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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: LOBIS Justice PART 6

KEIL, JENNIFER, ETAL.

-v-

ALBERT M. LEFKOVITS, M.D., ETAL

INDEX NO. 104668/10

MOTION DATE 9/20/11

MOTION SEQ. NO. 004

MOTION CAL. NO.

The following papers, numbered 1 to 15 were read on this motion to/for summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-14
Answering Affidavits — Exhibits	see mot Seq. #002
Replying Affidavits	15

Cross-Motion: ☐ Yes ☒ No

Upon the foregoing papers, it is ordered that this motion

FILED

DEC 20 2011

NEW YORK
COUNTY CLERK'S OFFICE

MOTION DECIDED IN ACCORDANCE WITH ACCOMPANYING DECISION

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: Dec. 15, 2011

JOAN B. LOBIS J.S.C.

Check one: ☐ FINAL DISPOSITION ☒ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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JENNIFER KEIL, as Executrix of the Estate of H. BRADEN KEIL a/k/a HERBERT BRADEN KEIL, Deceased, and JENNIFER KEIL, Individually,

Plaintiffs,

-against-

ALBERT M. LEFKOVITS, M.D., THE PARK AVENUE CENTER for ADVANCED MEDICAL and COSMETIC DERMATOLOGY, MOUNT SINAI DERMATOLOGY ASSOCIATES, MICHAEL DIAZ, M.D., DANIEL F. ROSES, M.D., NYU HOSPITALS CENTER, NYU MEDICAL CENTER, NYU LANGONE MEDICAL CENTER, and STEWART G. GREISMAN, M.D.,

Defendants.

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Index No. 104668/10

Decision and Order

JOAN B. LOBIS, J.S.C.:

Motion Sequence Numbers 002, 003, and 004 are hereby consolidated for disposition. In Motion Sequence Number 002, defendant Albert M. Lefkovits, M.D., moves, by order to show cause, for an order pursuant to C.P.L.R. Rule 3212(a), granting summary judgment in his favor and dismissing the action against him, with prejudice. In Sequence Numbers 003 and 004, Michael Diaz, M.D., Daniel F. Roses, M.D., and NYU Hospitals Center s/h/a NYU Hospitals Center, NYU Medical Center, and NYU Langone Medical Center ("NYU"), move for similar relief. Jennifer Keil, in her individual capacity and as executrix of the estate of her late husband, H. Braden Keil a/k/a Herbert Braden Keil, deceased, opposes the motions.

This action for medical malpractice and wrongful death arises out of defendants' respective treatment of Mr. Keil between November 2006 and December 2008. On November 27,

2006, Mr. Keil presented to Dr. Lefkovits, a dermatologist, with a complaint of a mole on his back that had been changing and was sensitive. Dr. Lefkovits excised the mole and had it biopsied. The biopsy of the excised tissue revealed malignant melanoma. Dr. Lefkovits referred Mr. Keil to Dr. Roses, an oncological surgeon. Mr. Keil presented to Dr. Roses on November 30, 2006. Dr. Roses recommended a wide deep excision of the tissue surrounding the area where the mole had been previously and removal of the sentinel lymph node. On December 1, 2006, Mr. Keil underwent a positron emission tomography ("PET") scan, which depicted a 5 millimeter nodule in the left lower lobe of his lungs; the physician who read the PET scan recommended a follow-up chest computed tomography ("CT") scan. On December 6, 2006, Dr. Roses performed the wide and deep excision of the malignant melanoma and the sentinel lymphadenectomy at NYU Hospitals Center. His notes reflect that the sentinel nodes were negative for metastatic melanoma, and that no residual melanoma was noted in the wide excision specimen.

Mr. Keil presented for two follow-up appointments with Dr. Roses on December 14, 2006, and January 4, 2006, during which the sutures were removed. On December 14, Dr. Roses wrote a consultation report to Dr. Lefkovits about the results of the December 1, 2006 PET scan, indicating that the 5 mm nodule on the left lung was of "no concern" but for which a follow-up CT scan would be performed. Dr. Roses testified at his examination before trial ("EBT") that he also reviewed the results of the PET scan with Mr. Keil prior to the surgery and, at each follow-up visit, reminded him of the need to have a CT scan, to continue monitoring his condition, and to come in for follow-up examinations. Dr. Roses' notes reflect that on January 4, 2007, he instructed Mr. Keil to return in two to three weeks; however this was the last date that Mr. Keil received treatment from Dr. Roses.

