Pianin v Altorki
2022 NY Slip Op 31590(U)
April 5, 2022
Supreme Court, New York County
Docket Number: Index No. 805412/2019
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK NEW YORK COUNTY

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

Justice

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DEBORAH PIANIN and SCOTT PIANIN,

Plaintiffs,

- v -

NASSER K. ALTORKI, M.D., DAVID POSNER M.D., JOHN DOE, M.D. (as yet unidentified radiologist), NORTHWELL HEALTH (LENOX HILL HOSPITAL), NORTHWELL HEALTH/NORTHWELL HEALTH PHYSICIAN PARTNERS, NEW YORK PRESBYTERIAN HOSPITAL/WEILL CORNELL MEDICAL CENTER and EAST RIVER IMAGING,

Defendants.

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INDEX NO. 805412/2019

MOTION DATE 03/14/2022

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 116, 117, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 134, 135, 136, 137, 146, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179

were read on this motion to/for DISMISS.

In this action to recover damages for medical malpractice, the defendants Nasser K. Altorki, M.D., and New York Presbyterian Hospital-Weil Cornell Medical Center (together the NYPH defendants) move pursuant to CPLR 3212 for summary judgment dismissing the amended complaint insofar as asserted against them, on the ground that the action against them is time-barred. The plaintiffs oppose the motion. The defendants David Posner, Northwell Health/Northwell Health Physician Partners (NHPP), and East River Imaging (ERI) also oppose the motion. The motion is granted.

On September 24, 2001, the plaintiff Deborah Pianin (hereinafter the patient), who was then under the care of Posner at NHPP at Lenox Hill Hospital, underwent a computed tomography (CT) scan of her chest to rule out a pulmonary embolism after experiencing left-sided pleuritic chest pain. The CT scan revealed a 9 mm ill-defined opacity in the anterior apical

segment of the right upper lobe (RUL). Between 2001 and 2011, the patient underwent regular CT scans of the chest to monitor the opacity for any significant changes. On January 11, 2011, another CT scan of the patient's chest revealed the existence of

> "[i]ll-defined parenchymal opacity in the anterior segment of the right upper lobe abutting the anterior lateral pleural surface.
>
> "The exam is compared to previous exams of December 11, 2008 and October 1, 2004. There has been slight progression in size over the time interval and area of aeration seen on the previous studies now have become more opacified. Given these changes further evaluation is recommended to exclude an underlying low-grade malignancy."

Based on those results, Posner referred the patient to Altorki, a cardiothoracic surgeon at NYPH. On January 18, 2011, the patient met with Altorki at NYPH for an initial consultation. On February 10, 2011, Altorki performed a video-assisted right upper lung thoracoscopy and wedge resection. The pathology report revealed lung tissue with fibrous pleural plaque and subpleural scarring, but otherwise found no tumor or granuloma present. On March 1, 2011, the patient saw Altorki for a post-operative follow up, in which she made no lung related complaints, after which Altorki noted that "she will follow with Dr. Posner."

Between 2011 and 2019, the patient continued to undergo routine radiological imaging tests conducted by Posner or NHPP at Lenox Hill Hospital to monitor any changes in her condition. On April 2, 2019, a CT scan of her chest found

> "[a]n irregular/nodular opacity is again seen in the posterior right upper lobe adjacent to the major fissure. This again demonstrates internal lucencies. This has increased in size over serial examinations. It currently measures 16 x 10 mm (image 65 series 4; previously 14 x 8 mm on 04/04/2018 and 10 x 8 mm on 04/19/2017. This was FDG avid on the PET-CT of 04/26/2017. The possibility of a malignant neoplastic lesion is considered.
>
> "There are spiculated nodular opacities in the superior segment of the right lower lobe measuring 7 mm (image 110) and 4-5 mm (image 122). These are visible in retrospect on 04/04/2018 and have enlarged having measured 4 mm and 2-3 mm respectively. The larger nodule is faintly visible in retrospect on 04/19/2017 having measured 2 mm. These are indeterminate. Developing neoplastic lesions are not excluded."

