Newhem v Millos
2022 NY Slip Op 33689(U)
October 26, 2022
Supreme Court, New York County
Docket Number: Index No. 805203/2019
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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INDEX NO. 805203/2019

MOTION DATE 08/01/2022

MOTION SEQ. NO. 003

IAN BLAKE NEWHEM, as Executor of the Estate of STEPHEN J. NEWMAN, Deceased, and IAN BLAKE NEWHEM, as Executor of the Estate of MARIS B. NEWMAN, Deceased,

Plaintiff,

- v -

ROSANA T. MILLOS, M.D., HUDSON VALLEY MEDICAL ASSOCIATES, PLLC, BRIJENDER BATRA, M.D., PULMONARY CONSULTANTS, P.C., LYALL A. GORENSTEIN, M.D., and ROCKLAND THORACIC & VASCULAR ASSOCIATES, P.C.,

Defendants.

DECISION + ORDER ON MOTION

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The following e-filed documents, listed by NYSCEF document number (Motion 003) 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 164, 168, 169, 170, 171, 172, 193, 194

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

I. INTRODUCTION

In this action, inter alia, to recover damages for medical malpractice based upon departures from good and accept medical practice and lack of informed consent, and to recover for wrongful death, the defendant Lyall A. Gorenstein, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiff opposes the motion. The motion is granted to the extent that Gorenstein is awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against him, and the motion is otherwise denied.

II. FACTUAL BACKGROUND

The plaintiff is the executor of the estate of his deceased father, Stephen J. Newman who was Gorenstein's patient (hereinafter the patient). The plaintiff is also the executor of the estate of his deceased mother, Maris B. Newman, who died subsequent to the patient's death.

The plaintiff makes claim on her behalf for loss of consortium during the time that the patient remained alive. The crux of the plaintiff's claim is that Gorsenstein, a cardiothoracic vascular surgeon, saw the patient between January 17, 2017 and March 21, 2017, but failed to diagnose the patient's lung, lymph-node, bone, and adrenal cancer after reading a January 9, 2017 positron active tomography (PET)/computed tomography (CT) scan that depicted numerous nodules in the patient's lungs, lymph nodes, ribs, and kidney, several of which were metabolic and suspicious for cancer. The plaintiff further asserted that Gorenstein negligently failed to order a workup for cancer, perform surgery in order to biopsy those nodules, refer the patient to an oncologist for treatment, and properly schedule follow-up appointments for further scans and examinations. The plaintiff further claims that, as a consequence of the failure to diagnose and failure to biopsy, the cancer metastasized, causing the patient to suffer for approximately 21 months until his death from cancer on October 15, 2018.

According to Gorenstein, the patient began treating with the defendant internist Rosanna Millos, M.D., in 2005, while the plaintiff asserted that the patient did not begin treating with her until 2011. The patient had been a cigarette smoker, having smoked 2.75 packs per day for 30 years. On December 16, 2016, the patient was involved in a motor vehicle accident in which the airbag deployed, and struck him in the chest. On December 20, 2016, he presented to Millos, and also was seen by Nurse Practitioner Deborah Occhiogrosso, at which time he complained that, beginning on December 17, 2016, he suffered from pain in his ribs in the center of the chest where he was hit by the airbag. On December 20, 2016, Occhiogrosso listened to the patient's lungs and documented they were clear to auscultation bilaterally. The patient had moderate bony/soft tissue tenderness just left of the midline in ribs three and four. Occhiogrosso ordered an x-ray of the ribs and chest, and the x-ray taken that day revealed a questionable nodular density in the left lower lung. A chest CT scan taken on December 23, 2016 revealed a 5-millimeter (mm) nodule in the right upper lobe of the patient's lungs, five

limited nodules within the left upper lobe, a 7-mm nodule along the left major fissure, an 11-mm nodule within the left lower lobe, and a 3-mm nodule within the left lower lobe.

On December 30, 2016, the patient presented to the defendant pulmonologist Brijender Batra, M.D., to whom he had been referred by Millos, for an evaluation of the lung nodules that had been identified on the December 20, 2016 and December 23, 2016 scans. Gorenstein alleged that the patient denied any shortness of breath or chest pain during Batra's examination and consultation, while the plaintiff asserted that the records did not reflect whether the patient made any such statement. Batra reviewed the December 23, 2016 CT scan and, upon examination, he concluded that the patient's heart was normal and his air entry was fair. Batra diagnosed the patient with multiple lung nodules and instructed him to undergo blood work and PET/CT scan. The patient underwent a PET/CT scan on January 9, 2017 that revealed a dominant 8-mm left lower lobe lung nodule described as "nonmetabolic," along with additional scattered tiny lung nodules that were also described as "nonmetabolic." The scan, however, also revealed multiple small hypermetabolic mediastinal and bilateral hilar lymph nodes that measured less than 1 mm to 4 mm and were, according to the radiology report "suspicious for foci of metastatic disease." In addition, the PET/CT scan revealed the presence of hypermetabolic skeletal lesions involving the left second rib and sternum, that, according to the report, were "suspicious for skeletal metastases." There was also a small lytic lesion on the scan involving the anterior aspect of the left second rib and a 2.1-centimeter (cm) mildly metabolic right adrenal nodule. The patient again saw Batra on January 10, 2017 to review the PET/CT scan, after which Batra referred him to Gorenstein to determine whether he needed surgery to secure samples of the nodules for the purpose of biopsy and a determination as to whether the nodules were malignant.

