McNamara v Mount Sinai Hosp.
2024 NY Slip Op 35186(U)
February 29, 2024
Supreme Court, Richmond County
Docket Number: Index No. 151739/2016
Judge: Charles M. Troia
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND

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NATALIE MCNAMARA, as Administratrix of the Estate of JOHN MCNAMARA, deceased, and NATALIE MCNAMARA, individually,

Plaintiff,

-against-

THE MOUNT SINAI HOSPITAL, RICHMOND UNIVERSITY MEDICAL CENTER, RAJA FLORES, M.D., INTERNAL MEDICINE ASSOCIATES, ADRIN KASEMI, M.D. VICTORY INTERNAL MEDICINE, P.C. GETNET TESFAYE, M.D., and BRIAN YEH, M.D.

Defendants.

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Present:
IAS PART 1

HON. CHARLES M. TROIA

DECISION and ORDER

Index No.151739/2016

Motion Sequences 006 and 007

The following papers numbered 1 to 6 were marked fully submitted on the 20th day of December 2023:

Notice of Motion (006) by Defendants, ADRIN KASEMI, M.D., INTERNAL MEDICINE ASSOCIATES, and VICTORY INTERNAL MEDICINE, P.C., with Supporting Papers and Exhibits.....1

Affirmation in Opposition by Plaintiff with Supporting Papers and Exhibits.....2

Defendants' Affirmation in Reply.....3

Notice of Motion (007) by Defendants, RAJA FLORES, M.D. and THE MOUNT SINAI HOSPITAL, with Supporting Papers and Exhibits.....4

Affirmation in Opposition by Plaintiff with Supporting Papers and Exhibits.....5

Defendants' Affirmation in Reply.....6

In this alleged medical malpractice and wrongful death action, the defendants, ADRIN KASEMI, M.D., INTERNAL MEDICINE ASSOCIATES, and VICTORY INTERNAL MEDICINE, P.C., (hereinafter "Kasemi", "IMA" and "VIM") and RAJA FLORES, M.D., and THE MOUNT SINAI HOSPITAL (hereinafter "Flores" and "MSH") move for summary judgment and dismissal of the complaint pursuant to CPLR § 3212, and for such other, further and different relief as this court deems just and proper.

The defendants, Kasemi, IMA and VIM, support their motion (006), *inter alia*, with: the expert affirmation of Preston L. Winters, M.D. a physician duly licensed to practice medicine in New York and who is board certified in internal medicine; and the expert affirmation of Paul E. Oberstein, M.D., a physician duly licensed to practice medicine in New York and who is board certified in medical oncology and internal medicine.

The plaintiff opposes Kasemi, IMA and VIM's summary judgment motion and in support has submitted her attorney's affirmation, but no expert affirmation.

The defendants Flores and MSH support their motion (007), inter alia, with the expert affirmation of Paul E. Oberstein, M.D., a physician duly licensed to practice medicine in New York and who is board certified in medical oncology and internal medicine.

The plaintiff opposes Flores and MSH's summary judgment motion and has submitted, *inter alia* the expert affirmation of a physician (name redacted) duly licensed to practice medicine in New York who is board certified in internal medicine and medical oncology.

The court notes that the case alleged against Brian Yeh M.D. was discontinued by a "so ordered" stipulation dated April 13, 2023 (NYSCEF Doc. No. 202). Additionally, subsequent to argument of their motion for summary judgment, the plaintiff's claims against RUMC and Tesfaye have been resolved by agreement. As such, the motion is deemed withdrawn as being moot as to defendants RUMC and Tesfaye.

Upon the foregoing papers, the motion of defendants, Kasemi, IMA and VIM., is granted in its entirety and the motion of defendants, Flores and MSH, is denied, except that the plaintiff's claim for lack of informed consent is dismissed. The court's decision is outlined below.

FACTS

In April 2014, the decedent JOHN MCNAMARA, presented to Victory Internal Medicine ("VIM") with complaints of difficulty swallowing for approximately five months and weight loss. He was referred to Dr. Divyang Parikh of DLD Endoscopy PLLC, for the performance of an esophagogastroduodenoscopy ("EGD").