On April 9, 2019, Posner recommended that the patient have a biopsy. On May 9, 2019, Dr. Sandor Kovacs of Lenox Hill Hospital performed a CT-guided fine needle aspiration and core biopsy of the RUL lesion, which came back positive for malignant cells consistent with adenocarcinoma. On May 13, 2019, the patient followed up with Posner to discuss her biopsy results, after which Posner against referred her to Altorki at NYPH. On May 15, 2019, the patient underwent a positron emission tomography (PET)-CT scan to assess for malignancy and metastasis throughout the body. The PET-CT scan revealed the following,

> "Progressive FDG avid lesions in the right lung apex and right upper lobe have the appearance of malignant neoplastic lesions. Correlation with precise biopsy results is requested.
>
> "No FDG avid lymphadenopathy within the thorax.
>
> "A small focus of increased FDG uptake in the liver without anatomic correlate is indeterminate. Contrast-enhanced abdominal MRI is advised to assess for a metastasis. There is no other evidence of extrathoracic FDG avid disease."

On May 21, 2019, the patient met with Altorki, who examined her and ordered further radiological imaging. Altorki's report indicated a diagnosis of malignant neoplasm of the upper lobe bronchus. On June 3, 2019, the patient underwent a RUL lobectomy performed by cardiothoracic surgeon Dr. Richard Lazzaro at Lenox Hill Hospital. Thereafter, the patient received additional cancer treatment.

On December 12, 2019, the plaintiffs commenced this action against the NYPH defendants, alleging that they failed to diagnose her cancer in 2011. On January 7, 2020, NYPH served its answer and, on February 5, 2020, Altorki served his answer. The NYPH defendants both asserted, as their third affirmative defense, that the causes of action against them were barred by the applicable statute of limitations. On June 23, 2021, a preliminary conference was held. On June 30, 2021, the plaintiffs moved pursuant to CPLR 3211(b) to dismiss the NYPH defendants' third affirmative defense (SEQ 002). On September 15, 2021, the plaintiffs withdrew that motion. On September 23, 2021, the plaintiffs moved for leave to file and serve a supplemental summons and amended complaint adding, as party defendants,

Posner, John Doe, M.D. (a yet unidentified radiologist), NHPP, and ERI, and to amend the caption accordingly (SEQ 003).

On September 24, 2021, the NYPH defendants made the instant motion pursuant to CPLR 3211(a)(5) to dismiss the complaint insofar as asserted against them, with prejudice, for failure timely to commence the action within the applicable statute of limitations (SEQ 004). On November 1, 2021, while this motion was pending, this court granted the plaintiffs' motion for leave to serve and file an amended complaint to add the additional defendants. On November 8, 2021, the plaintiffs opposed the instant motion. On January 27, 2022, this court issued an interim order notifying the parties that, inasmuch as it was procedurally improper to move pursuant to CPLR 3211(a)(5) after an answer had been served, the court was treating the motion designated as Motion Sequence 004 as a summary judgment motion, and permitted the parties to make additional submissions pursuant to CPLR 3211(c). On February 23, 2022, and February 24, 2022, the non-moving defendants opposed this motion.

According to the plaintiffs' bills of particulars as to the NYPH defendants, the NYPH defendants negligently treated the patient "from on or about February 10, 2011 through on or about May 21, 2019." In particular, the plaintiffs alleged that the NYPH defendants failed to timely diagnose and treat cancer, failed to order appropriate and necessary diagnostic testing, failed to make necessary and appropriate referrals, failed to appreciate the significance of the patient's prior radiological film studies, including CT scans showing growth and worsening of the lung mass, and failed to consider ordering imaging studies with a higher accuracy and/or better sensitivity in revealing and/or suggesting lung cancer. The plaintiffs also alleged that the NYPH defendants negligently performed a thoracoscopy and lung wedge removal procedure, negligently removed an insufficient area and the wrong portion of the patient's right lung, thereby rendering diagnosis unreliable and erroneous, and deprived the patient of the benefits of early detection of her cancer.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets its burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (s*ee id.*; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

