then experiencing a moderate heart murmur, the intensity of which was generally classified on physical examination as a level 2 on a scale of 6, although he noted that, at the patient's January 2022 visit with Bogal, it was a level 3 out of 6.

Dr. Grossbard asserted that the patient's daughter saw him a few times each week between January 1, 2022 and May 6, 2022, reported that the patient had not made any physical complaints, and did not observe any cough, fatigue, anxiety, or change in weight. He stated that a May 12, 2022 computed tomography (CT) scan of the patient's chest revealed enlarged mediastinal lymph nodes that were similar in size to the images depicted on a January 2020 CT scan, albeit reflecting increasing bilateral subpleural reticular and hazy opacities. According to Dr. Grossbard, the differential diagnosis for the pulmonary findings included interstitial lung disease, while the May 12, 2022 scan also revealed coronary artery calcification and splenomegaly. At about this time, the patient purportedly alerted his wife that he was having difficulty concentrating, and that he did not "feel like himself," after which he made an appointment to see Leitman on May 26, 2022. Dr. Grossbard asserted that Leitman and Bogal consulted with each other before the patient's scheduled May 26, 2022 visit with Leitman. He stated that, after that consultation, Leitman advised the patient that the radiologist who initially reviewed the CT scan saw signs of interstitial lung disease, and told the patient that a number of different causes can produce such scarring. Dr. Grossbard stated that plans were made for the patient to consult with pulmonologist Robert J. Kaner, M.D., but that the appointment was scheduled for September 2022. According to Dr. Grossbard, at the May 26, 2022 appointment, Leitman advised the patient to see a hematologist, after which the patient met on June 8, 2022 with Holstead for an assessment of whether the patient had a blood disorder or cancer.

Dr. Grossbard described the entry that Leitman made in the patient's chart as indicating that the patient's chief complaints were fatigue, loss of appetite, and a five-pound weight loss in the preceding two weeks, while the patient also asserted that he did not feel "right," was experiencing low energy, was having difficulty concentrating, and was suffering from a "little" cough. The note further indicated that the patient's stools were a bit softer than usual, but that the patient had no blood or melanoma in his stool and no dysuria, although his frequency of overnight urination increased from zero to one times per night to one to two times per night.

Moreover, although the patient had denied experiencing pain in any part of his body, the note indicated that he complained of a change in appetite, change in weight, malaise, fatigue, and the presence some anxiety. According to Leitman's note, other than a cardiac murmur, a physical examination of the patient was within normal limits. Leitman diagnosed the patient with hypertension, hyperlipidemia, insomnia, solitary pulmonary nodule, pulmonary fibrosis, other fatigue, anorexia, abnormal weight loss, unspecified cough, other unspecified anxiety disorders, and other nonspecific abnormal findings of lung field, but did not, at that juncture determine the etiology of the insomnia, weight loss, fatigue, anorexia, abnormal weight loss, or cough. Leitman developed a plan to obtain the results of blood laboratory testing on the following day, and directed the patient to remain well hydrated. Leitman also planned to confer with Bogal with respect to cardiac issues, and possible side effects of the medications that the patient was then being administered, as well as to call Dr. Kaner if the patient needed an appointment before September 2022.

According to Dr. Grossbard, blood tests revealed that the patient was experiencing elevated levels of C-reactive protein (noncardiac), C-reactive protein (high-sensitivity cardiac), blood urea nitrogen (BUN), creatinine, and total bilirubin, as well as an elevated neutrophil percentage, absolute neutrophil count, and white blood cell (WBC) count, along with a depressed glomerular filtration rate, lymphocyte percentage, mean corpuscular hemoglobin concentration, and red blood cell (RBC) count, and depressed levels of low density lipid cholesterol and hemoglobin. The results showed that the patient's hematocrit level was normal, as was the absolute count of lymphocytes, monocytes, eosinophils, and basophils. Dr. Grossbard explained that, based on a mildly elevated A1C count, there was evidence that the patient was suffering from a pre-diabetic condition such as insulin resistance. As Dr. Grossbard described it, after Leitman reviewed the results of the blood testing, the latter communicated with Bogal to review and discuss the results of that testing and the May 26, 2022 office visit. Dr. Grossbard averred that, in light of the patient's signs and symptoms, as well as the blood test

results and diagnostic imaging, both Leitman and Bogal included bacterial endocarditis in their differential diagnosis, but that “neither physician believed that it was high on the differential diagnosis,” and, accordingly, did not suggest, recommend, or arrange for a consultation with an infectious disease specialist, an in-person cardiac evaluation, an emergency room visit, or the performance of blood cultures, a transthoracic echocardiogram (TTE), or a transesophageal echocardiogram (TEE), even though Leitman noted that the patient’s spleen was “borderline” enlarged as of May 26, 2022. In this respect, given the testing and examination results, and the absence of lymphadenopathy, Grossbard explained that both Leitman and Bogal were considering a diagnosis of sarcoidosis, although both were aware that there was an ongoing inflammatory process that could have indicated a bacterial infection and bacterial endocarditis. Nonetheless, he asserted that the patient’s various complaints, examination findings, and the results of diagnostic testing were deemed to be nonspecific, and could have occurred in a multitude of conditions that did not involve an infectious process. In fact, Leitman wrote in the patient’s chart that, based on the patient’s own medical history and his family’s history of numerous cancers, Leitman’s primary concern was a malignancy, which would include a blood cancer or cancer somewhere else in the body.

As Dr. Grossbard interpreted the deposition transcripts in this action, Bogal testified that she never spoke with Holstead, although there were in-person communications with, as well as emails and texts exchanged between, Bogal and Leitman concerning the patient between May 26, 2022 and June 1, 2022.

Dr. Grossbard explained that Bogal had suggested that the patient undergo a CT scan of his abdomen and pelvis, and see a hematologist for a bone marrow biopsy. The patient did, in fact, undergo a follow-up abdominal CT scan on May 31, 2022, which Dr. Grossbard characterized as negative for any type of abdominal or pelvic nodes, lymphoma, liver disease, pancreatic disease, or malignancy, although it revealed a mildly enlarged spleen. At that point, Bogal purportedly deemed bacterial endocarditis to be low on the differential diagnosis because

the patient evinced no fever, congestive heart failure, Osler nodes, Janeway lesions, or petechiae and, consequently, she determined that that blood cultures, a TEE, or a TTE were unwarranted. She apparently reported that congestive heart failure is a primary presenting sign of endocarditis in 40% of patients, and that fever was the most common presenting symptom in subacute endocarditis, both of which were absent from the results of the patient's diagnostic testing. Leitman testified that he had the requisite medical knowledge and experience to develop a differential diagnosis that included infectious/bacterial endocarditis and act on that differential, if necessary, but that he had little to no suspicion of the presence of an infectious process since the patient's symptoms were nonspecific, while a patient suffering from bacterial endocarditis typically would present with a fever, chills, sweats, and shortness of breath, which the patient did not manifest. Dr. Grossbard asserted that the diminution in the patient's WBC count and the evidence of mild anemia were not significant, and that Leitman thus appropriately had little suspicion of infection.

Dr. Grossbard explained that, on June 7, 2022, the patient presented to a hospital emergency room, complaining of severe back pain, which the patient reported as 10 on a scale of 10, and that had begun approximately two weeks earlier. Emergency room personnel suggested that he undergo a magnetic resonance imaging (MRI) scan, which was in fact performed, at Leitman's direction, at Lenox Hill Radiology.

As Dr. Grossbard further explained, Holstead saw the patient on June 8, 2022, which was the patient's only visit with Holstead, and that, although Holstead requested to be provided with the most recent consultation note from the PAMP physicians, along with bloodwork and radiology results from Leitman, Holstead did not receive the consultation note, and only received the scans and diagnostic results. According to Dr. Grossbard, Holstead took a large sample of the patient's blood for testing, and noted that the reason for the PAMP defendants' referral of the patient to Holstead was to assess the reasons for the patient's weight loss and to rule out lymphoma, since the referral mentioned the patient's elevated WBC count, anemia, and

possible lymphoma. Dr. Grossbard asserted that Holstead performed a focused examination based on the imaging, bloodwork, symptoms, signs, and patient complaints, and determined that, if the patient were diagnosed with an oncological disorder, Holstead would treat it, but would otherwise discuss his evaluation with Leitman for the purpose of formulating suggestions for evaluation and treatment. Dr. Grossbard further explained that, inasmuch as Holstead had been informed that the patient had elevated C-reactive protein levels, it was appropriate for Holstead to forego repeat testing for that protein, but that Holstead nonetheless arranged to repeat a complete blood count (CBC) in order to obtain a trend of the patient's WBC count, RBC count, hemoglobin levels, and hematocrit levels.