The biopsy results of the esophageal tissue sampled by Dr. Parikh during the EGD, performed on April 25, 2014, revealed a poorly differentiated infiltrating adenocarcinoma of the esophagus with an ulcer (esophageal cancer). Thereafter, on April 28, 2014, the decedent underwent a CT scan, on referral from

VIM, which revealed a 10 x 10 x 9 mm nodule in the right lung, right paratracheal chain nodules 12 x 15 mm, and thickening in the lower third portion of his esophagus.

Thereafter, on May 1, 2014, the decedent consulted with Dr. Shah, a surgeon at NYU, regarding a plan of treatment. On May 6, 2014, the decedent presented to Dr. Cynthia Leichman, an oncologist at NYU's Cancer Center for an initial consultation and PET/MRI scan. Dr. Leichman noted the diagnosis of esophageal cancer in the lower portion of his esophagus near the GI junction with nodules seen in the right upper lobe of the lung. Dr. Leichman discussed possible tri-modal therapy (chemotherapy, radiation, and esophagectomy) pending further recommended pathological workup of the esophageal tumor, biopsy of lymph nodes and lung nodules and results of the PET scan. She noted that if the decedent was found to have metastatic disease he would be classified as stage IV, which would not be curable.

On May 8, 2014, the decedent sought a second opinion from the defendant, Flores (NYSCEF Doc. 226 p. 256) for an evaluation of a recent diagnosis of esophageal cancer and a right atypical lung nodule and complaints of dysphasia (difficulty swallowing). According to the note (NYSCEF DOC. No. 248 p. 17), Flores performed a physical examination and reviewed the prior CT images and EGD reports. Flores noted the presence of the lung nodule and set forth treatment options including observation with close CT scan follow up, CT guided needle biopsy, or a video-assisted thoracoscopic surgery (VATS) biopsy. The note indicates that after a discussion regarding the risks and benefits of each option, the plan was for the decedent to schedule and undergo an ultrasound, pulmonary function test, stress test, and fine needle aspiration ("FNA") to rule out metastasis or primary disease in the lung nodule seen on the CT imaging. However, the plaintiff disputes the details of what transpired during that visit. She testified that Flores was aware her husband was there for a second opinion, and they discussed the proposed plan of initially treating with chemo and radiation, to be followed by surgery and subsequent follow-up with Flores. She testified that Flores did not discuss the lung nodule or any associated treatment plan for it. (See NYSCEF Doc. 226 pgs. 262, 268, 270, 271 and 273).

The decedent pursued treatment for esophageal adenocarcinoma from May through October 2014, at NYU with NYU providers who had devised a plan of neo-adjuvant therapy in preparation for a possible esophagectomy. During that time, he did not seek treatment from Flores or Mt. Sinai.

As part of his oncological treatment at NYU, the decedent underwent a biopsy of his paratracheal lymph nodes and EGD evaluation by Dr. Seth Gross on May 12, 2014. Dr. Gross documented that the cancer was located in the lower third of the esophagus and the presence of an ulcerating and bleeding

mass, which was completely obstructing the lumen (opening) of the esophagus, such that a full proximal evaluation could not be completed. Biopsies of the lymph nodes revealed metastasis to his paratracheal lymph node consistent with his esophageal adenocarcinoma. Tissue from the esophagus was noted to be positive for invasive adenocarcinoma with ulceration and focal necrosis. (See NYSCEF Doc. 217).

The decedent continued to follow with NYU providers, including Dr. Leichman and Dr. Shah, who found that the decedent had locally advanced esophageal adenocarcinoma with progression to obstruction as was identified by the EGD. In response, an esophageal stent was placed to address the obstruction and allowing oral nutrition to pass. (See NYSCEF Doc. 217).