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

On a motion for summary judgment dismissing a complaint as time-barred, "a defendant must establish, prima facie, that the time within which to sue has expired. Once that showing

has been made," the burden shifts to the plaintiff to raise triable issue fact as to "whether the statute of limitations has been tolled, an exception to the limitations period is applicable, or the plaintiff actually commenced the action within the applicable limitations period" (*Flintlock Constr. Servs., LLC v Rubin, Fiorella & Friedman, LLP*, 188 AD3d 530, 531 [1st Dept 2020], quoting *Quinn v McCabe, Collins, McGeough & Fowler, LLP,* 138 AD3d 1085, 1085-1086 [2d Dept 2016]; *see Murray v Charap*, 150 AD3d 752 [2d Dept 2017]; *Williams v New York City Health & Hosps. Corp*., 84 AD3d 1358 [2d Dept 2011]; *Rakusin v Miano*, 84 AD3d 1051 [2d Dept 2011]).

The statute of limitations applicable to actions to recover for medical malpractice against a private health-care provider is 2½ years, measured from "the act, omission or failure complained of or last treatment where there is a continuous treatment for the same illness, injury or condition which gave rise to the said act omission or failure" (CPLR 214-a). The "continuous treatment" provision of CPLR 214-a posits that the limitations period "does not begin to run until the end of the course of treatment when the course of treatment which includes the wrongful acts or omissions has run continuously and is *related to the same original condition or complaint*" (*Nykorchuck v Henriques*, 78 NY2d 255, 258 [1991] [internal quotation marks omitted] [emphasis added]; *see Massie v Crawford*, 78 NY2d 516, 519 [1991]; *McDermott v Torre*, 56 NY2d 399, 405 [1982]; *Borgia v City of New York*, 12 NY2d 151, 155 [1962]; *Jajoute v New York City Health & Hosps. Corp*., 242 AD2d 674, 676 [1st Dept 1997]). The continuous treatment toll, however, is personal to the patient, and does not apply to toll a spouse's derivative cause of action to recover for loss of consortium (*see Devadas v Niksarli*, 120 AD3d 1000, 1008 [1st Dept 2014]; *Wojnarowski v Cherry*, 184 AD2d 353, 354-355, [1st Dept 1992]).

CPLR 214-a(b) provides, in pertinent part, that

> "[W]here the action is based upon the alleged negligent failure to diagnose cancer or a malignant tumor, whether by act or omission, the action may be commenced within two years and six months of the later of either

> (i) when the person knows or reasonably should have known of such alleged negligent act or omission and knows or reasonably should have known that such alleged negligent act or omission has caused injury, provided, that such action shall be commenced no later than seven years from such alleged negligent act or omission."

This provision of CPLR 214-a, however, applies only to acts, omissions, or failures occurring on or after January 31, 2018, and to causes of action that accrued after July 31, 2015 (*see* L 2018, ch 1, §§ 5-6; *McKinnon v North Shore-Long Is. Jewish Health Sys. Labs.*, 187 AD3d 890, 891 [2d Dept 2020]). Additionally, claims based on negligent failure to diagnose cancer or a malignant tumor that became time-barred after March 31, 2017, could be commenced by July 31, 2018 (*see* L 2018, ch 1, §§ 5-6; *Mula v Sasson*, 181 AD3d 686, 687 [2d Dept 2020]).