Although, according to Dr. Grossbard, Holstead was aware that the patient suffered from mitral valve prolapse, and that this condition was a recognized risk factor for bacterial endocarditis, Dr. Grossbard explained that the single hematology consultation that the patient had with Holstead was in connection with a primary complaint of abnormal weight loss, with a secondary complaint of an elevated white blood count, characterized as "unspecified." As Dr. Grossbard framed the issue, the patient was, at the time,

"70 years of age. The doctor reviewed the CT scan of the abdomen/pelvis taken on 05/31/2022, which revealed a mildly enlarged spleen at 13 cm. He also noted the results of the 5/12 CT scan of the chest, which showed enlarged mediastinal lymph nodes, which were stable. The doctor appreciated the patient's bloodwork which was performed at Dr. Leitman's request, including the WBC of 12.2, and the hemoglobin of 11.7. His baseline weight of 168 lbs. was appreciated. He weighted [sic] 160 lbs at the visit note [sic]."

According to Holstead's chart, the patient reported a dry cough, stress, a weight loss of eight pounds, low energy, lethargy, and unclear cogitation, but no fever, rigors, or chills. Holstead reported that, other than a systolic heart murmur, the physical examination of the patient was within normal range, with no evidence of lymphadenopathy or splenomegaly, despite the previous finding of an enlarged spleen, and that pulmonary, abdominal, and musculoskeletal examinations were all within normal limits. Dr. Grossbard asserted that Holstead's chart further reflected that the patient had

“no weakness and a normal range of motion in all four extremities. He had no pain. His E[astern] C[ooperative] O[ncology] G[r]oup performance status scale indicated he was fully active and able to carry on all of his pre-disease performance without restrictions.

“a repeat CBC . . . revealed a WBC that was mildly elevated at 11.5 (normal 4-10.5), a low hemoglobin level of 10.5 (normal 13-17), a low hematocrit level of 33.4 (normal 40-54), a low MCHC at 31.4 (normal 32-36). The granulocyte percentage was elevated at 78.4 (normal 42.2-75.2), the lymphocyte percentage was low at 12.9 (normal 20.5-51.1). Monocyte, basophil, and eosinophil levels were within normal percentage limits. The absolute number of monocytes was elevated at 0.8 (normal 0.1-0.6), and the ANC (absolute neutrophil count) was elevated at 9 (normal 1.5-6.5).”

He noted, however, that the patient had experienced an inflammatory event, but concluded that, with the patient’s increasing activity, it was unlikely to have been a “progressive sinister event,” while blood testing did not reveal any evidence of lymphoma or other cancer. Dr. Grossbard stated that Holstead planned to evaluate the patient for nutritional, metabolic, myeloproliferative, and autoimmune etiologies, and directed the patient to return in three weeks to review the results and repeat the CBC testing to ascertain any trends, and that Holstead told the patient to alert him of any changes. Holstead then forwarded his notes to Leitman and Bogal.

In connection with Holstead’s review of the May 31, 2022 CT scan and the June 7, 2022 lumbar spine MRI scan, Dr. Grossbard averred that Holstead was specifically looking for oncological issues, but detected no masses or space-occupying lesions, while confirming that the patient’s thoracic lymphadenopathy was stable, and that cancer and immune disease testing was negative, thus rendering those conditions “less likely,” albeit not completely ruling them out. In this regard, Dr. Grossbard asserted that Holstead “appreciated” the finding of elevated neutrophils and that the patient’s WBC count remained mildly elevated, but noted that it had slightly improved. According to Dr. Grossbard, the patient’s granulocyte level was high, but slightly decreased from Leitman’s testing, while the lymphocyte percentage was a bit lower than Leitman’s testing, although the absolute number of lymphocytes was actually slightly higher. Dr. Grossbard further noted the patient’s absence of a fever at the visit with Holstead. In light of the

foregoing, Holstead purportedly formed an impression that the patient had been experiencing an inflammatory event that was in the early stages of resolution and recovery, and desired to perform additional blood testing to rule out any other causes, but Dr. Grossbard opined that there was nothing in the test results that warranted a follow-up appointment earlier than three weeks later. He further asserted that, since the patient was afebrile, with no deterioration of physical condition, there was no need for an urgent evaluation at that juncture. According to Dr. Grossbard, Holstead's differential diagnosis included inflammatory disorders/processes, "which includes bacterial infection," but placed bacterial endocarditis low on the differential diagnosis, since "nothing in the testing or the symptomatology" was "definitive" for that condition.

Dr. Grossbard asserted that Leitman and Holstead conferred in connection with the patient's case, at which time Holstead told Leitman that the laboratory results were consistent with an inflammatory response due to a "self-limited" viral infection that was in the process of resolving, and that there was no evidence of cancer, but that if the patient's anemia progressed, a bone marrow biopsy might be warranted. On June 21, 2022, Holstead further told Leitman that the June 7, 2022 MRI scan suggested nothing that could relate the patient's symptoms to any type of cancer. When Holstead next spoke with the patient on June 24, 2022, the patient reported his continuing back pain, and the two discussed the possibility that the patient sustained an accident while exercising. Approximately one week later, the patient began to slur his words, had a slight facial droop and had difficulty writing, and was taken by ambulance to a hospital, where he was diagnosed with a stroke. According to Dr. Grossbard, subsequent testing revealed that the stroke was caused by an "embolic event from a vegetation breaking off his mitral valve."

Dr. Grossbard opined that, based on his understanding of the patient's medical history, as described above, Holstead performed an adequate and thorough physical examination of the patient, and made a timely and proper diagnostic evaluation. He concluded that Holstead obtained all relevant and appropriate clinical information. Specifically, he noted that Holstead

had alerted Leitman, the patient's primary care physician, that there was no evidence of lymphoma, other cancers, or neoplasm in any test results, and properly excluded those conditions as etiologies of the patient's complaints. Since this information was "timely" conveyed to Leitman, he concluded that there was no merit to the plaintiffs' contention that the NYCB defendants failed to advise Leitman of the absence of these diseases. Dr. Grossbard further asserted that the patient's various complaints, signs, symptoms, and findings, as well as the results of diagnostic imaging and bloodwork, were "nonspecific," and that such complaints, signs, symptoms, and findings appeared in connection with dozens of medical conditions. With respect to bacterial endocarditis, Dr. Grossbard asserted that patient did not present with characteristic symptoms, such as fever, chills, sweats, fatigue, headache, shortness of breath, chest pain upon respiration, and aching joints and muscles, or even with less common signs such as blood in the urine, tenderness of the left rib cage, painful red, purple, or brown flat spots on the bottom of the feet or the palms of the hands, known as Janway lesions, painful red or purple bumps or patches of darkened skin on the tips of the fingers or toes, known as Osler nodes, and tiny purple, red, or brown spots on the skin, known as petechiae. He explained that, although a cough is also a typical symptom for bacterial endocarditis, and that the patient did indeed present with a cough, he relied upon the patient's own attribution of the cough to seasonal allergies and post-nasal drip. Although Dr. Grossbard conceded that unexplained weight loss was another, albeit less common, sign of bacterial endocarditis, and that the patient did experience such a weight loss, since he did not present with any of the other symptoms, bacterial endocarditis was an unlikely explanation for the patient's complaints, signs, symptoms, and test results. He bolstered this conclusion by explaining that, although endocarditis is often seen in patients who have undergone long-term catheter use, have poor dental health, engage in illegal intravenous drug use, or have had heart devices and artificial heart valves implanted, none of these conditions or situations pertained to the patient.

As Dr. Grossbard phrased it, most importantly, Holstead saw the patient for a hematology consult, involving the limited purpose of ruling out the possibility of a blood disorder or cancer, not to evaluate him for infection, and that Holstead conducted an evaluation that was appropriate for that purpose. Moreover, he noted that, as of June 8, 2022, the patient's WBC count and overall condition were improving, the latter of which was reflected by the fact that the patient had increased his exercise workload and reported that he was feeling "more like himself" two days prior to his visit with Holstead. Dr. Grossbard thus concluded that it was not a departure from the standard of care for Dr. Holstead to have placed bacterial endocarditis very low on the differential diagnosis.

In any event, Dr. Grossbard asserted that the relevant medical records and the defendants' deposition testimony indicated that Holstead, as well as Leitman and Bogal, each included "an infectious process, including bacterial endocarditis," in their differential diagnoses, and that, consequently, Leitman was fully aware that the patient might be suffering from a cardiac-based process and/or infectious process, including bacterial endocarditis. He noted, with approval, that both Leitman and Bogal believed that bacterial endocarditis should be very low on the differential diagnosis, and concurred with their determinations that the patient did not require blood cultures, a TTE, a TEE, an infectious disease consultation, further cardiac consultation, or admission to hospital. Since, according to Dr. Grossbard, Leitman was aware that the patient's condition could have been attributable to bacterial endocarditis, and Holstead specifically advised Leitman that the patient was then experiencing an inflammatory process that might have included a bacterial infection, he expressly rejected the plaintiffs' contention that the NYCB defendants failed to advise Leitman that the plaintiff might have been suffering from an infectious process, including bacterial endocarditis.

