Bogin v Nicolo
2018 NY Slip Op 33141(U)
December 5, 2018
Supreme Court, New York County
Docket Number: 805160/16
Judge: Martin Shulman

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
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LORI BOGIN, as Executor of the Estate of Heath Bogin, and LORI BOGIN, Individually,

Index No. 805160/16

Plaintiffs,

Decision & Order

-against-

DANIELLE NICOLO, M.D., WEILL CORNELL MEDICAL ASSOCIATES, YASMIN METZ, M.D., MANHATTAN ENDOSCOPY, PLLC, JAMES STULMAN, M.D., RUBEN NIESVIZKY, M.D., and NEW YORK PRESBYTERIAN/WEILL CORNELL MEDICAL CENTER,

Defendants.
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Martin Shulman, J.:

In motion sequence 1, defendants Danielle Nicolo, M.D. (Dr. Nicolo), Cornell University s/h/a Weill Cornell Medical Associates (WCMA), James Stulman, M.D. (Dr. Stulman),[1] Ruben Niesvizky (Dr. Niesvizky) and The New York and Presbyterian Hospital s/h/a New York Presbyterian/Weill Cornell Medical Center (NYPH)[2] move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The remaining defendants, Yasmin Metz, M.D. (Dr. Metz) and Manhattan Endoscopy, PLLC (Manhattan Endoscopy), move for the same relief in motion sequences 2 and 3, respectively.[3] Plaintiffs, Lori Bogin, as Executor of the Estate of Heath Bogin, and Lori Bogin, Individually (Mrs. Bogin or

[1] Drs. Nicolo and Stulman testified that they are WCMA employees.

[2] Dr. Niesvizky testified that he was an NYPH employee during the relevant period of time.

[3] Upon granting summary judgment, Manhattan Endoscopy also seeks an order deleting it from the caption.

plaintiff) oppose each motion and cross-move for partial summary judgment as to Dr. Stulman. Motion sequences 1, 2 and 3 are consolidated for disposition.

FACTUAL BACKGROUND

The complaint alleges causes of action against all defendants for medical malpractice (first cause of action), lack of informed consent (second cause of action), loss of services (third cause of action) and wrongful death (fourth cause of action). The fifth cause of action alleges negligent hiring and/or negligent granting/renewal of privileges as against NYPH.

In simplistic terms, Mrs. Bogin's complaint is based upon allegations that defendants failed to timely diagnose and properly treat her late husband, Heath Bogin's (Mr. Bogin, patient or decedent), primary mediastinal large B cell lymphoma (PMBCL), resulting in a worsened prognosis and his unfortunate death at the age of 37. He left behind two young children, then ages 2 and 6.

Plaintiff's primary allegations as to Dr. Nicolo, Dr. Metz, Dr. Stulman is that they failed to timely order a chest x-ray (CXR), which allegedly would have resulted in earlier diagnosis and treatment. Vicarious liability is alleged with respect to WCMA for Drs. Nicolo and Stulman, and with respect to Manhattan Endoscopy for Dr. Metz. As to Dr. Niesvizky, plaintiff primarily alleges that he should have implemented chemotherapy sooner. Plaintiff asserts direct claims against NYPH as well as vicarious liability for Dr. Niesvizky's treatment of the decedent.

Mr. Bogin first presented to cardiologist/internist Dr. Nicolo at WCMA for a routine physical examination on November 18, 2014. The medical records reflect that the patient reported:

> puffy eyes in morning when wakes up and improves after about 30 minutes for the past week. Associated with some nasal congestion. . . . Has lost about 10lbs in last year with healthy diet. Denies chest pain, SOB [shortness of breath], palpitations. (Bracketed matter added).

Under "Assessment & Plan", Dr. Nicolo recorded, in relevant part: "allergies - likely related to facial swelling and nasal congestion". She recommended allergy medication.

Mr. Bogin next contacted Dr. Nicolo by telephone on December 29, 2014 to complain of difficulty swallowing (dysphagia). Dr. Nicolo referred him to gastroenterologist Dr. Metz. He presented to Dr. Metz the next day, at which time he completed and signed a Patient Interview Form (PIF) indicating he had symptoms of diarrhea, gas and food sticking in his esophagus and/or throat. The PIF's checklist included various other symptoms, such as chest pain, heartburn, cough, throat clearing, lump in throat, dyspnea, fever, weight loss, loss of appetite, nausea or vomiting, none of which the patient marked as having.

Dr. Metz's records from December 30, 2014 identify his chief complaint as difficulty swallowing over the last few weeks. Despite his written denial of chest pain and coughing in the PIF, Dr. Metz noted "slight chest discomfort, fatigue, and a dry cough." Under "Assessment" she noted "GERD [gastroesophageal reflux disease] and heartburn history presenting with dysphagia." Dr. Metz's plan

included performing an esophagogastroduodenoscopy (EGD) to investigate potential causes for his complaints.

Dr. Metz performed the EGD the next day at Manhattan Endoscopy. Specimens were taken at various sections of the esophagus and sent to be biopsied. Dr. Metz's findings from the EGD included a small hiatus hernia, mild inflammation in the upper third of the esophagus and esophageal mucosal changes suggestive of inflammation.

Dr. Metz sent copies of her December 30, 2014 office note and the December 31, 2014 EGD report to Dr. Nicolo. On January 1, 2015, Mr. Bogin was in pain and Mrs. Bogin called Dr. Metz, who noted that he "still had pain with swallowing" and prescribed an anesthetic mouthwash. Although not documented in Dr. Metz's records, Mrs. Bogin testified that on January 3, 2015 Mr. Bogin still had no relief and he called Dr. Metz, adding that, in addition to his other symptoms, he now was experiencing shortness of breath. She testified that she heard this conversation.