The NYPH defendants have established, prima facie, that the causes of action against them are time-barred. Altorki first met with the patient on January 18, 2011 for an initial consultation following a referral from Posner. Thereafter, Altorki met with the patient once on February 10, 2011 for a right upper lung thoracoscopy and wedge resection, and once on March 1, 2011 for a post-operative follow up. The two did not meet again until May 21, 2019, following a new, separate referral from Posner, and the 2019 visit was more than eight years after the patient's last visit with. Altorki. Accordingly, the NYPH defendants demonstrated that the action was time-barred since there was a more than 2½-year gap between the treatments rendered by Altorki. The NYPH defendants also established that the patient cannot avail herself of the benefit of the new discovery rule set forth in CPLR 214-a(b)(i), as the seven-year period of repose set forth in this provision had expired by the date of commencement of this action, as had the one-year revival period set forth in the statute. The court also notes that CPLR 214-a(b)(i) is inapplicable here, as the alleged failure to diagnose occurred on February 10, 2011, long before the provision went into effect on January 31, 2018.

In opposition, the plaintiffs argue that the continuous treatment doctrine is applicable for several reasons. They assert that the patient did not intend to abandon her reliance on Altorki

and that, in fact, the patient, Altorki, and Posner all anticipated the need for further surgery since Altorki opted for a wedge resection instead of removal of the entire nodule. The plaintiffs claim that, even though the wedge resection did not reveal the presence of cancer, Posner was nonetheless concerned about the nodule, that he thus continued to order radiological imaging studies between 2011 and 2019, and that such studies were sent to and maintained by Altorki. The plaintiffs also claim that Posner's treatment of the patient throughout the years may be imputed to Altorki for statute of limitations purposes since both doctors were affiliated, in some manner, with NYPH.

The Appellate, Division, First Department, has maintained that the continuous treatment doctrine takes account of a "plaintiff's belief" that he or she "was under the active treatment of defendant at all times, so long as" the treatments did not "result in an appreciable improvement" in his or her condition (*Devadas v Niksarli*, 120 AD3d 1000, 1006 [1st Dept 2014]). Even where a "plaintiff pursued no treatment for over 30 months after" the initial, allegedly negligent surgical treatment (*id*. at 1005),

> "[i]n determining whether continuous treatment exists, the focus is on whether the patient believed that further treatment was necessary, and whether he [or she] sought such treatment (*see Rizk v Cohen*, 73 NY2d 98, 104 [1989]). Further, this Court has suggested that a key to a finding of continuous treatment is whether there is 'an ongoing relationship of trust and confidence between' the patient and physician (*Ramirez v Friedman*, 287 AD2d 376, 377 [1st Dept 2001]). Plaintiff's testimony that he considered defendant to be his '[doctor] for life,' and that the efficacy of the [treatment] was guaranteed, was a sufficient basis for the jury to conclude that such a relationship existed"

(*id*.at 1006). Where such a situation obtains,

> "[c]ases such as *Clayton v Memorial Hosp. for Cancer & Allied Diseases* (58 AD3d 548 [1st Dept 2009]) are inapplicable . . . , to the extent they reiterate that 'continuous treatment exists "when further treatment is explicitly anticipated by both physician and patient as manifested in the form of a regularly scheduled appointment for the near future, agreed upon during that last visit, in conformance with the periodic appointments which characterized the treatment in the immediate past"' (58 AD3d at 549, quoting *Richardson v Orentreich*, 64 NY2d at 898-899)"

(*id*. at 1007). Nonetheless, where there is an absence of objective evidence demonstrating "continuous trust and confidence" between the patient and physician, the continuous treatment doctrine cannot be invoked (*see Rizk v Cohen*, 73 NY2d at 104-105; *De Peralta v Presbyt. Hosp.*, 121 AD2d 346, 349 [1st Dept 1986]; *see also McSheffrey v Helou*, 172 AD2d 728, 729 [2d Dept 1991]).

Applying the First Department's articulation of the law, as this court must (*see D'Alessandro v Carro*, 123 AD3d 1, 6 [1st Dept 2014]), the plaintiffs have failed to raise triable issues of fact as to whether continuous treatment existed. The plaintiffs submit an affidavit from the patient, in which she states that she considered Altorki to be her lung surgeon, that she believed that they had a doctor-patient relationship between 2011 and 2019, and that, as such, she did not see any other surgeon regarding her lungs in that time "because Dr. Altorki was my lung surgeon." She stated that Posner informed her of a possible need for subsequent lung surgery, that she assumed was to be performed by Altorki. The patient also stated that, between 2011 and 2019, she was under the impression that Altorki was being updated about, and thus monitoring, her lung condition. Nevertheless, the patient has not demonstrated that continuing trust and confidence existed beyond the purely subjective statements of her own affidavit.

