At an IAS Term, Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 1st day of July 2024.

P R E S E N T:

HON. GENINE D. EDWARDS,

Justice.

----------x

KAMIL KHAN, as the Administrator of the Estates of NAJIP KHANOV and MUKARRAMA MUKHAMEDZYANOVA, deceased,

Plaintiff, [1]

- against -

RAVI GUPTA, M.D., JOHN ASHKAR, M.D., HUNTZ H. LIU, M.D., JAMES O'DONNELL, M.D., and LUTHERAN MEDICAL CENTER,

Defendants.

----------x

DECISION AND ORDER

Index No. 14296/14

Mot. Seq. # 8-11

The following e-filed papers read herein: NYSCEF Doc Nos.:

Notice of Motion, Affirmations, and Exhibits. 34-46; 47-61; 62-78; 79-100
Affirmations in Opposition, and Exhibits 103-106
Reply Affirmations 107, 108, 109, 110

In this action to recover damages for medical malpractice, wrongful death, and lack of informed consent, Huntz H. Liu, M.D., James O'Donnell, M.D., and John Ashkar, M.D. ("Dr. Ashkar"), individually, and Ravi Gupta, M.D. ("Dr. Gupta"), and Lutheran Medical Center ("LMC") jointly, moved for summary judgment dismissing as against them (or him, as applicable) the complaint of Kamil Khan, as the administrator of the separate Estates of his late father, Najip Khanov, and his late mother and the original plaintiff herein, Mukarrama Mukhademzyanova (collectively, "plaintiff"). Plaintiff did not oppose the dismissal of the

[1] The original plaintiff, Mukarrama Mukhademzyanova, passed away during the pendency of this action. Her younger son, Kamil Khan, plaintiff herein, was subsequently substituted as the administrator for both of his parents' separate estates.

complaint as against Huntz H. Liu, M.D., and James O'Donnell, M.D. Further, plaintiff did not address or specifically oppose those branches of the motions which were for summary judgment dismissing the seventh cause of action for lack of informed consent. *See Clarke v. New York City Health & Hosps.*, 210 AD3d 631, 177 N.Y.S.3d 681 (2d Dept. 2022). The remainder of this Decision and Order addresses plaintiff's causes of action sounding in medical malpractice and wrongful death as against Dr. Gupta, LMC, and Dr. Ashkar (collectively, "defendants").

Background[2]

July-September 2012 (Before the Lung Cancer Diagnosis)

On July 12, 2012,[3] plaintiff's father, Najip Khanov (the "patient") – age 56 and a life-long cigarette smoker[4] – presented to LMC's emergency room with persistent respiratory complaints. From July 20th to July 27th, the patient was hospitalized on LMC's medical floor (the "hospitalization"). Dr. Gupta, an attending internist, was the patient's admitting and discharging physician during his hospitalization. During the patient's hospitalization, Dr.

[2] At the summary judgment stage, the Court viewed the record in a light most favorable to plaintiff as the non-movant. *See Matter of Eighth Jud. Dist. Asbestos Litig.*, 33 NY3d 488, 105 N.Y.S.3d 353 (2019). Further, "plaintiff [as the non-movant] was entitled to the benefit of the most favorable inferences that were to be drawn from the record." *McKay v. Town of Southampton*, 220 A.D.3d 59, 196 N.Y.S.3d 728 (2d Dept. 2023).

[3] Unless otherwise indicated, all references are to calendar year 2012.

[4] The patient quit smoking two months prior in May 2012. *See* LMC's records, page 144. When citing to LMC's records, the Court used the Bates-numbered version that was jointly e-filed by Dr. Gupta and LMC. When quoting from the medical records, the Court spelled out all abbreviations and corrected typographical errors.

Ashkar and nonparty Mark Sonnenschine, D.O. ("Dr. Sonnenschine"), served as his attending pulmonologist and oncologist, respectively.

On July 20th (which was the first day of his hospitalization), the patient underwent a contrast-enhanced CT chest angiogram (the "CTA"). The CTA revealed two concerning findings. First, the CTA revealed that the patient had a most-likely malignant mass in his right lung (the "right hilar mass"),[5] accompanied by the mediastinal and right hilar adenopathy (lymph-node swelling).[6] Because of the concurrent adenopathy, the right hilar mass was surgically unresectable at the time of its discovery. Nonetheless, the right hilar mass, at the time, was confined to the patient's right hemithorax without overt distant metastasic disease, meaning that his pancreas[7] and brain[8] were then free from metastases. The then-limited confinement of the right hilar mass was a potentially favorable finding for the patient because

[5] LMC's records, pages 271-273 (the CTA report noted, among other findings, "a mass in the region of the right hilum measuring approximately 3.5 x 4.2 x 5.9 cm"). The hilar mass was obstructing pulmonary arteries and the right-sided bronchi. LMC's records, page 271 ("The right interlobar pulmonary artery is significantly narrowed due to extrinsic compression secondary to [the right hilar] mass. . . ."); pages 271-272 ("The right middle lobe pulmonary arteries, especially the medial segmental branch is not seen and may be occluded due to extrinsic compression from the right hilar region mass."); page 272 ("The right lower lobe pulmonary artery is also significantly compressed [by the right hilar mass] although grossly patent. . . . There is marked narrowing of the superior right pulmonary vein due to the central right lung mass and adenopathy."); page 272 ("[T]here is significant narrowing of the right upper lobe bronchi due to the central mass. The middle lobe bronchi are similarly significantly attenuated, as are the origins of the lower lobe bronchi.").

[6] LMC's records, page 271 ("There is marked mediastinal lymphadenopathy measuring up to approximately 2.8 cm in short axis in the subcarinal space although enlarged lymph nodes are noted in the anterior mediastinum, pretracheal, precarinal, and right paratracheal space as well. . . . Evidence of [the] right hilar adenopathy measuring up to approximately 1.3 cm is noted.").

[7] LMC's records, page 272. The incidental finding on the CTA of a 4-cm nodule in the patient's left upper abdominal quadrant was a "splenule," rather than a metastasis to his pancreas. A "splenule" or "accessory spleen" is defined as "one of the small globular masses of splenic tissue occasionally found in the region of the spleen, in one of the peritoneal folds or elsewhere." Stedman's Medical Dictionary, Entry Nos. 839730 and 839090 (online edition), respectively.

[8] LMC's records, page 265 (noting that a non-contrast-enhanced cranial CT scan, performed on July 24th, was negative for the "space occupying lesion[s].").

chemotherapy and radiotherapy – the mainstay treatment modalities of the type of cancer the patient was then suffering from – could have been confined to a single tolerable radiation port.