While treating with the NYU providers, the decedent underwent six cycles of chemotherapy. A PET/CT scan performed during treatment revealed the cancer to still be present with a slight metabolic response. The metastatic supraclavicular lymph node remained the same in size as did the lung nodule. The radiologist's impression was that the lung nodule represented scarring but did not exclude the possibility of low-grade primary neoplasm. (See NYSCEF Doc. 217). Thereafter, the decedent underwent a second round of chemotherapy for five cycles and then underwent twenty-five radiation treatments ending in October 2014.

On October 15, 2014, Dr. Leichman discussed the results of the October 10, 2014, PET/CT scan with the decedent. The doctor's note indicates that there was considerable improvement but because there was still evidence of disease, surgery would be necessary. The lung nodule was also present, stable, unchanged and thought likely to be scar tissue. (See NYSCEF Doc. 217 p.1578).

On November 19, 2014, the decedent saw Dr. Shah who offered him surgical esophagectomy. However, the decedent returned to Flores on December 4, 2014, to discuss the next step. Flores examined the decedent and evaluated his esophageal cancer and lung mass. He reviewed the prior PET scan reports and was awaiting receipt of the October 10, 2014, PET scan imaging. He noted that the decedent completed chemoradiation in October 2014 and still had the lung mass, which had not been biopsied.

The plaintiff testified that (NYSCEF Doc. 226 p. 256): during the December 4, 2014 visit with Flores, the decedent told him that he had been cleared for the esophagectomy and that he was advised (by the NYU providers) to have the surgery by the end of the year and, as such wanted to discuss the surgery with him (NYSCEF Doc. 226 p. 412); Flores did not agree that surgery should be done by the end of the year because the decedent did great with chemo and had plenty of time (NYSCEF Doc. 226 p. 413); and, the

decedent was emphatic that he wanted the esophagectomy before the end of the year (NYSCEF Doc. 226 pgs. 413-414).

The plaintiff also testified: that during this visit, the lung nodule was discussed; that the nodule was unchanged following chemo and radiation; and that the consensus was it was likely scar tissue, however, Flores wanted to confirm it through biopsy (NYSCEF Doc. 226 p. 419); that the decedent told Flores that he wanted to do the biopsy quickly and have the surgery by the end of the year (NYSCEF Doc. 226 pgs. 422-423); that the decedent told Flores that he trusted the NYU oncology team, that he didn't want the biopsy, and wanted to proceed with the esophagectomy (NYSCEF Doc. 226 p. 423); and that Flores said moving forward with the lung biopsy prior to doing the esophagectomy would not put the decedent at any risk (NYSCEF Doc. 226 p.428). As such, the plan was to first evaluate the lung nodule via fine-needle aspiration (FNA).

On January 6, 2015, a FNA of the right lung nodule was performed at Mt. Sinai. Pathology revealed the presence of atypical cells and malignancy could not be ruled out as features were consistent with metastatic carcinoma of esophagus origin. In response, Flores recommended a VATS wedge resection for further biopsy of the lung nodule for a definitive diagnosis. A PET scan was performed at Mt. Sinai on January 23, 2015 (NYSCEF Doc. No. 279 pgs. 1-2). When compared to the prior scans, it was apparent that the esophageal cancer was beginning to recur. The lung nodule had remained unchanged. (NYSCEF Doc. No. 248 p. 11).

On February 6, 2015, Flores performed a physical examination and discussed the results of the imaging and pathology and the benefits and alternatives of pursuing a VATS wedge resection for further biopsy of the lung nodule for a definitive diagnosis. (NYSCEF Doc. No. 248 p. 12).

The VATS wedge resection was initially scheduled for February 23, 2015, but subsequently rescheduled to March 9, 2015. Flores performed the surgery and tissue was collected for pathological interpretation. The final pathology report was issued on March 16, 2015, and revealed that the lung nodule was a subpleural fibrous scar with atypical cells.

On March 26, 2015, the decedent returned to Flores who performed a physical exam, reviewed imaging studies, and reports and the results of the VATS wedge resection biopsy. Flores noted that he discussed further surgery, including a bronchoscopy, EGD and Ivor Lewis esophagectomy with the decedent.