On January 8, 2015, the patient returned to Dr. Nicolo, whose records identify a chief complaint of back pain. Dr. Nicolo's notes reference Mr. Bogin's recent visit to Dr. Metz and the EGD results showing reflux. She recorded that the back pain was "most likely related to muscle strain and may be also related to GERD since pain is radiating". Dr. Nicolo prescribed medication and referred him to a pain management and rehabilitation specialist. The records from that date further indicate that Mr. Bogin denied chest pain and shortness of breath,

despite making these complaints to Dr. Metz five days earlier. This was Dr. Nicolo's last contact with Mr. Bogin.

On January 12, 2015, Mr. Bogin saw non-party physiatrist Dr. Jaspal R. Singh. Dr. Singh's records list a chief complaint of neck pain rather than back pain, and further state that the patient reported that the pain started the prior month after sleeping the wrong way. Dr. Singh noted that Mr. Bogin denied fevers, chills, unexplained weight loss, chest pain and shortness of breath. His breathing was even and unlabored. The diagnosis was cervical discogenic pain with myofascial trapezius strain. Dr. Singh prescribed pain medication and physical therapy.

On January 13, 2015, Dr. Metz noted that the patient called complaining of a persistent cough. He denied dysphagia and Dr. Metz advised him to follow up with his primary care physician because she suspected that his complaints may not be gastrointestinally related. Dr. Metz did not advise Dr. Nicolo of a potential non-gastrointestinal etiology for his symptoms and this was Mr. Bogin's last contact with her.

On January 16, 2015, the patient contacted WCMA to follow up with Dr. Nicolo. As she was unavailable, he saw Dr. Stulman, an internist at WCMA. Dr. Stulman documented a chief complaint of coughing, describing it as a "hacking cough for 2 weeks". He suspected atypical pneumonia and his plan was to treat Mr. Bogin with antibiotics and if not improved, to perform a CXR the following week.

On January 22, 2015, Mr. Bogin returned to WCMA, where he saw non-party internist Dr. Joseph Chang. Dr. Chang recorded improved GERD symptoms and a worsening cough which had been present since late December 2014 and had not improved with antibiotics. Dr. Chang also noted "chronic upper back/neck pains" and ordered a CXR that day. The CXR revealed "[f]indings most consistent with a mediastinal mass with associated narrowing of the midthoracic trachea", "[m]ildly enlarged cardiomediastinal silhouette", "[m]oderate right pleural effusion" and "[m]ild interstitial edema".

Dr. Chang directed the patient to NYPH's ED, where a chest CT scan with contrast showed:

> an ill defined mass heterogenously measuring approximately 10.3 x 8.0 cm which extends superiorly up to the thoracic inlet. The mass encases but does not definitively invade the bilateral main pulmonary arteries, aorta and great vessels. There is severe narrowing of the bilateral main pulmonary arteries. Additionally, narrowing of the trachea and left main bronchus is identified. . . Large pericardial effusion ...

Mr. Bogin was admitted to NYPH for inpatient treatment that same day. He was first seen by non-party Dr. Paddock, a hematology/oncology fellow, whose assessment included mediastinal mass, pericardial effusion, pleural effusion concerning for Hodgkin's lymphoma, mediastinal BCL (B-cell lymphoma) or germ cell tumor. Dr. Paddock's plan for treatment included further testing and consultation with interventional radiology for a biopsy of the mass.

The next day, Dr. Paddock and Dr. Niesvizky, the attending hematology/oncology physician, performed a bone marrow aspiration and biopsy of the left iliac crest, which ruled out marrow involvement. Later that evening, the

mediastinal mass was biopsied and the pleural and pericardial effusions were drained. Dr. Niesvizky's initial plan for treatment was steroid therapy which was implemented immediately. He testified that he could not determine the necessary treatment, particularly chemotherapy, until he received the final pathology results.

Mr. Bogin was intubated for the biopsy procedure and remained intubated and hospitalized until the date of his death, breathing via mechanical ventilation. A January 25, 2015 endoscopy was performed to pass an oral-gastric tube (OG) and revealed mid-upper esophageal extrinsic compression. The OG could not be passed due to esophageal compression. Final pathology was obtained on January 26, 2015 and confirmed PMBCL. The patient began his first cycle of chemotherapy on January 27, 2015, which ended on February 1, 2015. Dr. Niesvizky saw Mr. Bogin again on January 28 and for the last time on January 29, 2015. Thereafter, the patient's oncology care was transferred to the next oncologist(s) on rotation.[4]

Although a February 1, 2015 CT scan revealed that the mass decreased in size after the first cycle of chemotherapy, according to the interpreting radiologist it also revealed "diffuse lung injury due to chemotherapy." On February 15, 2015, an infectious disease specialist documented that a CT and biopsy were both consistent with "acute lung injury from chemotherapy." The patient's treating oncologist documented on February 26, 2015 that his lung

[4] Dr. Niesvizky testified that NYPH's oncology inpatient service rotates every two weeks.

injury was not related to his lymphoma and decided not to administer the second round of chemotherapy until his lung condition had resolved.

Mr. Bogin developed numerous complications including hypoxic respiratory failure, serratia pneumonia, sepsis and acute respiratory distress syndrome (ARDS) complicated by barotrauma with bilateral lung collapse requiring intra-thoracic chest tubes. His second round of chemotherapy did not begin until March 5, 2015 due to his deteriorating condition.

Mr. Bogin never recovered and unfortunately died on March 8, 2015, prior to completing the second round of chemotherapy. The cause of death was noted as "respiratory and cardiovascular collapse from advanced diffuse large B cell lymphoma." Under "summary of events" the records elaborate: "primary mediastinal DLBCL[5] complicated by airway compression, pleural and pericardial effusions" and "post-op course was complicated by inability to extubate secondary to airway swelling and trachea/L main bronchus compression".

DISCUSSION

An award of summary judgment is appropriate when no issues of fact exist. *See* CPLR 3212(b); *Sun Yau Ko v Lincoln Sav. Bank*, 99 AD2d 943 (1st Dept), *aff'd* 62 NY2d 938 (1984); *Andrea v Pomeroy*, 35 NY2d 361 (1974). In order to prevail on a motion for summary judgment, the proponent must make a prima facie showing of entitlement to judgment as a matter of law by providing sufficient evidence to eliminate any material issues of fact. *Winegrad v New York*

[5] Diffuse large B cell lymphoma.