The patient presented to Gorenstein on January 17, 2017 and, as reflected in Gorenstein's records, described certain respiratory symptoms from which he continued to suffer. Gorenstein listened to the patient's lungs, and concluded that they were clear to auscultation,

with respirations described as non-labored and breath sounds characterized as "equal" Gorenstein recorded his impression that the PET/CT scan findings were consistent with reactive lymphadenopathy secondary to the motor vehicle accident and blunt trauma and, thus, did not present malignancy or metastasis. Gorenstein recommended that the patient undergo a repeat chest CT scan within two months

On February 21, 2017, the patient returned to see his internist, Millos, for a follow-up visit, at which time he reported that, although the chest pain from the car accident had abated, and he was not suffering from shortness of breath, he nonetheless was tired and remained unable to work due to the accident. Millos reported that, upon physical examination, the patient's lungs were clear, and concluded at that time that the patient did "not have any symptoms of lung disease or metastatic cancer." On March 13, 2017, a follow-up chest CT scan revealed that the lung nodules seen on the prior CT were stable and that one nodule had reduced in size from 10 mm to 7 mm. It further revealed that the hyperdense enhancing right adrenal nodule, which measured 1.8 cm in length, had not changed from the image depicted on the December 23, 2016 CT. The report indicated that the "[l]esion described left second rib on prior CT not definitely visualized on the exam."

On March 21, 2017, the patient returned to see Gorenstein for his second and final visit, at which they reviewed the imaging findings. Gorenstein claimed that the patient denied any complaints, while the plaintiff asserted that this allegation is not true. According to Gorenstein, he instructed the patient to return in six months, that a follow-up appointment was scheduled for the patient at his private practice, the defendant Rockland Thoracic & Vascular Associates, P.C. (Rockland), for October 10, 2017 at 12:30 p.m., and that he advised the patient to obtain a repeat chest CT in advance of the appointment. Gorenstein averred that the follow-up appointment was included in a patient print-out entitled "Visit Summary," and that an order for the six-month follow-up study was "placed" at 12:33 p.m. on March 21, 2017. According to the plaintiff, however, Rockland was unable to confirm that the follow-up October 17, 2017

appointment was in fact scheduled, as the Visit Summary was only accessible through Rockland's on-line patient portal, which the patient did not employ, a fact known to Rockland. The plaintiff further alleged that the patient was not directly told of the need for a follow-up study or appointment, and that the October 17, 2017 appointment did not appear anywhere in Rockland's scheduling system, other than as a note on "the powerchart side of the patient's visit summary note for their [sic] date of service in March 2017." Despite the fact that Gorenstein submitted screen shots depicting entries in Rockland's on-line patient portal, the plaintiff contended that Rockland never directed the patient to contact a radiology facility, despite the fact that a CT scan was a prerequisite for making an appointment, and that Rockland never followed up with the patient to obtain the results of any CT that was purportedly ordered. Ultimately, the patient did not obtain a follow-up CT scan and did not appear for a follow-up appointment at Rockland on October 17, 2017, or any time thereafter.

At a September 4, 2018 dental appointment with Bradley Plotkin, DMD, the patient complained of "worsening pain" in his left posterior mandible, a condition noted by Dr. Plotkin in his records. Dr. Plotkin identified a gumline mass. On September 19, 2018, the patient presented to oncologist Sushil Bhardwaj, M.D., for a consultation regarding a metastatic, poorly differentiated lung carcinoma primarily involving bone. Dr. Bhardwaj notified the patient and the plaintiff that the patient had a stage IV, poorly differentiated carcinoma of the lung, metastatic to the bone and possibly adrenal glands, for which his prognosis was guarded. He ordered mutation testing for the immune-related biomarker known as programmed death-ligand (PDL) 1, which would indicate whether the patient's cancer would be responsive to systemic treatment. In a September 21, 2018 GenPath Diagnostics report of the testing of a biopsy sample taken by oral surgeon Hunter Martin, M.D., the patient's PDL1 expression score was less than 1%, which was indicative that the patient was not likely to respond to available immunotherapies.

The patient underwent a whole-body PET scan on September 27, 2018 that revealed extensive metastases, including an infiltrating left hilar (lung) mass measuring 4.9 cm by 3.0 cm

and a hypermetabolic right adrenal gland mass that measured 3.9 cm by 5.6 cm. On October 3, 2018, the patient began radiation therapy to treat the left mandibular tumor mass, and met with Dr. Bhardwaj for a follow-up appointment on October 4, 2018. On October 11, 2018, the patient was admitted to Good Samaritan Hospital and was found to be septic. The hospital approved his request for discharge to his home, with hospice care services, that commenced on October 12, 2018. The patient died on October 15, 2018.

III. THE PLAINTIFF'S ALLEGATIONS

In his complaint, the plaintiff alleged that Gorenstein performed his obligations to examine, diagnose, and treat the patient in a careless and negligent manner and not in accordance with the good and accepted standards of medical care and practice, thereby causing the patient to sustain severe injuries, damages, and death. He further asserted that Gorenstein failed to obtain the patient's fully informed consent to whatever treatment or procedures Gorenstein ultimately rendered. In addition, the plaintiff contended that Gorenstein, caused the patient's death by virtue of his malpractice, resulting in pecuniary loss to the patient's estate. Moreover, the plaintiff contended that Gorenstein's malpractice caused the plaintiff's mother to lose the companionship of the patient's while the patient remained alive.