The surgery was scheduled for April 21, 2015. On that day, he was admitted to Mt. Sinai by Flores whose operative report states that following the bronchoscopy and the EGD, the esophagectomy was aborted due to the extension of disease. The EGD revealed extensive malignancy within the esophagus circumferentially, proximally, and distally that had progressed such that the endoscope was difficult to pass through the esophagus. The entire esophagus appeared to have progressive malignancy such that Flores indicated a complete resection could not be achieved.

The decedent was discharged from Mt. Sinai on April 24, 2015, with instructions to follow up with Flores in 1-2 weeks. The decedent had no further treatment by or contact with Flores.

Following April 2015, the decedent's esophageal adenocarcinoma continued to progress, despite returning to NYU and receiving additional chemotherapy from May 20, 2015 to June 24, 2015 and proton beam therapy from August 2015 to September 2015.

On September 15, 2015, the decedent was admitted to Richmond University Medical Center (RUMC), for difficulty swallowing and shortness of breath (NYSCEF Doc. No. 215, p. 51). He underwent thoracentesis to remove fluid from his lungs (NYSCEF Doc. No. 215, p.72) and an EGD with a stent insertion (NYSCEF Doc. No.215, p. 80). During the admission he was treated for pleural effusion, pneumonia, generalized weakness, and dysphasia. The defendant, Kasemi, an employee of the defendant VIM, was the covering hospitalist for the decedent from September 18 to September 20, 2015. He was discharged on September 22, 2015.

On September 28, 2015, the decedent saw Dr. Leichman. Her note indicates that there were widespread metastases to his lungs, liver and pelvis and that he was incurable. His life expectancy was very limited- expected to be months, at best. (See NYSCEF Doc. No.217, pgs. 2641, 2648).

On October 5, 2015, the decedent presented to the RUMC emergency department with complaints of worsening shortness of breath for a few days' duration. He was admitted with diagnoses of shortness of breath and pleural effusion. Kasemi was the on-call hospitalist that day. The decedent was evaluated by resident, Dr. Tesfaye, who noted a history of pneumonia and esophageal cancer. Dr. Tesfaye documented that he discussed a plan with Kasemi to administer oxygen by nasal cannula, administer nebulizer, obtain pulmonary consult, repeat chest x-ray and possible IR consult for pleural fluid analysis, IV fluids, IV antibiotics for possible aspiration pneumonia, obtain a consult from ID, institute anti reflux protocol, including PPI, Reglan and upright position, speech/swallow consult, gastroenterology consult for the esophageal cancer and rule out progression of the cancer distal to the stent. As the on-call hospitalist

for RUMC, Dr. Kasemi was called when he was assigned to the patient, however, the decedent expired before he could present to the hospital. At 6:30 p.m., the decedent became asystolic and unresponsive with blood in his mouth, pulseless and apneic. He was pronounced at 6:46 p.m. The death certificate lists the cause of death as acute hemorrhage resulting from metastatic esophageal cancer and aspiration pneumonitis.

DISCUSSION

Summary judgment is a drastic remedy that deprives litigants of their day in court, and it "should only be employed when there is no doubt as to the absence of triable issues." *Andre v Pomeroy*, 35 NY2d 361 (1974); *Bonaventura v Galpin*, 119 AD3d 625 (2d Dept 2014); *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011). The function of the court on a motion for summary judgment is not to resolve issues of fact or to determine matters of credibility, but merely determine whether such issues exist. *Guadalupe v New York City Tr. Auth.*, 91 AD3d 716 (2d Dept 2012); *Kolivas v Kirchoff*, 14 AD3d 493 (2d Dept 2005). Importantly, in determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party. *Pearson v Dix McBride, LLC*, 63 AD3d 895 (2d Dept 2009). The proponent of a summary judgment motion is required to tender sufficient evidence to demonstrate the absence of any material issues of fact, and the failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers. *Alvarez v Prospect Hosp*., 68 NY2d 320 (1986).