After her March 2011 post-operative visit with Altorki, there were no future visits scheduled and no further treatment was expected. At that time, Altorki advised the patient to follow up with Posner, as noted in Altorki's post-operative visit notes. In fact, the patient did follow up with Posner, and he noted that the patient was initially not pleased that she was operated on for what she characterized as "nothing." The record does not reflect, nor does the patient objectively establish, that, in 2011, Posner discussed the need for subsequent surgery that would be performed by Altorki. In any event, even if such a discussion did occur, Posner's unilateral proclamation of the potential need for further surgery cannot be ascribed to Altorki.

Although the patient asserted that she believed that she had a doctor-patient relationship with Altorki, there is an absence of continuing efforts by Altorki to treat the patient's condition (*see Nykorchuck v Henriques*, 78 NY2d 255, 258-259 [1991]; *Chisolm v New York Hosp.*, 181 Misc 2d 68, 73 [Sup Ct, Bronx County 1999] citing *Massie v Crawford*, 78 NY2d 516, 519 [1991]). The patient's only reference to continuing efforts by Altorki is her assertion that Altorki was monitoring her condition by way of updates from Posner. The NYPH defendants, however, have established, prima facie, that the radiological imaging reports in Altorki's records that were generated between 2011 and 2019 were provided to Altorki only *after* the May 21, 2019 visit, and were "scan[ned] on 7/15/2019." Inasmuch as Altorki first received the imaging reports more than eight years after the patient's last actual visit, the court cannot conclude that the patient placed her continuing trust and confidence in Altorki to monitor her condition throughout the years (*see Bruno v Gosy*, 48 AD3d 1147, 1148 [4th Dept 2008]; *Venson v Daun*, 277 AD2d 53, 53-54 [1st Dept 2000]; *Keith v Schulman*, 265 AD2d 380, 380 [2d Dept 1999]). The NYPH defendants also established that Altorki's records indicated that the patient was "*referred back* by Dr. Posner" (emphasis added), that the relevant biopsy report for the current visit was not available, and that Altorki was to "check PFTs [pulmonary function tests] from Dr Posner's office," all of which suggests a break in any physician-patient relationship after 2011. The NYPH defendants correctly explain that, had there been an ongoing doctor-patient relationship between the patient and Altorki, there would not have been a need for a new referral or a need for Altorki to check for relevant reports from Posner's office. The plaintiffs have failed to raise triable issues of fact in opposition to these showings.

The court concludes that the patient's May 21, 2019 visit with Altorki constituted a renewal, rather than a continuation, of treatment (*see Rizk v Cohen*, 73 NY2d at 105), even though the visit was related to the same condition as the 2011 visits (*see Roberts v City of NY*, 188 AD2d 337, 338 [1st Dept 1992]). Because the 2011 and 2019 visits were discrete, complete, and "for sole purpose of ascertaining the state of [her] condition," the continuous

treatment doctrine is inapplicable (*see* CPLR 214-a; *Werner v Kwee*, 148 AD2d 701, 702-703 [2d Dept 1989] citing *Davis v New York*, 38 NY2d 257, 260 [1975]; *Roberts v City of New York*, 188 AD2d at 338). Finally, the court notes that, despite having met with Altorki on May 21, 2019, the patient ultimately underwent surgery with a different cardiothoracic surgeon, Dr. Richard Lazzaro, at a different hospital. Surely, if the patient believed Altorki to be "her" lung surgeon, she would have had him perform her surgery.