In his bill of particulars addressed to Gorenstein, the plaintiff asserted that, between January 17, 2017 and October 15, 2018, Gorenstein departed from good and accepted medical practice by failing to appreciate the significance of the patient's history of smoking, as well his other medical and social history, and failing to monitor the patient while under his care. The plaintiff also averred that Gorenstein failed properly and adequately to perform a medical examination when the patient first presented to him January 17, 2017, as the examination that was performed failed to take account of the patient's complaints and the results of both the December 23, 2016 CT scan and the January 9, 2017 PET/CT scan. In this regard, the plaintiff contended that Gorenstein failed to appreciate the results of those scans, and thereupon order and schedule appropriate follow-up diagnostic testing in light of those results.

Given the concerns that the patient manifested nodules that were suspicious for metastatic disease, the plaintiff asserted that Gorenstein was negligent in failing to appreciate the significance of all of the nodules visualized on the prior scans, failing to refer the patient to appropriate specialists upon meeting with him on January 17, 2017, and failing to coordinate the patient's treatment with those specialists. The plaintiff specifically contended that Gorenstein departed from good and accepted practice by failing to include lung cancer in a differential diagnosis as of January 17, 2017, and either in failing to perform surgery for the purpose of obtaining biopsy samples or referring the patient to another physician for diagnostic lung surgery following the January 17, 2017 examination. In connection with the results of the January 9, 2017 PET/CT scan, the plaintiff faulted Gorenstein for failing to order a noncontrast magnetic resonance imaging (MRI) scan of the adrenal glands further to assess the mildly metabolic right adrenal nodule that was visualized on that scan.

Similarly, with respect to the patient's March 21, 2017 follow-up visit with Gorenstein, the plaintiff alleged that Gorenstein failed to appreciate the significance of the patient's medical and social history, perform a proper medical examination or order appropriate diagnostic tests in response to his complaints and the results of the follow-up March 13, 2017 CT scan, and appreciate the results of prior diagnostic and radiological testing, including the multiple lung nodules and right adrenal lesion shown in the March 13, 2017 CT scan. As with the January 17, 2017 appointment, the plaintiff averred that, following the March 21, 2017 appointment, Gorenstein should have referred the patient to appropriate specialists and coordinated testing and treatment of the patient with those specialists and should have included lung cancer in his differential diagnosis. He also contended that Gorenstein should have performed diagnostic surgery, and thereupon diagnosed the patient with lung cancer, thus permitting him to begin treatment, or referred the patient to another physician to perform diagnostic lung surgery. Moreover, as he asserted with respect to the January 17, 2017 appointment, the plaintiff alleged

with respect to the March 21, 2017 appointment that Gorenstein negligently failed to schedule the patient for a further examination, diagnostic testing, or follow-up care.

The plaintiff alleged that Gorenstein was negligent in diagnosing the patient with reactive lymphadenopathy secondary to the motor vehicle accident, failing timely to diagnose him with lung cancer, and failing properly to consult with other doctors as to his findings and conclusions. He also asserted that it constituted negligence for Gorenstein to have recommended, in March 2017, that the patient wait six months before undergoing another follow-up CT scan or submitting to a follow-up examination, other diagnostic testing, or further care. Additionally, the plaintiff averred that Gorenstein failed timely to refer the patient to an oncologist or pulmonologist/oncologist for treatment of lung cancer, or develop a proper plan to monitor, manage, or treat the cancer with appropriate medications or procedures.

In addition, the plaintiff asserted that Gorenstein's failure to "be cognizant of and/or review available alternatives regarding the pertinent aspects of the patient's care and treatment" constituted malpractice. He further faulted Gorenstein for failing properly to document the patient's symptoms, signs and changes, failing to keep abreast of relevant medical literature, delaying or failing to perform indicated procedures, and permitting the development of complications, all of which caused the patient's cancer to spread, eventuating in his death.

IV. THE SUMMARY JUDGMENT MOTION

In support of his motion, Gorenstein submitted the pleadings, the plaintiff's bill of particulars, transcripts of the parties' deposition testimony, and relevant medical, dental, and hospital records. He also submitted the expert affirmations of cardiothoracic and general surgeon Gary Kline, M.D., and internist, oncologist, and hematologist Jeffrey G. Schneider, M.D.

Dr. Kline opined that Gorenstein did not depart from good and accepted medical practice in examining and diagnosing the patient. As he explained it, at the time of Gorenstein's first evaluation of the patient on January 17, 2017, he properly examined the patient, including

listening to his lungs and reviewing the radiology and reports that were obtained in advance of the appointment. After describing the nodules that were visualized on the CT imaging, Dr. Kline asserted that