Dr. Grossbard explained that, although the patient presented with a mildly enlarged spleen, such a condition can be caused by a number of factors, including a viral, bacterial, or parasitic infectious process, as well as cirrhosis, hepatitis, leukemia, lymphoma, and congestive

heart failure. In this respect, he asserted that there was nothing specific to that condition that would compel a hematologist/oncologist to consider a diagnosis of bacterial endocarditis in the absence of other relevant signs, symptoms, or findings. Inasmuch as the patient did not present with night sweats, fever, pain in the left upper quadrant, or a feeling of satiation soon after eating, Dr. Grossbard concluded that Holstead was not obligated by the standard of care to test for bacterial endocarditis as an etiology of the enlarged spleen. Although he noted that the patient did present with fatigue, which he characterized as another sign of such enlargement, fatigue is a nonspecific finding that is seen in a multitude of illnesses and conditions. In any event, Dr. Grossbard concluded that Holstead appreciated the mildly enlarged spleen, and conveyed to Leitman that the totality of findings strongly suggested an inflammatory process, which could include a bacterial infection. He thus opined that the presence of a mildly enlarged spleen did not warrant “the leap to speculation that the patient might have had bacterial endocarditis at the time of a single visit to a hematologist/oncologist,” and rejected the plaintiffs’ claim that Holstead failed to appreciate the significance of the patient’s enlarged spleen.

Dr. Grossbard concluded that the findings and results of Holstead’s examination and blood testing were not highly suggestive of bacterial endocarditis or any other sinister process or progressive sinister process, and that, as such, Holstead did not deviate from the applicable standard of care when he did not recommend that Leitman or Bogal evaluate the patient for bacterial endocarditis or bacteremia. He rejected the plaintiffs’ contention that the NYCB defendants failed to appreciate the significance of abnormal initial and repeat laboratory findings in connection with blood drawn in May and early June 2022. Nor did he accept the plaintiffs’ contentions that Holstead should have suggested to Leitman that the latter refer the patient to an infectious disease specialist or a cardiologist, particularly because the patient already was seeing Bogal, who was a treating cardiologist involved in patient’s care and the assessment of the patient’s symptoms between May 26, 2022 and June 1, 2022, one week before the patient saw Holstead.

According to Dr. Grossbard, the chance that the patient was suffering from bacterial endocarditis on June 8, 2022 was “so remote that a consulting hematologist/oncologist cannot be charged with failing to recommend the patient be worked up” for that condition by an infectious disease specialist, let alone cardiology consultations, the performance of a TTE or TEE, or the recommendation for, or performance of, blood cultures. He described the plaintiffs’ allegations in this regard as based on mere hindsight, and that Holstead’s alleged failure to refer the patient on an urgent or emergent basis to an infectious disease specialist or cardiologist, or to suggest that Leitman do so, did not depart from the applicable standard of care.

Based on his review of Holstead’s records, Dr. Grossbard further concluded that the former was fully aware of the fact that the patient had mitral valve prolapse and had a murmur as a result of mitral valve regurgitation, as well as the fact that the patient suffered from hypertension. He asserted that Holstead was fully aware of the patient’s extensive medical and family history, including his cardiac history, and nonetheless properly placed bacterial endocarditis very low on the differential diagnosis, even though the patient ultimately was diagnosed with that condition. Dr. Grossbard thus opined that there was no merit to the plaintiffs’ contention that Holstead negligently allowed the infection to worsen. He asserted that it was appropriate for Holstead to arrange for the patient to be seen three weeks later for further bloodwork and examination, and that there was no need for earlier CBC panel testing or other bloodwork, including a blood culture, or for an earlier physical examination.

In his affirmation, which was submitted in support of the PAMP defendants’ motion, Dr. Feingold asserted that Leitman, in evaluating and treating the patient’s condition, acted appropriately and in conformity with the standard of care in relying upon the recommendations of specialists, including a cardiologist, hematologist, and pain management physician. He asserted that the standard of care did not require Leitman personally to recommend or order any further workup, evaluation, or treatment of the patient’s symptoms, beyond that which already had been recommended by the specialists evaluating and treating the patient. More

specifically, Dr. Feingold opined that Leitman did not negligently fail to diagnose and treat the patient for bacterial endocarditis in a timely manner.

Dr. Feingold explained that, when a patient presents to an internist for evaluation or treatment of signs and symptoms of a condition that requires a medical specialist, the standard of care requires that the internist consult with and/or refer the patient to an appropriate specialist for evaluation, diagnosis, and treatment. As such, Dr. Feingold concluded that Leitman's referral to PAMP cardiologist Bogal was appropriate and within the standard of care, as was Leitman's reliance upon Bogal's and Holstead's determination as to what constituted appropriate diagnostic testing and those physicians' evaluations. As he phrased it, the standard of care did not require Leitman to order or recommend any further or additional workups or diagnostic and laboratory testing for the patient's symptoms beyond what Bogal and Holstead recommended, and it "especially" did not require Leitman to reevaluate the patient's symptoms after the specialists ruled out certain etiologies in their own differential diagnoses.

Dr. Feingold reiterated much of the patient's medical history that Dr. Grossbard had described, including the patient's complaints to Leitman on May 26, 2022. He noted that Bogal had been the patient's treating cardiologist for several years prior to that date, and that Bogal had last examined the patient in January 2022, at which time the patient's degree of mitral regurgitation had increased from the previous visit. Dr. Feingold asserted that, at the May 26, 2022 visit, the patient's vital signs and physical examination results were within normal limits, and that the patient did not complain of any fevers and/or chills. According to Dr. Feingold, Leitman's diagnoses included essential hypertension, hyperlipidemia, insomnia, solitary pulmonary nodule, pulmonary fibrosis, fatigue, anorexia, abnormal weight loss, cough, anxiety, and other nonspecific abnormal findings in connection with the lung field, although, at that time, Leitman did not express an opinion as to the etiology of the plaintiff's specific complaints. Dr. Feingold asserted that Leitman appropriately recommended to the patient that the latter keep well hydrated, and properly directed the patient to obtain blood laboratory studies. He further

opined that Leitman properly consulted with Bogal, and opined that Leitman's differential diagnosis at that time was thorough and appropriate.

Dr. Feingold reiterated the results of the May 26, 2022 CBC panel testing that Dr. Grossbard had described, and concluded that, when Leitman, after reviewing the results, emailed Bogal on May 27, 2022, he appropriately asked for her impression, and inquired as to whether the patient's kidney function might be affected by any of the maintenance medications that he then was taking. Dr. Feingold further concluded that Leitman also properly indicated that he was concerned about the patient's abnormal WBC count and hemoglobin values. As Dr. Feingold explained it, Bogal emailed Leitman that evening, asserting that she was "worried" about the patient's "very elevated CRP (C-reactive protein)," and inquired as to whether the patient were febrile, with specific reference to the patient's abnormal WBC count, neutrophil predominance, and sharp drop in cholesterol levels. Dr. Feingold asserted that Bogal expressed her concern that the patient was experiencing an active, ongoing inflammatory process, but conceded that she had "no clues about location based on labs." She reportedly postulated that the patient might then have been suffering from sarcoidosis, but that malignancy was also a concern, upon which she recommended that the patient undergo an abdominal/pelvic CT scan, and that the patient be referred to a hematologist for evaluation and a possible bone marrow biopsy. As explained above, the patient was in fact referred to Holstead, whom he saw 12 days later.

Dr. Feingold opined that Leitman appropriately consulted with Bogal and properly relied on her recommendations. He noted that Bogal never recommended to Leitman that the patient return to see her for a cardiac evaluation, and that the standard of care did not require Leitman to recommend such a follow-up visit with Bogal, particularly because Bogal herself did not recommend such a visit. Dr. Feingold reiterated that the May 31, 2022 imaging identified lung nodules that previously had seen on prior scans, as well as a mildly enlarged spleen, but was otherwise negative. He further concluded that Leitman appropriately and timely arranged for the

patient to be seen by Holstead and that, thus, all of the care rendered by Leitman was appropriate and in accordance with the standard of care. Dr. Feingold additionally opined that it was within the standard of care for Leitman to rely upon Holstead's June 8, 2022 assessment, based both on tests that Leitman had ordered, as well as Holstead's own testing. As Dr. Feingold characterized the issue, Holstead

“acknowledged that the labs that Dr. Leitman had obtained revealed an elevated white blood cell count of 12.2 suggestive of leukocytosis and that there was elevated neutrophils of 74 reflective of granulocytosis but would not characterize that as evidence of a left shift because there was no elevation of any immature granulocytes myeloblasts or other immature cells. In addition, according to the labs that were drawn, when the patient saw Dr. Holstead on June 8 the white blood cell count had now decreased to 11.5 and that improvement taken together with the fact that the patient reported that he was starting to feel better based on his increased activity, Dr. Holstead felt that the patient likely had some type of inflammatory event but was resolving.”

