Thompson v Khotsyna
2020 NY Slip Op 32850(U)
August 31, 2020
Supreme Court, Kings County
Docket Number: 502377/13
Judge: Ellen M. Spodek

At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 31st day of August, 2020.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

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CHERYL THOMPSON, Individually and as the ADMINISTRATRIX OF THE ESTATE OF JEANETTE THOMPSON, Deceased,

Plaintiff,

- against -

Index No. 502377/13

MARGARITA KHOTSYNA, M.D. and NEW YORK METHODIST HOSPITAL,

Mot. Seq. No. 3

Defendants.

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The following e-filed papers read herein:

	Papers
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1
Opposing Affidavits (Affirmations)	2
Reply Affidavits (Affirmations)	3

Upon the foregoing papers, in this action by plaintiff Cheryl Thompson (plaintiff), individually and as administratrix of the estate of Jeanette Thompson (Ms. Thompson), for medical malpractice and wrongful death, defendants Margarita Khotsyna, M.D. (Dr. Khotsyna) and New York Methodist Hospital (Methodist) move, under motion sequence number three, pursuant to CPLR 3212, for summary judgment dismissing plaintiff's complaint as against them.

Facts and Procedural Background

On May 22, 2009, Ms. Thompson, who was then 68 years old, was admitted as a patient at Methodist, where Dr. Khotsyna was called as a medical consult. Dr. Khotsyna, is a physician board certified in internal medicine, geriatrics, and hospice and palliative care, and an employee of Methodist.[1] At the time she was admitted, Ms. Thompson had an extensive medical history, including chronic deep vein thrombosis, HIV infection, a stroke resulting in right-sided hemiparesis, coronary artery disease, seizures, and aphasia (i.e., the inability to speak). Ms. Thompson was treated for a urinary tract infection and discharged to subacute rehabilitation.

On July 21, 2009, Dr. Khotsyna, who was an attending physician in the outpatient department at Methodist, became Ms. Thompson's primary care physician. At that time, Ms. Thompson weighed 126 pounds. Ms. Thompson had further visits with Dr. Khotsyna on August 11, 2009, September 1, 2009, November 23, 2009, January 29, 2010, and February 25, 2010. Lab results on March 3, 2010 showed that Ms. Thompson had an elevated protein level. On March 29, 2010, Dr. Khotsyna ordered a serum protein electrophoresis and a urine protein electrophoresis. On April 3, 2010, the serum protein electrophoresis showed a monoclonal protein. On April 5, 2010, Dr. Khotsyna made a referral to a hemotologist/oncologist. On April 22, 2010, Ms. Thompson went to the emergency room at Methodist due to abdominal pain, constipation, and blood in her

[1] There is no dispute that Dr. Khotsyna was an employee of Methodist, and, as such, Methodist is vicariously liable for any medical malpractice by Dr. Khotsyna (*see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]).

stool. Ms. Thompson was admitted to Dr. Khotsyna's service with an assessment of gastrointestinal bleeding.

On April 24, 2010, a CT scan of Ms. Thompson's abdomen and pelvis without intravenous (IV) contrast was performed. The CT scan was interpreted by Fred C. Van Natta, M.D. (Dr. Van Natta), a radiologist. The reason given for the CT scan was listed as abdominal pain. The CT scan report, as relevant, reported as follows:

> "Mural thickening of the sigmoid colon, which is not well distended with oral contrast. Pathology in the sigmoid colon/rectum cannot be excluded. Inflammation in the fat adjacent to the sigmoid colon and above the dome of the bladder on the left. This may be inflammatory or neoplastic. The bladder is not well distended.[2] Cystitis[3] or *transitional cell carcinoma of the bladder cannot be excluded*" (emphasis added).

Dr. Van Natta set forth his impression as "[i]nflammatory changes adjacent to the sigmoid colon and adjacent to the dome of the bladder," and that [c]olon pathology and/or *bladder pathology cannot be excluded*" (emphasis added). He also set forth that "[f]urther evaluation of [the] bladder and further evaluation of the sigmoid colon [was] suggested."

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[2] Distended means stretched with fluid (*see* Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]). Dr. Khotsyna explained, at her deposition, that a bladder gets distended when it is full, and if the bladder is not completely distended or under-distended because there is little urine in the bladder, it is contracted and may appear to be mildly thickened (Dr. Khotsyna's deposition tr at 77-78, 80).