A physician moving for summary judgment dismissing a complaint alleging medical malpractice must establish, *prima facie*, either that there was no departure from accepted standards of medical care or that any departure was not a proximate cause of plaintiff's injuries. *Mackauer v Parikh*, 148 AD3d 873 (2d Dept 2017); *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011). To sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars. *Mackauer v Parikh*, 148 AD3d 873 (2d Dept 2017); *Schwartzberg v Huntington Hospital*, 163 AD3d 736 (2d Dept 2018). Once the showing has been made, the burden shifts to the plaintiff to 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 (*see Mackauer*; *Schwartzberg*).

In opposition to a summary judgment motion, the plaintiff's expert must address the contentions of the defense expert to establish an issue of fact. Failure to do so warrants dismissal of the action. *Senatore v Epstein*, 128 AD3d 794 (2d Dept 2015). "General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of

medical malpractice, are insufficient to defeat defendant physician's summary judgment." *Alvarez;* see also *Kramer v Rosenthal*, 224 AD2d 392 (2d Dept 1996). Moreover, "where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation … the opinion should be given no probative force and is insufficient to withstand summary judgment." *Diaz v New York Downtown Hosp*., 99 NY2d 542 (2002).

It is well-settled that expert testimony must be based on facts in the record personally known by the witnesses, and that an expert cannot reach a conclusion by assuming "material facts not supported by evidence." *Cassano v Hagstrom*, 5 NY2d 643 (1959). Expert opinions that are conclusory or unsupported by the record are insufficient to raise triable issues of fact. *Aliosha v Ostad*, 153 AD3d 591 (2d Dept 2017) (affirming the lower court's decision granting defendant's motion for summary judgment because plaintiff's unnamed expert was conclusory and speculative, and failed to address specific assertions made by the defendant's expert, especially those pertaining to proximate causation).

Furthermore, an expert affirmation in opposition to a motion for summary judgment must set forth the medically accepted standards of care or protocol and explain how it was departed from. *Geffner v North Shore University Hosp.,* 57 AD3d 839 (2d Dept 2008). Such an affirmation must address all the key facts relied on by the defendant's expert. *Geffner*; see also *Rebozo v Wilen*, 41 AD3d 457 (2d Dept 2007). In opposition, a plaintiff must "submit material or evidentiary facts to rebut the defendant's *prima facie* showing that he or she was not negligent in treating the plaintiff." *Langan v St. Vincent's Hosp. of N.Y*., 64 A.D.3d 632 (2d Dept 2015).

Kasemi, IMA and VIM

According to her bill of particulars, the plaintiff claims that these defendants negligently treated the decedent during the admissions to RUMC on September 5, 2015, and on October 5, 2015. However, in opposition (NYSCEF Doc. No. 330), the plaintiff concedes that the "main claim" against Kasemi (and VIM) is that he failed to examine and treat the decedent during the October 5, 2015 admission to RUMC. The court notes that no other claims have been advanced in opposition and as such claims related to treatment rendered by Kasemi prior to October 5, 2015, are deemed abandoned.

The plaintiff alleges that VIM failed to provide appropriate medical care to the decedent but has failed to identify any individuals or specific acts for which VIM may be held liable on the dates of alleged negligence. The plaintiff has failed to refute VIM's showing that at no time did the decedent treat at

VIM. Accordingly, the plaintiff's claims against VIM are solely vicarious in nature for treatment rendered by Kasemi on October 5, 2015.

The plaintiff has failed to assert any claims of negligence against IMA and does not refute that a bill of particulars was never served in response to its demand for the same. Furthermore, IMA argues that it is a defunct medical corporation and non-jural entity that did not provide health care services and did not employ any defendant involved in the decedent's care. The plaintiff does not refute this and has not opposed IMA's motion. Accordingly, the action alleged against it is dismissed.

Kasemi contends that he did not depart from accepted standards of care with respect to the treatment rendered to the decedent and that any alleged injuries were not proximately caused by any alleged deviations on his part. Kasemi supports his contentions with the expert affirmation of Preston Winters, M.D. who supports his opinions with references to the record including, deposition testimony and medical records.