> "[t]he patient was a known prior smoker, and Dr. Gorenstein appropriately recommended he obtain a repeat chest CT scan in light of these findings, as the differential for hypermetabolic areas can include infection, inflammation (in this case, secondary to a motor vehicle accident) or malignancy. As such. Dr. Gorenstein appropriately recommended the patient have a repeat chest CT in two months and return to his office at that time. Performing a repeat chest CT would provide Dr. Gorenstein with additional information to aid in his determination of whether the nodules were benign, as a stable.or interval decrease in the nodules would corroborate that the radiological findings were consistent with the body's response to the motor vehicle trauma.
>
> "*In addition, I note that lung biopsies were not indicated at the time of the January 17, 2017 office visit, based on the size of the nodules.* The Fleischner protocols dictate that for nodules between 6-8 millimeters a repeat CT scan for high risk patients is recommended in 3 to 6 months and then again at 18-24 months. For multiple nodules greater than 8mm, in high risk patients, again the protocol recommends a CT scan at 3-6 months or PET/CT or tissue sampling. Here, the largest nodule was in the left lower lung and was sized at 11mm on CT and 8mm on the PET scan and therefore Dr. Gorenstein was well within keeping of the protocol by ordering a repeat CT scan in 2 months"

(emphasis added).

Dr. Kline opined that the March 13, 2017 CT scan was "reassuring," as it "showed an interval decrease in size of the largest left lobe lung nodule to 7 millimeters." He characterized the patient as having had no symptoms, including shortness of breath, at his March 17, 2017 appointment. In light of the interval decrease in size of the largest lung nodule and the fact that the patient had no shortness of breath, Dr. Kline concluded that "it was reasonable for Dr. Gorenstein's impression to be that the nodules were benign and the hypermetabolic areas were secondary to inflammation following the motor vehicle accident." He further opined that it was within the standard of care to have the patient return six months thereafter, in October 2017, and to obtain repeat imaging before seeing Gorenstein at the October 2017 appointment. According to Dr. Kline, Gorenstein properly scheduled the patient for an appointment on

October 10, 2017 at 12:30 p.m., but "[t]he patient, however, did not obtain the ordered imaging and did not present for the October 2017 appointment."

Based on his review of the September 27, 2018 PET scan, Dr. Kline concluded that the patient did indeed have metastatic stage IV lung cancer at the time of his first appointment with Gorenstein on January 17, 2017, but nonetheless opined that the hypermetabolic areas that Gorenstein observed on the December 2016 and January 2017 scans "were reasonably determined to be due to inflammation secondary to trauma from the airbag deployment." Dr. Kline explained that, inasmuch as the hypermetabolic lesions on the adrenal gland and sternum that Gorenstein observed in January 2017 were also present in September 2018, a physician such as Gorenstein could only determine in hindsight that the patient suffered from metastatic stage IV lung cancer in January 2017. Hence, Dr. Kline opined that Gorenstein did not depart from good and accepted practice in either January 2017 or March 2017 in rendering his diagnosis of lymphadenopathy secondary to the patient's motor vehicle accident.

Dr. Schneider concluded that that the care and treatment that Gorenstein provided to the patient was not the proximate cause of stage IV metastatic lung cancer, its associated incurability, and the patient's death, and that Gorenstein's approach did not deprive the patient for a better chance of survival. He agreed with Dr. Kline that,

> "[i]n comparing the January 2017 PET scan to the September 2018 PET scan. . . as of January 2017, the decedent already had stage IV metastatic lung cancer. This hindsight-based diagnosis is based on the lytic lesion on the sternum and the adrenal gland lesion, which were present in both PET scans. Although the diagnosis of stage IV metastatic lung cancer is clear in hindsight, I agree that as of January and March 2017, it was reasonable for Dr. Gorenstein to consider the patient's recent motor vehicle trauma as the etiology of the observed radiographic abnormalities."

As Dr. Schneider explained it, since the metastatic process commenced prior to the patient's first visit with Gorenstein in January 2017, the patient would had to have commenced cancer treatments such as immunotherapy, surgery, or radiation therapy before the patient started treating with Gorenstein in order have any likelihood of a curative outcome or a chance

of significant prolongation of his life. Dr. Schneider concluded that, as such, any of Gorenstein's actions or inactions were not the proximate cause of the stage IV metastatic lung cancer or the patient's death.

Dr. Schneider went on to explain the meaning of the 2018 PDL1 test, noting that

> "PDL1 is a protein that helps keep immune cells from attacking non-harmful cells in the body. Cancer cells may have high amounts of PDL1. This allows the cancer cells to 'trick' the immune system, and avoid being attacked as foreign, harmful substances. If the cancer cells have a high amount of PDL1, a patient is more likely to benefit from immunotherapy which boosts the immune system to help it recognize and fight the cancer cells. The predictor of whether immunotherapy will be effective is based on score of 0-100; 0 being the least likely to have a response."

He asserted that the patient's PDL1 expression score of less than 1% in 2018 indicated that he was extremely unlikely to respond to systemic immunotherapy, as the PDL1 score was an objective predictor of outcome. Dr. Schneider averred that, with a score of zero, a patient has a less than a 5% chance of responding to immunotherapy. He therefore opined that earlier systemic treatment would not have avoided the metastatic cancer and the patient's death, and asserted that the patient's

> "symptoms, stage of carcinoma, metastasis, plan of care, pain and suffering, and chance of remission or survival did not change as a result of Dr. Gorenstein's alleged delay in potential diagnosis, as the decedent's course was already in motion and would not have been altered by systemic therapy . . . [and] that a diagnosis of lung cancer on or about January 2017 would not have changed the patient's course and did not deprive the patient o fa better chance of cure."

