[* 1]

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

PRESENT: LOBIS Justice

PART 6

DAVIDSON, PENNY, ET AL.

-v-

ALAN EGELMAN, M.D., ET AL.

INDEX NO. 101948/10

MOTION DATE 2/7/12

MOTION SEQ. NO. 02

MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion to/for Summary Judgment.

	PAPERS NUMBERED
Notice of Motion/Order to Show Cause — Affidavits — Exhibits ...	1→10
Answering Affidavits — Exhibits	11→15
Replying Affidavits	16

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION & ORDER

FILED

APR 04 2012

COUNTY CLERK'S OFFICE NEW YORK

Dated: 4/3/12

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.

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

[* 2]

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

----------X

PENNY DAVIDSON, Individually and as Administratrix of the Estate of LEO HIRSCH a/k/a LEOPOLD NATHAN HIRSCH,

Plaintiff,

-against-

ALAN EGELMAN, M.D., LHHN MEDICAL, P.C., LENOX HILL COMMUNITY MEDICAL GROUP, P.C., MANHATTAN'S PHYSICIAN GROUP, P.C. and LENOX HILL HOSPITAL,

Defendants.

----------X

Index No. 101948/10

Decision and Order

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

Defendants[1] Alan Egelman, M.D., LHHN Medical, P.C., Lenox Hill Community Medical Group, P.C., and Manhattan's Physician Group move, by order to show cause, for an order granting them summary judgment pursuant to C.P.L.R. Rule 3212 and dismissing the complaint. Plaintiff Penny Davidson, individually and as the administratrix of the estate of her late husband, Leo Hirsch a/k/a Leopold Nathan Hirsch, opposes the motion.

This case pertains to treatment that Dr. Egelman provided to Mr. Hirsch between 2001 and 2007. Mr. Hirsch was born in 1931 and worked as an attorney. He began seeing Dr. Egelman as his primary care physician in 1998. He initially sought care from Dr. Egelman for his high blood pressure and ongoing sarcoidosis.[2] He also saw Dr. Egelman for annual physicals and

---

[1] Plaintiff previously discontinued her action against Lenox Hill Hospital

[2] According to deposition testimony from nonparty pulmonologist David Valentine, M.D., sarcoidosis is an autoimmune disease that can affect any organ in the body, but most commonly it affects the lungs. It can cause inflammation, and inflammation can cause the destruction of whichever organ that the inflammation affects.

discrete health concerns such as colds and tendonitis. Regarding the blood pressure, Dr. Egelman's advice was to try to reduce it with changes in diet, exercise, and moderate weight loss (Mr. Hirsch originally weighed 168). The sarcoidosis was being treated with Flovent and Serevent as needed.

In April 2001, Mr. Hirsch underwent a colonoscopy, during which a small polyp was detected, removed, and biopsied. Though no adenocarcinoma was detected from the biopsy and Mr. Hirsch's carcinoembryonic antigen levels were normal, the gastroenterologist who performed the colonoscopy recommended that a computed tomography ("CT") scan of the abdomen and pelvis be conducted in order to further examine the rectum and pelvic lymph nodes. So, on August 22, 2001, when Mr. Hirsch presented to Dr. Egelman for a check-up, Dr. Egelman referred him for a CT scan, which was performed on August 31, 2001. The radiologist's impression from the August 31, 2001 CT scan was extensive adenopathy (swelling of the lymph nodes) in the abdomen and pelvis, "much more extensive than typically seen in sarcoid. The possibility of lymphoma must be considered." A follow-up CT scan was performed on October 22, 2001, which again showed extensive abdominal and pelvic adenopathy, and again the radiologist recommended that lymphoma be ruled out. Dr. Egelman and Dr. Levitt, a pulmonologist who had been following Mr. Hirsch, believed that the findings on the CT scans were consistent with sarcoidosis. The physicians also obtained CT scans taken of Mr. Hirsch in 1998 and compared them to the 2001 CT scans, and their impression was that there were no significant changes between them. Dr. Egelman testified at his deposition that the significance of "no changes" was that if there was lymphoma, it was clearly indolent, so nothing needed to be done, and if there was no lymphoma, then the CT scans were entirely consistent with sarcoidosis. Dr. Egelman testified at his deposition that always, in the back of his mind, was the

question of whether Mr. Hirsch had something other than sarcoidosis. Dr. Egelman further testified that fever, malaise, weakness, weight loss, and loss of appetite are the clinical signs that he looks for in a patient who might be developing lymphoma.