Univ. Med. Ctr., 64 NY2d 851, 853 (1985); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). Indeed, the moving party has the burden to present evidentiary facts to establish his cause sufficiently to entitle him to judgment as a matter of law. *Friends of Animals, Inc. v Associated Fur Mfrs., Inc.*, 46 NY2d 1065 (1979).

In deciding the motion, the court views the evidence in the light most favorable to the nonmoving party and gives him the benefit of all reasonable inferences that can be drawn from the evidence. *See Negri v Stop & Shop, Inc.*, 65 NY2d 625, 626 (1985). Moreover, the court should not pass on issues of credibility. *Assaf v Ropog Cab Corp.*, 153 AD2d 520, 521 (1st Dept 1989). While the moving party has the initial burden of proving entitlement to summary judgment (*Winegrad*, *supra*), once such proof has been offered, in order to defend the summary judgment motion, the opposing party must "show facts sufficient to require a trial of any issue of fact." CPLR 3212(b); *Zuckerman v City of New York*, 49 NY2d 557, 562 (1980); *Freedman v Chemical Constr. Corp.*, 43 NY2d 260 (1977); *see also*, *Friends of Animals, Inc.*, *supra*.

MEDICAL MALPRACTICE

"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) (citation omitted). A defendant physician seeking summary judgment must make a prima facie showing establishing the absence of a triable issue of fact as to the alleged departure from accepted standards of medical practice (*id*).

In opposition, "a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice'." *Id.*, citing *Alvarez v Prospect Hosp.*, 68 NY2d at 325. "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 a grant of summary judgment in a defendant's favor (citation omitted)." *Id.* However, where an expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, the opinion should be given no probative force and is insufficient to withstand summary judgment. *Id.*, citing *Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 (2002).

In this case, the record reveals that all parties' experts have extensive experience in the relevant medical specialties and are knowledgeable in their fields. Additionally, they all base their opinions on their review of Mr. Bogin's medical records as well as the pleadings and deposition transcripts herein. Therefore, it appears that all experts are qualified to offer their opinions. *See Frye v Montefiore Med. Ctr.*, 70 AD3d at 24-25; *Guzman v 4030 Bronx Blvd. Assoc. L.L.C.*, 54 AD3d 42, 49 (1st Dept 2008) ("whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court . . .").

In opposition, Mrs. Bogin denies that defendants have established prima facie entitlement to summary judgment. She characterizes each set of moving papers as relying upon conclusory statements. While plaintiff claims defendants'

showing is insufficient to shift the burden of proof to her and warrants denial of their summary judgment motions, nonetheless, in the event this court determines otherwise, plaintiff argues that her experts' affidavits raise issues of fact as to whether defendants departed from the applicable standard of care, thus warranting a trial.

For the reasons set forth below, this court finds that defendants established their prima facie entitlement to summary judgment by submitting detailed expert affirmations specifically addressing plaintiff's allegations. Accordingly, the burden shifted to plaintiff to establish that issues of fact preclude summary judgment. Plaintiff partially meets this burden.

A. Doctor Nicolo and WCMA

1. November 18, 2014 Office Visit

In support of her motion for summary judgment dismissing the complaint, Dr. Nicolo argues that she did not deviate from accepted medical standards in treating the decedent. She submits an expert affirmation from Edward Katz, M.D. (Dr. Katz), who is board certified in internal medicine, cardiovascular disease and adult comprehensive echocardiography.[6] This expert opines *inter alia* that a CXR was not indicated prior to January 22, 2015 as none of Mr. Bogin's complaints indicated cancer.

As previously noted, Mr. Bogin presented to Dr. Nicolo for the first time on November 18, 2014 for an annual physical examination. The patient had nasal

[6] Dr. Katz's affirmation also addresses Dr. Stulman's treatment of the decedent.

congestion and reported that during the past week his eyes were puffy when he awoke but the condition dissipated approximately 30 minutes later. No other symptoms or complaints are noted in the medical records. Dr. Nicolo attributed these symptoms to allergies and recommended allergy medication. Dr. Katz opines that it was reasonable for Dr. Nicolo to attribute the decedent's puffy eyes and nasal congestion to allergies, especially since he had seen his ophthalmologist the day before and been diagnosed and treated for blepharitis and mild allergies.

In opposition, plaintiff submits an affirmation from a physician whose identity has been redacted. This expert is a physician who is board certified in internal medicine with a sub-certification in pulmonology who has practiced medicine for over thirty years. Plaintiff's internal medicine and pulmonology expert disagrees with Dr. Katz's opinion that ordering a CXR was not indicated on that date based upon Mr. Bogin's symptomology, which Dr. Katz concludes did not suggest cancer.

Plaintiff's internal medicine and pulmonology expert explains that PMBCL, while a fast growing form of cancer, also responds well to treatment. He/she opines to a reasonable degree of medical certainty that:

- Mr. Bogin died of untreated PMBCL which caused severe compression of his trachea, esophagus, superior vena cava (SVC) and lungs, leading to respiratory failure, infection and multi-system organ failure;
- the decedent would not have died had his PMBCL been treated sooner rather than allowing it to progress to the point of severely damaging his airway and predisposing him to infections and other complications; and

- the patient's PMBCL was readily receptive to treatment, as evidenced by a February 1, 2015 CT scan showing that the mass immediately shrank after chemotherapy was administered.

Plaintiff's expert opines that Dr. Nicolo departed from accepted standards of medical care by not considering SVC compression, which causes reduced blood flow to the face and resulting facial swelling, in her differential diagnosis. He/she states that Dr. Nicolo's diagnosis of allergies "does not make sense" because allergies do not dissipate soon after waking. He/she also maintains that had Dr. Nicolo considered SVC compression as part of her differential diagnosis, she would have ordered a CXR and Lactate Dehydrogenase (LDH) testing, which can be done as part of an annual physical examination and would have indicated the presence of lymphoma.