[3] Cystitis is defined as "[i]nflammation of the urinary bladder" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]).

Ms. Thompson also had a skeletal survey at Methodist on April 24, 2010 for possible metastatic disease. The impression of the skeletal survey, which was signed by Paul Baez, was that at that time, there was "[n]o evidence for metastatic disease."

On April 26, 2010, an ultrasound of Ms. Thompson's upper abdomen was noted to be an extremely limited study. It showed cholelithiasis, but there was no evidence of cholecystitis. On April 27, 2010, Ms. Thompson underwent a flexible sigmoidoscopy, which showed normal mucosa up to splenic flexure and hemorrhoids. The recommendation was for a fiber rich diet. On April 28, 2010, Ms. Thompson was discharged home.

On May 4, 2010, Ms. Thompson went to the emergency department at Methodist with the chief complaint of vomiting for four days. Ms. Thompson had been rubbing her abdomen and moaning when touched. The diagnosis was persistent vomiting and gastritis, and she was treated with IV fluids and Zofran.

On May 5, 2010, Ms. Thompson underwent a physical by Dr. L. Elliott at Methodist, who found tenderness in her lower abdomen. The assessment was constipation and abdominal pain. A limited abdominal ultrasound showed cholelithiasis, possible calculus within the cystic duct, and a mass in the lower pole of Ms. Thompson's right kidney.

On May 6, 2010, a CT scan of Ms. Thompson's abdomen and pelvis with IV contrast was performed. This CT scan was interpreted by Yousaf Mahmood, M.D., a radiologist. Among other things, there was an impression of "[m]ultiple renal lesions on

the right kidney, including what appear[ed] to be a hyperdense cyst in the midpole measuring 8 mm and a 1.3 cm indeterminate enhancing lesion at the lower pole." With respect to Ms. Thompson's bladder, the finding was that her bladder was "incompletely distended and *[an] assessment of mild wall thickening c[ould] not be confirmed*" (emphasis added). The CT report advised that it was necessary to correlate clinically the possibility of cystitis. On May 8, 2010, Ms. Thompson was discharged home from Methodist.

On June 17, 2010, Ms. Thompson followed up with Dr. Khotsyna. Dr. Khotsyna did not refer Ms. Thompson to a urologist at that time (Dr. Khotsyna's deposition transcript at 88). Ms. Thompson's weight was then 123 pounds. Ms. Thompson was noted to be stable. The plan was to continue Ms. Thompson's current treatment. On July 19, 2010, Dr. Khotsyna noted that Ms. Thompson's weight had dropped to 106 pounds and labs were ordered. At Ms. Thompson's October 19, 2010 and November 3, 2010 visits, Ms. Thompson's weight was 117 pounds. At a January 11, 2011 visit, Dr. Khotsyna noted that Ms. Thompson had frequent soft bowel movements.

On January 18, 2011, Ms. Thompson was seen by Dr. Khotsyna, who noted that Ms. Thompson's abdominal pain was worsening, and that Ms. Thompson was pointing to her lower abdomen. Ms. Thompson was advised to go to the emergency room for further evaluation.

On January 18, 2011, Ms. Thompson underwent a CT scan of the abdomen and pelvis with IV contrast, which was interpreted by John Eric Ditzenberger, M.D., a

radiologist. Ms. Thompson's bladder was found to be "irregular in contour with soft tissue thickening along the posterior and inferior aspect," and a "mural nodule [was] seen along the left posterior lateral wall of the bladder measuring 6.2 mm." The impression was "[i]rregularity of the bladder contour with 8 mm neural nodule along the left posterior lateral wall," and "[t]hickening of the bladder wall predominantly at the posterior and inferior aspect."