In opposition to Gorenstein's motion, the plaintiff relied upon the documentation submitted by Gorenstein, and also submitted the expert affirmations of a thoracic surgeon and an oncologist, as well as Rockland's supplemental response to his third notice to produce.

The plaintiff's retained thoracic surgeon asserted that he or she is board certified in thoracic surgery. That expert concluded that Gorenstein departed from good and accepted medical practice in several ways.

The thoracic surgeon first addressed Gorenstein's procedures for scheduling follow-up appointments for patients. Contrary to Dr. Kline's characterization of the manner in which

Gorenstein or Rockland purportedly scheduled a six-month follow-up appointment after the patient's March 21, 2017 visit, the thoracic surgeon noted that, based on his review of Rockland's records and the plaintiff's deposition testimony, he concluded that the appointment was never scheduled. As he described it,

> "the October 10, 2017 appointment referenced in Dr. Kline's Expert Affirmation at Paragraph 21 was never entered by defendant ROCKLAND into its appointment system (*see* Exhibit "A" annexed to plaintiff's opposition papers, page 11). While said appointment was inputted into The Decedent's "visit summary" from his March 21, 2017 appointment (*Id.; see also* Exhibit "F" annexed to the motion, Page 67), such printout was not given to The Decedent and the summary itself could only have been reviewed in the patient portal (*see* Exhibit "Q", 50-51), which The Decedent never signed up for nor accessed (*see* Exhibit "A" annexed hereto, Page 1)."

He or she continued that, inasmuch as the follow-up appointment was never entered into Rockland's appointment system, normal protocols were not followed, such as calling the patient to remind him of his upcoming appointment or calling or sending correspondence to him after the appointment was missed both to find out what had happened and to reschedule. The expert asserted that such communication reminders and check-ins would normally be documented Rockland's electronic medical record if they were transmitted to a patient, and there is nothing evincing any such documentation in Rockland's records. Moreover, he noted that, although Gorenstein produced computer screenshots showing that a "6- month CT" order was placed with Hudson Valley Radiology Associates (HVRA) on March 21, 2017, he provided nothing to demonstrate that HVRA received the CT order or scheduled an appointment with the patient.

The expert opined that, when a patient misses a duly-scheduled CT, an ordering physician such as Gorenstein or a medical provider such as Rockland would only know that the patient missed the appointment when the patient returned for a follow-up examination. The expert asserted that

> "[n]ot only do the records establish that defendant GORENSTEIN's recommended follow-up appointment was never scheduled, there is nothing in the record to establish that the need for a follow-up CT and appointment was communicated to The Decedent.

> "At the very least, your Affirmant is advised that whether the follow-up Study and/or the follow-up appointment were scheduled is a disputed matter between the parties, and for purposes of defendant GORENSTEIN's instant motion, I can assume that neither was scheduled."

With respect to Gorenstein's examinations, diagnoses, and recommendations, the plaintiff's expert thoracic surgeon explained that the patient was a high-risk patient with very concerning PET scan findings. The expert explicitly opined that, consequently, the patient's presentation "must be considered cancer until proven otherwise," and that Gorenstein thus "departed from good and accepted standards of medical care by diagnosing reactive lymphadenopathy secondary to blunt chest trauma *without further workup testing to explain the PET scan findings*" (emphasis added). The expert further opined that the

> "workup necessary to rule out or diagnose cancer should have been initiated at The Decedent's first meeting with defendant GORENSTEIN on January 17, 2017, and would have consisted of any of the following, or a combination thereof: (i) communicating with the reporting radiologist about his findings, (ii) ordering a biopsy of the hypermetabolic left second rib lytic lesion shown in the scan (as recommended by the reporting radiologist), (iii) prescribing an MR evaluation of the hypermetabolic right adrenal gland (as recommended by the reporting radiologist) to confirm or rule out characteristics for metastatic disease, which could lead to a possible subsequent biopsy, and (iv) requesting a biopsy by Endobrachial Ultrasound (EBUS) of the hypermetabolic right para tracheal lymph node and possibly the hilar lymph nodes. . . [C]ancer could have been confirmed or ruled out with this workup, and scheduling future radiographic studies without this workup would do nothing but delay a possible cancer diagnosis."

The thoracic surgeon also noted that Dr. Kline's affirmation was silent as to whether Gorenstein properly declined to exercise the option to biopsy the 2.1 cm adrenal nodule or the rib lesion.

The plaintiff's expert thoracic surgeon stated that he or she found no reports in the medical literature of blunt trauma secondary to air-bag deployment causing the findings on PET scans that were observed in the March 13, 2017 scan, "yet defendant GORENSTEIN confirmed at his deposition that reactive lymphadenopathy was his *official* diagnosis and not a *possible* diagnosis included as part of a differential" (emphasis added). The expert asserted that an official diagnosis of reactive lymphadenopathy secondary to blunt chest trauma would have communicated to the patient little concern for his condition, as such inflammation of the lymph

nodes would have eventually resolved on its own. He or she thus opined that Gorenstein's attribution of the PET scan findings to trauma, without including metastatic cancer as the more likely cause in the differential diagnosis, was a departure from the standard of care. The expert averred that it thus was confusing that Gorenstein testified at his EBT that, despite making an official diagnosis of reactive lymphadenopathy secondary to blunt chest trauma, he ordered the March 13, 2017 follow-up CT because he had not ruled out malignancy as a possible cause of the metabolic activity seen in the January 9, 2017 PET/CT. As the expert put it, if Gorenstein concededly had not ruled out cancer, a two-month follow-up CT would only delay a possible cancer diagnosis, while a workup to confirm or rule out cancer was necessary as of the January 17, 2017 examination, and Gorenstein's failure to conduct such a workup was a departure from the good and accepted standards of medical care regardless of what Gorenstein's primary working diagnosis was at that time. The expert further concluded that Gorenstein's diagnosis of reactive lymphadenopathy secondary to blunt trauma could not have been made without such workup in the first instance, and that suspicions of lung cancer required an immediate workup to confirm or rule out a cancer diagnosis without further delay.