Plaintiff fails to meet her burden of demonstrating that issues of fact preclude summary judgment in Dr. Nicolo's favor as to the treatment she rendered to the decedent on November 18, 2014. Her expert does not deny that Mr. Bogin's symptoms were indicative of allergies, nor does he/she address the fact that the day before his visit to Dr. Nicolo, the decedent's ophthalmologist attributed his puffy eyes to allergies and had just begun treating the condition with eye drops. Nowhere is it claimed that the applicable standard of care requires that a patient presenting for a physical examination with nasal congestion and swollen eyes be sent for a CXR. Finally, none of the other symptoms of PMBCL, such as upper body pain, pain when swallowing, coughing

and shortness of breath,[7] was noted at this initial visit to Dr. Nicolo. Nor did plaintiff testify that her husband sought treatment for anything other than a physical examination and treatment for puffy eyes.

As to Dr. Nicolo's failure to order LDH testing, plaintiff's expert states that such testing would have revealed elevated LDH, a potential tumor marker, for Dr. Nicolo to suspect lymphoma and order a CXR. Nonetheless, this conclusion at that early juncture is mere speculation. Moreover, he/she does not specifically state that the standard of care requires ordering LDH testing upon a routine annual physical examination.

For the foregoing reasons, partial summary judgment is granted in Dr. Nicolo's favor as to her November 18, 2014 treatment of Mr. Bogin. It follows that there can be no vicarious liability attributable to WCMA, and summary judgment is similarly granted in WCMA's favor concerning this treatment.

2. December 29, 2014 Telephone Call

Mr. Bogin next contacted Dr. Nicolo by telephone on the evening of December 29, 2104. There is no record of this conversation in Dr. Nicolo's notes and she testified she did not recall the conversation. Mrs. Bogin testified she was present during the call and heard her husband describe his symptoms to Dr. Nicolo. Although she testified that he had been experiencing coughing and upper body and back pain during the month of December, she stated that Mr. Bogin

[7] The records indicate that Mr. Bogin specifically denied chest pain and shortness of breath.

only described his difficulty swallowing to Dr. Nicolo during that call,[8] whereupon she referred him to gastroenterologist Dr. Metz.

Dr. Katz opines that it was appropriate for Dr. Nicolo to refer Mr. Bogin to gastroenterologist Dr. Metz since "dysphagia is typically associated with the digestive system and related gastrointestinal issues, especially in a 37 year old patient." By contrast, plaintiff's expert concludes that Dr. Nicolo deviated from the applicable standard of care by not ordering her own testing (to wit, immediate imaging of the chest, neck and throat and/or a motility study) to rule out a non-gastrointestinally related cause of the patient's swallowing difficulty. This expert states that Dr. Nicolo's differential diagnosis on December 29, 2014 should have included mediastinal mass/tumor and PMBCL.

Plaintiff's expert does not opine that Dr. Nicolo deviated from the standard of care by referring Mr. Bogin to Dr. Metz. Nonetheless, an issue of fact exists as to whether Dr. Nicolo deviated from the standard of care by not ordering an imaging and/or a motility study at that time, instead of simply referring Mr. Bogin to Dr. Metz in response to his complaint of difficulty swallowing. Dr. Katz does not address why imaging and/or other studies were unwarranted at this time in addition to the referral to Dr. Metz, nor is this issue addressed in reply.

Accordingly, summary judgment is denied with respect to Dr. Nicolo's treatment of the decedent on December 29, 2014. Summary judgment is

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[8] Plaintiff's internal medicine and pulmonology expert apparently assumed that Mr. Bogin relayed his symptoms of coughing and upper body/back pains to Dr. Nicolo during the call, but as noted in Dr. Nicolo's reply, the record does not support this claim.

similarly denied as to WCMA for the treatment rendered to Mr. Bogin on this date.

3. January 8, 2015 Office Visit

With respect to the decedent's last treatment with Dr. Nicolo on January 8, 2015, Dr. Katz opines as follows:

- based upon the patient's chief complaint of mid-back pain, Dr. Nicolo appropriately referred him to a pain management and rehabilitation specialist, as such a complaint is typically musculoskeletal in nature in patients in Mr. Bogin's age range; and
- the standard of care did not require a CXR for complaints of back pain and a mildly elevated pulse, nor did these complaints warrant suspicion for PMBCL; and
- with respect to his reflux/GERD it was appropriate for Dr. Nicolo to defer to Dr. Metz, who was treating this condition.

Dr. Nicolo testified that she read Dr. Metz's notes either before or during the visit (Nicolo EBT at 189). As such, she acknowledged she was aware of Mr. Bogin's complaint of difficulty swallowing "at the time that he was evaluated by Dr. Metz." *Id.* at 190, lines 12-13. She went on to testify that the patient discussed reflux with her but did not report that he still had difficulty swallowing at that time. *Id.*

Plaintiff's internal medicine/pulmonology expert does not claim that Dr. Nicolo departed from accepted standards of care when she referred Mr. Bogin to a physiatrist for his back pain. He/she opines that Dr. Nicolo deviated from the standard of care when she still did not consider and rule out a mediastinal mass in her differential diagnosis by ordering a CXR or chest CT.

The basis for this opinion is not clearly stated and is largely conclusory. Plaintiff's internal medicine/pulmonology expert does not explain why or how a CXR was indicated for back pain, which the records indicate was the only symptom reported to Dr. Nicolo. This expert does not address Dr. Nicolo's entry in the medical records that Mr. Bogin was treating with Dr. Metz for GERD, still had some pain but was "taking PPI [proton pump inhibitor] with good improvement", or the notation that he denied chest pain, shortness of breath or palpitations at that time. The expert also does not address Mr. Bogin's presentation to Dr. Singh four days after his visit to Dr. Nicolo, at which time he denied various symptoms indicative of PMBCL, such as fevers, chills, unexplained weight loss, chest pain and shortness of breath.