Between November 2001 and September 2002, Dr. Egelman's notes reflect that Mr. Hirsch felt well and his appetite was good. In September 2002, Dr. Egelman recommended restarting Flovent and seeing a pulmonologist for bilateral wheezing associated with sarcoidosis. In July 2003, Mr. Hirsch presented for a ruptured abscess on his perineum and for sarcoidosis monitoring. Mr. Hirsch reported that he had stopped taking Flovent six to nine months prior, with no difference in his symptoms. He reported a good appetite, no cough, no fever, normal appetite, no weight decrease, aerobic exercise three times a week, and that he felt well. Dr. Egelman heard some wheezing in Mr. Hirsch's left upper lung. Dr. Egelman questioned whether Mr. Hirsch should restart the Flovent, and he instructed Mr. Hirsch to follow-up by phone, but if he was okay, to return in six months for a further checkup.

In April 2004, Mr. Hirsch returned to Dr. Egelman regarding hip pain and also reported that he felt early satiety during meals, although he was hungry at the onset of meals. Dr. Egelman referred him to an orthopedist regarding the hip. Dr. Egelman testified that he was not concerned about the satiety issue because Mr. Hirsch reported that he was hungry at the start of meals. His weight was 158 pounds. Dr. Egelman's impression was that the weight decrease could be related to the sarcoidosis or lymph adenopathy, so he referred Mr. Hirsch to a pulmonologist and the plan was to perform blood tests and possibly order a repeat CT scan. Two weeks later, Mr.

Hirsch saw Dr. Egelman for an asthma event. He had some wheezing in his lungs. Dr. Egelman put him on antibiotics, Advair, albuterol, Biaxin, and Singulair, and instructed him to follow-up within twenty-four hours.

On October 14, 2004, Mr. Hirsch was seen by Dr. Egelman for an upper respiratory infection with wheezing. He reported that he had been off all medications for six months and that he had increased shortness of breath associated with higher humidity. Dr. Egelman's impression was that the increased asthma was secondary to sarcoidosis, and that Mr. Hirsch would benefit from a daily metered dose of inhaled steroids; the plan was to try Pulmicort. Mr. Hirsch also had some weight loss and a decreased appetite. From examining Mr. Hirsch's laboratory results, Dr. Egelman saw no change and no drop in his blood count, which he testified would be expected if there were malignancy. Therefore, he was not concerned of a possible malignancy at this time, but attributed Mr. Hirsch's symptoms to increased sarcoidosis and untreated pulmonary inflammation.

On February 10, 2005, Mr. Hirsch was seen by Dr. Egelman for symptoms related to a cold—increased wheezing, no significant cough, minimal clear rhinitis, and decreased appetite. Mr. Hirsch had not been taking the Pulmicort. Dr. Egelman's impression was asthmatic bronchitis exacerbation, and prescribed Serevent, Azmacort, and Biaxin. Four days later, Mr. Hirsch was again seen by Dr. Egelman, and he had less wheezing but a cough at night. Dr. Egelman's impression was reactive airway disease, improvement in asthma, and weight loss secondary to pulmonary disease responding to treatment. At this point, Mr. Hirsch weighed 147 pounds.

Between March 2005 and February 2006, Dr. Egelman's notes for Mr. Hirsch reflect progression of the sarcoidosis, increased asthma, and decreased weight. He had started experiencing shortness of breath and trouble climbing stairs, but he was not using his inhalers regularly. He was regularly exercising at the gym two to three times a week. Dr. Egelman attributed Mr. Hirsch's increases in symptoms to his mostly untreated inflammation from progressing sarcoidosis. A colonoscopy had also revealed the return of the polyp. In February 2006, Mr. Hirsch weighed 149 pounds.

Mr. Hirsch next presented to Dr. Egelman for an office visit in October 2006. He reported spontaneous improvement of his sarcoidosis symptoms and no regular use of his steroid inhalers. He was using Spiriva (an inhaled bronchodilator). Dr. Egelman's notes reflect that Mr. Hirsch's last episode of severe symptoms was one and one half years ago, though he reported weakness in his legs after twenty minutes on the treadmill and that he felt like he was slowing down. His weight had also dropped to 146 pounds. Dr. Egelman's impression was that there was no need for chronic therapy for the sarcoidosis unless there was an exacerbation of symptoms; he believed that the weakness and weight loss was related to decreased muscle due to the effects of sarcoidosis.