Moreover, contrary to the plaintiffs' contention, a failure to make a proper diagnosis, in and of itself, does not establish an ongoing course of treatment, as such a claim constitutes a "self-contradictory proposition" (*Nykorchuck v Henriques*, 78 NY2d at 259; *see Young v New York City Health & Hosps. Corp.*, 91 NY2d 291 297 [1998]; *Toxey v State of New York*, 279 AD2d 927, 928 [3d Dept 2001]). The plaintiffs' interpretation of several First Department cases such as *Marun v Coleburn* (291 AD2d 340, 341[1st Dept 2002]) is misplaced, as those cases have held that "failure to make the correct diagnosis as to the underlying condition *while continuing to treat the symptoms*" can constitute continuous treatment (*Hein v Cornwall Hosp.*, 302 AD2d 170, 174 [1st Dept 2003] [emphasis added]). Here, Altorki did not continue to treat the patient's symptoms or, for that matter, treat her in any capacity between her last visit in 2011 and her next visit in 2019. Hence, the plaintiffs have failed to raise triable issues of fact as to Altorki's continuous treatment of the patient.

"[W]here treatment is provided by more than one physician or health care provider, the continuing treatment by one will be imputed to the other" only "in the presence of an agency relationship, or some other relevant association which continues the nexus between the two providers" (*Ganapolskaya v V.I.P. Med. Assoc.*, 221 AD2d 59, 62 [1st Dept 1996]). Mere affiliation with a hospital as a regular, attending physician is insufficient to impute a doctor's continuing treatment to the hospital (*see De Peralta v. Presbyterian Hospital*, 121 AD2d 346, 350 [1st Dept 1986] citing *Ruane v Niagara Falls Mem. Med. Ctr.*, 60 NY2d 908, 909 [1983]). The NYPH defendants established, prima facie, that there was no agency or other relevant

relationship between them and Posner. They demonstrated that Posner, who was affiliated with Northwell Health/Lenox Hill Hospital during the course of his treatment of the patient, was initially granted privileges at NYPH Department of Medicine/Pulmonary Critical Care on July 27, 2011, but that his status in this capacity was inactivated on June 1, 2015, and has remained inactive ever since. Finally, the NYPH defendants established that Posner's records indicated that the patient's relevant care was received through Northwell Health/Lenox Hill Hospital, and that Altorki has no affiliations with Northwell Health/Lenox Hill Hospital. The plaintiffs failed to raise a triable issue of fact in opposition to this showing.

In any event, even if Posner's limited affiliation with NYPH were alone sufficient to impute his continuous treatment of the patient to NYPH, his affiliation with NYPH ended four years prior to the commencement of this action and, thus, any claim against NYPH would still be time-barred. Moreover, the court rejects the plaintiffs' argument that, since both Posner and Altorki were treating the patient from different respective disciplines, Posner's treatment may be imputed to Altorki, as this is not a sufficient association to provide a nexus between the two doctors (*contra Ganapolskaya v V.I.P. Med. Assoc.*, 221 AD2d at 62). Hence, the continuous treatment doctrine cannot be imputed by virtue of an agency relationship between Posner and Altorki.

To apply the doctrine of equitable estoppel to preclude an assertion of the statute of limitations, the plaintiff must show that the defendant's conduct was not merely negligent, but that it was an intentional, "purposeful concealment and misrepresentation of the fact and consequences of the malpractice" (*Simcuski v Saeli*, 44 NY2d 442, 454 [1978]; *Chesrow v Galiani*, 234 AD2d 9, 10 [1st Dept 1996]). In addition to fraudulent conduct by the physician, the plaintiff must show reasonable reliance on the misrepresentation and due diligence in commencing the action once he/she learned of the facts (*see Pahlad v Brustman*, 33 AD3d 518, 519-520 [1st Dept 2006]). The plaintiffs have failed to show that Altorki intentionally concealed and misrepresented any malpractice. The patient claims that Altorki and Posner told her after