Dr. Feingold also noted that, although the patient had experienced an eight-pound weight loss over the several weeks prior to the June 8, 2022 visit with Holstead, the weight loss had by then stabilized. He stated that Holstead appropriately attributed the weight loss to family stress, in conjunction with the patient's sudden onset of fatigue, leukocytosis, and anemia, and concluded that it was within the standard of care for Holstead to determine that, in light of the patient's test results and presentation, the diagnosis “pointed somewhat away” from a “progressive sinister process” such as cancer.

Dr. Feingold asserted that Leitman also properly relied upon Holstead's determination to decline recommending that the patient be seen by a cardiologist for any additional testing, as well as Bogal's assessment that no cardiology consultation was required since both Holstead and Bogal were “specialists aware of Mr. Marshall's cardiac history.” He also asserted that no referral to any other specialist, such as an infectious disease specialist, was required at that juncture. As germane to the instant motion, Dr. Feingold explained that, inasmuch as there was no clinical indication for Leitman to have suspected that the patient was suffering from bacterial endocarditis, the standard of care did not require Leitman to undertake any further evaluation to

diagnose or treat that condition, nor did it require Leitman to order additional diagnostic studies, including a blood culture. Dr. Feingold asserted that Leitman recommended appropriate symptomatic treatment for patient's symptoms, such as fatigue, loss of appetite, weight loss, low energy, difficulty concentrating, and a small cough. As he framed the issue, "[h]aving referred plaintiff to the appropriate specialists (a cardiologist and a hematologist) for further evaluation, the standard of care simply did not require Dr. Leitman to take any further action to further evaluate and treat these symptoms himself."

Dr. Feingold noted that, although the patient subsequently reported an onset of new back pain on or about June 17, 2022, which he conceded could sometimes be associated with or related to bacterial endocarditis, since the patient reported that the back pain began after exercising, and the back pain improved after the administration of trigger point injection, the severity of the pain did not warrant further investigation because these factors suggested a musculoskeletal etiology rather than bacterial endocarditis.

Dr. Feingold ultimately concluded that nothing that Leitman did or did not so proximately caused or contributed to a delay in the diagnosis and treatment of bacterial endocarditis.

Dr. Pollock essentially reiterated the conclusions reached and the opinions rendered by Dr. Feingold, although he more particularly addressed his opinion to the plaintiffs' allegations that Leitman should have ordered a blood culture and appropriate diagnostic evaluations, and should have referred the patient to an Infectious disease specialist. As did Dr. Feingold, Dr. Pollock concluded that, based on the patient's presenting symptoms on May 26, 2022 and the ensuing laboratory results, Leitman appropriately and timely referred the patient to the correct specialists, and properly determined to forego ordering blood cultures, since there were no indicia of an infectious process. Dr. Pollock further opined that none of the alleged departures by Leitman caused or contributed to the claimed outcome.

Dr. Pollock reiterated Dr. Grossbard's and Dr. Feingold's description of the patient's medical history over the course of his visits with Leitman, Bogal, and Holstead, and explained

that the patient presented with no “classical” features of endocarditis that would have prompted the performance of a blood culture, such as common symptoms including fever, chills, and night sweats, or less common symptoms such as headache, systemic embolic phenomena, focal neurological signs, visual complaints, petechial hemorrhages, Osler nodes, joint swelling, or tenderness. Dr. Pollock agreed with the other defendants’ experts that the patient’s weight loss, anorexia, fatigue, respiratory complaints, and nocturia “were entirely non-specific and consistent with multiple non-infectious diagnoses including neoplastic disease.” Dr. Pollock opined that Leitman acted appropriately and in accordance with the standard of care for a primary care physician by obtaining appropriate laboratory studies, and referring the patient both to the latter’s own cardiologist and hematologist/oncologist Holstead for the evaluation of possible neoplastic disease. He concluded that Leitman’s differential diagnosis was thorough and appropriate, and that the laboratory studies that Leitman did order were appropriate.

Dr. Pollock also recounted the email correspondence between Bogal and Leitman, in which Dr. Pollock asserted that Bogal appropriately expressed her concerns about the patient’s “very elevated CRP,” and inquired if the patient had been experiencing any fever, while also noting the patient’s abnormal WBC with increased neutrophils. Dr. Pollock repeated Dr. Feingold’s explanation that Bogal “felt” that there was some active inflammatory process, but had “no clues about location based on labs,” and that Bogal postulated that the patient’s condition “could be consistent with sarcoidosis” due to an abnormal chest x-ray, but that malignancy was also a concern. He reiterated Bogal’s recommendation that the patient undergo an abdominal and pelvic CT scan, and that the patient be referred to a hematologist, which, in fact, was done. Dr. Pollock asserted that Leitman appropriately consulted with Bogal, and properly relied upon her recommendations for follow-up examinations and testing, and that Leitman’s failure to diagnose an acute bacterial infection did not constitute a departure from the applicable standard of care.

Dr. Pollock explained that the abnormal CBC panel results from blood drawn on May 26, 2022, which showed findings of leukocytosis and anemia, the latter of which could have been a sign of bacterial endocarditis, was outweighed by the fact that these finding were “entirely nonspecific,” and could “easily point to many other conditions, such as a neoplastic systemic disease, e.g., cancer.” He also agreed with Drs. Grossbard and Feingold that the patient’s enlarged spleen, as depicted on the May 31, 2022 CT scan, was a nonspecific finding that may be found in “an extensive variety of infectious diseases,” including endocarditis, but also as a symptom of EBV, HIV, tuberculosis, malaria, toxoplasmosis, and disseminated fungal infections, as well as “innumerable” non-infectious diseases, including auto-immune diseases, leukemias and lymphomas, cirrhosis, hepatitis, rheumatoid arthritis, Felty's syndrome, and congestive heart failure. In concurrence with Dr. Feingold’s opinion, Dr. Pollock explained that, while an enlarged spleen may sometimes suggest an infection, since the patient did not present with fever, chills, or night sweats, such a finding “would clearly point away from an infectious disease diagnosis and, absent the classical features of endocarditis, Dr. Leitman's evaluation as a general practitioner, did not fall below the standard of care.”

Dr. Pollock additionally opined that none of the defendants caused or contributed to any of the patient’s alleged injuries, characterizing any contrary opinion as “purely speculative.” He asserted that the plaintiffs

“will likely argue that had Mr. Marshall been placed on antibiotic therapy before the stroke, a better outcome would have been achieved. However, the literature confirms that even after a diagnosis of endocarditis is established and the patient is treated with antibiotics, many patients will continue to experience systemic emboli even after weeks of treatment. It is my opinion to a reasonable degree of medical certainty that these findings suggests [sic] that having starting antibiotics earlier would not necessarily have prevented the stroke. It is further my opinion that the notion that a correct diagnosis and prompt antibiotic treatment can prevent embolic events is not supported in the literature.”

Dr. Pollock further stated that, to the extent that the plaintiffs’ bills of particulars contained allegations regarding the treatment provided by Leitman “and the staff of Park Avenue beyond those addressed specifically” in his affirmation, neither Leitman nor any other PAMP personnel

departed from accepted standards of care, and that their treatment was not a proximate cause of the injuries that the patient claimed to have sustained.

In support of her motion, Bogal relied on Dr. Pollock's affirmation, and specifically pointed to those of his opinions that had concluded that Bogal took all appropriate steps once the patient was referred back to her after May 26, 2022 and June 8, 2022, and that nothing that she did or did not do caused or contributed to any delay in diagnosing the patient with bacterial endocarditis. She also submitted a statement of allegedly undisputed material facts, her own answer, and the plaintiffs' bills of particulars addressed to her, along with an attorney's affirmation. Bogal's attorney reiterated the salient opinions rendered by Dr. Pollock, and adopted that expert's arguments as to why Bogal neither departed from the standard of care applicable to a patient's regular, treating cardiologist, and that nothing that she did or did not do caused or contributed to the patient's claimed injuries.