On January 19, 2011, Ms. Thompson saw Edward Zoltan, M.D. (Dr. Zoltan), a urologist, for a consultation, and he recommended a urine cytology or a possible bladder wall biopsy and to continue to follow-up on Ms. Thompson. On January 20, 2011, an ultrasound of Ms. Thompson's kidneys showed mild hydronephrosis and hydroureter consistent with mild obstruction at the level of the ureteral ostia, and that there was an associated diffusely thickened wall of the urinary bladder suggestive of chronic cystitis. The ultrasound also showed a sub-centimeter polypoid mass in Ms. Thompson's urinary bladder, and a cystoscopy was advised. Dr. Pujol consulted and assessed that Ms. Thompson had possible bladder carcinoma. On January 21, 2011, Dr. Jeffrey Ball, a hematologist, noted that a urine cytology report showed atypical urothelial cells and that neoplasm could not be ruled out. Ms. Thompson was discharged home with oral antibiotics and a plan for a cystoscopy as an outpatient.

On February 25, 2011, Dr. Zoltan saw Ms. Thompson in his office for the renal mass. The January 18, 2011 CT scan was reviewed, and a septated renal mass was

noted. The assessment was renal mass, and the plan was to follow-up in six months with a renal ultrasound.

On March 3, 2011, Ms. Thompson followed-up with Dr. Khotsyna. Dr. Khotsyna noted that she had discussed Ms. Thompson with Dr. Zoltan, and that Dr. Zoltan stated that he would perform a cystoscopy on Ms. Thompson.

On March 23, 2011, Ms. Thompson was assessed by Dr. Zoltan in his office. A cystoscopy and bladder biopsy with fulguration were performed. A one centimeter left lateral wall tumor in the bladder was found and biopsied.

On March 25, 2011, Ms. Thompson went to the emergency room at Methodist with bloody urine. She was discharged with an assessment of hematuria. On April 12, 2011, Dr. Khotsyna noted that Ms. Thompson had lost weight and was only 109 pounds, and that she had lower abdominal tenderness.

On April 15, 2011, Ms. Thompson underwent a bone scan, which showed that she had metastatic bone disease, (the cancer spread from her bladder, its original site, to her bones). On April 21, 2011, Dr. Khotsyna noted that Ms. Thompson's prognosis was poor and planned a palliative care evaluation. On April 29, 2011, pain management was consulted for generalized pain secondary to metastases from bladder cancer. Since Ms. Thompson's prognosis was grave, she was started on a morphine drip. On May 2, 2011, Ms. Thompson was transferred to inpatient hospice. On May 12, 2011, Ms. Thompson died from cancer.

On May 7, 2013, plaintiff, who is Ms. Thompson's daughter and the administratrix of her estate, filed the instant action against Dr. Khotsyna and Methodist, alleging medical malpractice and wrongful death.

Discussion

"The essential elements of a cause of action to recover damages for medical malpractice are a deviation or departure from accepted medical practice and evidence that such departure was a proximate cause of injury [or death]" (*Harris v St. Joseph's Med. Ctr.*, 128 AD3d 1010, 1012 [2d Dept 2015]; *see also Poter v Adams*, 104 AD3d 925, 926 [2d Dept 2013]; *Hayden v Gordon*, 91 AD3d 819, 820 [2d Dept 2012]; *Guzzi v Gewirtz*, 82 AD3d 838, 838 [2d Dept 2011]). "Proximate cause is established where the defendant's conduct was a 'substantial factor' in bringing about the injury [or death]" (*King v St. Barnabas Hosp.*, 87 AD3d 238, 245 [1st Dept 2011]; *see also Goldberg v Horowitz*, 73 AD3d 691, 694 [2d Dept 2010]).

In an action sounding in medical malpractice, a defendant moving for summary judgment has the initial burden of making "'a prima facie showing either that there was no departure from accepted medical practice [or the accepted standard of care], or that any departure was not a proximate cause of the patient's injuries [or death]'" (*Stucchio v Bikvan*, 155 AD3d 666, 667 [2d Dept 2017], quoting *Matos v Khan*, 119 AD3d 909, 910 [2d Dept 2014]; *see also Larcy v Kamler*, __ AD3d __, 2020 NY Slip Op 03652 [2d Dept 2020]; *Joyner v Middletown Med., P.C.*, 183 AD3d 593, 594 [2d Dept 2020]; *Neyman v Doshi Diagnostic Imaging Servs., P.C.*, 153 AD3d 538, 543 [2d Dept 2017]; *Elmes v*