the February 10, 2011 surgery that the nodule had been completely removed, and that both doctors were aware that it had not been entirely removed and was possibly malignant. Yet, in a letter from Posner to the patient's primary care doctor, Posner explained that he discussed the wedge resection surgery and its associated factors with the patient such as "false negative biopsies," and stated that "she is highly intelligent and I do believe in the end she understood the logic behind this *limited* wedge resection" (emphasis added). Therefore, the court concludes that the patient knew or should have known that the nodule was not completely removed. Moreover, a fraudulent concealment claim cannot prevail where the plaintiff relies on the same act that formed the basis of his or her negligence claim (*see Rizk v Cohen*, 73 NY2d at, 105; *Chesrow v Galiani*, 234 AD2d 9, 10-11 [1st Dept 1996]). Thus, the patient's allegations do not establish that Altorki, "acting with knowledge of *prior* malpractice, made *subsequent* misrepresentations in an attempt to conceal his earlier negligence" (*Rizk v Cohen*, 73 NY2d at 105-106). Hence, equitable estoppel cannot be asserted as ground to bar the affirmative defense of the statute of limitations.

Summary judgment may not be defeated on that ground that more discovery is needed, where, as here, the party advancing such an argument has failed to obtain the facts due to his or her own inaction (*see Meath v Mishrick*, 68 NY2d 992, 994 [1986]; *Paul Tausig & Son, Inc. v Providence Washington Ins. Co.*, 28 AD2d 279, 281 [1st Dept 1967] *affd* 21 NY2d 1022 [1968]). Moreover, allegations of mere hope by a plaintiff that discovery might reveal something is insufficient to deny summary judgment (CPLR 3212[f]; *Bryan v City of NY*, 206 AD2d 448, 449 [2d Dept 1994]; *Jones v Gameray*, 153 AD2d 550, 551 [2d Dept 1989]). This action was commenced on December 12, 2019, and a preliminary conference was held with the NYPH defendants on June 23, 2021. The plaintiffs had sufficient time after commencing this action and after the preliminary conference to obtain evidence relevant to the issues raised in this motion. Furthermore, insomuch as the plaintiffs had previously filed their own motion to strike the affirmative defense of the statute of limitations, they have essentially conceded that

discovery was not necessary to ascertain facts referable to continuous treatment. Nevertheless, the facts that the plaintiffs seek to obtain through further discovery have already been established or rebutted by the NYPH defendants in their current moving papers. The plaintiffs have failed to explain what essential, additional facts would be uncovered through further discovery (*see Brown v Bauman*, 42 AD3d 390, 393 [1st Dept 2007]). Thus, summary judgement is warranted.

The court notes that since relief was not sought against Posner, NHPP, and ERI, and none of the defendants has asserted any cross claims against each other, Posner, NHPP, and ERI thus have no stake in the outcome of this summary judgment motion, and no standing to oppose the motion. It has been held that "a defendant is not aggrieved by the dismissal of the plaintiff's complaint against a codefendant, but, rather, only by the dismissal of that defendant's cross claim or third-party claim against a codefendant" (*Mixon v TBV, Inc.*, 76 AD3d 144, 152 [2d Dept 2010]; *Grigoropoulos v Moshopoulos*, 44 AD3d 1003, 1005 [2d Dept 2007]; *Coons v Beltrone Constr. Co.*, 4 AD3d 584, 585 [3d Dept 2004]; *Scoville v Town of Amherst*, 277 AD2d 1038, 1039 [4th Dept 2000]; *Hauser v North Rockland Cent. Sch. Dist. No. 1*, 166 AD2d 553, 554 [2d Dept 1990]; *Nunez v Travelers Ins. Co.*, 139 AD2d 712, 713 [2d Dept 1988]; *Blake Realty, Inc. v Shiller*, 87 AD2d 729 [3d Dept 1982]). A person is aggrieved when he or she asks for relief, but that relief is denied in whole or in part, or when someone asks for relief against him or her, which the person opposes, and the relief is granted in whole or part (*Mixon v TBV, Inc.*, 76 AD3d at 156-157). Here, neither Posner, NHPP, nor ERI fall within the definition of an aggrieved person, as the NYPH defendants have not sought relief against any of them, but, rather, only against the plaintiffs. Furthermore, since Posner, NHPP, and ERI do not have cross claims or third-party claims against the NYPH defendants, they would not be aggrieved by the dismissal of the plaintiffs' complaint against the NYPH defendants.