Mr. Keil presented to Dr. Lefkovits twelve times between February 2007 and November 2008. At these visits, Dr. Lefkovits would remove suspicious lesions and order biopsies. The lesions removed during this period of time were benign, although one mole was noted as changing from benign to malignant. Dr. Lefkovits testified at his EBT that on multiple occasions, he asked Mr. Keil to return to Dr. Roses for further evaluations.

In August 2007, Mr. Keil asked Dr. Lefkovits to refer him to an internist for complaints of a cough, and Dr. Lefkovits referred him to Dr. Diaz. At the first appointment on August 2, 2007, Mr. Keil presented to Dr. Diaz with complaints of dizziness and dyspnea. Dr. Diaz ordered blood work, which was normal except for elevated cholesterol. Dr. Diaz wanted to rule out vestibulitis and mitral valve prolapse and referred Mr. Keil to a cardiologist. He instructed Mr. Keil to return on an "as needed" basis. Dr. Diaz next saw Mr. Keil on April 8, 2008, with shingles and a recent outbreak of genital herpes. Dr. Diaz prescribed Lyrica for muscle pain associated with shingles and blood work performed at this visit was normal. On September 5, 2008, Mr. Keil presented with complaints of chest and back pain. Dr. Diaz diagnosed chest pain syndrome and neuralgia consistent with the shingles. Blood tests indicated elevated findings that Dr. Diaz associated with the singles and herpes outbreaks. Dr. Diaz again prescribed Lyrica, which reportedly provided Mr. Keil with relief of his symptoms.

On November 21, 2008, Mr. Keil presented to Dr. Diaz with congestion, cough, thick sputum, back pain with coughing, and a sore throat. He was running a mild temperature and reported chills, muscle spasms, and occasional crackles and wheezing. Dr. Diaz ordered an x-ray and prescribed Levaquin for suspected bronchitis. A urine sample provided on November 24, 2008,

showed trace protein. On November 26, 2008, Dr. Diaz presented with fatigue and headaches that had been persisting for one week, pain in his lower back and right lower rib cage, pain upon coughing, and occasional sore throat and nausea. Dr. Diaz's examination noted muscle pain and clear lungs, and his notes reflect that Mr. Keil appeared well developed and well nourished. His continued working diagnosis was postherpatic neuralgia and reactivation of Epstein-Barr virus, which had been previously diagnosed. Blood work was evaluated as consistent with Epstein-Barr, with a normal blood count but an elevated sedimentation rate. Liver function tests and tests for bone and kidney disease yielded normal results.

On or about December 22, 2008, after a phone call to Dr. Lefkovits' office, Mr. Keil was referred to Mitchell S. Raps, M.D., at Mount Sinai Medical Center ("Mount Sinai"), for evaluation of severe pain in the right lower back and buttock radiating to his right leg. Radiological studies showed widespread metastatic disease. Physicians at Mount Sinai diagnosed Mr. Keil with Stage IV metastatic malignant melanoma that had manifested in his bone, brain, spine, liver, and lungs, although the lung nodule detected on the PET scan two years prior appeared to have only grown by 2 millimeters. Mr. Keil died on March 10, 2009, within two and one-half months of the diagnosis.

Plaintiff's allegations against Drs. Lefkovits, Roses, and Diaz are similar. The essential allegations are that they were negligent in failing to perform follow-up CT scans, PET scans, complete blood work, and other tests; failing to advise Mr. Keil that he needed adjuvant cancer treatment, such as chemotherapy or radiation therapy; failing to seek a consultation with an oncologist, an oncological surgeon, or other specialist after Dr. Roses performed the surgery on

December 6, 2006; and failing to diagnose the recurrence or spread of Mr. Keil's cancer. Plaintiff alleges that the follow-up tests should have been performed three months after December 1, 2006, and every six months thereafter. The allegations against Dr. Roses also include a failure to inform Mr. Keil that he had a nodule in the left lower lobe of his lungs and bilateral renal cysts; failure to treat same; and failure to follow Mr. Keil as a patient and to emphasize disease prevention. Plaintiff contends that these failures deprived Mr. Keil of the chance to fight or cure his cancer, to prolong his life, and/or to improve the quality of his life. The allegations against NYU sound in vicarious liability.