In addition, the thoracic surgery expert asserted that Gorenstein departed from good and accepted standards of medical care by reiterating his diagnosis of reactive lymphadenopathy secondary to blunt chest trauma upon review of the March 13, 2017 chest CT scan, as the concerns for cancer that were reflected in the January 9, 2017 PET/CT scan had not been ruled out by the March 13, 2017 scan. The expert opined that the workup that should have been conducted or commenced at the January 17, 2017 examination should already have been conducted and that, even if it hadn't been conducted as of Marcy 21, 2017, could and should also have been conducted or commenced at the March 21, 2017 examination. The expert further averred that Gorenstein should not have recommended that the patient wait six months until his next examination because, had the patient in fact been suffering only from reactive lymphadenopathy secondary to blunt trauma, there would have been no need for a six-month

follow-up, while if the follow-up was recommenced because Gorenstein was concerned that the patient had cancer, the lengthy delay was unwarranted and presented significant risks.

Upon reviewing records from Gorenstein and Rockland, the plaintiff's thoracic surgery expert concluded that there was no indication therein that they communicated the date for the scheduled follow-up to the patient, and "as far as the follow-up examination is concerned, there is indication in the record that defendant GORENSTEIN and ROCKLAND never scheduled the same." According to the expert, only if the follow-up appointment had been scheduled and conducted would those defendants have learned whether the recommenced follow-up CT had been performed, and only by scheduling the appointment would the plaintiff have received communications from those defendants to remind him of the appointment or inform him that he missed the appointment. The expert thus concluded that Gorenstein, as well as Rockland, departed from good practice by failing to schedule the six-month follow-up examination or communicate with the patient, as Gorenstein never discharged the patient from his care, nor referred him to another specialist for further workup. Hence, the thoracic surgery expert opined that Gorenstein and Rockland committed malpractice, as they "lost track of their patient."

The plaintiff's expert in thoracic surgery ultimately concluded that Gorenstein further committed malpractice by communicating a diagnosis of reactive lymphadenopathy secondary to blunt chest trauma to the patient, with no cause for concern. The expert explained that, in light of the patient's long history of smoking, multiple lung nodules present on a chest CT scan, and suspicious findings on PET/CT scan, the failure to inform the patient that there was a possibility that he had cancer, or to emphasize the importance of future follow-up examination in light of the that concern, was a departure from good and accepted. practice.

The plaintiff's retained expert oncologist, who is board certified in internal medicine, hematology, and oncology, opined that both Gorenstein and his practice, Rockland, departed from good and accepted standards of medical care in failing to refer the patient to an oncologist after both the January 17, 2017 examination and the March 21, 2017 examination. The

plaintiff's oncologist reiterated the thoracic surgery expert's criticism of Gorenstein's protocol for scheduling follow-up appointments and communicating with the patient to assure that he obtained the recommended follow-up CT scan and appeared for the follow-up appointment, and concluded that the patient did not obtain the follow-up scan due to the insufficiencies in Gorenstein's administration of his office practices.

The expert oncologist asserted that the delay in the lung cancer diagnosis attributable to Gorenstein should not be measured from January 2017 through March 2017, as suggested by Dr. Schneider in his expert affirmation. Rather, the plaintiff's expert contended that the delay in diagnosis should be measured from January 2017 through September 2018, when the gumline mass was seen by the patient's dentist and was worked up.

The oncologist agreed with Dr. Schneider's assessment that the patient likely had Stage IV metastatic cancer when he first presented Gorenstein on January 17, 2017, but expressly disagreed with Dr. Schneider's opinion that "to have had any likelihood of . . . a chance of significant prolongation of his life, cancer treatments such as immunotherapy, surgery or radiation therapy would have had to have been started before the decedent started treating with" Gorenstein. According to the plaintiff's oncologist,

> "[m]issing from Dr. Schneider's expert affirmation is any discussion of chemotherapy, and how such could significantly prolong The Decedent's life if implemented soon after The Decedent first presented on January 17, 2017, when he returned on March 21, 2021, and even six months thereafter, in October 2017 had defendant GORENSTEIN or his practice, defendant ROCKLAND, properly scheduled The Decedent's follow-up appointment. All pertinent literature on the subject indicates that majority of patients with advanced non-small cell lung cancer, which is the type of cancer that killed The Decedent herein, who receive chemotherapy in the supportive care setting improves overall survival rates by up to one year if not longer. It is my opinion to a reasonable degree of medical certainty that four to six cycles of chemotherapy using a platinum-based doublet like Cis-Platinum and Taxol or Carboplatinum and Taxotere could have been implemented with a likely increase in The Decedent's survival rate by a year or more without impact on quality of his life."