The second concerning finding on the patient's CTA was "a pleural-based 2.1 x 1.8 cm nodule in the right upper lobe" (the "right lung nodule").[9] The right lung module was metastatic in nature.[10]

The CTA findings of potential malignancy – namely: (1) the right hilar mass accompanied by the adenopathy, and (2) the right lung nodule – were subject to final diagnostic confirmation by biopsy (tissue sampling) and cytology (cell sampling).

On July 24th, the patient underwent a CT-guided core biopsy of the right lung nodule (but not of the right hilar mass), performed by interventional radiologist Dr. Liu.[11] The tissue which was retrieved during the right lung nodule biopsy proved to have been inadequate for pathology analysis.

Three days later on the morning of July 27th, the patient underwent an X-ray-guided bronchial biopsy of the right hilar mass[12] that was performed by attending pulmonologist

---

[9] LMC's records, page 272.

[10] Dr. Ashkar's deposition tr at page 70, lines 10-11 (The right lung nodule was "most probably a metastatic disease.").

[11] LMC's records, page 269.

[12] Dr. Ashkar's bronchoscopy at LMC tested the patient's right hilar mass but not his lymph nodes or his right lung nodule. Dr. Ashkar's deposition tr at page 95, lines 9-16; page 98, lines 17-23. Although Dr. Ashkar conceded that the patient's CTA "showed enlargement of the lymph nodes which [enlargement] is probably a cancer metastasis," he did not biopsy the patient's lymph nodes during his X-ray-guided bronchoscopy because LMC lacked the endobronchial ultrasound ("EBUS") equipment. Dr. Ashkar's deposition tr at page 92, lines 2-16. No bronchoscopy images were preserved. Dr. Ashkar's deposition tr at page 97, lines 17-21.

Dr. Ashkar (the "bronchoscopy").[13] Later the same day of July 27th but before the bronchoscopy results were made available, the patient was discharged from LMC by Dr. Gupta's internal medicine resident, Junior Macias Madaula, M.D. ("Dr. Madaula"), in consultation with attending pulmonologist Dr. Ashkar. Upon discharge, the patient and his family were instructed by Dr. Madaula (on behalf of his internal medicine attending Dr. Gupta and, concurrently, on behalf of attending pulmonologist Dr. Ashkar) to obtain the bronchoscopy results in an outpatient follow-up with resident internist Mathew Biju, M.D. ("Dr. Biju"), at LMC's Family Health Centers ("LMC-FHC").[14]

The parties disputed as to which version of the patient discharge instructions ("PDI") were given to the patient and his family at discharge on July 27th. The controversy arose from the inclusion in LMC's records of two versions of the PDI. For the reasons stated below, the Court designated the version of the PDI (which appeared at LMC's records, page 011) as *final*, whereas the Court designated the other version of the PDI (which appeared at LMC's records,

[13] LMC's records, pages 091-096. Dr. Ashkar acknowledged (at page 73, lines 5-21 of his deposition testimony) that the EBUS bronchoscopy (rather than the X-ray-guided bronchoscopy which he performed on the patient) represented a "gold" standard in bronchoscopy. Dr. Ashkar further acknowledged (at page 74, lines 2-5 and page 75, lines 7-11 of his deposition testimony) that the option of the EBUS bronchoscopy was not offered to (nor discussed with) the patient because LMC did not have the equipment to perform it. Dr. Ashkar's deposition tr at page 75, lines 9-11 ("I did not recommend for [the patient] to do [the EBUS] procedure that we do not do it in the hospital [LMC].").

[14] Dr. Ashkar's handwritten notes (as read out by him during his deposition at page 94, lines 13-25) for the subject bronchoscopy stated:

> "Findings: No endobronchial lesion. Normal mucosa. Biopsy done. Right middle lobe, medial segment. Estimated blood loss zero. Preop diagnosis, rule out lung cancer. Postop diagnosis, rule out lung cancer. Postop status of patient, stable. Chest X-ray, no pneumothorax.
>
> Procedure: Bronchoscopy done. See procedure report. No endobronchial lesion. Biopsy done. Right middle lobe, medial segment. Chest X-ray, no pneumothorax."

page 013) as *preliminary*. It would be ultimately for the jury at trial to determine which version of the PDI had primacy.

Drawing all factual inferences in plaintiff's favor at this stage of litigation, the Court inferred that the patient and his family were handed at discharge the *final* PDI, which was dated July 27, 2012 and timed at 5:15 p.m., rather than the *preliminary* PDI, which was undated and untimed. Three reasons supported such inference. First, the *final* PDI (unlike the *preliminary* PDI) was co-signed (indicating its acceptance) by the patient's elder son, Akhmat. Second, the *final* PDI (unlike the *preliminary* PDI) downplayed the potentially cancerous status of the patient's right hilar mass. In that regard, the *final* PDI stated that: (1) the patient's discharge diagnoses were "lung mass/hyponatremia" (rather than "lung cancer" as was stated in the *preliminary* PDI); and (2) he was to follow up in one week with resident internist Dr. Biju in LMC-FHC (rather than with oncologist Dr. Sonnenschine as was directed in the *preliminary* PDI).[15] Third and finally, a Russian-language translation of the *final* PDI (which translation was separately signed/initialed by the patient's son, Akhmat, and which translation accompanied the *final* PDI) instructed the patient to take two newly prescribed medications, Atenolol and Zolpidem, whereas such medications were not listed in the *preliminary* PDI.[16]

---

[15] Whereas the *final* PDI which characterized the patient's radiographic findings of a large hilar mass with mediastinal adenopathy as simply a "mass," the *preliminary* PDI explicitly stated that: (1) the patient's discharge diagnosis was "lung cancer"; and (2) he was to follow up in one week with oncologist Dr. Sonnenschine.

[16] LMC's records, page 015 (Clinical Pharmacology, page 1 of 15, which starts with the phrase that "[The patient] was given the following MedCounselor Sheets on 07/27/2012"). The *final* PDI (unlike the *preliminary* PDI) added two newly prescribed medications for the patient to take post-discharge: Atenolol for hypertension and Zolpidem for insomnia. *Compare* LMC's records, page 011 (*final* PDI) *with* LMC's records, page 013 (*preliminary* PDI). The Atenolol and Zolpidem (though listed in the *final* PDI) were not listed in the *preliminary* PDI.