In opposition to the NYCB defendants,' the PAMP defendants,' and Bogal's motions, the plaintiffs relied on many of the same documents that those defendants had submitted, and also submitted expert affirmations from a board-certified family medicine physician (hereinafter the family physician), a board-certified internist and hematologist/oncologist (hereinafter the hematologist), a board-certified internist and cardiologist/cardiovascular disease specialist (hereinafter the cardiologist), and a board-certified internist, infectious disease specialist, and medical microbiologist (hereinafter the infectious disease specialist). They also submitted attorneys' affirmations, additional medical records, and a response to the PAMP defendants' and Bogal's statements of material facts.

The plaintiffs' expert family physician recounted the patient's medical history from December 21, 2013 until September 2, 2022, which included all of the individual defendants' examinations and testing, as well as the patient's subsequent diagnosis of bacterial endocarditis, mitral valve replacement surgery, and his stroke. That expert explained that the patient's fatigue, weight loss, and elevated WBC count, with a high percentage of neutrophils,

which was described as a type of white blood cell that fights bacterial infections, as well as a very high CRP level, which was characterized as a nonspecific marker of inflammation, required Leitman to include a disseminated infection, including bacteremia and bacterial endocarditis, high in his differential diagnosis. The family physician asserted that the May 26, 2022 laboratory blood testing showed strong evidence of a disseminated bacterial infection, and further asserted that the patient presented to Leitman with mitral valve regurgitation, which the expert characterized as the “most prevalent risk factor for endocarditis.” The family physician further described as “profoundly upsetting” the answers that Leitman gave during his deposition, which were to the effect that, when presented with a older male patient with a history of moderate mitral regurgitation, unexplained weight loss, loss of appetite, fatigue, malaise, low energy, difficulty concentrating, an elevated blood creatinine level, and an increased WBC count, Leitman could not say whether those signs and symptoms reasonably raised the possibility of infection, and that the standard of care did not require that some infectious process be included somewhere in the differential diagnosis. The expert opined that the standard of care required Leitman to “reasonably exclude a disseminated bacterial infection,” and concluded that Leitman’s failure to do so was a deviation from the standard of care.

As the family physician explained it, bacteremia, which is a bacterial infection of the blood, is an extremely serious and relatively common disseminated bacterial infection, and that endocarditis, a subtype of bacteremia in which infection is present in the interior of the heart, usually the valves, is relatively common in persons with moderate mitral regurgitation. The expert averred that the initial and crucial test employed to exclude bacteremia and endocarditis is a blood culture, which the expert asserted can easily be obtained in an outpatient laboratory. The expert expressly asserted that the standard of care required Leitman to “urgently order a blood culture,” and that Leitman’s failure to do so was a deviation from the standard of care.

The family physician concluded that Leitman’s negligence, as described above, increased the risk of harm to the patient, and made it more likely that the patient would suffer

harm, and that it was likely that, had Leitman ordered a blood culture and referred the patient to an infectious disease specialist, the patient would not have suffered severe mitral valve damage requiring repair, and would not have suffered a stroke. The expert specifically asserted that the patient developed *Streptococcus salivarius-vestibularis* group bacterial endocarditis that caused “vegetation” to appear on and in his mitral valve. This expert further opined that the *Staphylococcus* bacteria ultimately cultured during a June 25, 2022 hospital visit had caused the bacterial endocarditis that had, in fact, already been manifested by the clinical signs and symptoms and laboratory results documented in Leitman’s chart, and that this conclusion was corroborated by blood culture results obtained on June 29, 2022 and TEE results obtained on July 1, 2022, while septic embolization to the patient’s brain was confirmed by further imaging. The family physician further noted that none of the defense experts disputed that the patient developed bacterial endocarditis causing vegetation to appear on or in his mitral valve, or that the patient was not actually experiencing bacterial endocarditis when he presented to Leitman and Holstead, but only that they did not depart from the standard of care by failing to recognize or diagnose that condition.

The family physician further asserted that Leitman’s discussions with Bogal subsequent to the May 26, 2022 visit “did not absolve Dr. Leitman of the responsibility to reasonably exclude bacteremia and endocarditis with blood cultures.” In addition, this expert adverted to Bogal’s deposition testimony, in which the latter conceded that the absence of fever or congestive heart failure did not rule out a diagnosis of bacterial endocarditis at that juncture. The family physician thus expressly disagreed with Dr. Pollock’s opinion in this respect, instead reiterating that, when Leitman received the results of the patient’s laboratory tests following the May 26, 2022 visit, which reflected the presence of a highly elevated CRP level, an elevated WBC count, and a predominance of neutrophils, the standard of care required Leitman to consider and reasonably exclude disseminated infection, particularly bacteremia and bacterial endocarditis. The expert further explicitly disagreed with Dr. Pollock’s opinion that Leitman’s consultation with

Bogal, and Leitman's deference to Bogal's determination to forego further testing, satisfied the applicable standard of care. This expert also expressly rejected Dr. Pollock's opinions that "[h]aving start[ed] antibiotics earlier would not necessarily have prevented the stroke" and that medical literature did not support the conclusion that a "correct diagnosis and prompt antibiotic treatment can prevent embolic events." Rather, the family physician opined that "[a]ll physicians treat persons with bacterial endocarditis with intravenous antibiotics immediately because it is known such treatment decreases death and lessens the chances of complications, including embolic events."

The plaintiff's retained family physician further opined that the standard of care is not satisfied by a family medicine practitioner merely by referring patients to specialists, but, instead, requires a primary care physician to form a reasonable differential diagnosis, and to reasonably exclude the inapplicable diagnoses included therein. Since the expert asserted that infection, bacteremia, and endocarditis all should have been included in a reasonable differential diagnosis, he or she asserted that the consultation with a hematologist/oncologist did nothing to address this aspect of what constituted a reasonable differential diagnosis, nor did the conversation with a cardiologist, which did not even include an examination of the patient.

The family physician asserted that the patient had been suffering from bacterial endocarditis both before and at his presentation to Leitman, and that blood cultures taken "anytime on or after 5/26/2022 would have been positive for the same Staphylococcus bacteria cultured following the hospital admission of 6/25/2022." This expert explained that antimicrobial therapy with the correct antibiotic is the "foundational, standard of care treatment for bacterial endocarditis and surely would have been begun immediately after positive blood culturing," and that the administration of antibiotics tailored to the bacteria substantially decreases the possibility of a stroke. Specifically, the expert opined that, after 72 hours of antibiotic treatment, "it is more likely than not that embolization and resultant stroke and seizures will not occur."

The plaintiffs' retained hematologist opined that Holstead departed from accepted standards of care, and that such departures were a substantial factor in causing the stroke and resultant morbidity evidenced by the patient at New York Presbyterian Hospital (NYPH), and thereafter. This expert further asserted that Holstead's deviations from accepted standards of care deprived the patient of a substantial possibility of a less morbid and permanent outcome, that is, it diminished the patient's chance for a better outcome and increased the severity of the injury that the patient sustained. The hematologist averred that the patient's condition presented "loudly" with fatigue, weight loss, anemia, signs of inflammation, an audible murmur secondary to mitral valve prolapse, and abnormal blood counts---including an elevated WBC count. This expert asserted that, had Holstead provided reasonable care under the circumstances, and been appropriately attentive to the patient's signs and symptoms, Holstead, of necessity, would have made a correct and timely diagnosis of bacterial endocarditis.

The hematologist opined that Holstead departed from the accepted standard of care when, on June 8, 2022, he failed to initiate a plan to carry out urgent blood culturing, by either sending the patient to a laboratory or a hospital emergency department, and "repeated" this failure during the course of his engagement with the patient. The expert concluded that this departure was a substantial factor in allowing bacterial endocarditis to remain undiagnosed and untreated, which, in turn, was a substantial factor in allowing the bacteria to multiply unchecked, with the bacteria "destroying" the patient's mitral valve, necessitating a surgical valve replacement. The hematologist also asserted that the release of mitral valve vegetation and the unchecked dissemination and circulation of bacteria resulted in a septic/mycotic aneurysm and need for surgical intervention to address that condition.

Moreover, the hematologist asserted that, despite reviewing the CBC panel testing and other blood test results, and recognizing that the patient had a mitral valve murmur, unexplained weight loss, and fatigue, Holstead was oblivious to the "hallmark importance of the murmur in the context of the patient's salient symptoms," which rendered his physical examination "wholly

inadequate and of no value to the patient,” thus constituting a departure from the standard of care. The hematologist expressly rejected Dr. Grossbard’s opinion that the only purpose of Holstead’s evaluation was to exclude lymphoma, cancer, and neoplasm. This expert asserted that the standard of care required a hematologist such as Holstead to understand the significance of a persistently elevated WBC count, particularly “the need to absolutely rule out an underlying infection,” and that Holstead’s failure to rule out an underlying blood-borne infection by initiating blood cultures was a departure from the standard of care. In this respect, the expert asserted that bacterial Infections are commonly diagnosed and treated by hematologists/medical oncologists caring for immunocompromised cancer patients undergoing chemotherapy, and, thus, the recognition of bacterial endocarditis would have been in Holstead's knowledge base, particularly in light of Holstead’s deposition testimony that he had the necessary training, knowledge, and experience to formulate a differential diagnosis that included bacterial endocarditis. Although the hematologist conceded that the standard of care did not require that Holstead diagnose bacterial endocarditis while the patient was in his office, it mandated that he include a blood-borne infection in his differential diagnosis, and, having done so, to rule it in or out by the employment of urgently ordered blood cultures.