Plaintiff's expert again fails to refute Dr. Nicolo's prima facie entitlement to summary judgment dismissing all claims related to Mr. Bogin's January 8, 2015 treatment. Accordingly, partial summary judgment is granted in Dr. Nicolo's favor as to her treatment of Mr. Bogin on that date, as well as in favor of WCMA.

B. Dr. Metz's Treatment

In support of her motion for1 summary judgment dismissing the complaint, Dr. Metz submits expert affirmations from Michael S. Frank, M.D. (Dr. Frank), who is board certified in internal medicine and gastroenterology, as well as James M. Vogel, M.D. (Dr. Vogel), who is board certified in internal medicine with sub-certifications in hematology and medical oncology. In opposition to Dr. Metz's motion, plaintiff submits a redacted affirmation from a physician who is board certified in internal medicine and gastroenterology.

Dr. Frank opines with a reasonable degree of medical certainty as follows:

- the "gold standard" for a gastroenterologist investigating dysphagia is an upper EGD, which Dr. Metz performed the next day;
- in performing an EGD, unless there is clear narrowing of the esophagus from an external source, there is no way to determine if a mass in the mediastinum is present, and Dr. Metz did not observe any narrowing of the esophagus, as reflected in the photographs taken during the procedure;
- it was reasonable for Dr. Metz to diagnose reflux and pathology confirmed reflux in the distal esophagus and antrum of the stomach, which was consistent with Dr. Metz's observation of inflammation in the proximal portion of the esophagus;
- difficulty swallowing can be a symptom of reflux;
- as of her January 13, 2015 telephone conversation with Mr. Bogin Dr. Metz had no further responsibility to investigate his complaints or order further testing because he denied dysphagia, thereby confirming the diagnosis and that Dr. Metz's treatment had resolved his complaints;
- when the patient mentioned during the January 13, 2015 phone call with Dr. Metz that his cough persisted, she appropriately instructed him to contact his internist since the cough was not gastrointestinally related;
- Dr. Metz was not required to call Dr. Nicolo to advise that the patient's cough was not GI related, nor would such a call have made any difference, since Dr. Stulman treated the cough as non-GI related only three days later; and
- as a gastroenterologist, there was no reason for Dr. Metz to suspect cancer since malignancies other than cancer of the esophagus or upper GI tract are outside this specialist's expertise, and Mr. Bogin did not demonstrate classic cancer symptoms such as fever, unexplained weight loss and night sweats.

Dr. Vogel states that the alleged 23 day delay between Mr. Bogin's EGD and his PMBCL diagnosis was unrelated to his prognosis and ultimate death.[9] He opines that:

- PMBCL is treated in the same manner regardless of when it is diagnosed, thus, if the patient had been diagnosed on December 30, 2014 when he first presented to Dr. Metz, he would have undergone the same treatment, including biopsies and chemotherapy, and suffered the same complications from these treatments which caused his death;
- the outcome and prognosis for PMBCL is determined by a patient's response to two to three cycles of chemotherapy, and since Mr. Bogin completed only one cycle it is impossible to reasonably predict his prognosis;
- the decedent had advanced PMBCL when he presented to NYPH's ED on January 22, 2015, as evidenced by his elevated LDH level, the size of the mass and the fact that the mass was compressing vascular structures and his trachea;
- the mere 23 day delay between Mr. Bogin's EGD and his diagnosis was insignificant since the mass was slow-growing and there was no significant change during that time period;[10] and
- the decedent did not die directly from cancer or failure to diagnose it but from side effects of the required therapies.

Plaintiff's internal medicine and gastroenterology expert discusses Dr. Metz's treatment of the decedent, emphasizing that PMBCL is a fast growing but treatable tumor, meaning that delays of mere days in treating it can significantly impact a patient's prognosis. With respect to Dr. Metz, he/she opines that::

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[9] Dr. Vogel refers to the 23 day period from the EGD to the patient's diagnosis on January 22, 2015.

[10] Accepting plaintiff's allegation that Mr. Bogin's cough was secondary to the mediastinal mass compressing his trachea, the disease was advanced as of December 30, 2014 when Dr. Metz noted that he had a dry cough.

- Dr. Metz erroneously diagnosed GERD even though Mr. Bogin's symptoms and the endoscopic findings were inconsistent with GERD;[11]

- Dr. Metz improperly failed to order imaging studies or other tests to rule out and/or diagnose intrathoracic and/or mediastinal mass or obstruction of the esophagus;

- Dr. Metz failed to properly communicate with Dr. Nicolo to determine proper testing and diagnosis;[12]

- Dr. Metz improperly failed to take action concerning abnormal vital signs[13] on December 30, 2014; and

- the 23 day period between Mr. Bogin's EGD and his date of hospitalization made a substantial difference in his cancer progression and prognosis, as evidenced by his worsening symptoms, changes in lung sounds, and the fact that Dr. Metz reported no difficulties when she inserted the endoscope in late December 2014, yet placement of a smaller orogastric feeding tube could not be accomplished three weeks later.

Dr. Metz's motion for summary judgment is granted with respect to the lack of informed consent cause of action. Plaintiff does not address this cause of action in her opposition and it is appropriately dismissed.

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[11] Plaintiff's expert contends that Mr. Bogin did not have heartburn, a primary symptom of GERD. Further, and contrary to Dr. Frank's opinions, he/she states that difficulty swallowing is not a symptom of GERD.

[12] As of January 13, 2015 Dr. Metz suspected a non-GI cause for Mr. Bogin's persistent cough, but never had him return for further work up and never so advised Dr. Nicolo, who continued to erroneously believe GERD was the cause of his symptoms. As to Dr. Stulman, he testified that he was unaware that three days prior to seeing the patient Dr. Metz thought his symptoms might be caused by something other than reflux.

[13] Plaintiff's expert disagrees with Dr. Frank's assessment that the decedent's elevated heart rate and low oxygen saturation were insignificant. He/she opines that Mr. Bogin was tachycardic due to the tumor compressing his pulmonary vasculature and preventing blood from getting back to the heart. Plaintiff's expert further concludes that lung compression caused his low oxygen saturation.