On August 3rd, the patient (as instructed by the *final* PDI) visited LMC-FHC to obtain the results of the bronchoscopy which attending pulmonologist Dr. Ashkar had performed on him on July 27th at LMC. On August 3rd, the patient met with the internist then on duty at LMC-FHC, nonparty Teodorico Alcantara, M.D. ("Dr. Alcantara").[17] In the course of the patient's visit, Dr. Alcantara informed him that: (1) the bronchoscopy was "negative for malignancy";[18] (2) he was to follow up with "pulmonology" for further surveillance;[19] and (3) he was to return to LMC-FHC in six months.[20] During the visit, Dr. Alcantara assessed the patient as suffering from: (1) a "benign neoplasm of bronchus/lung"; (2) "chronic, unspecified bronchitis"; and (3) hyponatremia.[21]

Several weeks passed after plaintiff's discharge from LMC on July 27th and after he was informed of the negative bronchoscopy results at LMC-FHC on August 3rd. Then, on August 21st, Dr. Gupta's internal medicine resident, Dr. Biju, dictated a note to file, titled "Discharge Summary," for his own and for Dr. Gupta's signatures.[22] Therein, Dr. Biju emphasized the seriousness of the patient's condition, in that: (1) the patient's "[r]ight lung

---

[17] LMC-FHC's records, pages 000008-000010 (the patient's August 3, 2012 office visit with Teodorico Alcantara, M.D.). At the time of the patient's visit, Dr. Alcantara was apparently covering for Dr. Biju at LMC-FHC because, as noted, the final PDI instructed the patient to follow up with Dr. Biju at LMC-FHC.

[18] LMC-FHC's records, page 000008.

[19] It was unclear from Dr. Alcantara's note whether his reference to "pulmonology" meant Dr. Ashkar. LMC-FHC's records, page 000008.

[20] LMC-FHC's records, page 000010.

[21] LMC-FHC's records, page 000009.

[22] LMC's records, pages 140-141 (Discharge Summary, pages 1-2). The Discharge Summary was dictated by Dr. Biju on August 21st at 13:24 hours and was transcribed on August 22nd at 18:38 hours. The "DD" and "DT" codes stand for the "date dictated" and the "date transcribed," respectively.

[hilar] mass [was] likely malignant;" and (2) he was also suffering from "[h]yponatremia [low sodium] secondary to [the] syndrome of inappropriate diuretic hormone secretion (SIADH)."[23] Dr. Biju electronically signed the Discharge Summary on September 2nd at 10:24 hours, while his internal medicine attending Dr. Gupta electronically signed it three days later on September 5th (no time indicated).[24] Contrary to defendants' position, the Discharge Summary was never shared with the patient or his family.[25]

Attending pulmonologist Dr. Ashkar (by way of his deposition testimony) offered a competing narrative. According to Dr. Ashkar, approximately seven to ten days after the patient's discharge from LMC (*i.e.*, when the bronchoscopy had already been reported as negative), he instructed an unidentified resident from Dr. Gupta's internal medicine team that "we need to call the patient, let him come for a follow[-]up, because we [had] already discussed [with the patient before the bronchoscopy] that a negative biopsy does not rule out cancer. . . [,] and send him for further procedure."[26] According to Dr. Ashkar's recollection,

---

[23] LMC's records, page 140 (Discharge Summary, page 1). The patient's hyponatremia was a side effect from the nature of his cancer as "neuroendocrine carcinoma." *See* LMC-FHC's records, page 000017 (the immunohistochemistry analysis of the patient's cancer, performed by nonparty Memorial Sloan Kettering).

[24] Although the Discharge Summary stated at the top of its page 1 that it was electronically "generated . . . [on] Jul[y] 28," the date of its electronic generation was superseded by the dates when it was electronically signed (*i.e.*, on September 2 by Dr. Biju and on September 5 by Dr. Gupta), as reflected on the bottom of its page 2.

[25] Dr. Gupta and LMC's joint position (in ¶¶ 25 and 27 of their Statement of Undisputed Facts, dated September 18, 2023) that "[t]he fact that the [patient] had a likely malignancy was also listed in the discharge summary as well," and that "[the patient] was discharged from [LMC] with a diagnosis of lung cancer," missed the crucial point, in that: (1) the Discharge Summary, which was prepared weeks after the patient's discharge, was never shared with the patient or his family; and (2) the *preliminary* PDI which listed "lung cancer" as the patient's discharge diagnosis was effectively superseded by the *final* PDI that was handed to (and accepted by) the patient's son (as indicated by the latter's signature thereon), with the patient's diagnosis identified therein as "lung mass/hyponatremia."

[26] Dr. Ashkar's deposition tr at page 24, line 19 to page 26, line 18; page 27, line 12 to page 28, line 20; page 29, lines 4-21; page 124, lines 10-25.

such internal medicine resident informed him that "they got in touch with the patient and they ma[d]e sure that he's going to follow up." When pressed for some documentary corroboration of his testimony, Dr. Ashkar initially relied on the patient's August 3rd internal-medicine visit to LMC-FHC as the proof of the follow-up appointment that was made by Dr. Gupta's internal-medicine resident.[27] In the course of further questioning, however, Dr. Ashkar equivocated as to whether Dr. Gupta's resident did (or did not) promise him that an appointment for the patient at the *pulmonology* clinic of LMC-FHC would be made.[28]

Meanwhile, the patient (crediting the deposition testimony of his son, plaintiff herein, and that of the patient's late wife, the former plaintiff herein) remained unaware that he was suffering from cancer, as more fully set forth in the margin.[29] Because his pulmonary symptoms worsened upon, and following, his hospitalization at LMC, he was no longer working as an ambulette driver.[30]

---

[27] Dr. Ashkar's deposition tr at page 30, line 2 to page 31, line 23.

[28] *Compare* Dr. Ashkar's deposition tr at page 36, lines 3-18 ("I was promised that [an appointment for the patient with the pulmonary clinic] would be made") *with* page 37, lines 2-10 ("I don't know [whether a pulmonology clinic appointment was made for this patient].").

[29] *See* Plaintiff's deposition tr at page 73, line 17 to page 74, line 4 ("Q. [A]t the point of [the patient's] discharge [from LMC], did the hospital [LMC] tell him that he might have cancer, lung cancer? . . . A. Lutheran, no, they didn't mention it. Q. You already testified that there was a biopsy? A. I said, before the biopsy, yes, they said it's a possibility. But after he was discharged [from LMC,] they never mentioned it."); page 110, lines 20-22 ("Q. Was your father advised to go to an oncologist upon his discharge [from LMC]? A. No."); page 121, line 24 to page 122, line 4 ("Q. At any point upon admission to [LMC], at any time[,] was your father told that he needed to see an oncologist? A. No."). *See also* Mukhamedzyanova's deposition tr at page 35, line 19 to page 36, line 12 ("They [LMC-FHC] told him [the patient] that they did not find anything. . . . That he could go free. . . . [That] they did not find cancer. . . . He was told to come back after six months.").