Dr. Winters opines that the records and testimony show: that the care and treatment provided by Kasemi was at all times rendered in accordance within accepted medical practices; that the immediate cause of death was due to the acute rupture and hemorrhage of the esophageal tumor; that as the covering hospitalist, Kasemi had little involvement in the decedent's care and treatment; that during the October 5, 2015 terminal admission to RUMC, Kasemi was only involved in a single phone consultation with the assigned hospital resident, Dr. Tesfaye, during which he confirmed an appropriate plan of care; that reviewing the plan by phone was in full accord with the standard of care for internists acting in the role of hospitalist, and with RUMC's policy that admitting attending hospitalist examine the patient within 24 hours of admission; that his limited involvement in the form of a single telephone consultation and approval of the recommended treatment plan was appropriate; that no further action needed to be taken by Kasemi; and that he had no further contact with anyone at RUMC concerning the decedent before his passing five hours later.

Kasemi and VIM, vicariously, have satisfied their burden thereby establishing prima facie entitlement to summary judgment as a matter of law. As such, the burden thereafter shifted to the plaintiff to produce evidentiary proof in admissible form sufficient to establish issues of fact, which would require a trial of the action. In opposition, the plaintiff has failed to submit proof in admissible form, or the affirmation of any qualified expert, that demonstrates the existence of a triable issue of fact as to Dr. Kasemi and VIM, vicariously.

Flores and Mt. Sinai

At the outset, the court notes that in opposition, the plaintiff has limited her claims of malpractice against Flores and Mt. Sinai to treatment rendered on and after December 4, 2014. Additionally, she does not rebut the defendants' showing that the care rendered prior to December 4, 2014, was proper and appropriate. Therefore, the issues of the statute of limitations and the application of the continuous treatment doctrine raised by these defendants are moot. Accordingly, the defendants' motion to amend the answer is denied.

The plaintiff claims that these defendants departed from accepted medical practice: by failing to timely perform an esophagectomy upon the decedent following his completion of chemotherapy and radiation on September 15, 2014; by negligently delaying surgery for four months to evaluate a lung nodule; by failing to perform the esophagectomy in December of 2014 or January of 2015, thereby denying the decedent an opportunity for a cure; by failing to advise the decedent that his cancer was recurring as shown on the January 23, 2015 PET scan; by misleading the decedent into believing that he had plenty of time; by advising the decedent that he needed a VATS wedge resection to assess the lung nodule, even though it was most likely benign; and, by delaying performing the esophagectomy in order to work-up the lung nodule. The plaintiff also claims that Stacy Heath, a physician's assistant employed by Mount Sinai Hospital, departed from accepted medical care by failing to fully respond to the decedent's questions and by failing to advise him that the PET scan of January 23, 2015 revealed that his esophageal cancer was recurring.

The defendants contends that they did not depart from accepted standards of care with respect to the treatment rendered to the plaintiff and that his alleged injuries were not proximately caused by any alleged deviations on their part. The defendants support their contentions with the expert affirmation Paul E. Oberstein, M.D., a physician duly licensed to practice medicine in New York and who is board certified in medical oncology and internal medicine. Oberstein supports his opinions with specific references to the record including, deposition testimony and medical records.

Dr. Oberstein opines: that the medical care rendered by Flores and Mt. Sinai was appropriate and within the standard of care; that the decedent suffered from invasive and advanced stage, poorly differentiated, esophageal adenocarcinoma that had infiltrated and obstructed the lower third portion of