The oncologist thus opined that, not only did Gorenstein depart from good and accepted standards of medical care by failing to refer the patient to an oncologist at any point after his first

examination on January 17, 2017, but, in connection with the issue of proximate cause, that such departure prevented the plaintiff from receiving chemotherapy at a time when such therapy would have significantly prolonged his life. In this regard, the oncologist explicitly asserted that, had Gorenstein referred the patient to an oncologist at any time before the end of 2017, the patient's life would have been prolonged by one year, if not more. The expert explained, with more specificity, that the patient

> "indeed had limited options when his cancer was finally diagnosed in September 2018, but it is my opinion to a reasonable degree of medical certainty that such options became limited over time because the metastatic disease had progressed to a point where it could no longer be treated. While immunotherapy may not have been successful upon The Decedent's presentation or throughout 2017 because of a low PDL1 score, as set forth in Dr. Schneider's expert affirmation, chemotherapy remained a viable option and it is my opinion to a reasonable degree of medical certainty that if started over the period of time where The Decedent became defendant GORENSTEIN's patient, when the volume of cancer in The Decedent's body was lower, his life could have been prolonged by at least one year, if not longer."

In reply, Gorenstein submitted only an attorney's affirmation, in which his attorney characterized the plaintiff's expert submissions as speculative, and asserted that the plaintiff raised new issues in his opposition papers that were not raised in the complaint or bill of particulars. Gorenstein essentially placed the blame on the patient for failing to arrange for his own six-month follow-up CT scan with a radiologist, and for failing to appear for his six-month follow-up appointment with Gorenstein himself.

V. SUMMARY JUDGMENT STANDARDS

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR

3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc*., 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (s*ee id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc*., 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet its burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. It must affirmatively demonstrate the merit of its defense (se*e Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

A. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]).

Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226,

[1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

Gorenstein established his prima facie entitlement to judgment as a matter of law dismissing the medical malpractice cause of action insofar as asserted against him, as his experts opined that he acted within the standard of care in reading the CT and PET/CT scans

submitted to him in January and March 2017, that his diagnosis of lymphadenopathy secondary to a motor vehicle accident was appropriate under the circumstances, and that the presence of lung cancer could only be recognized in hindsight. He also established, prima facie, that any delay in ordering a workup for cancer was within the standard of care, and that he properly directed the patient on March 21, 2017 to follow up with a CT scan and examination by October 2017. In addition, Gorenstein made a prima facie showing, with his expert's affirmations, that, as of both January 17, 2017 and March 21, 2017, the patient already had missed an opportunity for a cure, as, in hindsight, they could now conclude that, as of January 2017, his cancer was too far advanced to respond to radiation treatment or immunotherapy, particularly in light of his PDL1 levels.

The plaintiff, however, raised triable issues of fact with his expert's affirmations as to whether Gorenstein committed malpractice by misdiagnosing the cause of the several lung, lymph, bone, and adrenal nodules and lesions that he visualized on the December 2016, January 2017, and March 2017 scans, failing to recognize the importance of the fact that several of the nodules were suspicious for cancer, failing to order a workup to rule in or rule out cancer, and failing to refer the patient to an oncologist. The plaintiff further raised a triable issue of fact as to whether Gorsenstein departed from good and accepted practice in delaying any further follow-up for six months after the March 21, 2017 appointment, as well as in the manner in which he purportedly recommended a follow-up CT scan and scheduled the follow-up appointment, and the protocol he employed to inform or remind the patient of any scheduled follow-up appointment. In addition, the plaintiff raised a triable issue of fact as to proximate cause with the affirmation of his expert oncologist, who clearly opined that, had Gorenstein timely performed the indicated cancer workup, and had the patient been referred to an oncologist in a timely manner, chemotherapy would likely have given him a chance of survival for at least one more year. The expert oncologist's affirmation thus raised a triable issue of fact as to whether there was a "substantial possibility" that patient would have obtained a better

outcome, sustained a lesser injury, or survived if he received proper diagnosis, referral, or treatment, and whether the malpractice caused him to lose a chance or opportunity for a cure (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]).

The court rejects Gorenstein's contention that the plaintiff's expert's opinions were speculative, or that he raised new contentions in opposition to the motion. The essence of the plaintiff's claims against Gorenstein has remained consistent---that he failed to diagnose cancer because he failed to appreciate the importance of the patient's history and the presence of numerous growths, some of which were concededly suspicious for cancer, that he failed to order or delayed in ordering a cancer workup or refer the patient to an oncologist, and that it was Gorenstein's responsibility, not the patient's, to assure that the patient knew to return for the allegedly scheduled follow-up appointment in October 2017.

Consequently, that branch of Gorenstein's motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against him must be denied.

B. LACK OF INFORMED CONSENT

The elements of a cause of action for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "'The mere fact that the plaintiff signed a consent form does not

establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless. a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]). Here the alleged failure to diagnose cancer or order a proper workup did not lead to unnecessary surgery or an unnecessary procedure, and did not lead to an invasion of bodily integrity that caused the patient's injuries. Rather, this matter presents the more common situation in which the failure to diagnose allegedly led to the delay in performing a more invasive procedure that, had it been performed in timely manner, purportedly would have avoided the decedent's injuries.