The moving defendants seek summary judgment in their favor and dismissal of plaintiff's claims against them. On a motion for summary judgment, a defendant in a medical malpractice action bears the initial burden of demonstrating that there was either no departure from the standard of care, or that any such departure did not proximately cause plaintiff's alleged injury or damage. King v. St. Barnabas Hosp., 87 A.D.3d 238, 245 (1st Dep't 2011). To satisfy that burden, the defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Roques v. Nobel, 73 A.D.3d 204, 206 (1st Dep't 2010). If the defendant meets this burden,

> to avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries. In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged.

Id. at 207 (internal citations omitted).

Dr. Lefkovits contends that he is entitled to summary judgment primarily because, as a dermatologist, he owed no duty to Mr. Keil to order a CT scan, a PET scan, or other diagnostic studies, or to prescribe adjuvant therapy. He maintains that the duty to order specialized diagnostic tests or therapies was the function of the oncologist or oncological surgeon, Dr. Roses. Having referred Mr. Keil to Dr. Roses, Dr. Lefkovits avers that he was entitled to rely on Dr. Roses' expertise for any necessary follow-up treatment. Dr. Lefkovits argues that the fact that he continued to follow Mr. Keil as his dermatologist did not create a further duty to ensure that Mr. Keil received treatment of a specialized nature or require him to take steps outside the normal scope of a dermatologist. Additionally, Dr. Lefkovits maintains that his own treatment—removing and having biopsies performed of external skin lesions and referring Mr. Keil to Dr. Roses—was within the standard of care. He maintains that none of the alleged departures asserted against him substantially caused Mr. Keil's injuries or death.

In Dr. Lefkovits' own affidavit in support of his motion for summary judgment, he opines that the standard of care from 2006 through 2008 did not require a dermatologist, who made a timely diagnosis of melanoma and referred a patient to an oncological surgeon, to follow up with radiologic or diagnostic tests. It was his understanding that Dr. Roses would order a CT scan, since Dr. Roses' consultation letter stated that a follow-up CT scan would be obtained and that Dr. Roses would continue to follow Mr. Keil in the future. Further, Dr. Lefkovits opines that it is not the function of a dermatologist to determine whether adjuvant therapy is warranted nor to order adjuvant therapy, as that is the appropriate function of an oncologist or oncological surgeon. He states that the standard of care for a dermatologist treating melanoma is excision and referral to an oncologist or oncological surgeon. He further opines that he did not depart from accepted practice in failing

to diagnose the spread of melanoma. Dr. Lefkovits states that the guidelines set forth by the National Cancer Institute and the American Academy of Dermatology do not indicate that a dermatologist should order testing to determine whether a melanoma has metastasized to internal organs. Dr. Lefkovits opines that he acted within in the standard of care by excising the original lesion and any other suspicions lesions; obtaining an immediate biopsy of the original lesion and the other suspicious lesions; referring Mr. Keil to Dr. Roses; and constantly reminding Mr. Keil of the importance of following up. Dr. Lefkovits opines that once he referred Mr. Keil to Dr. Roses, he was not required to make other referrals. Moreover, he opines that Mr. Keil never presented with any symptoms of metastatic disease during the time he was under Dr. Lefkovits' care.

In further support of his motion for summary judgment, Dr. Lefkovits submits an affidavit from Mark A. Fialk, M.D., a physician duly licensed to practice in the State of New York and board certified in internal medicine, medical oncology, hematology, and hospice and palliative medicine. He sets forth that he has reviewed the pertinent records and litigation materials. Dr. Fialk opines that further studies—such as CT scans, PET scans, or blood studies—are not indicated for asymptomatic patients, such as Mr. Keil, who have a Stage I lesion and a negative sentinel lymph node biopsy. He opines that not only are these studies unreliable and of minimal value, but that detection of distant metastasis is rare. Dr. Fialk further opines that Mr. Keil was not a candidate for adjuvant therapy, since the sentinel lymph node biopsy was negative; the primary lesion excised by Dr. Lefkovits was only .7 millimeters in depth; and there was no ulceration. He opines that the standard of care under the aforementioned circumstances is excision.

In Dr. Fialk's opinion,

> had metastatic disease been diagnosed at an earlier time than December 2008, adjuvant therapy would have made no difference in the outcome because the patient would already have been Stage 4 and incurable at that point. No effective treatments currently exist for patients with widespread, late-stage melanoma. Once melanoma metastasizes and becomes Stage 4, the response rate and low survival rate are not affected by the time of initiation of the therapy.