Dr. Metz's motion is otherwise denied. Issues of fact exist as to the following:

- the parties' experts dispute the significance of the decedent's abnormal vital signs on December 30, 2014, thus raising an issue as to whether or not Dr. Metz should have performed other testing in addition to the December 31, 2014 EGD, particularly where Dr. Metz's records indicate she was also aware that Mr. Bogin had chest discomfort and a dry cough, notwithstanding his denial of these symptoms in the PIF;

- whether Dr. Metz should have considered an external cause for the patient's dysphagia and ordered further testing to discover its cause, particularly where: Mr. Bogin continued to report pain swallowing after the EGD; the experts dispute that dysphagia is a GERD symptom, thus calling into question whether GERD was a reasonable diagnosis; the biopsy of the upper esophagus, where GERD was noted, showed normal findings; and the experts dispute whether esophageal compression could be ruled out even where Dr. Metz had no difficulty passing the endoscope and the photographs from the EGD do not show narrowing of the esophagus;

- the experts disagree as to whether the mass was fast or slow growing, such that Mr. Bogin would have had the same outcome if diagnosed on December 30, 2014 (as per Dr. Vogel) or whether, as plaintiff's expert opines, the progression of symptoms indicates it was slow growing and every day that it went undiagnosed worsened Mr. Bogin's prognosis; and

- whether the standard of care obligated Dr. Metz to contact Dr. Nicolo to advise of a potentially non-gastrointestinal cause of the patient's symptoms.

C. Manhattan Endoscopy

In support of its motion for summary judgment dismissing the complaint, Manhattan Endoscopy argues that it did not depart from accepted medical standards in treating plaintiff's decedent. It submits an expert affirmation from David A. Greenwald, M.D. (Dr. Greenwald), who is board certified in internal medicine and gastroenterology, and opines as follows:

- Dr. Metz was Mr. Bogin's private gastroenterologist, and Manhattan Endoscopy's staff and employees appropriately followed her directions

during the patient's EGD, thus Manhattan Endoscopy did not exercise any independent medical judgment;

- none of the orders Dr. Metz directed to Manhattan Endoscopy's staff was contraindicated and staff acted appropriately in carrying out her orders;
- the care and treatment rendered to the decedent at Manhattan Endoscopy did not lead to a delay in diagnosing and/or treating his PMBCL; and
- Manhattan Endoscopy obtained proper informed consent from the patient prior to the EGD, and the sufficiency thereof is Dr. Metz's responsibility.

Manhattan Endoscopy further argues that it cannot be held vicariously liable for Dr. Metz's treatment of Mr. Bogin pursuant to the doctrine of ostensible agency.

To support her claim of vicarious liability, Mrs. Bogin notes that Dr. Metz is a part owner of Manhattan Endoscopy and is featured on its webpage, thus holding out to the public that Dr. Metz is one of its physicians. Dr. Metz testified that when she performs procedures at Manhattan Endoscopy she uses its equipment and is obligated to comply with its protocols and bylaws, thus indicating an inference of control. Plaintiff further notes that Mr. Bogin's endoscopy report appears on Manhattan Endoscopy's letterhead. Further, Dr. Metz provides patients with a brochure for Manhattan Endoscopy and billing for the EGD is done by a billing service Manhattan Endoscopy retained.

Generally, a hospital, clinic or other medical facility may not be held vicariously liable for the acts of a private physician who is not its employee.[14]

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[14] However, a hospital may be liable if its staff commits "independent acts of negligence or the attending physician's orders are contradicted by normal practice". *Suits v Wyckoff Hgts. Med. Ctr.*, 84 AD3d 487, 488 (1st Dept 2011). Here, there is no allegation or any indication in the record that Dr. Metz's orders were "contradicted by normal practice" such that Manhattan Endoscopy staff should have declined to follow her orders.

Dragotta v Southampton Hosp., 39 AD3d 697, 698-699 (2d Dept 2007). However, vicarious liability for the medical malpractice of an independent, private attending physician may be imposed under a theory of apparent or ostensible agency by estoppel (*id.*). In order to create such apparent agency, there must be words or conduct of the principal, communicated to a third party, which give rise to the appearance and belief that the agent possesses the authority to act on behalf of the principal. The third party must reasonably rely on the appearance of authority, based on some misleading words or conduct by the principal, not the agent. Moreover, the third party must accept the services of the agent in reliance upon the perceived relationship between the agent and the principal, and not in reliance on the agent's skill (*see Hallock v State of New York*, 64 NY2d 224, 231 [1984].

Here, there is no dispute that Dr. Metz is not employed by Manhattan Endoscopy and Mr. Bogin was her private patient. Notwithstanding Dr. Metz's ownership interest in Manhattan Endoscopy and the other factors plaintiff cites, nothing in the record indicates that Mr. Bogin relied on any representations regarding the relationship between Dr. Metz and Manhattan Endoscopy. Accordingly, summary judgment is granted in Manhattan Endoscopy's favor dismissing the complaint.

D. Dr. Stulman and WCMA

On January 16, 2015, the patient presented to Dr. Stulman at WCMA. Dr. Stulman noted a chief complaint of a two week long dry cough as well as dyspnea on exertion (DOE) and GERD symptoms. Having reviewed the

endoscopy results, he was aware that Mr. Bogin "had an endoscopy on December 31, 2014 for reflux and dysphagia" (Stulman EBT at 80). Dr. Stulman went on to testify that the patient did not report dysphagia to him at that time (*id.* at 82).

Expert Dr. Katz concludes that there was no need for Dr. Stulman to order an emergent CXR because the records state that the patient's lungs were clear. Further, a review of systems revealed Mr. Bogin was not in distress and did not have a fever. As such, Dr. Katz opines that it was appropriate to prescribe antibiotics for atypical pneumonia with the plan to order a CXR the following week if the cough did not improve.

