Short Form Order

SUPREME COURT - STATE OF NEW YORK
TRIAL TERM, PART 17 NASSAU COUNTY

PRESENT:
Honorable Karen V. Murphy
Justice of the Supreme Court

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DIANA CHRISTIE, Individually and as Executrix of the Estate of GEORGE CHRISTIE, Deceased,

Plaintiff(s),

-against-

ISLAND UROLOGICAL ASSOCIATES, P.C. and CHARLES J. KANDLER,

Defendant(s).

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Index No. 17773/08

Motion Submitted: 3/3/10
Motion Sequence: 001

The following papers read on this motion:

Notice of Motion/Order to Show Cause.....X
Answering Papers.....X
Reply.....X
Briefs: Plaintiff's/Petitioner's.....
Defendant's/Respondent's.....

This motion by the defendants Island Urological Associates, P.C. and Charles Kandler for an order pursuant to CPLR § 3212 granting them summary judgment dismissing the complaint against them is denied.

The plaintiff in this action, Diana Christie, Individually and as Executrix of the Estate of George Christie, seeks to recover damages for the wrongful death of her husband George Christie, which was allegedly caused by the defendants' medical malpractice. She has advanced causes of action seeking to recover for George's conscious pain and suffering, his wrongful death, her loss of consortium and lack of informed consent. Succinctly put, she alleges that the defendants failed to properly monitor her husband's Prostate Specific Antigen

("PSA") and to perform adequate biopsies of his prostate, which led to a significantly delayed diagnosis of prostate cancer and ultimately his death. The defendant Dr. Kandler and the practice with which he is affiliated, the defendant Island Urological Associates, P.C., seek summary judgment dismissing the complaint.

"On a motion for summary judgment pursuant to CPLR § 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." (***Sheppard-Mobley v. King***, 10 A.D.3d 70, 74, 778 N.Y.S.2d 98 (2d Dept., 2004), citing ***Alvarez v. Prospect Hosp.***, 68 N.Y.2d 320, 324, 501 N.E.2d 572, 508 N.Y.S.2d 923 (1986); ***Winegrad v. New York Univ. Med. Ctr.***, 64 N.Y.2d 851, 853, 476 N.E.2d 642, 487 N.Y.S.2d 316 [1985]). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." (***Sheppard-Mobley v. King, supra***, at p. 74; ***Alvarez v. Prospect Hosp., supra; Winegrad v. New York Univ. Med. Ctr., supra***). Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. (***Alvarez v. Prospect Hosp., supra***, at p. 324). The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. (See, ***Demshick v. Community Housing Management Corp.***, 34 A.D.3d 518, 521, 824 N.Y.S.2d 166 (2d Dept., 2006), citing ***Secof v. Greens Condominium***, 158 A.D.2d 591, 551 N.Y.S.2d 563 [2d Dept.,1990]).

"To establish a prima facie case of liability for medical malpractice, a plaintiff must prove that the defendant deviated from accepted practice, and that such deviation proximately caused his or her injuries." (**Dehaarte v. Ramenovsky**, 67 A.D.3d 724, 725, 889 N.Y.S.2d 68 (2d Dept., 2009), citing ***Novik v. Godec***, 58 A.D.3d 703, 872 N.Y.S.2d 152 (2d Dept., 2009); ***Monroy v. Glavas***, 57 A.D.3d 631, 870 N.Y.S.2d 371 (2d Dept., 2008); ***Rabinowitz v. Elimian***, 55 A.D.3d 813, 866 N.Y.S.2d 286 [2d Dept., 2008]). "On a motion for summary judgment dismissing the complaint in a medical malpractice action, a defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or, if there was a departure, that the plaintiff was not injured thereby." (***Shectman v. Wilson***, 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept., 2009), citing ***Murray v. Hirsch***, 58 A.D.3d 701, 871 N.Y.S.2d 673 (2d Dept., 2009); ***Shahid v. New York City Health & Hospitals Corp.***, 47 A.D.3d 800, 850 N.Y.S.2d 519 [2d Dept., 2008]; ***Alvarez v. Prospect Hosp., supra***). "Bare allegations which do not refute the specific factual allegations of medical malpractice in the bill of particulars are insufficient to establish entitlement to judgment as a matter of law." (***Grant v. Hudson Valley Hosp. Center***, 55 A.D.3d 874, 866 N.Y.S.2d 726 (2d Dept., 2009), citing ***Berkey v. Emma***, 291 A.D.2d 517, 518, 738 N.Y.S.2d 250 (2d Dept., 2002); ***Drago v. Chung Ho King***, 283 A.D.2d 603, 603-604, 725 N.Y.S.2d 859 (2d Dept., 2001); ***Terranova v. Finklea***, 45 A.D.3d 572, 845 N.Y.S.2d 389 (2d Dept., 2007); ***Kuri v. Bhattacharya***, 44 A.D.3d 718, 842 N.Y.S.2d 734 [2d Dept., 2007]).