[30] Plaintiff's deposition tr at page 66, lines 7-21.

October 2012 to June 2013 (After the Lung Cancer Diagnosis)

On October 9, 2012, the patient was brought to the emergency room of nonparty Maimonides Medical Center ("MMC") with complaints of coughing up blood and chest pain with shortness of breath.[31] A contrast-enhanced CTA of chest, abdomen, and pelvis, performed on October 9th found the since-enlarged masses in the patient's right lung,[32] together with the distant metastasis in his pancreas.[33] While hospitalized at MMC, the patient was diagnosed with small cell lung carcinoma ("lung cancer")[34] in the extensive stage[35] by way of the EBUS bronchoscopy of the right hilar mass and lymph nodes on October 11th and by way of the

---

[31] MMC's records, page 4 of 32. "In September [2012], [the patient] noted worsening chest pressure. On October 4, 2012, he had an episode of syncope. Several days later [*i.e.*, on October 9, 2012], he was brought by his family to the emergency room and admitted to [MMC]." MMC's treating oncologist's follow-up note, dated March 25, 2013, page 1 of 4.

[32] MMC's records, page 13 of 32 ("The left lung is clear and there is no left pleural effusion.").

[33] MMC's records, page 13 of 32 ("There is a 3.1 x 3.0 cm ill-defined low attenuation mass in the head of the pancreas abutting the superior mesenteric vein. . . . This could represent a metastasis from lung cancer. . . ."). The pancreatic mass was a new finding at MMC on October 9th, which developed after the patient underwent the chest CTA at LMC on July 20. The newly found pancreatic mass at MMC on October 9, 2012 was not the same splenule which had been found at LMC on the July 20th chest CTA because the MMC CTA of October 9 found *both* the splenule *and* the pancreatic mass. *Compare* MMC's records, page 13 of 32 ("[T]here is a 4.4 cm splenule in the left upper quadrant.") *with* LMC's records, page 272 ("The visualized upper abdomen reveal[s] a 4-cm nodule in the left upper quadrant. This may represent a splenule."). There was a further complication with the pancreatic mass because it invaded the superior mesenteric vein. *See* MMC's treating oncologist's follow-up note, dated March 25, 2023, page 1 of 4.

[34] "Small cell [lung] carcinoma" is defined (in relevant part) as "an anaplastic [*i.e.*, composed of undifferentiated or poorly differentiated cells], highly malignant, and usually bronchogenic carcinoma composed of small ovoid cells with very scanty cytoplasm." Stedman's Medical Dictionary, Entry No. 143900. Small cell lung carcinoma is an aggressive, high-grade subtype of lung cancer characterized by rapid growth and early spread. *See* Plaintiff's Medical Expert Affirmation, dated January 3, 2024, ¶ 60 ("Small cell lung cancer is distinguished from non-small cell lung cancer by its rapid doubling time. In other words, small cell lung cancer which is what [the patient] was ultimately diagnosed with grows much faster than non-small cell lung cancer.").

[35] Small cell lung cancer was generally separated into two stages: (1) the "limited stage," and (2) "extensive stage." The patient's lung cancer, at the time of his diagnosis at MMC, was in the "extensive stage." *See* Memorial Sloan Kettering's Initial Consultation note, dated April 3, 2013, page 1; MMC's treating oncologist's follow-up note, dated November 9, 2012, page 3 of 4.

ultrasound-guided endoscopy of the pancreas on October 17th.[36] Two days later, on October 19th, he was started on chemotherapy.[37] After undergoing one cycle of chemotherapy as an inpatient, the patient was discharged home from MMC on October 22, 2012, with instructions to continue chemotherapy at an outpatient cancer center.[38]

On February 8, 2013, the patient completed six cycles of chemotherapy[39] with a partial response, and then took an approximately four-week break from cancer treatment.[40] He appeared stable but then relapsed. A CTA, performed on March 11, 2013, "showed progression of [the] mediastinal adenopathy compared to the interim . . . [CTA that had been performed at MMC after three cycles of chemotherapy]."[41]

On April 2, 2013, the patient sought and obtained a second opinion from nonparty Memorial Sloan Kettering. The second opinion confirmed the interim "progression of the [patient's] mediastinal disease."[42] Because of the "very high proliferative index [of the

[36] As noted, the EBUS (or the endobronchial ultrasound) biopsy was not available (nor was discussed with the patient at) LMC. Dr. Ashkar in his deposition testimony (at page 87, lines 20-23) confirmed that the EBUS bronchoscopy was performed on the patient at MMC.

[37] MMC's records, page 89 (Problem Oriented Progress Note, dated October 22, 2012 and timed at 12:57 hours).

[38] MMC's records, page 110 (Problem Oriented Progress Note, dated October 22, 2012 and timed at 12:57 hours).

[39] MMC's treating oncologist's follow-up note, dated April 30, 2013, page 2 of 4.

[40] Memorial Sloan Kettering's Initial Consultation Note, dated April 3, 2013, pages 1-2.

[41] MMC's treating oncologist's follow-up note, dated April 30, 2013, page 2 of 4.

[42] Memorial Sloan Kettering's Initial Consultation Note, dated April 3, 2013, page 2.

patient's tumor],"[43] the consulting oncologist was concerned that the patient could "develop [a] superior vena cava syndrome in the near future without radiation therapy."[44]

Thoracic radiation, for a total of ten sessions, was then undertaken. By April 30, 2013, the patient "completed thoracic radiation for . . . [the] impending bronchial obstruction."[45] On April 30, 2013, the patient's treating oncologist at MMC "recommended that the patient resume plans for [the] second line chemotherapy as soon as he [felt] able [to]."[46] The patient had his last chemotherapy session in Brooklyn, NY, on May 13, 2013. Thereafter, he and his family traveled to Denver, Colorado.

On May 30, 2013, the patient was admitted to the University of Colorado Medical Center with complaints of upper extremity weakness, chest pain, imbalance, tremor, and increased nausea and vomiting, suggestive of the ongoing pancreatitis, as well as the metastases to the brain. An abdominal CTA revealed "superimposed [acute] pancreatitis in the setting of pancreatic neoplasm," as well as "[t]he right adrenal nodule and multiple renal nodules, suspicious for metastatic disease."[47] On June 4, 2013, the patient was noted to "[l]ikely [have] very poor prognosis[,] with known metastasis to pancreas[,] with [six sites of]

---

[43] Memorial Sloan Kettering's Cytopathology Report, dated April 9, 2013, page 1 of 2 ("The KI-67 [protein] proliferation index is greater than 20%. Findings are consistent with high grade neuroendocrine carcinoma with small cell features.") (unnecessary capitalization omitted).