Plaintiff's internal medicine/pulmonology expert disagrees, opining that Dr. Stulman deviated from good and accepted medical practices when he failed to consider the possibility of a mediastinal mass and/or PMBCL and failed to order a CXR. Based upon Mr. Bogin's age, his ability to perform his activities of daily living and the fact that his tumor later immediately shrunk in response to chemotherapy, plaintiff's expert concludes that his prognosis would have been much improved had a CXR been performed on that date since, with this aggressive and fast growing cancer, "each day made a difference." Plaintiff's expert goes on to state that the one week delay in performing a CXR "would have avoided a week of mass and PMBCL progression, which to a reasonable degree of medical certainty, would have made a difference between life and death."

This court finds that no issue of fact exists and Dr. Stulman, as well as WCMA, are entitled to summary judgment dismissing the complaint as to him. There is no claim from plaintiff's expert that the standard of care requires that a CXR be ordered for a patient having a cough lasting two weeks, particularly in a patient like Mr. Bogin who presented with no signs of distress. Importantly, nothing in the record indicates that the patient advised Dr. Stulman that he was still experiencing dysphagia. Finally, the assertion that not performing a CXR on January 16, 2015 "would have made a difference between life and death" is merely speculative.

Plaintiff's cross-motion for partial summary judgment as to Dr. Stulman is based upon his testimony that he did not order a CXR "primarily because it was very late on a Friday and the availability of the x-ray was closed in my building". The cross-motion must be denied because, as defense counsel notes, it is untimely and plaintiff does not establish good cause for the delay in bringing it. *Fiorino v North Shore Univ. Hosp.*, 78 AD3d 1116, 1118 (2d Dept 2010). Nor is this a situation where the court can exercise its discretion and consider the untimely cross-motion on the grounds that it is based upon nearly identical grounds as the motion. *Williams v Wright*, 119 AD3d 670, 671-672 (2d Dept 2014).

Parenthetically, even had the cross-motion been timely served it would be denied as lacking in merit. First it is impermissibly predicated upon a redacted expert's affirmation. See *O'Brien v Richmond Mem. Hosp. & Health Ctr.*, 263 AD2d 532, 533 (2d Dept 1999); *Marano v Mercy Hosp.*, 241 AD2d 48, 49 (2d

Dept 1998) (while parties opposing summary judgment in a medical malpractice case may do so without disclosing the identity of their medical experts, parties moving for summary judgment in such cases must reveal their experts' identities). Finally, the supporting affirmations mischaracterize Dr. Stulman's testimony, as he also testified that he believed that Mr. Bogin was stable enough not to require an emergent CXR and if he had believed it was needed he would have sent him to the ED.[15]

E. Dr. Niesvizky

In support of Dr. Niesvizky's request for summary judgment, defendants submit an affirmation from Amir Steinberg, M.D. (Dr. Steinberg), who is board certified in internal medicine, hematology and medical oncology. With respect to Dr. Niesvizky and NYPH, Dr. Steinberg opines as follows:

- upon presenting to NYPH on January 22, 2015 Mr. Bogin was immediately worked up with imaging which confirmed a large anterior mediastinal mass, then was seen by a hematology/oncology fellow that same day for further testing;
- biopsies were performed the next day to rule out bone marrow involvement and obtain tissue to confirm the type of cancer;
- Dr. Niesvizky properly waited for final pathology results before implementing treatment, such as chemotherapy, since initiating chemotherapy without confirming the diagnosis could pose a fatal risk to the patient;
- Dr. Niesvizky correctly waited to start corticosteroids until after the mass was biopsied because steroids can ruin a tumor's morphology and affect the results of the tissue obtained;

[15] To bolster Dr. Stulman's assessment, defense counsel notes that Mr. Bogin was stable enough to travel to Miami that same weekend on business.

- the patient was timely and properly started on corticosteroids the day after the biopsy, as well as on broad spectrum antibiotics;

- upon obtaining the final pathology results on January 26, 2015, Dr. Niesvizky timely commenced a proper treatment regimen for PMBCL, including chemotherapy which began the next day;

- after Dr. Niesvizky's last contact with Mr. Bogin on January 29, 2015, the patient was appropriately and timely followed by NYPH's hematology/ oncology team until his death on March 8, 2015;

- it was appropriate and a matter of medical judgment to delay the second round of chemotherapy from the planned date of February 17, 2015 to March 5, 2015 given the patient's worsening respiratory status, ARDS, and infection/potential for drop in white blood cell count, along with his severely immunocompromised state; and

- nothing Dr. Niesvizky and NYPH did or did not do proximately caused the decedent's injuries.

In opposition, plaintiff submits an affirmation from a physician who is board certified in internal medicine with sub-certifications in hematology and medical oncology who has practiced medicine for over forty years. This expert discusses Dr. Niesvizky's treatment of Mr. Bogin, stating that:

- given the overwhelming certainty that the patient had PMBCL, the standard of care required that he be treated with chemotherapy prior to obtaining the pathology report (*i.e.*, chemotherapy should have commenced on January 22, 2015, rather than five days later on January 27, 2015);

- Dr. Niesvizky testified that one can identify PMBCL by looking at the cells and as such, plaintiff's expert concludes that a careful microscopic evaluation on January 23, 2015 would have provided further assurances to immediately begin chemotherapy; and

- the failure to start chemotherapy caused the mass to progress which caused further damage to the lungs, trachea and other structures that manifested itself in an elevated heart rate and decrease in blood pressure to the point of requiring pressors and high pressure mechanical ventilation.

Summary judgment is granted in Dr. Niesvizky's favor. Plaintiff's expert fails to cite anything in the record to support his/her conclusory statement that there was an overwhelming certainty that Mr. Bogin's cancer was PMBCL. No mention is made of any of the other potential diagnoses such as Hodgkin's lymphoma and germ cell tumor. He/she also does not address Dr. Steinberg's opinion that beginning chemotherapy without a definitive diagnosis posed potentially life threatening risks.[16]

Plaintiff's expert similarly does not address Dr. Niesvizky's treatment plan to begin steroid therapy immediately after performing the biopsy, a matter of his medical judgment. Plaintiff's expert's opinions are essentially made with the benefit of hindsight and do not negate the factors on which Dr. Niesvizky based his judgment. For the foregoing reasons, summary judgment of dismissal is granted in Dr. Niesvizky's favor.