the esophagus and metastasized to non-adjacent or non-regional paratracheal lymph nodes; that given his advanced stage malignancy, with rapid progression, invasiveness, and micrometastases, the cancer was very likely incurable even before the decedent began treatment with Flores; that Flores' recommendation to assess and workup the suspicious spiculated lung nodule prior to performing an esophagectomy was proper, appropriate and in full accord with accepted standards of care; that Flores appropriately noted the decedent's diagnosis of locally advanced and infiltrating metastatic adenocarcinoma of the esophagus following his review of imaging reports and obtaining a proper history; that Flores appropriately evaluated the risks and benefits of an esophagectomy versus a pathological workup of the undiagnosed suspicious lung nodule; that the assistance and/or care rendered by Mt. Sinai employees, nursing staff, residents, fellows, physician's assistants, and other healthcare providers was appropriate and within the applicable standards of care; that it was appropriate for Flores to perform a diagnostic work up of the lung nodule and that the same was properly discussed with the decedent; that any alleged departure had no effect on decedent's ultimate outcome and did not eliminate an opportunity for cure as the same did not likely exist for the decedent; that any alleged delay and failure to perform an immediate esophagectomy had no effect on the decedent's outcome given that his advanced stage, aggressive and invasive metastatic adenocarcinoma was at all times considered non-curative and fatal.

Through their submissions, Flores and MSH have satisfied their burden of establishing their *prima facie* entitlement to summary judgment regarding the plaintiff's claims of negligence and causation. Dr. Oberstein specifically refers to the facts established by the medical records and opines that the medical care rendered by Flores and MSH was appropriate and within the standard of care. As such, the burden thereafter shifted to the plaintiff to produce evidentiary proof in admissible form sufficient to establish issues of fact, which would require a trial of the action.

In opposition, the plaintiff submits a detailed affidavit of an expert (redacted as to identity) who is duly licensed to practice medicine in New York and who is board certified in internal medicine and medical oncology. The opinions of this expert are supported with specific references to the record including, deposition testimony and medical records.

This expert opines that Flores departed from accepted medical practice: by delaying the performance of the esophagectomy; by not performing surgery in December of 2014 or January of 2015; by depriving the decedent of a cure; by denying him tri-modal therapy which included surgical removal of residual cancer; by failing to perform the esophagectomy within the 8-12 week recommendation or as soon thereafter; by delaying the performance of the esophagectomy to work-up the lung nodule; by

delaying the esophagectomy for four months in the face of growing cancer to work-up the lung nodule; by failing, together with Stacey Heath, PA, to advise the decedent that the PET scan of January 23, 2015 showed that the cancer was recurring; by failing to immediately perform an esophagectomy in January 2015 upon learning from the PET scan that the cancer was recurring; by failing to perform tests to assess the status of the esophageal cancer from January 23, 2015 to April 21, 2015; and, by failing to obtain an informed consent. The expert further opines: that there was no micrometastasis; that as late as January 23, 2015, no metastatic disease was found; that only residual cancer was at the esophagus; that had a timely esophagectomy performed by Flores in December 2014 or January 2015, it was more likely than not that the decedent would have been cured; that the departures caused the residual esophageal cancer to progress to widespread metastasis, including spread to the lungs and liver; and that the departures by Flores and Stacey Heath denied the decedent of his chance for a cure, resulting in pain, suffering and death on October 5, 2015.

The plaintiff has satisfied her burden demonstrating that issues of fact exist as to whether the defendants departed from accepted standards in the medical care and treatment rendered to the decedent and whether any departure was the proximate cause of the injuries alleged. This finding is supported by the detailed expert opinion offered by the plaintiff in opposition to the motion. Accordingly, the defendants' motion must be denied.

Informed Consent

The plaintiffs' claim for lack of informed consent alleged against the defendants must be dismissed as a matter of law. Simply stated, it is not applicable in this case as it is merely duplicative of the medical malpractice claims, including that the esophagectomy was impermissibly delayed.

