SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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FRANCES P. GORMLEY,

Plaintiff,

- v -

ALISON ESTABROOK, M.D., MOUNT SINAI-ST LUKES ROOSEVELT HOSPITAL, NEW YORK RADIOLOGY PARTNERS, WEST SIDE RADIOLOGY ASSOCIATES, P.C., RADNET, INC., STEVEN KAUFMAN, M.D., PETER IVAN MASLIN, D.O.,

Defendants.

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INDEX NO. 805236/2016

MOTION DATE 04/01/2024

MOTION SEQ. NO. 007

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 007) 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 257, 259, 265, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 305, 306

were read on this motion to/for JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, and violation of Public Health Law § 2404-c, the defendants Alison Estabrook, M.D., and Mount Sinai-St. Luke's Roosevelt Hospital (together the Mount Sinai defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted to the extent that the Mount Sinai defendants are awarded summary judgment (a) dismissing, as time-barred, any and all medical malpractice claims asserted against them that were premised on their alleged departures from good practice occurring prior to December 8, 2013, which is the date two years and six months prior to the commencement of this action, (b) dismissing the lack of informed consent cause of action insofar as asserted against them, and (c) dismissing the Public Health Law § 2404-c cause of action insofar as asserted against them. The motion is otherwise denied, inasmuch as there are triable issues of

fact as to whether they departed from good and accepted medical practice, between February 21, 2014 and March 25, 2015, by failing to recognize the presence of a suspicious mass in the plaintiff's breast during her annual breast examinations, by failing to refer the plaintiff for ultrasound, sonogram, or imaging other than mammography and, thus, by failing to diagnose the plaintiff with a malignant breast tumor, and whether those departures caused or contributed to a diminution in the plaintiff's life expectancy and survivability rates, and an increase in her chance of the recurrence of cancer. In this regard, the court concludes that the continuous treatment doctrine is not applicable to save any claims premised upon departures that allegedly occurred prior to December 8, 2013, as the plaintiff was seen by the Mount Sinai defendants solely for routine breast cancer screening, rather than for a particular, identifiable, ongoing condition, or for the monitoring of any "suspicious" breast tissue or "abnormality" to ascertain the presence or onset of a disease or condition.

FACTUAL BACKGROUND

The crux of the plaintiff's claims against the Mount Sinai defendants is that that Estabrook, the defendant breast surgeon, while employed by Mount Sinai-St Luke's Roosevelt Hospital, committed malpractice by failing to diagnose lobular cancer in the plaintiff's right breast between January 2010 and November 2015, thus permitting her condition to develop, worsen, and deteriorate, which, in turn, allowed the cancer to progress to Stage 2B, thus diminishing the plaintiff's life expectancy and survivability rates, and increasing her chances that the cancer would recur.

On March 23, 1998, the plaintiff underwent an ultrasound scan at nonparty Rye Radiology Associates in Rye Brook, New York, that yielded an image of a suspicious cyst in the right breast. On April 9, 1998, she underwent a core biopsy and fine needle-aspiration of a right breast lesion, which revealed the presence of a benign cyst. The plaintiff was advised to schedule a follow-up examination six months later.

The plaintiff, who was then 42 years old, first saw Estabrook on November 18, 1998.

She reported a family history of colon cancer in her mother and paternal grandfather and a possible history of ovarian cancer in her paternal aunt. The plaintiff's own history included a sebaceous cyst in her right breast and ovarian cysts. In a letter dated that same day, Estabrook wrote to non-party obstetrician/gynecologist Mary Wilson, M.D., that her physical examination of the plaintiff revealed a cyst that was palpable at the 7:00 o'clock position in the right breast, measuring approximately 1.5 centimeters (cm). Estabrook's records reflected that she aspirated the cyst, and she documented that the breast demonstrated gross cystic disease upon physical examination bilaterally. Estabrook recommended that the plaintiff return for a bilateral mammography and ultrasound in one year.