According to the plaintiffs’ expert hematologist, one of the classic features of bacterial endocarditis is that it almost always causes continuous bacteremia and that, as such, “had blood cultures been drawn, it is a virtual certainty, and clearly more likely than not, that within 48-72 hours they would have been positive for the bacteria” that ultimately was cultured at NYPH, namely, *Streptococcus salivarius-vestibularis* group. The hematologist further averred that Holstead was confronted by an unexplained anemia, and that, as a hematologist, part of his responsibility was to explain the etiology of that anemia. The expert asserted that Holstead’s failure to do so was a departure from the standard of care, and that a diligent attempt to do so on Holstead’s part might have led to the correct diagnosis.

The hematologist further explained that,

“[w]hether Dr. Holstead should have recommended an infectious disease consultation, an issue discussed by Dr. Grossbard, is wholly beside the point. Of course, recommending an infectious disease consultation would have been superior to doing nothing to rule out a life-threatening infection. Under the circumstance, as here, where Dr. Holstead’s failed to take the steps necessary for blood cultures to be obtained, or otherwise rule out an infection, the failure to obtain infectious disease consultation was a deviation from accepted care.”

Nonetheless, because the expert hematologist noted that Holstead had the training, means, and responsibility to make the diagnosis himself, the identification of bacterial endocarditis is a responsibility of a hematologist caring for or consulting with a patient with the signs, symptoms, and laboratory findings evinced by the patient here, and a hematologist such as Holstead “does not have the privilege of ignoring or diminishing those findings and assigning the responsibility for establishing a correct diagnosis to another doctor, even the referring doctor (Leitman).” As the hematologist framed the issue, “[t]o imply otherwise is to make a farce of the division of internal medicine into subspecialties, with each subspecialist claiming that another subspecialist had the primary responsibility to make the correct diagnosis.” In this respect, he explained that, for a physician to become board certified in hematology and/or oncology, the physician “must first become board specialized in internal medicine as a whole.”

The plaintiff’s retained hematologist took exception with Dr. Grossbard’s opinion that the patient’s absence of fever rendered the failure to suspect or test for bacterial endocarditis as falling within the standard of care. As the hematologist explained it, endocarditis without fever is common enough to have its own designation, “euthermic endocarditis,” and the expert referred to a Mayo Clinic report on a series of 240 cases of endocarditis without fever. According to the hematologist, that study reported that patients with euthermic endocarditis are, like the patient here, older, and that the lack of fever is associated with longer symptom duration, in the same manner as presented by the patient here. The expert further described, as “irrelevant,” the enumeration by Dr. Grossbard of physical findings that are sometimes seen in endocarditis and which were not manifested by the patient.

The hematologist went on to explain that

“[S]troke is a common cause of significant neurological morbidity. An ischemic stroke, which represents close to 90% of all strokes, is the result of an obstruction/blockage within a blood vessel or blood vessels supplying blood to the brain. In a cardiogenic/cardioembolic ischemic stroke secondary to bacterial endocarditis, the obstruction is caused by a vegetative debris that originates on a heart valve. Once the vegetation breaks free it is called a septic embolus or emboli, rather than a thrombus.”

The expert noted that the antibiotics used to treat bacterial endocarditis have been found highly effective not only in eradicating the infection, but also in stabilizing the vegetation to prevent septic embolization, and asserted that, because of the high risk of septic embolization when bacterial endocarditis is untreated with antibiotics, a delay of days and weeks in initiating antibiotics is “playing with fire,” and constitutes a deviation from the standard of care. The hematologist claimed that, in the vast majority of cases, stroke caused by bacterial endocarditis-induced septic embolization can be prevented by timely antibiotic initiation, which is why it is extremely important to obtain blood culture results quickly so that antibiotic therapy may be initiated as swiftly as possible. This expert thus opined that the onset of the patient’s acute symptoms approximately two weeks before his presentation to Leitman, which continued through his presentation to Holstead, was due to already existing bacterial endocarditis, which was corroborated by the June 2022 blood cultures and the TEE results. In this respect, the hematologist asserted that there were no clinical data in the medical records that would reasonably allow any opinion *other* than that it was bacterial endocarditis “that brought Mr. Marshall to Drs. Leitman and Holstead,” and that the patient’s clinical signs and symptoms were wholly consistent with bacterial endocarditis.

The plaintiffs’ retained cardiologist opined that Bogal, Leitman, and Holstead each departed from the standard of care, and that such deviations were a substantial factor in causing the patient’s stroke and other attendant morbidities that were diagnosed at NYPH, as well as having increased the chance and severity of the patient’s other injuries, and having diminished his chance of a better outcome. The cardiologist concluded that Bogal departed from accepted practice in failing to order urgent blood cultures or to recommend to Leitman that

he do so, and this expert agreed with the plaintiffs' hematologist that, had blood cultures been undertaken in May or early June 2022, prior to the patient's admission to NYPH, the results would, more likely than not, have been positive for bacterial endocarditis. This expert further concluded that this failure was a substantial factor in permitting that condition to remain undiagnosed and untreated for more than one month. The cardiologist effectively reiterated the hematologist's opinions and conclusions concerning the multiplication and dissemination of bacteria throughout the patient's body, the consequent instability of the patient's mitral valve due to bacterial vegetation, the consequent destruction of the patient's mitral valve and the need for surgical replacement thereof, and the consequent septic/mycotic aneurysm and the need for surgical intervention in connection therewith.

As the plaintiffs' cardiologist explained it, the inner lining of the heart is called the endocardium, while endocarditis is a life-threatening inflammation of the inner lining of the heart's chambers and valves, and endocarditis caused by bacteria is called bacterial endocarditis. The cardiologist further explained that such bacteria enter the bloodstream and settle in the heart lining, heart valves, or a blood vessel, and that the hallmark of bacterial endocarditis is the presence vegetation in and on a heart valve, including the mitral valve---one of four heart valves---which was what occurred in the patient's case. This expert noted that the mitral valve is located between the left atrium and the left ventricle, and explained that mitral regurgitation is a condition where the mitral valve does not close properly, causing turbulent blood flow and allowing blood to flow backward into the left atrium. The cardiologist asserted that, when a patient such as the one here experiences mitral regurgitation, he or she is at high risk for bacterial endocarditis because bacteria in the blood can stick to the valve due to turbulent flow, that is, the bacteria is not washed completely through the system, while the eddies and currents caused by the regurgitation can cause the bacteria to get stuck, clump, multiply, and thus become vegetation on the mitral valve. This expert asserted that pieces of the vegetation can break off and travel to many other parts of the body, including the brain, and

that such emboli, known as septic emboli, can cause a blockage, or blockages, resulting in a stroke. The cardiologist further averred that septic embolization is a well-known complication of bacterial endocarditis, especially bacterial endocarditis that is untreated or inadequately treated. This specialist additionally explained that a mycotic aneurysm is a fungal or bacterial infection of an arterial wall that results in an abnormal dilation/widening at the site of the infection, and is common in patients who are suffering from bacteremia, with this type of aneurysm most often occurring in patients suffering from bacterial endocarditis. According to this cardiologist, these types of aneurysms frequently are found within the arteries to the brain, and that, in the patient's case, the aneurysm developed in his right middle cerebral artery, which the expert characterized as a large supplier of blood to the brain.

The plaintiffs' retained cardiologist opined that bacterial endocarditis is more common in adult men than in adult women, and even more common in older men, particularly those, such as the patient here, who already had been experiencing certain heart problems or other risk factors, such as mitral valve prolapse with mitral regurgitation. The expert additionally asserted that, in some cases involving acute bacterial endocarditis, the symptoms start suddenly and are severe, while in other cases that are denominated as subacute bacterial endocarditis, such as the patient's case here, the symptoms develop more slowly and are less severe. This expert asserted that definitive management requires the immediate use of appropriate intravenous antibiotics, and that the earlier in the course of the illness that a patient is treated with antibiotics, the less likely that he or she will develop an infected aneurysm. Likewise, the cardiologist explained that the earlier that the administration of antibiotics is initiated, any infected aneurysm that had already formed will stabilize and heal without rupture or the development of stroke.