Public Health Law § 2805-d (2) states that "the right of action to recover for medical, dental or podiatric malpractice based upon a lack of informed consent…is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure, which involved invasion or disruption of the integrity of the body." Plaintiff's cause of action based on lack of informed consent is devoid of merit. The plaintiff has not shown that Flores failed to obtain the decedent's informed consent in connection with the performance of any treatment or testing involving a violation of his physical integrity, which is an essential element of said cause of action. See Public Health Law § 2805- d; *Flanagan v Catskill Regional Med. Ctr.,* 65 AD3d 563 (2d Dept 2009); *Smith v Fields*, 268 AD2d 579 (2d Dept 2000) (plaintiff's lack of informed consent claim was dismissed because it essentially sought to recover damages for the defendant's failure to inform her of the risks of allowing a disease to go untreated). As a result,

under these circumstances the defendants are entitled to summary judgment on the issue of lack of informed consent because there is simply no evidence of a cognizable informed consent claim. See *Zapata v Buitriago*, 107 AD3d 977 (2d Dept 2013) (plaintiff failed to establish that the alleged lack of informed consent was a proximate cause of her injuries); *Johnson v Staten Is. Med. Group*, 82 AD3d 708 (2d Dept 2011); *Spano v. Bertocci*, 299 AD2d 335 (2d Dept 2002).

Causation

To establish a case of medical malpractice, a plaintiff must prove that the departures from accepted standards of medical care and practice were a substantial factor in causing an injury or injuries. See *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011); see also *Johnson v Staten Is. Med. Group*, 82 AD3d 708. If the departures were not a substantial factor in causing the claimed injuries, the causes of action for medical malpractice must be dismissed. See, e.g., *Senatore v Epstein*, 128 AD3d 794, (2d Dept 2015). A plaintiff need not eliminate entirely all possibility that a defendant's conduct was not a cause but must offer sufficient evidence from which one may conclude that it is more probable than not that the injury was caused by the defendant (See *Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]; *Kennedy v Peninsula Hospital Center*, 135 A.D.2d 788 [2d Dept 1987]; *Monahan v Weichert*, 82 AD2d 102). In a medical malpractice action, causation is relevant both to liability and to damages and liability cannot be established unless it is shown that the defendant's malpractice was a substantial factor in causing the plaintiff's injury. *Oakes v Patel*, 20 NY3d 633, (2013).

Furthermore, in a medical malpractice action, the law is well settled that causation is established upon proof that the defendant's act or omission decreased or diminished the plaintiff's chance of a cure or of a better outcome or increased the injury. See *Neyman v Doshi Diagnostic Imaging Services, P.C.,* 153 A.D.3d 538 (2d Dept 2017); *Borawski v Huang*, 34 A.D.3d 409 (2d Dept 2006); *Wong v Tang*, 2 A.D.3d 840 (2d Dept 2003); *Scanga v Family Practice Assocs. of Rockland, P.C.,* 302 A.D.2d 443 (2d Dept 2003); *Calvin v. New York Med. Grp., P.C.,* 286 A.D.2d 469 (2d Dept 2001); *Jump v Facelle*, 275 A.D.2d 345, (2d Dept. 2000) "As to causation, the plaintiff's evidence may be deemed legally sufficient even if its 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 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 his injury" (*Neyman v Doshi Diagnostic Imaging Services, P.C.,* 153 AD3d 538 [2d Dept 2017]; *Flaherty v Fromberg*, 46 AD3d 743, 745 [2007]; see *Goldberg v Horowitz*, 73 AD3d 691, 694 [2010]; *Alicea v Ligouri*, 54 AD3d 784, 786 [2008]; Jump v Facelle, 275 AD2d 345 [2d Dept 2000]). 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. “Curing cancer, while an ultimate and worthy aspiration, is not the only positive treatment outcome. 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 [1st Dept 2013]). Here, issues of fact exist as to whether Flores and MSH departed from accepted medical practice and whether the decedent was denied a cure.

The court has considered any remaining contentions of the parties and finds them to be unpersuasive.

Accordingly, it is hereby,

ORDERED, that the motion of defendants, Kasemi, IMA and VIM., is granted in its entirety and that the Clerk enter Judgment accordingly; and it is further,

ORDERED, that the motion of defendants, Flores and MSH, is denied, except that the plaintiff’s claim for lack of informed consent is dismissed; and it is further,

ORDERED, that any additional requests for relief are hereby denied.

Dated: February 29, 2024

ENTER

A.J.S.C.

Hon. Charles M. Troia
Justice of the Supreme Court