The plaintiff next saw Estabrook on April 5, 1999, at which time Estabrook palpated a lump, from which she aspirated a few drops of cystic fluid. On the same day, the patient underwent a mammogram at the defendant West Side Radiology Associates, P.C. (West Side), which is located in the same building as Estabrook's office, and is the professional corporation under which the defendant radiologist Stephen Kaufman, M.D., sued herein as Steven Kaufman, M.D., practices medicine. The impression of the West Side radiologist who reviewed the 1999 scans was the presence of cysts along the lateral aspect of the right breast in the area where the plaintiff previously had undergone a needle biopsy. The radiology report indicated that some of the cysts contained "interval echoes," suggesting the presence of debris. In response to this imaging, Estabrook recommended that the plaintiff undergo a mammogram in one year.

The plaintiff saw Estabrook for breast examinations intermittently between 2001 and 2008, and simultaneously continued to undergo screening mammograms at West Side. During that period of time, the mammograms performed on the days that she saw Estabrook were noted to be negative. In 2006, the plaintiff reported that she had started experiencing hot flashes, and advised Dr. Estabrook that she was considering hormone replacement therapy, and intended to discuss that option for treatment with her gynecologist, nonparty Peter Dottino,

M.D. According to Estabrook, she advised the plaintiff that if menopausal symptoms could not be tolerated, it would be permissible to commence hormone replacement therapy, but that the treatment should only be of two-years duration, after which it should be tapered off. In 2007, the plaintiff reported to Estabrook that she had seen Dr. Dottino, had begun that therapy, and was feeling much better, with a decrease in the frequency of hot flashes and a "clearer" mind.

In 2008, the plaintiff underwent surgery to remove her thyroid, which was benign.

Beginning in 2008, at the plaintiff's routine annual visits, Estabrook undertook bilateral examinations of the plaintiff's breasts. According to Estabrook, during each such examination, she examined each of the plaintiff's breasts via palpation by beginning from the outside and moving towards the nipple in circles. Estabrook testified at her deposition that, during the breast examinations, she had the patient sit and put her arms up by her side, and examined both armpits and inspected both breasts for any differences. She further averred that she then had the plaintiff lay flat on the table and lift each of her arms, while Estabrook examined each breast and moved from side to side. As Estabrook characterized it, her clinical findings were always normal and never suggestive of any sign of malignancy or cancer, while concurrent mammograms confirmed the absence of cancer.

On January 20, 2010, the plaintiff returned to Estabrook for a routine annual examination. Estabrook reported that she conducted the examination, that the results were normal, and that the report from a screening mammogram at West Side undertaken that same day was read by the former codefendant radiologist Peter Maslin, D.O., who noted that the scan was negative for cancer, but depicted stable calcifications in both breasts, as well as a stable and benign intra-mammary lymph node in the upper outer region of the left breast. Maslin's impression was Breast Imaging-Reporting and Data System (BI-RADS) Category 2 Benign, with Category 1 representing a scan that was completely negative for any adverse conditions, and Category 6 representing a scan reflecting a current diagnosed breast cancer undergoing further imaging or biopsy. As Estabrook recalled it, she recommended that the plaintiff undergo a

repeat mammogram in one year, and further explained to the plaintiff that the stable intra-mammary lymph node is in the breast, as opposed to the axilla, that is, the armpit, and would not be palpable on the breast exam. On January 26, 2011, approximately one year later, Estabrook again examined the plaintiff's breasts, and concluded that they were normal. Kaufman read a screening mammogram taken the same day at West Side, concluded that it was negative, and reported his impression that there had been no change from the January 20, 2010 study that had characterized the plaintiff's condition as BI-RADS Category 2 Benign, with no mammographic evidence of malignancy. Estabrook averred that she recommended the plaintiff for a routine follow-up mammogram was recommended in one year.