[44] Memorial Sloan Kettering's Initial Consultation Note, dated April 3, 2013, page 3.

[45] MMC's treating oncologist's follow-up note, dated April 30, 2013, page 2 of 4.

[46] MMC's treating oncologist's follow-up note, dated April 30, 2013, page 3 of 4.

[47] University of Colorado Hospital's Encounter Note, dated May 30, 2013 and timed at 5:35 p.m., page 6.

brain metastases [as were] noted in [the June 2, 2013] MRI."[48] On June 5, 2013, a course of palliative whole-brain radiation therapy was attempted to alleviate his neurologic symptoms. After undergoing only one session of such therapy, however, the patient suffered "increased fatigue, nausea and vomiting, and worse pain."[49] Shortly thereafter, he and his family elected palliative care for him. On June 10, 2013, he was discharged to the Denver Hospice for palliative care. The short course of hospice care was marked by his episodes of restlessness and agitation because of the poorly controlled pain.[50] On June 20, 2013, the patient passed away. The immediate cause of his death was "metastatic lung cancer," with "atrial fibrillation" as a contributing condition.[51]

Litigation

In October 2014, plaintiff commenced this action to recover damages, on behalf of the patient's estate, for medical malpractice and wrongful death. Plaintiff alleged, in essence, that attending internist Dr. Gupta, attending pulmonologist Dr. Ashkar, and their employer LMC were negligent in their substandard treatment of the patient. Plaintiff's principal claim was that Dr. Gupta and Dr. Ashkar directly (and LMC vicariously) failed to promptly diagnose the patient's lung cancer, despite its classic radiographic presentation on the patient's CTA on

[48] University of Colorado Hospital's Encounter Note, dated June 4, 2013 and timed at 8:09 a.m., page 39; and another Encounter Note, also dated June 4, 2013 and timed at 3:33 p.m., page 44.

[49] University of Colorado Hospital's Discharge Summary, dated June 10, 2013, pages 70-71.

[50] Denver Hospice's Admission History & Physical Note, dated June 18, 2013, page 3; Denver Hospice's Intensive Care Coordination Progress Note, dated June 19, 2013, page 1.

[51] The patient's Certificate of Death, dated June 26, 2013.

July 27, 2012, and to immediately refer him for chemoradiation treatment at any time during his July 2012 hospitalization at LMC and, subsequently, at his August 3, 2012 outpatient visit to LMC-FHC. According to plaintiff's expert oncologist, the patient's lung cancer in July-August 2012 was in the limited stage and without distant metastases.[52]

After discovery was completed and a note of issue was filed, these motions ensued. On March 8, 2024, the Court reserved decision on the motions, as fully submitted.

Standard of Review

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury." *Sunshine v. Berger*, 214 A.D.3d 1020, 186 N.Y.S.3d 326 (2d Dept., 2023) (internal quotation marks omitted). "On a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant . . . has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby." *Neumann v. Silverstein*, 227 A.D.3d 914, 209 N.Y.S.3d 584 (2d Dept. 2024) (internal quotation marks omitted). "If the defendant makes such a showing, the burden then shifts to the plaintiff to raise a triable issue of fact as to those elements on which the defendant met its prima facie burden of proof." *Armond v Strangio*, 227 A.D.3d 758, 210 N.Y.S.3d 491 (2d Dept. 2024). "Generally, where the parties adduce conflicting competent medical expert

[52] *See* Plaintiff's Medical Expert Affirmation, January 3, 2024 ("Plaintiff's Expert Affirmation"), ¶ 62 ("At the time of [his] presentation to LMC on July 20, 2012, [the patient] suffered from limited stage lung cancer."); ¶ 62 ("The CT[A] findings dated July 20, 2012 [at LMC] are further significant in that there was no evidence of distant metastatic disease.").

opinions, summary judgment is not appropriate, as such credibility issues can only be resolved by the trier of fact." *Id.*

Discussion

The Court reviewed the patient's medical records and the parties' voluminous submissions. The Court isolated three principal points that were necessary for its determination of the opposed motions – the joint motion by Dr. Gupta and LMC jointly, and the separate motion by Dr. Ashkar.

1. The Departure Element on Dr. Gupta and LMC's Prima Facie Case

Neither Dr. Gupta nor LMC met the respective prima facie burden on the element of departure. The opinions expressed in the affirmation of Dr. Gupta and LMC's internal medicine expert[53] were premised on: (1) Dr. Gupta's self-serving, medically unsupported deposition testimony to the effect that he repeatedly informed the patient of the lung cancer diagnosis;[54] (2) a plausible assumption (which, however, was uncorroborated by LMC's records) that the patient and his family received a *preliminary* PDI *with* the oncology-referral directive (rather than a *final* PDI *without* the oncology-referral directive) at the time of his discharge from LMC on July 27;[55] and (3) an implausible assumption (which was likewise

[53] *See* Expert Affirmation of Internist Lawrence Diamond, M.D. ("Dr. Diamond"), dated September 14, 2023.

[54] Dr. Diamond's Expert Affirmation, ¶¶ 49, 50, 55, 57, 58, 60, and 64. Each of the afore-referenced paragraphs cited to, and relied on, Dr. Gupta's self-serving, medically unsupported deposition testimony that he allegedly informed the patient of the lung cancer diagnosis in the course of the LMC hospitalization.

[55] Dr. Diamond's Expert Affirmation, ¶¶ 61 and 67 (assuming, in each instance, that the patient received, at discharge from LMC, the *preliminary* PDI instructing the latter to follow up with an "oncologist," rather than the *final* PDI which, unlike the *preliminary* PDI, said nothing about his follow-up with an oncologist).

uncorroborated by LMC's records) that the patient and family might have been informed of the contents of the after-the-fact Discharge Summary that Dr. Gupta and his resident Dr. Biju prepared and separately signed in late August and early September (which was weeks after the patient's discharge from LMC on July 27th and after his outpatient follow-up visit at LMC-FHC on August 3rd).[56] Thus, Dr. Gupta and LMC failed to eliminate triable issues of fact on the departure element of plaintiff's medical malpractice claim as against them, without regard to the sufficiency of his opposition papers. *See Neumann v. Silverstein*, 227 A.D.3d 914, 209 N.Y.S.3d 584 (2d Dept. 2024); *Glassman v. Caremount Med., P.C.*, 226 A.D.3d 878, 209 N.Y.S.3d 527 (2d Dept. 2024).