Dr. Fialk opines that the 5 millimeter nodule seen on the December 1, 2006 PET scan was not metastatic disease but rather an incidental finding unrelated to the malignant melanoma, because the growth of that nodule by only 2 millimeters over two years rules out the possibility that it was the source of the ultimate metastasis. He believes that the melanoma had already seeded hematogenously (spread through the blood system) to several distant sites by the time Dr. Roses performed the December 6, 2006 surgery, since the sentinel node biopsy was negative. Dr. Fialk sets forth that a patient with "dormant metastasis" can have a tumor excised, have no apparent symptoms of metastatic disease for months or years, and then develop widespread metastatic disease. In Dr. Fialk's opinion, removal of the original 5 millimeter nodule would not have changed Mr. Keil's ultimate outcome or prevented the spread of the disease.

Plaintiff maintains that issues of fact exist that preclude granting Dr. Lefkovits summary judgment. She submits an affidavit from a physician (name redacted) licensed to practice medicine in the State of New Jersey and board certified in dermatology. Plaintiff's dermatology expert opines, based on a review of the relevant materials, that since Dr. Lefkovits knew that Dr. Roses recommended a follow-up CT scan and since he removed a lesion that was changing from benign to malignant, Dr. Lefkovits departed from accepted dermatological practice by failing to write an order that Mr. Keil have a CT scan. The dermatology expert opines that Dr. Lefkovits should

have ordered the CT scan when Mr. Keil first returned to him after the December 2006 surgery, and at every subsequent visit thereafter. The expert opines that when a physician is aware that follow-up tests are needed, it is that physician's obligation to order the test or request that another physician order the test. Plaintiff's dermatology expert notes that a dermatologist has the authority to write prescriptions and orders for their patients that include diagnostic radiology. Under the circumstances, plaintiff's expert opines that Dr. Lefkovits was the main physician in charge of the treatment of Mr. Keil's melanoma, and was responsible for ensuring that a follow-up CT scan was ordered. The expert opines that a follow-up CT scan could have revealed the spread of melanoma earlier, giving Mr. Keil a better chance to fight the cancer.

Sufficient questions of fact exist as to preclude granting summary judgment to Dr. Lefkovits. While the existence of a duty is a question of law, it is undisputed that Dr. Lefkovits owed a duty to Mr. Keil with respect to their physician-patient relationship. "[A] doctor who actually treats a patient has 'a duty of care' toward that patient." Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 307 (1st Dep't 2007), citing McNulty v. City of New York, 122 N.Y.2d 227, 232 (2005). Dr. Lefkovits' argument that he owed no duty to Mr. Keil to order a follow-up CT scan addresses the nature and extent of Dr. Lefkovits' duty, not whether a duty existed in the first place. In contrast to cases where physicians refer a patient to a specialist and then stop treating that patient, here, Dr. Lefkovits continued to treat Mr. Keil and testified a number of times during his EBT that he was aware that, while Dr. Roses recommended follow-up appointments and a follow-up CT scan, his patient had not gone back to Dr. Roses. The two experts present differing opinions as to the nature and extent of Dr. Lefkovits' duty towards Mr. Keil with respect to follow-up care. Further, the experts offer opposing opinions as to whether Mr. Keil presented with symptoms of metastatic

cancer and whether the standard of care would have required Dr. Lefkovits to order Mr. Keil radiological studies. Additionally, Dr. Fialk failed to explain, by referring to Mr. Keil's records or medical literature, his conclusion that a diagnosis of metastatic cancer, prior to December 2008, would have been futile because the patient would have already been at Stage IV, for which no treatment is available. Based on the aforementioned unresolved issues of fact, summary judgment to Dr. Lefkovits is denied.

Dr. Diaz argues that he is entitled to summary judgment, on the grounds that he did not depart from the standard of care in treating Mr. Keil; that he never undertook to treat Mr. Keil for melanoma or cancer; and that his care did not proximately cause Mr. Keil's alleged injuries. He submits his own affirmation in support of his summary judgment motion. Dr. Diaz opines that the standard of care does not require a physician, who treated his patient in the manner that Dr. Diaz did, to order follow-up CT scans, chest radiographs, PET scans, or the other therapies that plaintiff alleges Dr. Diaz failed to perform. He maintains that there is no merit to plaintiff's contention that he inappropriately failed to order certain tests; failed to diagnose Mr. Keil's spreading cancer; or failed to advise Mr. Keil that he needed adjuvant therapy. Dr. Diaz states that at no point during his care of Mr. Keil were any of these issues indicated. Dr. Diaz states that he agrees with Dr. Fialk's opinion that had Mr. Keil's metastatic disease been diagnosed prior to December 2008, adjuvant therapy would have made no difference in Mr. Keil's outcome because he "would have already been Stage IV and incurable at that point." He opines that the standard of care in 2007 and 2008 did not require an internist who sees a patient after a diagnosis of melanoma, with a history of negative lymph nodes, and under the care of a dermatologist and oncological surgeon, to determine whether