If the moving defendant meets his burden, "[i]n opposition a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." (***Shectman v. Wilson, supra,*** citing ***Swezey v. Montague Rehab & Pain Management, P.C.***, 59 A.D.3d 431, 872 N.Y.S.2d 199 (2d Dept., 2009); ***Murray v. Hirsch, supra; Shahid v. New York City Health & Hospitals Corp., supra***). "[G]eneral allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" do not suffice. (***Shectman v. Wilson, supra***, citing ***Alvarez v. Prospect Hosp., supra; Shahid v. New York City Health & Hospitals Corp., supra***; see also ***Diaz v. New York Downtown Hosp.***, 99 N.Y.2d 542, 784 N.E.2d 68, 754 N.Y.S.2d 195 (2002); ***Romano v. Stanley***, 90 N.Y.2d 444, 684 N.E.2d 19, 661 N.Y.S.2d 589 (1997); ***Amatulli by Amatulli v. Delhi Const. Corp.***, 77 N.Y.2d 525, 571 N.E.2d 645, 569 N.Y.S.2d 337 [1991]). The plaintiff's expert must set forth the medically accepted standards or protocol and explain how it was departed from. (***Geffner v. North Shore University Hosp.***, 57 A.D.3d 839, 842, 871 N.Y.S.2d 617 (2d Dept., 2008), citing ***Mustello v. Berg***, 44 A.D.3d 1018, 1019, 845 N.Y.S.2d 86 (2d Dept., 2007); ***Behar v. Coren***, 21 A.D.3d 1045, 1047, 803 N.Y.S.2d 629 (2d Dept., 2005); ***LaMarque v. North Shore Univ. Hosp.***, 227 A.D.2d 594, 594-595, 643 N.Y.S.2d 221 [2d Dept., 1996]). And, the plaintiff's expert must address all of the key facts relied on by the defendant's expert. (See, ***Kaplan v. Hamilton Medical Associates, P.C.***, 262 A.D.2d 609, 692 N.Y.S.2d 674 (2d Dept., 1999); see also ***Geffner v. North Shore University Hosp., supra***; ***Rebozo v. Wilen***, 41 A.D.3d 457, 838 N.Y.S.2d 121 [2d Dept., 2007]).

"To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." (***Alicea v. Ligouri***, 54 A.D.3d 784, 785, 864 N.Y.S.2d 462 (2d Dept., 2008), quoting ***Johnson v. Jamaica Hosp. Med. Ctr.***, 21 A.D.3d 881, 883, 800 N.Y.S.2d 609 (2d Dept., 2005), citing ***Holton v. Sprain Brook Manor Nursing Home***, 253 A.D.2d 852, 678 N.Y.S.2d 503 [2d Dept., 1998]). The plaintiff's expert need not quantify "'the extent to which the defendant's act or omission decreased the plaintiff's chance of better outcome or increased [the] injury as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury.'" (***Alicea v. Ligouri, supra***, at p. 786, quoting ***Flaherty v. Fromberg***, 46 A.D.3d 743, 849 N.Y.S.2d 278 (2d Dept., 2007), citing ***Barbuto v. Winthrop University Hosp.***, 305 A.D.2d 623, 624, 760 N.Y.S.2d 199 (2d Dept., 2003); ***Wong v. Tang***, 2 A.D.3d 840, 841, 769 N.Y.S.2d 381 [2d Dept., 2003]).

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting expert opinions . . . . Such credibility issues can only be resolved by a jury." (***Feinberg v. Feit***, 23 A.D.3d 517, 519, 806 N.Y.S.2d 661 (2d Dept., 2005), citing ***Barbuto v. Winthrop University Hosp., supra; Halkias v. Otolaryngology-Facial Plastic***

Surgery Assoc., 282 A.D.2d 650, 724 N.Y.S.2d 432 (2d Dept., 2001); see also, ***Roca v. Perel***, 51 A.D.3d 757, 759, 859 N.Y.S.2d 203 (2d Dept., 2008); ***Graham v. Mitchell***, 37 A.D.3d 408, 829 N.Y.S.2d 628 [2d Dept., 2007]).

The pertinent facts are as follows:

The decedent became a patient at Island Urological Associates in 1997, at which time he had a history of an enlarged prostate, also known as Benign Prostatic Hypertrophy and elevated PSA levels. A biopsy of his prostate had come back negative a year and a half earlier but revealed the abnormality epithelial dysplasia. The decedent became a patient of Dr. Kandler on December 21, 1998, and he was treated by Dr. Kandler until he was diagnosed with prostate cancer in January 2006. A biopsy of his prostate performed on December 21, 1998 was also negative, but again revealed the abnormality epithelial dysplasia. On January 4, 1999 the decedent was placed on Cardura for his enlarged prostate and at his February 8, 1999 visit, he reported decreased urinary urgency and frequency. When Dr. Kandler saw the decedent on August 4, 1999, his prostate remained enlarged and he suffered from nocturia, i.e., frequent night urination, and incomplete emptying of his bladder.