Yelon, 140 AD3d 1009, 1010 [2d Dept 2016]; *Nisanov v Khulpateea*, 137 AD3d 1091, 1093 [2d Dept 2016]; *Guctas v Pessolano*, 132 AD3d 632, 633 [2d Dept 2015]; *Poter*, 104 AD3d at 926; *Salvia v St. Catherine of Sienna Med. Ctr.*, 84 AD3d 1053, 1053-1054 [2d Dept 2011]; *Heller v Weinberg*, 77 AD3d 622, 622-623 [2d Dept 2010], *lv denied* 16 NY3d 707 [2011]). "The failure to make such [a] prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers" (*Stiso v Berlin*, 176 AD3d 888, 889 [2d Dept 2019]; *see also Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]).

It is only "[o]nce a defendant has made such a [prima facie] showing [that] the burden shifts to the plaintiff to 'submit evidentiary facts or materials to rebut the prima facie showing by the defendant'" and to establish the existence of triable issues of fact (*Harris*, 128 AD3d at 1012, quoting *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *see also Stukas v Streiter*, 83 AD3d 18, 25-26 [2d Dept 2011]). "Once the defendant has made such a showing, the plaintiff, in opposition, must submit evidentiary facts or materials to rebut the defendant's prima facie showing, but only as to those elements on which the defendant met the prima facie burden" (*Neyman*, 153 AD3d at 543; *see also Keesler v Small*, 140 AD3d 1021, 1023 [2d Dept 2016]; *Elmes*, 140 AD3d at 1010; *Nisanov*, 137 AD3d at 1093-1094; *Poter*, 104 AD3d at 926; *Stukas*, 83 AD3d at 23-24).

In support of their motion, Dr. Khotsyna and Methodist have submitted the affirmation of their medical expert, Brian Feingold, M.D. (Dr. Feingold), a physician

duly licensed to practice medicine in the State of New York who is board certified in the field of internal medicine. Dr. Feingold notes that plaintiff alleges, in her bill of particulars that there was an alleged failure by Dr. Khotsyna and Methodist to diagnose Ms. Thompson's bladder cancer, which allowed the cancer to metastasize to the bone and bone marrow. Dr. Feingold states that his review of the records of Methodist and Dr. Khotsyna indicate that the treatment rendered was, at all times, in accordance with good and accepted standards of medical practice, and that there was no failure to diagnose and treat bladder cancer.

Dr. Feingold acknowledges that the report of the April 24, 2010 CT scan showed inflammatory changes and advised that colon or bladder cancer had to be ruled out, and that this required close monitoring and follow-up. He states, however, that the May 6, 2010 follow-up CT scan showed no lesions and "no bladder wall thickening" or nodules. He asserts that the findings on this May 6, 2010 follow-up CT scan "were reassuring to" Dr. Khotsyna, as compared to the April 24, 2010 CT scan. He opines that, therefore, in reacting to the results of the April 24, 2010 CT scan, Dr. Khotsyna acted in accordance with good and accepted medical practice by following up on the results of that CT scan with the May 6, 2010 CT scan, and that the findings of the May 6, 2010 CT scan "were reassuring and not indicative of any bladder pathology."

Dr. Feingold notes that Ms. Thompson showed a 17-pound weight loss during her July 19, 2010 visit. He opines that Dr. Khotsyna acted in accordance with good and accepted medical practice by advising Ms. Thompson's daughter to monitor Ms.

Thompson's appetite. Dr. Feingold states that by Ms. Thompson's next visit on October 19, 2010, Ms. Thompson had gained 11 pounds from her prior visit, and that her weight remained at 117 pounds when she was seen on November 3, 2010. He does not comment on the fact that on April 12, 2011, Ms. Thompson's weight had dropped to only 109 pounds

Dr. Feingold observes that Ms. Thompson's January 18, 2011 CT scan showed that Ms. Thompson had a possible bladder tumor. He asserts that Dr. Khotsyna obtained the appropriate in-house consults in urology, infectious disease, and hematology. He opines that Dr. Khotsyna acted in accordance with good and accepted medical practice by discharging Ms. Thompson and advising her to go for a cystoscopy on an outpatient basis. He notes that this cystoscopy was not performed until March 23, 2011, approximately two months after the January 18, 2011 CT scan, and that a bladder tumor was revealed by this cystoscopy. He states that this was due to the fact that Dr. Zoltan failed to perform the cystoscopy during Ms. Thompson's initial visit with him on February 25, 2011. He opines that Dr. Khotsyna acted appropriately and within accordance with good and accepted medical practice by requesting a cystoscopy on an outpatient basis when the January 18, 2011 CT scan revealed a possible bladder tumor.