As germane to the instant motion, the plaintiffs' cardiologist opined that the standard of care requires a cardiologist such as Bogal, as well as an internist such as Leitman and a hematologist such as Holstead, to consider the history, signs, symptoms, laboratory results, and

imaging as a whole, and not in isolation. The expert asserted that, had these defendants done so in the patient's case when they examined and tested him during May and early June 2022, they would have been compelled to include a blood-borne infection high on their differential diagnoses. Crucially, the cardiologist opined that, once such an infection is included *anywhere* in the differential diagnosis, "blood cultures are mandatory," and "must be done with utmost urgency," since, if bacterial endocarditis is present, the patient is at risk for stroke or even death.

According to the plaintiffs' cardiologist, although the presence of *Streptococcus salivarius-vestibularis*, mitral valve endocarditis and mycotic aneurysm in the middle cerebral artery were confirmed at NYPH beginning on June 25, 2022, and the patient later was found in August 2022 to have tonic-clonic seizures and an abnormal electroencephalogram while at Stony Brook University Hospital, the conclusion that Bogal and her codefendants committed malpractice in May and early June 2022 is not mere hindsight. Rather, this expert reiterated that, using foresight, Bogal, Leitman, and Holstead should have obtained blood cultures on an urgent basis and, even if they did not do so, they should have made an urgent referral to an infectious disease specialist, and that their failure to do either things constituted a deviation from the applicable standards of care. In this respect, the cardiologist noted that the patient was experiencing his baseline state of health until approximately May 12, 2022, but that the signs and symptoms that he ultimately presented to Leitman developed over the following two weeks, which was the reason he made the appointment to see Leitman in the first instance. The cardiologist concluded that these signs and symptoms were, in fact, signs and symptoms of bacterial endocarditis, and reiterated the hematologist's opinion that there was no information in the medical records that would reasonably allow any conclusion *other* than that bacterial endocarditis was what caused the patient to seek Leitman's assistance, and later Holstead's involvement.

The plaintiffs' cardiologist noted Bogal's contention that bacterial endocarditis was "probably" included in her differential diagnosis, albeit at a low position, and concluded that, no

matter how low that condition was on her differential diagnosis, “the standard of care mandated that she order urgent blood cultures on her patient,” that she “[r]ecommend to Dr. Leitman that urgent cultures be obtained for their patient,” or, failing that, that she “recommend an urgent infectious disease consultation.” Concurring with the opinions rendered by the plaintiffs’ hematologist, the cardiologist concluded that Bogal’s departures caused bacteria to spread, leading to bacteremia, thus generating untreated vegetation on the patient’s mitral valve, consequently leading to mycotic aneurysm and multiple septic emboli that travelled to the patient’s brain, and ultimately resulting in a stroke and a seizure disorder, and the need for procedures to replace the patient’s mitral valve and to intervene for the purposes of removing the aneurysm. As this expert explained it, once antibiotics tailored to the culture proven bacteria are begun, it takes 48 to 72 hours to stabilize the vegetation and prevent embolization, and the expert agreed with the hematologist as to the percentage chance of preventing embolization. Although the cardiologist asserted that the longer that such an infection goes untreated, the more difficult it becomes to pinpoint with exactitude when antibiotics might be ineffective to prevent stroke, he or she nonetheless concluded that the initiation of antibiotic therapy on or before June 17, 2022 would, more likely than not, have prevented an embolism, stroke, seizure disorder, and other sequelae related to embolization, such as an aneurysm, while initiation on or before June 20, 2022 would have yielded a “substantial possibility” that embolism, stroke, and seizure disorder would have been prevented, that initiation on or before June 10, 2022 more likely than not would have prevented the need for mitral valve replacement, and that initiation on or about June 8, 2022 would have resulted in a “substantial possibility” that mitral valve replacement could have been avoided.

The plaintiffs’ cardiologist took issue with Dr. Pollock’s analysis, which relied heavily on the notion that the symptoms and signs that the patient presented to Leitman and Holstead, and the diagnostic findings that they made, were “nonspecific,” noting that, while, in part true, such a focus on the “nonspecific” nature of the symptoms, signs, and findings misrepresented clinical

medicine as is practiced under the standard of care. As the cardiologist framed the issue, if a patient has a series of abnormalities that are consistent with bacterial endocarditis, it does not matter if they are “nonspecific,” since only a blood culture can determine if these symptoms are, or are not, due to bacterial endocarditis. Thus, this expert concluded that, although the findings that the patient experienced weight loss, significant fatigue, elevated CRP levels, an enlarged spleen, reduced hemoglobin, and an elevated WBC count with a left shift¹, did not, by themselves, prove the presence of endocarditis, the simultaneous presence of these findings is consistent with bacterial endocarditis, particularly in light of the patient’s history of mitral regurgitation, which rendered these cluster of findings “concerning” for bacterial endocarditis. In this respect, the cardiologist asserted that it is “an error in clinical medicine to try to analyze each of these abnormal findings individually and not as a whole. But when taken together in the same patient at the same time, it raises a significant concern about an infectious diagnosis (including endocarditis).” The cardiologist also asserted that it was irrelevant as to whether these findings were, individually and/or in aggregate, also consistent with cancer or inflammatory disease, since, so long as an infection is on the differential diagnosis, “as it must be, it must be evaluated by blood culture studies.” The plaintiffs’ cardiologist also faulted Dr. Pollock for minimizing the clinical findings in this case, for example, by characterizing the patient’s anemia as mild and nonspecific, when, in fact, the patient evinced a significant diminution in his hemoglobin level in comparison with his baseline levels, indicating a more serious anemia. In addition, this expert reiterated that Dr. Pollock’s reliance on the absence of fever, chills, or night sweats was misplaced, since a diagnosis of endocarditis does not require the presence of fever, chills, or night sweats; indeed, the cardiologist pointed out that the patient still had not manifested a fever on June 25, 2022 when he was admitted to NYPH, despite the fact that he tested positive for bacterial endocarditis at that time.

¹ Dr. Feingold had opined that there was no definitive evidence of a left shift, which generally indicates an increase in immature neutrophils, primarily band cells, and usually suggests an acute infection.

The plaintiffs' retained cardiologist additionally took issue with Dr. Pollock's reliance on the absence of headache, embolization, neurological changes, visual complaints, petechia, Osler nodes, and joint tenderness as of May 26, 2022 and June 8, 2022 in concluding that none of the individual defendants departed from accepted standards of care by downplaying the possibility of bacterial endocarditis and foregoing a blood culture. According to this expert, most of these findings are almost never now seen in endocarditis patients, inasmuch as these symptoms first were identified as correlating with endocarditis in the pre-antibiotic era, when patients would slowly die from the infection over a period of months or years. The expert calculated that the patient's infection began on approximately May 12, 2022, while the diagnosis was made on June 25, 2022, 44 days later, a period over which the patient would not have had time to develop symptoms such as petechia, Osler nodes, and joint tenderness. Moreover, the expert noted that, although the patient did ultimately develop neurological changes and headache, these symptoms developed only after he had bled into his brain, a course of events that the cardiologist described as "not how to optimally diagnose endocarditis."

The plaintiffs' retained infectious disease specialist opined that, at the time of the patient's presentation to Leitman and Holstead, the patient more likely than not had active Streptococcus bacteremia that had caused bacterial endocarditis, and that the initiation of antibiotics between May 26, 2022 and June 7, 2022 more likely than not would have prevented the stroke caused by his undiagnosed and untreated endocarditis, or even between June 8, 2022 and June 17-18, 2022 would more likely than not have prevented the stroke caused by the patient's undiagnosed and untreated endocarditis. According to the infectious disease specialist, the failure to initiate antibiotics between May 26, 2022 and June 17-18, 2022 diminished the patient's chance of a better outcome with respect to his bacterial endocarditis, and increased his chance of stroke, and, had Leitman, Holstead, or Bogal referred the patient to an infectious disease specialist, more likely than not, such a specialist would have ordered

blood cultures, thereupon recommended that the patient be admitted to a hospital for intravenous antibiotic therapy, and a further workup and management of endocarditis.

The infectious disease specialist expressly agreed with both the plaintiffs' retained hematologist and cardiologist that the presence of constitutional symptoms such as weight loss for a period of more than two weeks before the patient's presentation to Leitman, along with an elevated WBC count with left shift, anemia, and elevated inflammatory markers such as CRP, raised the "strong possibility of infection, which must be included in the differential diagnosis." This expert concluded that these constitutional symptoms and laboratory abnormalities were, in fact, due to bacterial endocarditis. In this respect, the infectious disease specialist explained that infection is the most common cause of an abnormally high WBC count and neutrophilia, as was manifest in the testing of the patient's blood, and concluded that "[o]btaining a blood culture in this setting would more likely than not, have identified bacteria secondary to *Streptococcus viridans* species," particularly in light of the positive, late-June 2022 blood cultures.