In any event, plaintiff raised sufficient questions of fact on the element of Dr. Gupta's (and, vicariously, LMC's) departures to warrant a trial. In that regard, plaintiff offered an affirmation from his medical expert who opined that Dr. Gupta (and vicariously LMC) departed from the standard of care by (among other departures): (1) failing to obtain a surgical consultation for a diagnostic video-assisted thoracoscopic surgical procedure during the patient's hospitalization at LMC; (2) discharging the patient from LMC without informing him and his family that his CTA showed that he was then suffering from lung cancer; and

[56] Dr. Diamond's opinion (in ¶ 66 of his expert affirmation) that "Dr. Gupta discharged his duty towards this patient after he was discharged from [LMC]," overlooked the crucial fact that in late August and early September (which was after the patient's discharge from LMC on July 2th7), Dr. Gupta's resident, Dr. Biju, prepared the after-the-fact Discharge Summary which each of them separately electronically signed in September. If, as Dr. Diamond posited, Dr. Gupta's duties toward the patient ended at the latter's discharge from LMC on July 27th, then there would have been absolutely no reason to prepare and for them to electronically sign the after-the-fact Discharge Summary in late August and early September.

(3) failing to direct the patient and his family to have a follow-up with an oncologist for his lung cancer.[57]

In a summary judgment context where a court's function is "issue-finding, rather than issue-determination,"[58] plaintiff – by way of his expert's affirmation, LMC's records, LMC-FCP's records, and Dr. Gupta's deposition testimony – raised sufficient questions of fact as to whether Dr. Gupta (and, vicariously, LMC) failed to take steps that would have led to an earlier diagnosis of the patient's lung cancer and (as more fully discussed below) whether the delayed diagnosis of lung cancer diminished the patient's chance of survival or death which was earlier than it might have been otherwise. *See Borodkin v. Friedwald Ctr. for Rehabilitation & Nursing, LLC*, 225 A.D.3d 657, 206 N.Y.S.3d 710 (2d Dept. 2024); *Lopresti v. Alzoobaee*, 217 A.D.3d 759, 191 N.Y.S.3d 171 (2d Dept. 2023).

2. The Departure Element on Dr. Ashkar's Prima Facie Case

"Although physicians owe a general duty of care to their patients, that duty may be limited to those medical functions undertaken by the physician and relied upon by the patient." *Romanelli v. Jones*, 179 A.D.3d 851, 117 N.Y.S.3d 90 (2d Dept. 2020) (internal quotation marks omitted). "The existence and scope of a physician's duty of care is a question of law to be determined by the court." *Romanelli v. Jones*, 179 A.D.3d 851.[59]

---

[57] Plaintiff's Expert Affirmation, ¶¶ 41, 46-48, 51, 55-57.

[58] *See Johnson v. City of NY*, 15 N.Y.3d 676, 917 N.Y.S.2d 10 (2010) (internal quotation marks omitted), *rearg. denied* 16 N.Y.3d 807, 920 N.Y.S.2d 772 (2011).

[59] Contrary to Dr. Ashkar's contention (in Point I of his counsel's Reply Affirmation, dated January 22, 2024), the crucial (footnote continued)

Here, Dr. Ashkar's papers (including his deposition testimony, LMC's records, and LMC-FHC's records) failed to eliminate triable issues of fact as to whether he assumed a duty to assist in the diagnosis of the patient's lung cancer and whether his alleged departures delayed its diagnosis and decreased the patient's chances of having a better outcome. *See Wiater v. Lewis*, 197 A.D.3d 782, 153 N.Y.S.3d 176 (2d Dept. 2021).

A review of Dr. Ashkar's deposition testimony revealed its fundamental inconsistency. On the one hand, Dr. Ashkar testified that the patient did *not* need his services as an outpatient pulmonologist because, in his opinion, the patient had already been suffering from lung cancer during his hospitalization at LMC. In support of his "cancer-positive" position that the patient had already been suffering from lung cancer while at LMC, Dr. Ashkar testified that: (1) he was "99.9 percent [sure that the patient had] lung cancer" [in the course of the latter's hospitalization at LMC][60]; (2) "every day [when] I [Dr. Ashkar] saw [the patient at LMC] I told him that it's [the right hilar mass was] most likely a lung cancer";[61] and (3) he was "100 percent sure" that he told the patient that, despite the negative results from the July 27th bronchoscopy, he had lung cancer and needed to "follow up with an *oncologist* upon discharge."[62] If Dr. Ashkar's "cancer-positive" position was accepted, there would have been

---

point here was whether Dr. Ashkar *assumed a duty* to the patient, which was a question of law for the Court to determine.

[60] Dr. Ashkar's deposition tr at page 86, lines 21-22.

[61] Dr. Ashkar's deposition tr at page 114, lines 10-18.

[62] Dr. Ashkar's deposition tr page 116, lines 6-14 ("Q. . . . Did you tell [the patient] that even with a negative biopsy [from the bronchoscopy] it is your opinion that he still has lung cancer? Did you tell him that? A. Yes. Q. Where is that reflected in your note? A. It's not reflected in my note, but I'm 100 percent sure I did tell him that."); page 118, line 23 to page 119, line 2 (testifying that the patient "was told he needs to follow up with an oncologist upon discharge. . . . [H]e was referred to see an *oncologist* upon discharge.") (emphasis added).

nothing for him, as an outpatient *pulmonologist*, to do after the discharge because, in that event, the patient would have needed to start cancer treatment with an *oncologist* immediately.

On the other hand, Dr. Ashkar testified that the patient *still needed* his services as an *outpatient pulmonologist* because the patient's lung cancer had ***not*** yet been diagnosed at LMC, and the patient was at fault for failing to follow-up with him (or with any other pulmonologist) as an outpatient to obtain a proper diagnosis. In support of his "undiagnosed-cancer" position that the patient had *not* been diagnosed with lung cancer while hospitalized at LMC (or at his outpatient visit to LMC-FHC), Dr. Ashkar testified that: (1) the X-ray-guided bronchoscopy that he performed on the patient at LMC was not a gold standard in diagnostic bronchoscopy (despite his pulmonary expert's opinion to the contrary[63]); (2) he discussed the patient's case with an unidentified internal medicine resident for the need to follow-up on the patient *either with the internal medicine or with the pulmonary clinic* (but not with the oncology clinic) after the patient's discharge from LMC; and (3) he received confirmation from an unidentified internal medicine resident that the patient would follow-up *either with the internal medicine or with the pulmonary clinic* (but again not with the oncology clinic) after the patient's discharge from LMC.[64]

---

[63] Expert Affirmation of Pulmonologist Ian Newmark, M.D. ("Dr. Newmark"), dated September 11, 2023; ¶ 25. Dr. Newmark's opinion (in ¶ 25 of his affirmation) that "an EBUS bronchoscopy is not typically the first bronchoscopy performed in the context of *clinical suspicion* for lung cancer," missed the point. According to Dr. Ashkar's deposition testimony, he was "99.9 percent" sure (which was well beyond a mere "clinical suspicion" that the patient was suffering from lung cancer.