The next visit was May 2, 2007; Mr. Hirsch sought treatment for persistent aching and slow improvement from a fall at home. He was also having shortness of breath, though he reported no significant sputum or a cough for two years. He had also stopped going regularly to the gym due to work issues. He reported no fever, night sweats, or fatigue. His weight had decreased to 143 pounds. Dr. Egelman testified that Mr. Hirsch looked sick at this visit, and he was suspicious

that something had significantly changed with Mr. Hirsch's health, so he ordered blood work. Dr. Egelman testified that in comparison to blood work taken seven months prior, there was a significant change: his blood count had dropped significantly beyond the range of what it had been in the previous years, and he had anemia and a higher sedimentation rate, which is a measure of proteins in the body and is a sign of inflammation or malignancy. However, Dr. Egelman testified that the sedimentation rate could have been affected by bruises secondary to the fall, so he wanted to recheck the blood work in a month. Mr. Hirsch returned in the beginning of June 2007, and Dr. Egelman again ordered blood work. The blood work showed a protein spike, elevated immunoglobulins, and other results that were highly suggestive of multiple myeloma. Dr. Egelman then ordered a skeletal survey, the results of which showed lytic lesions on his skull and his right forearm, consistent with myeloma. Dr. Egelman also scheduled Mr. Hirsch to see Dr. Yudelman, an oncologist.

On July 9, 2007, Dr. Egelman updated Mr. Hirsch's chart with a note after he discussed the case with Dr. Yudelman. Mr. Hirsch underwent a bone marrow biopsy in the beginning of July 2007, which showed B-cell lymphoma. Dr. Egelman testified that by July 16, 2007, at the time the bone marrow biopsy results were reported, the physicians who were involved with Mr. Hirsch's care knew that he had cancer. Dr. Egelman ordered a CT scan, which took place on July 30, 2007. The CT scan showed extensive lymphadenopathy and further indicated multiple myeloma. Mr. Hirsch underwent a biopsy of his axillary lymph node on August 14, 2007, the results of which indicated B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma. Dr. Egelman only saw Mr. Hirsch one more time after he was diagnosed with lymphoma, which was on October 9, 2007; Mr. Hirsch had requested a letter attesting to his medical condition in order to excuse his

absence from court appearances. Mr. Hirsch was ultimately diagnosed with Stage IV lymphoma, and he succumbed to the disease on February 28, 2008, at the age of 76.

On February 16, 2010, plaintiff commenced this action by purchasing an index number and filing a summons and verified complaint. The complaint raises four causes of action: medical malpractice; lack of informed consent; negligent hiring and supervision; and wrongful death. Plaintiff alleges that Dr. Egelman failed to diagnose Mr. Hirsch's lymphoma from the August 31, 2001 CT scan through his last appointment with Dr. Egelman in October 2007.

Defendants now move for summary judgment as to all claims. At the outset, plaintiff has neither rebutted nor addressed defendants' showing in their motion papers that the claims for lack of informed consent and negligent hiring must be dismissed. Accordingly, these claims shall be dismissed.

Defendants argue that the action is time barred by the statute of limitations. They maintain that in this case, where plaintiff commenced her suit on February 16, 2010, all claims that pre-date August 16, 2007 (or two and one-half years prior to the date the action was commenced) are time barred and must be dismissed. As Mr. Hirsch was formally diagnosed with cancer on July 16, 2007, when the pathology report for the bone marrow biopsy revealed B-cell lymphoma, defendants maintain that plaintiff's claims based on defendants' alleged failure to diagnose cancer are time barred. They further maintain that the continuous treatment doctrine does not serve to toll the statute of limitations, because Dr. Egelman was neither treating nor monitoring Mr. Hirsch for

lymphoma between November 2001 and October 2007, except for a period from April 2004 through October 2004.

In opposition, plaintiff argues that the continuous treatment doctrine does apply to the treatment rendered by Dr. Egelman because between 2001 and 2007, he was treating Mr. Hirsch for symptoms consistent with lymphoma, even though he wrongly assumed that the symptoms were related to sarcoidosis. Plaintiff alleges that Dr. Egelman failed to undertake the necessary and required diagnostic tests to determine the etiology of Mr. Hirsch's worsening symptoms and to rule out lymphoma. She argues that Mr. Hirsch's regular, continuing visits to Dr. Egelman for management and treatment of sarcoidosis—together with his complaints of loss of appetite, weight loss, wheezing, and shortness of breath—serve as a basis for reliance on the continuous treatment doctrine for claims of malpractice dating back to 2001.