Dr. Feingold also addresses a purported claim by plaintiff alleging a formation of a Stage II decubitus ulcer on Ms. Thompson's right buttocks. Dr. Feingold opines that the Stage II decubitus ulcer was unavoidable due to Ms. Thompson's co-morbid medical conditions and deteriorating overall condition. Plaintiff and her expert, in response, do

not address this claim, and it thus appears that plaintiff is not pursuing any claim with respect to this Stage II decubitus ulcer. Dr. Feingold also notes that plaintiff's bill of particulars refers to the metastasis to Ms. Thompson's bones and bone marrow as multiple myeloma. Dr. Feingold states that a diagnosis of multiple myeloma was never made, but only a diagnosis of monoclonal gammopathy of unknown significance, referred to by him as MGUS, which is a precursor to multiple myeloma and may evolve into multiple myeloma. This issue is not addressed by plaintiff or her expert. However, since there is no question that the bladder cancer had metastasized to Ms. Thompson's bones and that Ms. Thompson died of cancer, this issue does not impact the determination of Dr. Khotsyna and Methodist's summary judgment motion.

In conclusion, Dr. Feingold opines, within a reasonable degree of medical certainty, that the care and treatment rendered by Dr. Khotsyna and Methodist were, at all times, in accordance with good and accepted medical practice. He specifically opines, within a reasonable degree of medical certainty, that there was no failure to timely diagnose and treat bladder cancer, and that Dr. Khotsyna and Methodist, at all times, acted appropriately based on Ms. Thompson's test results that were available. Dr. Feingold further opines, within a reasonable degree of medical certainty, that there is no causal connection between the care and treatment rendered by Dr. Khotsyna and Methodist and Ms. Thompson's injuries and ultimate death.

In opposition, plaintiff submitted the affirmation of her medical expert, Harvey Gross, M.D. (Dr. Gross), a physician duly licensed to practice medicine in the State of

New York who is board certified in family medicine and geriatrics. Dr. Gross asserts that the assessment in the May 6, 2010 CT scan was that mild thickening of the wall of the urinary bladder existed, but that an assessment of it could not be confirmed because the bladder was not well distended. He explains that a poorly distended bladder could create an artificial appearance of bladder wall thickening, and that is why it could not be confirmed. He states that bladder wall thickening could have a wide differential diagnosis, which includes infections, such as cystitis and bladder carcinoma. He opines that given the fact that the two CT scans in April and May 2010 had indicated the possibility of bladder carcinoma, the standard of care required that Ms. Thompson be referred to a urologist with a view towards further evaluation of the bladder with a cystoscopy. He points out that there was also a right kidney mass that merited further evaluation.

Dr. Gross asserts that the physicians at Methodist, including Dr. Kozlovskaya (who, around May 2010, was covering for Dr. Khotsyna), noted the radiologist's comments regarding the right renal mass and planned a urology referral for Ms. Thompson as an outpatient. However, there was no urology referral made for Ms. Thompson until January 2011, over eight months after the May 6, 2010 CT scan. Dr. Gross opines that this delay in following-up on the radiological findings constitutes a departure from the accepted standard of care. He sets forth that the standard of care required, at a minimum, a follow-up of the radiologist's indication on April 24, 2010 that

bladder pathology could not be excluded. He asserts that since no such follow-up, work-up, or referral took place, this was a departure from the accepted standard of care.

Dr. Gross opines, to a reasonable degree of medical certainty, that Dr. Khotsyna, who then assessed Ms. Thompson in her office on June 17, 2010, departed from the accepted standard of care by failing to refer Ms. Thompson to a urologist. He further opines that Dr. Khotsyna continued to depart from the accepted standard of care on each and every subsequent office visit by Ms. Thompson to her (i.e., on Ms. Thompson's July 19, October 19, and November 3, 2010 office visits) by repeatedly failing to refer Ms. Thompson to a urologist as an outpatient.