On January 27, 2012, the plaintiff returned to see Estabrook, who undertook a breast examination that she characterized as normal. Estabrook noted in the plaintiff's chart that the plaintiff's last menstrual period had occurred two years prior to this visit, but that the plaintiff reported that she had experienced a light menstrual flow in November 2011. At the time of this visit, the plaintiff was on maintenance dosages of the hormone replacement drugs Enjuvia and Prometrium, the synthetic thyroid hormone synthroid, and Vitamin D. Radiologist Bradley Handler, M.D., read the West Side screening mammogram scan that had been generated that same day, noted it to be negative, compared it to the 2010 and 2011 mammograms, and concluded that there was no mammographic evidence of malignancy, no change from prior examinations, and no change from the prior characterization of the scan as reflecting BIRADS Category 2 Benign. Again, Estabrook recommended a routine follow-up mammogram on year hence.

The plaintiff returned to see Estabrook on January 28, 2013, and reported that there had been a discharge of some substance from her right breast when another doctor had palpated her breasts secondary to full body dermatological checkup. Estabrook's examined the patient's breasts at that time, and concluded that they were normal and negative for any discharge.

Maslin read the West Side mammography scan taken the same day, concluded that it was negative for malignancy, compared it to the 2010, 2011, and 2012 studies, and reported his impression that there were benign, stable calcifications in both breasts and a benign, stable well intra-mammary lymph node in the upper outer region of the left breast. Maslin further reported that there was no change from those prior studies, and that the diagnosis remained BI-RADS Category 2 Benign. Maslin recommended a routine follow-up mammogram in one year.

Between January 28, 2013 and February 21, 2014, the plaintiff's gynecologist, Dr. Dottino, removed a fibroid growth. The plaintiff's maintenance hormone replacement medications remained the same as they had been during the previous two years. On February 21, 2014, the plaintiff again saw Estabrook, who examined her breasts and reported them to be normal. Kaufman read the West Side screening mammogram scan taken the same day, and concluded that it was negative, but that the breast parenchymal pattern was heterogeneously dense, which may have lowered the sensitivity of the mammogram. Kaufman compared the 2014 scans with the 2010, 2011, 2012, and 2013 scans, and formed an impression that there was no mammographic evidence of malignancy, and no change from prior scans or the diagnosis of BI-RADS Category 2 Benign. His recommendation remained a routine follow-up mammogram in one year. Kaufman's report did not indicate that he detected any areas of architectural distortion on that mammogram, or that he detected the presence of any areas of focal asymmetry either on that mammogram, or on any of the prior studies between 2010 and 2014. Nonetheless, at his deposition, Kaufman testified that, on the February 21, 2014 study, he did observe an area of focal asymmetry, located in the upper outer quadrant of the right breast, but did not make any notations in his report to document this finding. He further testified that this finding "could be an abnormality that has to be evaluated," and that the possible etiologies of this focal asymmetry included "malignant possibilities." In addition, Kaufman testified at his deposition that the focal asymmetry that he observed on the 2014 imaging was

the same as he had observed on the four prior images from 2010 through 2013, but that he did not believe it was necessary to memorialize it in a report because there had been no change.

On March 25, 2015, the plaintiff, who was by then 58 years old, presented to Estabrook for her annual breast examination. The plaintiff had remained on the same hormone replacement medications. Estabrook reported that the examination was normal. Kaufman again read a screening mammogram image generated the same day, again concluded that it was negative, again compared the image to the images from all prior scans, again formulated an impression of no mammographic evidence of malignancy, again reported that the breast was heterogeneously dense, again reported that there had been no change from prior exam, and again diagnosed BI-RADS Category 2 Benign. Estabrook once again recommended a repeat mammogram in one year. Although Estabrook claimed that she discussed ordering an ultrasound scan at this visit, the plaintiff contended that this discussion probably did not occur at that visit, but may have been discussed on another occasion.