Generally, a medical malpractice action must be commenced within two and one-half years of the date of the alleged "act, omission, or failure complained of." C.P.L.R. § 214-a. However, the time in which to bring a medical malpractice action is stayed if there is a continuous course of treatment that "includes the wrongful acts or omissions . . . and is related to the same original condition or complaint." McDermott v. Torre, 56 N.Y.2d 399, 405 (1982) (citation omitted); see also C.P.L.R. § 214-a. This exception, known as the continuous treatment doctrine, "rests upon the belief that the best interests of a patient warrant continued treatment with an existing provider, rather than stopping treatment, as 'the [existing provider] not only is in a position to identify and correct his or her malpractice, but is best placed to do so.'" Rudolph v. Jerry Lynn,

D.D.S., P.C., 16 A.D.3d 261, 262 (1st Dep't 2005) (brackets in original), quoting McDermott, 56 N.Y.2d at 408.

On a motion to dismiss a cause of action as time barred, the defendant bears the initial burden of showing that the alleged malpractice took place more than two and one-half years prior to the commencement of the action. Texeria v. BAB Nuclear Radiology, P.C., 43 A.D.3d 403, 405 (2d Dep't 2007). Once that burden is met, the plaintiff must establish the applicability of the continuous treatment doctrine or other exceptions to the statute of limitations. Massie v. Crawford, 78 N.Y.2d 516, 519 (1991); Texeria, 43 A.D.3d at 405. "In order to establish that the [continuous treatment] doctrine applies, the plaintiff is required to demonstrate that there was a course of treatment, that it was continuous, and that it was in respect to the same condition or complaint underlying the claim of malpractice." Stewart v. Cohen, 82 A.D.3d 874, 876 (2d Dep't 2011) (citations omitted).

Plaintiff has raised an issue of fact as to whether the continuous treatment doctrine applies to the treatment rendered by Dr. Egelman from August 2001 through the date that the diagnosis of lymphoma was made. Dr. Egelman was treating Mr. Hirsch for sarcoidosis by prescribing medicines and monitoring the progress of the disease. It is undisputed that Dr. Egelman was monitoring Mr. Hirsch's sarcoidosis and, on at least three occasions, he was concerned that Mr. Hirsch had lymphoma and ordered further testing and evaluation. He also testified that at all times, in the back of his mind, was the question of whether Mr. Hirsch's symptoms were related to the sarcoidosis or something else. Defendants did not conclusively establish that Mr. Hirsch had no

awareness that his symptoms were being monitored for the purpose of detecting lymphoma. As there are issues of fact pertaining to the continuous treatment doctrine and whether Mr. Hirsch had a valid cause of action to recover damages for medical malpractice at the time he died, and since the wrongful death cause of action was commenced within two years of Mr. Hirsch's death, the wrongful death claim survives that branch of the motion seeking to dismiss it for untimeliness. Norum v. Landau, 22 A.D.3d 650, 651 (2d Dep't 2005).

However, even viewing plaintiff's case in the best possible light, plaintiff's claim for pain and suffering due to medical malpractice is time barred. Mr. Hirsch was diagnosed with lymphoma by July 16, 2007, at the time the bone marrow biopsy results were reported. The action was not commenced until February 16, 2010. The statute of limitations for pain and suffering due to medical malpractice is two and one-half years (C.P.L.R. § 214-a), though if a person dies before the statute of limitations expires, the action may be commenced by his representative within one year of the death. C.P.L.R. § 210(b). In order for the claim for pain and suffering due to medical malpractice to be timely, it would have had to have been brought on or before January 16, 2010. Plaintiff does not allege a departure from the standard of care based on any act or omission by Dr. Edelman that occurred within two and one half years of the commencement of the action. Accordingly, the claim for medical malpractice for pain and suffering is time barred and shall be dismissed.