Dr. Gross opines, to a reasonable degree of medical certainty, that the bladder carcinoma, which was clearly shown in the January 18, 2011 CT scan, was already present in 2010, when the April and May 2010 CT scans were taken, and was the cause of the changes in the bladder seen in these two CT scans. He sets forth that the April and May 2010 CT scans showed diffuse bladder wall thickening, and that while it was possible that this bladder wall thickening seen in these CT scans could have been due to a partially distended bladder, since it could also have been due to cystitis or bladder cancer, a referral to a urologist was needed in April to June 2010 and thereafter. He states that at a minimum, a further investigation of this bladder wall thickening was required by the accepted standard of care.

Dr. Gross disagrees with the statements made by Dr. Feingold in his expert opinion. Dr. Gross states that Dr. Feingold is in error when he states that the May 6,

2010 CT scan showed no bladder wall thickening and was reassuring to Dr. Khotsyna. Dr. Gross asserts that contrary to Dr. Feingold's statement, the May 6, 2010 CT scan did, in fact, show mild bladder wall thickening, and, as discussed above, indicated only that the bladder wall thickening could not be confirmed as pathological since the bladder was not well distended. Dr. Gross further asserts that Dr. Feingold incorrectly states that the May 6, 2010 CT scan showed no lesions, when, in fact, it showed a right renal mass which merited further evaluation. Dr. Gross also points to the fact that Dr. Feingold failed to mention that during Ms. Thompson's May 2010 hospital admission, there was a plan to refer Ms. Thompson to a urologist as an outpatient, which was not carried out by Dr. Khotsyna. Dr. Khotsyna testified, at her deposition, that it was up to her to refer Ms. Thompson to a urologist, and she did not refer Ms. Thompson to a urologist in May 2010, and that Ms. Thompson was not referred to a urologist until 2011 (Dr. Khotsyna's deposition transcript at 88, 90-92).

Dr. Gross opines, to a reasonable degree of medical certainty, that if Dr. Khotsyna had acted in accordance with the applicable standard of care and referred Ms. Thompson to a urologist in June 2010, Ms. Thompson's bladder carcinoma would have been diagnosed in or around June 2010, at an earlier stage before the development of distal metastases. He further opines that Ms. Thompson's prognosis would then have been significantly better, and her death on May 12, 2011 from metastatic bladder cancer could have been avoided. He also opines that Ms. Thompson lost the opportunity for a cure due to the failure to make a timely urology referral. While Dr. Feingold notes that Dr.

Zoltan did not perform a cystoscopy when she was seen in his office on February 25, 2011 and first performed the cystoscopy on March 23, 2011, Dr. Gross opines that this one-month delay in the diagnosis of bladder carcinoma was unlikely to have contributed to the Ms. Thompson's final outcome since it is likely that the widespread bony metastases which were diagnosed in April 2011 were already present in January and February 2011. He explains that the January 18, 2011 CT scan already showed that the bladder cancer was locally advanced in that there was bilateral ureteral obstruction leading to bilateral hydroureter and hydronephrosis

In reply, Dr. Khotsyna and Methodist do not deny the fact that the May 6, 2010 CT scan showed bladder wall thickening or the fact that no urology referral was made in 2010. Rather, Dr. Khotsyna and Methodist argue that since the bladder wall thickening shown could have been due a partially distended bladder, there was no definitive finding that Ms. Thompson had bladder cancer at the time of the May 6, 2010 CT scan. They contend that this renders Dr. Gross' expert opinion that bladder cancer was present at that time conclusory, speculative, not evidentiary based, and indefinite. Dr. Khotsyna and Methodist argue that since Dr. Gross has offered only speculation that bladder cancer was present in May 2010, plaintiff cannot show that Dr. Khotsyna and Methodist proximately caused Ms. Thompson's injuries and death. In addition, despite the statement in Dr. Gross' expert affirmation that Ms. Thompson's loss of an opportunity for a cure and her death from metastatic bladder cancer were due to Dr. Khotsyna's failure to timely

diagnose Ms. Thompson's cancer, Dr. Khotsyna and Methodist claim that Dr. Gross is silent as to the issue of proximate cause.