diagnostic testing was warranted. Dr. Diaz opines that there was never an indication for him to undertake such during the course of his treatment of Mr. Keil.

In opposition to Dr. Diaz's opinion that his treatment of Mr. Keil did not depart from the standard of care, plaintiff submits an affidavit from a physician (name redacted) licensed to practice medicine in the State of New York and board certified in internal medicine and infectious disease. Plaintiff's internal medicine expert sets forth that he/she has reviewed the pertinent records and litigation materials. Having reviewed Dr. Diaz's deposition transcript, plaintiff's internal medicine expert opines that Dr. Diaz never had the reoccurrence of melanoma in his differential diagnosis. The expert opines that when Mr. Keil's tests results were normal at his first visit with Dr. Diaz, Dr. Diaz should have placed melanoma on the differential diagnosis, and his failure to do so departed from good and accepted practice. Plaintiff's internal medicine expert sets forth that the standard of care during Dr. Diaz's treatment of Mr. Keil was to request, obtain, and review medical records from a melanoma patient's other treating physicians, and opines that Dr. Diaz's failure to do so departed from good and accepted practice. The expert opines that Dr. Diaz was treating Mr. Keil without having all of the necessary data, and that this prevented an earlier diagnosis of the reoccurrence of melanoma. The expert maintains that Dr. Diaz should have ordered a scan of Mr. Keil at each visit. Further, the expert maintains that when Mr. Keil presented with shingles, both Drs. Diaz and Lefkovits should have been concerned, as shingles is a marker for a significantly weakened immune system, often heralding or signaling cancer, AIDS, or another immunodeficiency disorders. The expert opines that the physicians' failure to order imaging studies in the face of Mr. Keil's presentation with shingles constituted a departure from good and accepted medical practice. Plaintiff's internal medicine expert opines that had imaging studies been ordered within six months

to one year of the original surgical excision of the melanoma, there would have been evidence of the reoccurrence of the cancer. The expert opines that Dr. Diaz's departures caused or contributed to Mr. Keil's death because he was deprived of the chance to have medications administered to fight the cancer.

Again, there are sufficient issues of fact that remain unresolved as to Dr. Diaz that will preclude granting him summary judgment. There is an issue as to whether Dr. Diaz should have regarded Mr. Keil's signs and symptoms to be indicative of a reoccurrence of melanoma. While Dr. Diaz opines that his treatment was proper, plaintiff's internal medicine expert opines that at all times, given Mr. Keil's history, Dr. Diaz should have operated under a differential diagnosis that the cancer could have reoccurred. The two physicians also differ as to whether earlier detection and diagnosis would have changed Mr. Keil's outcome. When there are two expert opinions that conflict with each other on the same issue, an issue of fact exists and summary judgment is not warranted.

In Dr. Roses' and NYU's motion for summary judgment, they maintain that the statute of limitations for the claims for medical malpractice against these two defendants expired before plaintiff commenced this action, thereby rendering these claims untimely. Dr. Roses last treated plaintiff on January 4, 2007, and as to NYU, treatment occurred only on December 6, 2006. These defendants concede that at the time Mr. Keil died on March 10, 2009, a cause of action for medical malpractice was still viable. Therefore, any action for medical malpractice had to have been commenced by March 10, 2010 (one year from the date of Mr. Keil's death). C.P.L.R. § 210(a). The action was not commenced until April 9, 2010, so Dr. Roses and NYU maintain that the cause of action for medical malpractice is time barred.