To the extent that the wrongful death claim is not dismissed on statute of limitations grounds, defendants argue that they are entitled to summary judgment. As established by the Court

of Appeals in Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) and Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 (1985), and as has recently been reiterated by the First Department, it is "a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that [he or she] is entitled to judgment as a matter of law." Ostrov v. Rozbruch, 91 A.D.3d 147, 152 (1st Dep't 2012), citing Winegrad, 64 N.Y.2d at 853. In order to establish entitlement to summary judgment in a medical malpractice case, a physician must demonstrate that s/he did not depart from accepted standards of practice or that if there was a departure, it did not proximately cause the patient's injury. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). "When medical malpractice forms the basis of a wrongful death action, in establishing that he/she did not proximately cause the injuries alleged to have caused plaintiff's death, a defendant establishes prima facie entitlement to summary judgment as to the wrongful death action as well." Id. Once a movant meets this burden, it is incumbent upon the opposing party to proffer evidence sufficient to establish the existence of a material issue of fact requiring a trial. Ostrov, 91 A.D.3d at 152, citing Alvarez, 68 N.Y.2d at 324. In medical malpractice actions, expert medical testimony is the sine qua non for demonstrating either the absence or presence of material issues of fact pertaining to departure from accepted medical practice or proximate cause.

In support of their motion, defendants submit an affirmation from Michael Grossbard, M.D., who sets forth that he is a physician duly licensed to practice medicine in New York and board certified in internal medicine and medical oncology. Dr. Grossbard states that he has reviewed plaintiff's bill of particulars, the pertinent medical records, and the deposition testimony pertaining

to this matter. Based on this review, Dr. Grossbard opines, within a reasonable degree of medical certainty, that defendants treated Mr. Hirsch in accordance with the acceptable standard of care and that none of defendants' treatment proximately caused Mr. Hirsch's injuries. Dr. Grossbard states that Mr. Hirsch had a well-documented history of sarcoidosis, in which abnormal inflammatory cells accumulate in the organs, including the lymphatic system and the lungs. Dr. Grossbard states that there is a great deal of overlap in the symptoms of sarcoidosis and lymphoma, including cough, shortness of breath, weight loss, fevers, and lymphadenopathy, and that Mr. Hirsch exhibited all of those symptoms with the exception of fever. Dr. Grossbard opines that it was reasonable and appropriate for defendants to attribute those symptoms to sarcoidosis. He further opines that sarcoidosis and lymphoma are entirely pathologically unrelated, and neither condition causes or exacerbates the other.

Dr. Grossbard sets forth that low grade lymphoma, like Mr. Hirsch's, is a malignant disease that presents at Stage III or IV in more than 70% of patients. He states that once the disease is at such an advanced stage, it is incurable with any conventional therapy program. He further opines that at the time that Mr. Hirsch had the CT scans of his abdomen and pelvis in August 2001 and October 2001, Mr. Hirsch was already afflicted with Stage III lymphoma. He sets forth that through 2007, there was no data to suggest to the medical community that earlier treatment of low grade lymphoma could improve a patient's prognosis, longevity, or overall survival; rather, treatment was reserved to palliative care and reduction of tumor bulk. Dr. Grossbard maintains that between 2001 and 2007, the standard of care for treating low grade lymphoma was to treat only when the disease caused the patient to experience symptoms, and that the goal was not to cure the disease or

prolong the patient's life. Dr. Grossbard opines that even if Mr. Hirsch had been diagnosed with Stage III lymphoma in late 2001, he would have been referred to an oncologist who would not have provided Mr. Hirsch with any treatment but would have simply monitored him until he became symptomatic. Then, if he became symptomatic, the treatment would have been geared towards relief of the symptoms, but the lymphoma would have remained and ultimately progressed exactly as it did in this case.

Further, Dr. Grossbard opines that Mr. Hirsch did not manifest symptoms of lymphoma until May 2007, when he presented looking ill. He opines that there was no reason for defendants to suspect that Mr. Hirsch had lymphoma based on his episodic and intermittent complaints of cough and shortness of breath, nor was his weight loss over the six years a clinically significant change.

In opposition, plaintiff submits an affirmation from a physician (name redacted) who sets forth that he/she is a physician licensed to practice medicine in New York and board certified in internal medicine and medical oncology. Plaintiff's expert states that he/she reviewed the pertinent medical records. The expert opines, to a reasonable degree of medical certainty, that defendants departed from good and accepted standards of medical care by failing to definitively diagnose Mr. Hirsch's lymphoma from 2001 through 2007. The expert states that biopsy is the only definitive way to diagnose lymphoma and sarcoidosis, and opines that defendants' failure to perform a biopsy at any time between 2001 and 2007 was a deviation from good and accepted standards of care.