[64] Dr. Ashkar's deposition tr at page 24, line 19 to page 26, line 18; page 27, line 12 to page 28, line 20; page 29, lines 4-21; page 124, lines 10-25; Dr. Ashkar's EBT tr at page 30, line 2 to page 31, line 23; page 36, lines 3-18; page 37, lines 2-10.

Dr. Ashkar's quibbling in his deposition testimony over the lack of a confirmed lung-cancer diagnosis at the time of the patient's discharge from LMC contradicted other portions of his deposition testimony affirming that the patient was suffering from lung cancer during the LMC hospitalization (as was confirmed by the ominous radiographic findings on the July 20th CTA), and that the patient needed to consult an oncologist immediately. Because Dr. Ashkar failed to make a prima facie showing on the departure element of plaintiff's medical malpractice claim as against him, the burden never shifted to plaintiff on that element. Accordingly, plaintiff's opposition as to the departure element of his medical malpractice claim against Dr. Ashkar was not considered. *See Martinez v. Orange Regional Med. Ctr.*, 203 A.D.3d 910, 165 N.Y.S.3d 573 (2d Dept. 2022).

3. <u>The Causation Element on Defendants' Respective Prima Facie Cases</u>

The expert affirmations of defense oncologists, James M. Vogel, M.D. ("Dr. Vogel"), for Dr. Gupta/LMC, and Jeffrey G. Schneider, M.D. ("Dr. Schneider"), for Dr. Ashkar, each established, prima facie, that the approximately three-month delay in the lung-cancer diagnosis did not affect the patient's ultimate prognosis,[65] which (in the defense oncologists' respective

---

[65] *See* Dr. Vogel's Affirmation, dated September 15, 2023, ¶ 72 ("Plaintiff-decedent's small cell lung carcinoma was at an *extremely advanced stage at the time of its diagnosis in October of 2012, and based upon the extent of metastasis at that time, had not changed from just three months earlier during his July 20-27, 2012 admission* [at LMC]. Once a small cell lung cancer has metastasized (the disease has spread to other distant organs), as was the case here, it is lethal[,] and the patient has no chance of a cure. Thus, it is my opinion, within a reasonable degree of medical certainty, that a diagnosis of small cell carcinoma just three months earlier on or about <u>July of 2012</u> would not have altered the outcome of this case, as a patient with metastatic small cell lung cancer had zero percent chance of survival."); ¶ 74 ("Had [the patient] been diagnosed with lung cancer on or around July 2012, he would have received the same chemotherapy followed by radiation. Given the following factors, which were all outside [Dr. Gupta's] and [LMC's] control: the advanced state and aggressive nature of the patient's small cell lung cancer, the limited treatment modalities available to the patient[,] and the patient's suboptimal reaction to the chemotherapy, ***even if the cancer had been diagnosed three months earlier, [the patient's]***

(footnote continued)

opinions) would have been essentially the same if his lung cancer had been diagnosed three months earlier.[66] According to both defense experts, the patient's ultimate outcome (even with a timely diagnosis in July 2012) would have been the same for three reasons: (1) the patient's lung cancer was in the "extensive stage" as early as July 2012; (2) the patient already had distant metastasis in his pancreas as early as July 2012; and (3) the patient's lung cancer was not "chemotherapy-sensitive." Thus, both sets of defendants established, prima facie, that the three-month delay in the lung-cancer diagnosis was not a proximate cause of the patient's injuries and death. *See Kelly v. Gonzalez-Torres*, 219 A.D.3d 711, 194 N.Y.S.3d 312 (2d Dept. 2023); *Bendel v. Rajpal*, 101 A.D.3d 662, 955 N.Y.S.2d 187 (2d Dept. 2012); *Pichardo v. Herrera-Acevedo*, 77 A.D.3d 641, 908 N.Y.S.2d 446 (2d Dept. 2010).

The burden then shifted to plaintiff to raise a triable issue of fact on the element of proximate cause. "To raise a triable issue of fact [on that element], a plaintiff need not establish

---

treatment and outcome would have been identical. In my opinion, had the patient started the cancer treatment three months earlier in July of 2012, it would have made no difference in the patient's prognosis or outcome."); ¶ 79 ("Within a reasonable degree of medical certainty, there was no loss of chance of survival based upon an alleged failure to diagnose lung cancer, since the patient had metastatic, incurable . . . lung cancer *as of the date of his first presentation to [LMC]*, making the patient's prognosis at that time very poor. Thus, *even if his cancer was diagnosed in July of 2012 it was the same stage it was in October of 2012* and thus any alleged delay during this time frame had no proximate causation or impact on his injuries, he still would have, unfortunately, received the same exact treatment and died within the same timeframe that he ultimately did.") (italics added; underlining in the original).

[66] *See* Dr. Schneider's Expert Affirmation, dated September 15, 2023, ¶ 23 ("It is my opinion within a reasonable degree of medical certainty that [the patient] had *extensive stage* small cell lung cancer with *distant metastatic spread* upon his initial presentation to Lutheran on July 20, 2012."); ¶ 30 ("*Extensive stage* small cell lung cancer with distant metastatic spread in 2012 had a cure rate of less than 5%. It is my opinion within a reasonable degree of medical certainty that any alleged delay in the confirmation of this diagnosis between July 27, 2012 and October 9, 2012 did not impact this prognosis or alter the courses of treatment that would have been available."); ¶ 31 ("It is my opinion within a reasonable degree of medical certainty that initiation of chemotherapy in July 2012 would not have meaningfully extended the duration or quality of [the patient's] life. If chemotherapy had been administered in July of 2012, it is my opinion to a reasonable degree of medical certainty that there would have been no improvement in quality or quantity of [the patient's] life. Moreover, the facts demonstrate that [the patient's] *primary tumor was not chemotherapy-sensitive*, diminishing the impact that any earlier initiation of treatment would have provided.") (italics added).

that, but for a defendant doctor's failure to diagnose, the patient would have been cured." *Neyman v. Doshi Diagnostic Imaging Servs., P.C.*, 153 A.D.3d 538, 59 N.Y.S.3d 456 (2d Dept. 2017). "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." *Neyman v. Doshi Diagnostic Imaging Servs., P.C.*, 153 A.D.3d 538 (internal quotation marks omitted). "Where a medical malpractice plaintiff alleges a failure to timely diagnose a condition, the plaintiff must show that the departures from the standard of care delayed diagnosis and decreased the chances of a better outcome or increased the injury." *Paglinawan v. Jeng*, 211 A.D.3d 743, 180 N.Y.S.3d 237 (2d Dept. 2022).[67]

Here, plaintiff's oncology expert addressed in detail the specific assertions made by the defense oncology experts Dr. Vogel and Dr. Schneider, as well as set forth his/her own reasoning as to how those departures proximately caused the patient's injuries and death.[68] First, plaintiff's expert opined that the patient's lung cancer was in the *limited* stage (rather than in the *extensive* stage) at the time of his presentation to LMC in July 2012.[69] Second, plaintiff's expert opined that the patient's lung cancer had not spread to his pancreas (*i.e.*, that

---

[67] *See generally Holton v. Sprain Brook Manor Nursing Home*, 253 A.D.2d 852, 678 N.Y.S.2d 503 (2d Dept. 1998) ("In a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant."), *lv. denied* 92 N.Y.2d 818, 685 N.Y.S.2d 420 (1999).