Finally, a plaintiff may amend the complaint as of right while a motion to dismiss the initial complaint is pending (*see* CPLR 3205[a]; 3211[f]; *D'Amico v Correctional Med. Care, Inc.,* 120 AD3d 956, 957 [4th Dept 2014]; *Union State Bank v Weiss*, 65 AD3d 584, 585 [2d Dept 2009]; *STS Mgmt. Dev. v New York State Dept. of Taxation & Fin*., 254 AD2d 409, 410 [2d Dept 1998]). An amended complaint supersedes the initial complaint, leaving it the only complaint in the action (*see Pomerance v McGrath*, 104 AD3d 440, 442 [1st Dept 2013]; *Plaza PH2001, LLC v Plaza Residential Owner L.P.*, 98 AD3d 89, 99 [1st Dept 2012]). Nonetheless, the service of an amended pleading does not moot a pending motion to dismiss (*see Fownes Bros. & Co., Inc. v. JPMorgan Chase & Co*., 92 AD3d 582, 582-583 [1st Dept 2012]). When the plaintiff chooses to amend rather than defend the original complaint, the court may direct that the pending motion be directed to the amended pleading (*see DiPasquale v Security Mutual Life Insurance Co*., 293 AD2d 394 [1st Dept 2002]). The court elects to do so here.

Accordingly, it is

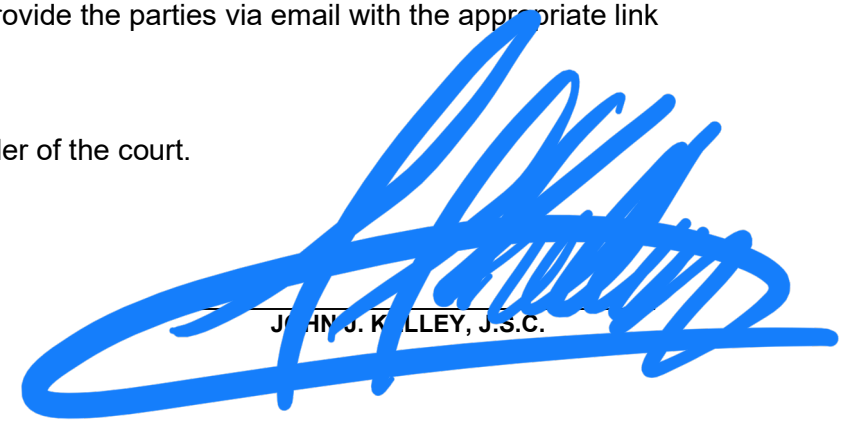
ORDERED that the converted motion of the defendants Nasser K. Altorki, M.D., and New York Presbyterian Hospital-Weil Cornell Medical Center for summary judgment dismissing the amended complaint insofar as asserted against them is granted, the amended complaint is dismissed insofar as asserted against the defendants Nasser K. Altorki, M.D., and New York Presbyterian Hospital-Weil Cornell Medical Center, and the action against the defendants Nasser K. Altorki, M.D., and New York Presbyterian Hospital-Weil Cornell Medical Center is severed (CPLR 5012); and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the amended complaint against the defendants Nasser K. Altorki and New York Presbyterian Hospital-Weil Cornell Medical Center; and it is further,

ORDERED that the plaintiffs and the defendants David Posner, Northwell Health/Northwell Health Physician Partners, and East River Imaging shall appear for a remote compliance conference on May 3, 2022, at 11:00 a.m., via the Microsoft Teams remote

conference application, and the court shall provide the parties via email with the appropriate link to access the conference.

This constitutes the Decision and Order of the court.



4/5/2022
DATE

JOHN J. KELLEY, J.S.C.

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