Plaintiff's expert states that Mr. Hirsch's symptoms from 2001 through 2007 were more consistent with lymphoma than sarcoidosis. The expert, in looking at the sedimentation rates for blood tests performed on Mr. Hirsch between 2001 and 2007, opines that the sedimentation rates were consistently and abnormally elevated. The expert states that normal sedimentation rate ranges are between 10 and 20, but that Mr. Hirsch had results of 25 on September 4, 2001; 139 on September 19, 2002; 142 on October 14, 2004; 142 on October 13, 2006, and 144 on May 8, 2007. Also, plaintiff's expert notes that Mr. Hirsch's blood test results showed that he was anemic. The expert faults defendants for failing to adequately investigate these issues. The expert points out that Mr. Hirsch's weight decreased from 168 pounds in 2001 to 135 pounds in 2007, and he was complaining of coughing with sputum, wheezing, shortness of breath, decreased appetite, and loss of stamina. Plaintiff's expert states that rather than investigating these symptoms, defendants continued to presume that the symptoms were related to sarcoidosis and merely replenished medications to help Mr. Hirsch breathe.

Plaintiff's expert also points out that the radiologists' reports in 2001 noted extensive adenopathy and stated that lymphoma must be considered or ruled out. Plaintiff's expert states that the only way to determine whether adenopathy is a malignant condition is to perform a biopsy, and that failure to perform a biopsy in light of the 2001 radiological studies was a departure from good and accepted standards of medical care. The expert believes that a biopsy would have conclusively diagnosed the presence of lymphoma and ruled out sarcoidosis. The expert also opines that defendants should have referred Mr. Hirsch to an oncologist, and that their failure to do so was a departure from good and accepted standards of medical care.

Plaintiff's expert believes that, based on the overall picture of Mr. Hirsch's health between 2001 and 2007—including his progressing symptoms, the results of his blood work, and his failure to respond to therapy for sarcoidosis—defendants failed to diagnose Mr. Hirsch's underlying disease, thereby causing a delay in the proper diagnosis of lymphoma. Plaintiff's expert opines that defendants' failure to diagnose and treat Mr. Hirsch's lymphoma over six years ultimately resulted in Mr. Hirsch's premature death. If he had been diagnosed earlier, plaintiff's expert opines, Mr. Hirsch could have received treatment, would have experienced fewer symptoms, and would have lived longer. Plaintiff's expert sets forth that 75% of patients with low grade lymphoma can be expected to survive for 10 years, but that Mr. Hirsch was not given that opportunity.

Defendants have made out a prima facie case for their entitlement to summary judgment by proffering expert opinion evidence that nothing they did or did not do proximately caused Mr. Hirsch's death from lymphoma. In opposition, while plaintiff's expert is thorough on the issue of departure, his/her opinion that defendants' failure to diagnose Mr. Hirsch's lymphoma from 2001 through 2007 proximately caused Mr. Hirsch's premature death is conclusory. The expert does not rebut defendants' showing that any treatment for lymphoma available during the time period in question would have been palliative only and could have neither prolonged Mr. Hirsch's life nor prevented his death. Plaintiff's expert never explains what treatment or disease management would have been available to Mr. Hirsch, or how earlier treatment would have prolonged Mr. Hirsch's life, had Dr. Egelman diagnosed the lymphoma prior to July 2007. The expert fails to point out which symptoms would have been alleviated or treated differently had defendants made an

earlier diagnosis. Plaintiff's expert also failed to address or rebut Dr. Grossbard's contention that treatment for lymphoma is only commenced once the patient shows symptoms of lymphoma, as Mr. Hirsch did in May 2007.

The court notes that plaintiff's claims against LHHN Medical, P.C., Lenox Hill Community Medical Group, P.C., and Manhattan's Physician Group are premised on vicarious liability for Dr. Egelman. She has not asserted claims that any of these three entities are directly liable for injury to Mr. Hirsch. Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is granted, in its entirety, in conformity with the above decision; and it is further

ORDERED that the complaint is dismissed against defendants Alan Egelman, M.D., LHHN Medical, P.C., Lenox Hill Community Medical Group, P.C., and Manhattan's Physician Group, and the clerk is directed to enter judgment accordingly.

Dated: April 3, 2012

ENTER:

JOAN B. LOBIS, J.S.C.