Contrary to Dr. Khotsyna and Methodist's argument, Dr. Gross' expert opinion is not conclusory. Rather, Dr. Gross identifies deviations from the standards of accepted practice and makes specific references to the medical records. Dr. Gross' expert opinion is based on and supported by the May 6, 2010 CT scan. The fact that bladder cancer was not definitively shown by the May 6, 2010 CT scan does not render Dr. Gross' expert opinion speculative. Indeed, the fact that bladder cancer could not be ruled out due to the incomplete bladder distension shows that there was a need for a referral to a urologist in order to make a finding as to bladder cancer.

The Court finds that Dr. Khotsyna and Methodist met their prima facie burden. The burden then shifted to plaintiff to show there are issues of fact sufficient to defeat summary judgment. The Court finds that plaintiff has satisfied that burden. Plaintiff, through Dr. Gross' expert affirmation, has raised triable issues of fact as to whether Dr. Khotsyna and Methodist departed from good and accepted medical practice by failing to take steps that would have led to an earlier diagnosis of Ms. Thompson's bladder cancer and by delaying the detection of Ms. Thompson's bladder cancer (*see Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]; *Weinberg v Guttman Breast and Diagnostic Inst.*, 254 AD2d 213, 213 [1st Dept 1998]; *Donnelly v Finkel*, 226 AD2d 672, 672 [2d Dept 1996]). "Where, as here, the parties adduce conflicting medical expert opinions, summary judgment is not appropriate, as such credibility issues can only be resolved by a jury"

(*Bjorke v Rubenstein*, 53 AD3d 519, 520 [2d Dept 2008]; *see also Castillo v Surasi*, 181 AD3d 786, 788-789 [2d Dept 2020]; *M.C. v Huntington Hosp.*, 175 AD3d 578, 581 [2d Dept 2019]; *Elmes*, 140 AD3d at 1011; *Nisanov*, 137 AD3d at 1094; *Guctas*, 132 AD3d at 633; *Feinberg*, 23 AD3d at 519).

Plaintiff has also raised triable issues of fact as to proximate cause. "To raise a triable issue of fact, a plaintiff need not establish that, but for a defendant doctor's failure to diagnose, the patient would have been cured" (*Neyman*, 153 AD3d at 546). In an action for medical malpractice, "where causation is often a difficult issue," a plaintiff is not required to do any more "than offer 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 [plaintiff's] injury [or death]" (*Goldberg*, 73 AD3d at 694 [internal quotation marks omitted]; *see also Neyman*, 153 AD3d at 545). The plaintiff's evidence as to causation may be deemed legally sufficient even where his or her expert "cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased his [or her] injury," as long as there is evidence "presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased his [or her] injury" (*Flaherty v Fromberg*, 46 AD3d 743, 745 [2d Dept 2007]; *see also Goldberg*, 73 AD3d at 694). "Whether a diagnostic delay affected a patient's prognosis is typically an issue that should be presented to a jury" (*Polanco v Reed*, 105 AD3d 438, 442 [1st Dept 2013]; *see also Neyman*, 153 AD3d at 546).

Here, as discussed above, Dr. Gross specifically opines that Ms. Thompson lost the opportunity for a cure and that her death from metastatic bladder cancer could have been avoided if the cancer was diagnosed at an earlier stage. Therefore, a jury could conclude that Dr. Khotsyna and Methodist's conduct, if found to have constituted a departure from good and accepted medical practice, diminished Ms. Thompson's chance of a better outcome or caused her ultimate death, and that such delay in treatment was a proximate cause of Ms. Thompson's death (*see Neyman*, 153 AD3d at 546; *Polanco*, 105 AD3d at 442; *Goldberg*, 73 AD3d at 694; *Flaherty*, 46 AD3d at 745; *Dallas-Stephenson McMahon v Badia*, 195 AD2d 445, 446 [2d Dept 1993]). Thus, as plaintiff has raised material and triable issues of fact as to Dr. Khotsyna and Methodist's departure from good and accepted medical practice and as to whether such alleged departure was the proximate cause of Ms. Thompson's injuries and ultimate death, Dr. Khotsyna and Methodist's motion for summary judgment must be denied.

Conclusion

Accordingly, Dr. Khotsyna and Methodist's motion for summary judgment dismissing plaintiff's complaint as against them is denied.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.