The infectious disease specialist essentially reiterated the cardiologist's analysis as to why the absence of fever should not have led the individual defendants to discount bacterial endocarditis, particularly because the patient was older than 70 years of age, and asserted that splinter hemorrhages, Osler nodes, and Janeway lesions are uncommon presentations in endocarditis. This expert further opined that the enlarged spleen that was detected on the patient's May 31, 2022 CT scan was not only consistent with endocarditis, but, in the patient's case, was "due to bacterial endocarditis." The infectious disease specialist concurred with the hematologist and cardiologist that, "[t]aken in combination, the presence of multiple suggestive signs and symptoms, along with laboratory and imaging findings, is suggestive of endocarditis," and that, "[h]ad a blood culture been obtained as part of standard infectious/bacterial endocarditis workup on or after 5/26/2022, it more likely than not would have been positive for the bacteria cultured in late June 2022 at New York Presbyterian."

The plaintiffs' retained infectious disease specialist further reiterated the opinions of the plaintiffs' other experts, which were to the effect that

"[a]ntimicrobial therapy with the correct antibiotic is the foundation of treatment for bacterial endocarditis. Initiation of active antimicrobial therapy significantly reduces the risk of embolic stroke in infective endocarditis, and the daily rate of strokes decreases substantially after initiation of antibiotics.

"Starting antibiotics earlier in Mr. Marshall's case would have significantly reduced the chances of him later presenting to New York Presbyterian on June 25, 2022 with a stroke related to his undiagnosed and untreated endocarditis.

"It is more likely than not that the failure to take a blood culture in the period May 26 through June 18 was a substantial factor in Mr. Marshall's Bacterial Endocarditis being undiagnosed and thus untreated with appropriate antibiotics.

"Furthermore, it is more likely than not that the failure to initiate antibiotics in the period of May 26 through June 18 was a substantial factor in the following:

- A. allowing bacteria to multiply unchecked;
- B. allowing the unchecked bacteria to destroy Mr. Marshall's mitral valve and the resultant need for surgical replacement;
- C. allowing continuous circulation of the unchecked bacteria resulting in mycotic aneurysm and the need for intervention;
- D. allowing the vegetation on the mitral valve to be unstable with embolic potential;
- E. allowing the unstable valve to release emboli which traveled to the brain and caused a stroke and neurologic damage and sequelae."

In reply, the NYCB defendants, the PAMP defendants, and Bogal each submitted an attorney's affirmation, in which counsel for the respective defendants characterized the opinions of the plaintiffs' four retained experts as speculative, conclusory, and not supported by the medical records, and suggested that the plaintiffs' experts relied on hindsight.

The court concludes that the NYCB defendants, the PAMP defendants, and Bogal each established their prima facie entitlements to judgment as a matter of law with their submissions, including the expert affirmations of Drs. Grossbard, Feingold, and Pollock. Nonetheless, the court further concludes that, except with respect to the claims the defendants departed from good and accepted practicing by failing to refer the patient to another cardiologist for further

workup and evaluation and failing to take an appropriate medical history of the patient, since the plaintiffs did not address those issues in their opposition papers, the plaintiffs have raised triable issues of fact in opposition to the several motions. Contrary to the defendants' contentions, the opinions of the plaintiffs' 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 patient (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to whether the patient's complaints and the results of his diagnostic testing required the defendants not only to include bacterial endocarditis on their differential diagnoses, but high up on their diagnoses, required the defendants to order an urgent blood culture test, and/or required the defendants to refer the patient to an infectious disease specialist. Moreover, the opinions of the plaintiffs' experts were "supported by facts and . . . not based upon hindsight" (*Beharry v Marin*, 2023 NY Misc LEXIS 29868. *4 [Sup Ct, Suffolk County, Nov. 9, 2023]). There is no question that the plaintiffs' experts were qualified by education, training, and experience to render the opinions that they did, and 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).

"In general, under the doctrine of respondeat superior, a hospital [or practice] 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]). "[V]icarious liability for medical malpractice generally turns . . . on agency or control in fact" (*Hill v St. Clare's Hosp.*, 67 NY2d at 79-80). Moreover, where a healthcare professional working for his or her own professional corporation,

limited liability company, or limited liability partnership renders health care to a patient “within the scope of his or her employment” for that corporation, company, or partnership, that entity may be held vicariously liable for the negligence of that healthcare provider (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]; *Yaniv v Taub*, 256 AD2d 273, 274 [1st Dept 1998]; *Connell v Hayden*, 83 AD2d 30, 46 [2d Dept 1981]; Business Corporation Law § 1505[a][i]; Limited Liability Company Law § 1205[a]; Partnership Law § 121-1500[q] *see also Galpern v De Vos & Co., PLLC*, 10-CV-1952 (CBA) (JMA), 2011 US Dist LEXIS 117095 *39 , 2011 WL 4597491, *13 [ED NY, Sep. 30, 2011] [Limited Liability Company Law is simply a reflection of the common-law rule that a member of a professional limited liability company is liable for those torts of the company in which he or she is a participant]; *see generally Brown-Jodoin v Pirrotti*, 2011 NY Slip Op 34223[U], 2011 NY Misc LEXIS 7307 [Sup Ct, Westchester County Aug. 17, 2011] [denying motion to dismiss in legal malpractice action made by attorney and his professional limited liability partnership]). There is no dispute that Holstead was employed by and working for NYCB at the time that he examined, tested, and treated the patient. Nor is there any dispute that Leitman was employed by and working for PAMP when he examined, tested, and treated the patient. Moreover, Bogal was an owner of PAMP and working for it when she examined, tested, and treated the patient. Hence, to the extent that this court has determined that there are triable issues of fact as to whether these three physicians committed malpractice that caused or contributed to the patient’s injuries, there are triable issues of fact as to whether NYCB and PAMP may be held vicariously liable therefor.

As a derivative claim, the loss of consortium cause of action asserted by Deborah Marshall, as the patient’s wife, remains viable to the extent that the patient’s medical malpractice cause of action remains viable (*see Robinson v Northwell Health, Inc.*, 2021 NY Slip Op 33146[U], *8. 2021 NY Misc LEXIS 8552, *16-17 [Sup Ct, Queens County, Dec. 6, 2021]; *see generally Clarke v City of New York*, 82 AD3d 1143, 1144 [2d Dept 2011]; *Kaisman v Hernandez*, 61 AD3d 565, 566 [1st Dept 2009]).

Accordingly, it is,

ORDERED that the motion of the defendants New York Cancer & Blood Specialists and Ryan Holstead for summary judgment dismissing the amended complaint insofar as asserted against them (MOT SEQ 001) is granted only to the extent that they are awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against them as was premised upon their alleged failure to refer the plaintiff Jeffrey Marshall to a cardiologist other than Monika Bogal for further workup and evaluation, and their alleged failure to take an appropriate medical history of Jeffrey Marshall, those claims are dismissed insofar as asserted against them, and their motion is otherwise denied; and it is further,


ORDERED that the motion of the defendants Park Avenue Medical Professionals, P.C., and Jeffrey S. Leitman for summary judgment dismissing the amended complaint insofar as asserted against them (MOT SEQ 002) is granted only to the extent that they are awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against them as was premised upon their alleged failure to refer the plaintiff Jeffrey Marshall to a cardiologist other than Monika Bogal for further workup and evaluation, and their alleged failure to take an appropriate medical history of Jeffrey Marshall, those claims are dismissed insofar as asserted against them, and their motion is otherwise denied; and it is further,

ORDERED that the motion of the defendant Monika Bogal for summary judgment dismissing the amended complaint insofar as asserted against her, which was erroneously designated as a cross motion (MOT SEQ 002), is granted only to the extent that she is awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against her as was premised upon her alleged failure to refer the plaintiff Jeffrey Marshall to another cardiologist for further workup and evaluation, and her alleged failure to take an appropriate medical history of Jeffrey Marshall, those claims are dismissed insofar as asserted against her, and her motion is otherwise denied; and it is further,

ORDERED that, on the court’s own motion, the attorneys for all of the 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 April 29, 2026, at 2:15 p.m., at which time they shall be prepared to discuss resolution of the action, the scheduling of a future two-hour, mediation-style settlement conference, and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

4/2/2026
DATE


JOHN J. KELLEY, J.S.C.

MOTION 001:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE
MOTION 002:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/> REFERENCE
CROSS MOTION 002:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION		
	<input type="checkbox"/>	GRANTED	<input type="checkbox"/> DENIED	<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/>	SETTLE ORDER		<input type="checkbox"/>	SUBMIT ORDER	