[68] Plaintiff's Expert Affirmation, ¶¶ 58-67.

[69] Plaintiff's Expert Affirmation, ¶ 62 ("At the time of presentation to LMC on July 20, 2012, [the patient] suffered from limited stage lung cancer."); ¶ 63 ("[I]t is my opinion, to a reasonable degree of medical certainty that [the patient] suffered from a limited stage lung cancer in July and early August 2012.").

there were *no* distant metastasis) at the time of his presentation to LMC in July 2012.[70] Third, plaintiff's expert opined, albeit in general (rather than in specific) terms, that "[s]mall cell lung cancer is highly responsive to multiple chemotherapeutic drugs and chemotherapy is routinely used to improve prognosis and survival."[71] Although plaintiff's expert did not specifically address Dr. Schneider's opinion (in ¶ 31 of his affirmation) that the patient's "primary tumor was not chemotherapy-sensitive, [thus] diminishing the impact that any earlier initiation of treatment would have provided,"[72] plaintiff's expert sufficiently opined that "with appropriate and timely commencement of cancer treatment in July or early August 2012, [the patient] would have had a substantial improvement in his life expectancy and survival."[73] Thus, plaintiff's expert sufficiently raised triable issues of fact on the element of proximate cause. *See Stewart v North Shore Univ. Hosp. at Syosset*, 204 A.D.3d 858, 166 N.Y.S.3d 676 (2d Dept. 2022); *Neyman v. Doshi Diagnostic Imaging Servs., P.C.*, 153 A.D.3d 538; *Scanga v. Family Practice Assoc. of Rockland, P.C.*, 302 A.D.2d 443, 753 N.Y.S.2d 744 (2d Dept. 2003); *Cavlin v. New York Med. Group, P.C.*, 286 A.D.2d 469, 730 N.Y.S.3d 337 (2d Dept.

---

[70] Plaintiff's Expert Affirmation, ¶ 62 ("Contrary to defendants' contention, there was no evidence of metastatic spread to the pancreas or other distant organs. Defendants[`] experts contend that a 4 cm nodule in the left upper quadrant seen on the July 20, 2012 CT[A] . . . represented metastasis to the pancreas. However, I disagree with this opinion. The 4 cm nodule seen on the July 20, 2012 [CTA] represented a splenule which is a benign nodule of splenic tissue. The same splenule was visualized on the October 9, 2012 CT scan performed at [MMC]. This visible splenule was separate and distinct from the 3.1 x 3.0 cm ill[-]defined mass in the head of the pancreas abutting the mesenteric vein."); ¶ 63 ("The CT[A] . . . findings dated July 20, 2012 are further significant in that there was no evidence of distant metastatic disease.").

[71] Plaintiff's Expert Affirmation, ¶ 64.

[72] The force of Dr. Schneider's broadly advanced contention (in ¶ 31 of his affirmation) that the patient's "primary tumor was not chemotherapy-sensitive" was mitigated by his immediately following qualification that the nature of the patient's tumor merely "diminish[ed]," rather than rescinded and nullified, "the impact that any earlier initiation of [the chemotherapy] treatment would have provided."

[73] Plaintiff's Expert Affirmation, ¶ 67.

2001); *Hughes v. New York Hosp.-Cornell Med. Ctr.*, 195 A.D.2d 442, 600 N.Y.S.2d 145 (2d Dept. 1993).[74]

The Court considered the parties' remaining contentions and found them either moot or without merit in light of its determination. All relief not expressly granted is denied.

Conclusion

Based on the foregoing, it is

ORDERED that Dr. Liu's motion for summary judgment is granted without opposition, and the complaint is dismissed in its entirety as against him without costs or disbursements, and it is further

ORDERED that Dr. O'Donnell's motion for summary judgment is granted without opposition, and the complaint is dismissed in its entirety as against him without costs or disbursements, and it is further

ORDERED that the joint motion of Dr. Gupta and LMC for summary judgment is granted to the extent that plaintiff's seventh cause of action for lack of informed consent is dismissed as against them, and the remainder of their motion is denied, and it is further

[74] *See also Santiago v. Abramovici*, 226 A.D.3d 720, 208 N.Y.S.3d 289 (2d Dept. 2024); *Pezulich v. Grecco*, 206 A.D.3d 827, 169 N.Y.S.3d 680 (2d Dept. 2022); *Valenti v. Gadomski*, 203 A.D.3d 783, 164 N.Y.S.3d 171 (2d Dept. 2022); *Tardio v. Saleh*, 193 A.D.3d 901, 146 N.Y.S.3d 646 (2d Dept. 2021); *Joynes v. Donatelli*, 190 A.D.3d 845, 140 N.Y.S.3d 241 (2d Dept. 2021).

ORDERED that Dr. Ashkar's motion for summary judgment is granted to the extent that plaintiff's seventh cause of action for lack of informed consent is dismissed as against him, and the remainder of his motion is denied, and it is further

ORDERED that the action is severed and continued against the remaining defendants, Dr. Gupta, LMC, and Dr. Ashkar, and the caption is amended as follows:

----------x
KAMIL KHAN, as the Administrator of
the Estates of NAJIP KHANOV and
MUKARRAMA MUKHAMEDZYANOVA, deceased,

Plaintiff,

- against -

RAVI GUPTA, M.D.,
JOHN ASHKAR, M.D., and
LUTHERAN MEDICAL CENTER,

Defendants.
----------x

; and it is further

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this Decision and Order with notice of entry on the other parties' respective counsel and to electronically file an affidavit of service thereof with the Kings County Clerk, and it is further

ORDERED that the remaining parties are directed to appear virtually for an Alternative Dispute Resolution Conference on September 30, 2024, at 11AM.

This constitutes the Decision and Order of the Court.

ENTER,

Hon. Genine D. Edwards, J. S. C.