Hence, in opposition to Gorenstein's prima facie showing of entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action, the plaintiff failed to raise a triable issue of fact. Consequently, that branch of the motion seeking summary judgment dismissing that cause of action insofar as asserted against Gorenstein must be granted.

C. WRONGFUL DEATH

"'In a wrongful death action, an award of damages is limited to the fair and just compensation for the pecuniary injuries resulting from the decedent's death to the persons for whose benefit the action is brought'" (*Leger v Chasky*, 55 AD3d 564, 565 [2d Dept 2008], quoting *Plotkin v New York City Health & Hosps. Corp*., 221 AD2d 425, 426 [2d Dept 1995]; *see* EPTL 5-4.3 [a]). EPTL 11-3.2(b) provides that, in addition to a wrongful death cause of action,

> "[n]o cause of action for injury to person or property is lost because of the death of the person in whose favor the cause of action existed. For any injury an action may be brought or continued by the personal representative of the decedent,"

thus permitting the representative of the estate to prosecute a so-called "survival action" to recover for the conscious pain and suffering or other compensable damages caused by the defendant and sustained by a decedent while the decedent remained alive. The court notes that a survival claim for conscious pain and suffering that is prosecuted pursuant to EPTL 11-3.2(b) belongs to the estate, and not to the distributees of the estate, while wrongful death claims to recover pecuniary loss "belong" to the distributees (*Cragg v Allstate Indem. Corp.,* 17 NY3d 118, 121 [2011]; *see Heslin v County of Greene*, 14 NY3d 67, 76-77 [2010]).

> "There are four elements of compensable loss encompassed by the general term pecuniary loss: (1) decedent's loss of earnings; (2) loss of services each survivor may have received from decedent; (3) loss of parental guidance from decedent; and (4) the possibility of inheritance from decedent"

(*Huthmacher v Dunlop Tire Corp*., 309 AD2d 1175, 1176 [4th Dept 2003] [citations omitted]).

Although a wrongful death claim seeking to recover pecuniary loss to a decedent's estate belongs to the distributees of the estate, it may only be *prosecuted* by a duly appointed representative of the estate.

> "A personal representative who has received letters of administration [or testamentary] of a decedent's estate *is the only party who is authorized to commence* a survival action to recover damages for personal injuries sustained by the decedent or a wrongful death action to recover damages sustained by the decedent's distributees on account of his or her death"

(*Shelley v South Shore Healthcare*, 123 AD3d 797, 797 [2d Dept 2014] [emphasis added*]; see Gulledge v Jefferson County*, 172 AD3d 1666, 1667 [3d Dept 2019]; *Ambroise v United Parcel Serv. of Am.*, 143 AD3d 929, 932 [2d Dept 2016]; *Jordan v Metropolitan Jewish Hospice*, 122 AD3d 682, 683 [2d Dept 2014]; *Mingone v State of New York*, 100 AD2d 897, 899 [2d Dept 1984]; EPTL 1-2.13, 5-4.1 [1]; 11-3.2 [b]). The plaintiff, as the duly appointed representative of the patient's estate, thus has standing and capacity to prosecute a wrongful death claim, as well as the medical malpractice survival action to recover for the patient's conscious pain and suffering.

This court has determined that Gorenstein is not entitled to summary judgment dismissing the cause of action alleging departures from good practice insofar as asserted against him, and that there are triable issue of fact as to whether Gorenstein's departures from good and accepted practice caused or contributed to the patient's death. Inasmuch as Gorenstein has failed to establish, prima facie, that the patient's estate did not sustain pecuniary loss by virtue of the patient's death, Gorenstein is not entitled to summary judgment dismissing the wrongful death cause of action insofar as asserted against him.

D. LOSS OF SPOUSAL CONSORTIUM

A surviving spouse may prosecute a derivative cause of action for loss of consortium, albeit one that is limited to the period of time during which the decedent was alive and suffering from injuries caused by a defendant (*see Liff v Schildkrout*, 49 NY2d 622, 632 [1980]). Here, the patient's spouse survived him and, hence, she would be entitled to prosecute this limited claim for loss of consortium. She died after the patient's death and, prior to commencing this action, the plaintiff also was appointed executor of her estate. The plaintiff thus has capacity and standing to prosecute the loss of consortium cause of action as a "survival action" on behalf of his mother's estate pursuant to EPTL 11-3.2(b). Since Gorenstein adduced no evidence that the patient's wife would not be entitled to recover for loss of consortium for the period beginning on January 17, 2017 and ending with the patient's death on October 15, 2018, he has failed to

establish his prima facie entitlement to judgment as a matter of law, and summary judgment must be denied to Gorenstein in connection with the derivative cause of action to recover for loss of consortium.

VI. CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendant Lyall A. Gorenstein, M.D., is granted only to the extent that he is awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against him, that cause of action is dismissed insofar as asserted against him, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

10/26/2022
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:	[ ]	**CASE DISPOSED**		[X]	**NON-FINAL DISPOSITION**		
	[ ]	**GRANTED**	[ ] **DENIED**	[X]	**GRANTED IN PART**	[ ]	**OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**		[ ]	**SUBMIT ORDER**		
CHECK IF APPROPRIATE:	[X]	**INCLUDES TRANSFER/REASSIGN**		[ ]	**FIDUCIARY APPOINTMENT**	[ ]	**REFERENCE**