F. NYPH

As summary judgment has been granted in Dr. Niesvizky's favor, plaintiff's claim that NYPH is vicariously liable for the treatment he rendered to the decedent must also be dismissed. As to plaintiff's direct liability claims against NYPH, plaintiff's opposition fails to address the care NYPH staff rendered to Mr. Bogin after Dr. Niesvizky's treatment concluded. Accordingly, summary judgment is properly granted dismissing this action as to NYPH.

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[16] In reply, defense counsel characterizes the opinion that Dr. Niesvizky departed from the standard of care by not commencing chemotherapy upon admission and prior to confirming the diagnosis as "appalling" and "ABSOLUTELY chilling and egregious."

WRONGFUL DEATH

As held in *Chong v New York City Trans. Auth.*, 83 AD2d 546, 547 (2d Dept 1981):

> The elements of a cause of action to recover damages for wrongful death are (1) the death of a human being, (2) the wrongful act, neglect or default of the defendant by which the decedent's death was caused, (3) the survival of distributees who suffered pecuniary loss by reason of the death of decedent and (4) the appointment of a personal representative of the decedent (citation omitted).

Having concluded Mrs. Bogin failed to establish that Dr. Stulman, Dr. Niesvizky, Manhattan Endoscopy and NYPH departed from the applicable standard of care or were otherwise vicariously liable for the actions of any co-defendant, plaintiff cannot establish that any "wrongful act, neglect or default" caused Mr. Bogin's death. Accordingly, the fourth cause of action alleging wrongful death must be dismissed as to these defendants. As to defendants Dr. Nicolo, Dr. Metz and WCMA, the cause of action for wrongful death must be dismissed to the extent that summary judgment was granted in these defendants' favor.

LACK OF INFORMED CONSENT

As stated in *Colarusso v Lo*, 42 Misc3d 1210(A), 2013 WL 6985388, [*5] (Sup Ct, NY County, Schlesinger, J.S.C.):

> Claims of lack of informed consent are statutorily defined. Pub. Health § 2805–d. The law requires persons providing professional treatment or diagnosis to disclose alternatives and reasonably foreseeable risks and benefits involved to the patient to permit the patient to make a knowing evaluation. *Id.* § 2805–d(1). Causes of action for lack of informed consent are limited to non-emergency procedures or other treatment and include diagnostic procedures that involve invasion or disruption to bodily integrity. *Id.* §

> 2805–d(2). To ultimately prevail on a lack of informed consent claim, a claimant must prove that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis had the patient been fully informed, and the claimant must prove that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought. *Id.* § 2805–d(3).

Only defendants Dr. Metz and Manhattan Endoscopy address the second cause of action alleging lack of informed consent. Plaintiff fails to address this cause of action and it is thus dismissed as to these defendants.

Although not addressed in Dr. Nicolo, Dr. Stulman, Dr. Niesvizky, WCMA and NYPH's motion for summary judgment, upon searching the record the cause of action alleging lack of informed consent is dismissed as to them. Nothing in the record supports this cause of action. The complaint, bills of particulars and amended bills of particulars contain only general allegations. Plaintiff has failed to specify what alternatives and risks these defendants allegedly failed to disclose. Nor is there any basis in the record to conclude that any alleged lack of informed consent proximately caused the decedent's injuries.

DERIVATIVE CLAIMS

Finally, the third cause of action alleging loss of consortium, services and society, must be dismissed with respect to those parties and claims as to which summary judgment was granted. *Holmes v City of New Rochelle*, 190 AD2d 713, 714 (2d Dept 1993), citing *Maddox v City of New York*, 108 AD2d 42 (2d Dept 1985), *affd* 66 NY2d 270 (1985) (loss of services claims are derivative in

nature and dismissal of the primary causes of action necessitates their dismissal).

Accordingly, it is

ORDERED that summary judgment is granted in favor of defendant Dr. Nicolo and WCMA solely with respect to Dr. Nicolo's treatment of plaintiff's decedent on November 18, 2014 and January 8, 2015, and is denied as to said defendants with respect to the treatment rendered on December 29, 2015; and it is further

ORDERED that summary judgment is granted in favor of Dr. Metz with regard to the second cause of action alleging lack of informed consent, and is otherwise denied; and it is further

ORDERED that Manhattan Endoscopy's motion for summary judgment is granted in its entirety and the Clerk is directed to enter judgment dismissing this action with prejudice as to this defendant, together with costs and disbursements as taxed by the Clerk upon the submission of an appropriate bill of costs; and it is further;

ORDERED that defendant Manhattan Endoscopy's counsel is directed to serve a copy of this order by e-mail upon the Clerk of the Court (cc-nyef@nycourts.gov), and upon the Trial Support Office (trialsupport-nyef@nycourts.gov), who are directed to amend their records to delete Manhattan Endoscopy, LLC from the caption herein; and it is further

ORDERED that summary judgment is granted in favor of defendants Dr. Stulman, Dr. Niesvizky and NYPH, the complaint is dismissed as to them, and the Clerk is directed to enter judgment dismissing this action with prejudice as to these defendants, together with costs and disbursements as taxed by the Clerk upon the submission of an appropriate bill of costs; and it is further

ORDERED that summary judgment is granted in WCMA's favor dismissing the complaint with regard to treatment Dr. Stulman rendered to plaintiff's decedent; and it is further

ORDERED that plaintiff's cross-motion for partial summary judgment as to defendant Dr. Stulman is denied.

Counsel for plaintiff and the remaining defendants are directed to appear for a pre-trial conference at Part 1 MMSP, 60 Centre St., Room 325, New York, New York on December 18, 2018 at 9:30 a.m. In the event that no settlement can be reached, counsel shall be prepared on that date to stipulate to a firm trial date in Part 40 TR.

The foregoing constitutes this court's Decision and Order.

Dated: New York, New York
December 5, 2018

HON. MARTIN SHULMAN, J.S.C