In opposition, plaintiff maintains that an issue of fact exists as to whether Dr. Roses continued to treat Mr. Keil as his patient after January 4, 2007, by having independent conversations with Mr. Keil and Dr. Lefkovits in 2007 and 2008. Plaintiff concedes that Dr. Roses had no appointments with Mr. Keil after January 4, 2007; that Dr. Roses' chart reflects that Dr. Roses told Mr. Keil to return to his office in two to three months; and that Mr. Keil never returned to Dr. Roses after January 4, 2007. Plaintiff maintains that the fact that Dr. Roses and Dr. Lefkovits spoke about Mr. Keil, and the fact that both knew that Mr. Keil needed a follow-up CT scan, is enough to raise issues of fact as to the continuous treatment doctrine. These discussions, as the two physicians described at their depositions, were brief and took place casually at a synagogue that both physicians periodically attended.

Dr. Roses and NYU met their burden on summary judgment by showing that the time within which plaintiff could bring a medical malpractice claims against them expired before she commenced this action. Plaintiff has failed to rebut this showing. First, she has not argued that the continuous treatment doctrine would apply to NYU. Second, there is no basis to conclude that the relationship between Dr. Roses and Mr. Keil continued past January 4, 2007. The statute of limitations is not tolled when a patient is instructed to make a follow-up appointment but fails to do so. See Bellmund v. Beth Israel Hosp., 131 A.D.2d 796, 797-98 (2d Dep't 1987). Further, the conversations as described by Drs. Roses and Lefkovits are insufficient to establish a triable issue of fact that Dr. Roses provided any treatment to Mr. Keil after January 4, 2007. The causes of action sounding in medical malpractice against Dr. Roses and NYU shall be dismissed.

As to the cause of action against him sounding in wrongful death, Dr. Roses opines, in his own affidavit, that by informing Mr. Keil, Dr. Lefkovits, and Dr. Diaz of the results of the December 1, 2006 PET scan and the need for a follow-up CT scan, and by instructing Mr. Keil on January 4, 2007, to return to him in two to three months, he did not depart from good and accepted practices of surgical oncology. He maintains that, to the extent that plaintiff is claiming that the mass seen on the December 1, 2006 PET scan represented metastatic melanoma, this would mean that Mr. Keil had Stage IV metastatic melanoma at the time. Dr. Roses maintains that no action or inaction on his part could have predictably affected Mr. Keil's ultimate outcome, as treatment for Stage IV metastatic melanoma is considered palliative rather than curative, and has not been shown to prolong life. He states that the five year survival rate for patients with Stage IV melanoma to visceral sites, such as lung, liver, or brain, is between 6-10%. He further states that the most common treatment for Stage IV melanoma is chemotherapy, but for the most part, chemotherapy results are disappointing. Dr. Roses opines that nothing he did or omitted to do in treating Mr. Keil could have prolonged Mr. Keil's life or changed his ultimate outcome.

Dr. Roses' argument in favor of summary judgment on plaintiff's wrongful death cause of action against him, distilled, is that if the PET scan showing a mass was depicting metastatic melanoma as far back as December 2006, then that mass was Stage IV cancer. Further, if the mass was Stage IV cancer, then Mr. Keil's death was an inevitability and any wrongful conduct by Dr. Roses could not have proximately caused Mr. Keil's death. This argument suffers from the same open issues of fact as described above regarding the other two physicians and the issue of proximate cause. First, there is a contradiction in Dr. Roses saying that Mr. Keil's death was inevitable, but also that a small percentage of patients with this type of cancer do survive. Second, in opposition,

plaintiff puts forth an affidavit from an expert (name redacted) who opines that even without the lung nodule on the PET scan, all three moving defendants should have ordered Mr. Keil a follow-up CT scan, and that the failure to do so deprived Mr. Keil of the chance to fight his cancer, for short and/or long term survival, and for a better quality of life. There are sufficient conflicting opinions to find that issues of fact exist as to whether defendants' acts or omissions proximately caused some diminution in Mr. Keil's chance for survival. Summary judgment as to Dr. Roses on the claim for wrongful death is denied. Accordingly, it is hereby

ORDERED that summary judgment is partially granted on Motion Sequence Number 004, to the extent that Dr. Roses and NYU are granted summary judgment on the cause of action sounding in medical malpractice, this cause of action is dismissed against these two defendants, only, and the clerk is directed to enter judgment accordingly; and it is further

ORDERED that the remainder of Motion Sequence Number 004, and Motion Sequence Numbers 002 and 003 in their entirety, are denied; and it is further

ORDERED that the parties shall appear for a previously scheduled settlement conference on January 24, 2012, at 10:00 a.m.

Dated: Dec. 15, 2011

ENTER:

JOAN B. LOBIS, J.S.C.