Throughout the time that the decedent was being treated by Dr. Kandler, his prostate levels were being monitored by his private physician, Dr. Gottlieb. On October 4, 1999, the decedent's PSA was 9.0 and on December 13, 1999 it was 7.7. When Dr. Kandler saw the decedent on March 27, 2000, his PSA levels were lower than previously. He refused a biopsy. However, on September 27, 2000, the decedent's PSA levels rose to 14.8 and on October 2, 2000, it rose to 17. At his visit with Dr. Kandler on October 2, 2000, a prostate biopsy was again suggested but because the decedent was traveling, the biopsy was postponed. A prostate biopsy performed on November 27, 2000 was negative but still revealed epithelial dysplasia. The decedent returned to see Dr. Kandler on June 14, 2001. He remained on Cardura. On June 6, 2002, the decedent's PSA level was 13.7 and on April 3, 2003 it was 21.5, however, on August 7, 2003 it decreased to 14.5 and on September 5, 2004 it was 11.4. On September 15, 2004, Dr. Kandler put the decedent on Avodart, a medication used to shrink the prostate. Fourteen months later, on December 7, 2005, his PSA level rose to 44 and it remained high. The decedent was referred to Dr. Kandler and when the biopsy was positive, the decedent was diagnosed with prostate cancer. He was thereafter treated by Dr. Potters at Sloan Kettering Memorial Hospital. He died on October 21, 2007.

In support of their motion, the defendants Dr. Kandler and Island Urological Associates have submitted the affirmation of a Board Certified urologist, Dr. Arnold Melman. Having reviewed the decedent's medical records and the pertinent legal documents of this case, he opines to a reasonable degree of medical certainty that Dr. Kandler acted in accordance with good and accepted standards of medical practice throughout his treatment

of the decedent. Dr. Melman notes that the decedent presented at Island Urological with a history of elevated PSA levels, prostatitis and a negative prostate biopsy. The biopsy performed in December 1998 was negative, too. He notes that the decedent consistently had elevated PSA levels and that when they nearly doubled in September 2000, a biopsy was performed which again proved negative. He notes that the decedent's PSA levels remained consistently elevated until December 2005, at which time a biopsy was warranted and performed. Dr. Melman explains that the decedent's elevated PSA levels were consistent with his enlarged prostate, prostatitis and benign prostatic hyperplasia. He opines that "the accepted standards of medical practice within the urological community do not call for continuous biopsies, especially considering, in this case, an elderly patient with three negative biopsies for cancer." He opines that only when the decedent's PSA levels nearly quadrupled between September 2004 and December 2005 was a further biopsy called for. He further explains and opines that under the circumstances presented, "the concern of the patient expiring from prostate cancer is diminished to a point where [his] constant surveillance . . . in an effort to diagnose prostate cancer is not warranted and not accepted practice within the urological community." And, he concludes to a reasonable degree of medical certainty that the defendants' care of the decedent did not proximately cause his demise.

The defendants have established their entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In opposition, the plaintiff has submitted the expert affirmation of a Board Certified Urologist. Having reviewed the decedent's medical records and the transcripts of the examinations-before-trial, [s]he opines to a reasonable degree of medical certainty that Dr. Kandler deviated from good and accepted standards in his care and treatment of the decedent which departures were substantial causative factors of his death. [S]he explains that [s]he has treated thousands of patients like the decedent. [S]he states that while the decedent suffered from the benign condition epithelial dysplasia for ten years, it is a possible precursor to prostate cancer. [S]he notes that the biopsies did not rule out cancer because the procedures involved limited samplings. Because of this, the decedent was at high risk for prostate cancer and strict monitoring of his PSA levels was required to ascertain whether the condition had become malignant because the higher the PSA level, the likelihood of cancer increases. The plaintiff's expert specifically faults Dr. Kandler for failing to conduct a PSA test three to six months after putting him on Avodart. [S]he explains that Avodart typically lowers a man's PSA by 50% if the elevation is being caused by a benign condition, however, an elevation due to malignancy does not respond like that. Therefore, if there is no decline in a patient's PSA level after three to six months on Avodart, a strong indication of malignancy is present. [S]he opines that had such a test been done, the expected 50% decline in the decedent's PSA level would not have been seen because of the malignancy, which, [s]he explains, must have

been there since when it was discovered in February, 2006, it was so far advanced that it had to have been there in early 2005. [S]he further opines that had the test been done and the malignancy suspicion revealed, a biopsy would have revealed the malignant condition and enabled diagnosis and treatment far sooner. Further, [s]he opines that had it been diagnosed timely, it would not have metastasized to the decedent's bones and been Stage IV as it was when it was found in February 2006. The plaintiff's expert opines that Dr. Kandler's failure to test not only led to a delay in diagnosis but was a proximate cause of the decedent's death. [S]he opines that Dr. Kandler's mistake reduced the decedent's chance of a cure to zero and increased his chance of future morbidity and mortality to 100%.

Through her expert, the plaintiff has established the existence of a material issue of fact requiring the denial of the defendant Dr. Kandler and Island Urological Associates' motion.

The foregoing constitutes the Order of this Court.

Dated: March 23, 2010
Mineola, N.Y.

Karen V. Murphy
J. S. C.