On August 28, 2015, the plaintiff presented to the Martha's Vineyard Hospital emergency department in Massachusetts for evaluation of sudden tenderness and swelling of the right breast at the 12:00 o'clock position. The chart from that hospital reported that a 4 cm by 4 cm mass was palpated on her right breast, and that induration was seen on the sonogram undertaken in the emergency department. According to the chart, the plaintiff was advised to apply warm compresses to the area, and emergency room physicians started her on the antibiotic Cephalexin. On August 31, 2015, the plaintiff called Estabrook to report her examination and treatment in Massachusetts, and was seen by Estabrook later that day, at which time the plaintiff reported that the emergency physician suspected that she had mastitis. She told Estabrook, however, that her breast had not been hot or red and that she did not have a fever. Estabrook's physical examination was positive for a 3 cm by 2 cm right upper inner quadrant breast mass, which the plaintiff reported as tender to the touch. According to Estabrook, the mass was not associated with any swelling or redness, and there was no

discharge from the nipple. Estabrook further concluded that her examination of the plaintiff's axillary lymph nodes was negative for cancer. As Estabrook characterized it at her deposition, this growth was a new mass that was not located in any area where she previously aspirated a cyst. Estabrook formulated a differential diagnosis that included an abscess caused by infection or cancer. Estabrook performed an ultrasound and a fine needle aspiration biopsy of the breast mass to determine or rule out other potential causes, but initially thought that the sudden onset of the mass, only several days earlier, suggested an infection, and thus instructed plaintiff to continue taking antibiotics and to return to see her on September 14, 2015. If the mass did not decrease by then, Estabrook's plan was to have the plaintiff undergo a core biopsy during the next visit, which she explained employed a needle larger than the one that had been employed for the aspiration biopsy.

Pathologist Arzu Buyuk, M.D., upon examining tissue sample from the August 31, 2015 fine needle aspiration biopsy, prepared a cytopathology report that was made available on September 1, 2015, and which concluded that the sample was negative for malignancy, but noted that an immediate evaluation revealed tissue that was "Hypocellular. Benign. Proliferative breast disease. Rare ductal cells and only a few neutrophils," the latter of which were a type of white blood cells suggestive of fat necrosis, which generally occurred in a breast after an infection. When the plaintiff returned to Estabrook on September 14, 2015, Estabrook reported that the mass appeared the same as it had on August 31, 2015. At the September 14, 2015 visit, Estabrook performed an ultrasound and an ultrasound guided core biopsy of the breast mass, and reformulated her differential diagnosis to consist of phyllodes tumor or cancer. According to Estabrook, at this juncture, lobular breast cancer was high on the differential because it grows differently from ductal cancers, with the latter forming spherical masses, while lobular breast cancers spread in a single file and are difficult to detect radiologically.

A September 16, 2015 surgical pathology report indicated that the September 14, 2015 sample was positive for an invasive lobular carcinoma of the right breast, with the sample

evaluated as estrogen receptor positive 90%, progesterone receptor positive 90%, and HER2 protein negative, with a Marker of Proliferation Ki-67 value of 15%. Estabrook contacted the plaintiff by telephone, informed her that the biopsy was positive for breast cancer, and instructed her return to her office the following day to undergo a mammogram and an ultrasound and to discuss surgery. The plaintiff returned to see Estabrook on September 17, 2015, at which time they discussed the diagnosis of invasive lobular breast cancer. Kaufman read the report of a diagnostic mammogram taken at West Side that day which, according to Estabrook, she discussed with Kaufman. By its terms, the report was compared with the prior studies of March 2015, February 2014, January 2013, January 2012, January 2011, and January 2010. Kaufman memorialized his impressions of the scan as depicting stable, benign calcifications seen in both breasts, a stable benign-appearing nodule in the upper quadrant of the left breast, focal asymmetry at the area of palpable concern in the superior right breast that had been present since 2010, and architectural distortion within the focal asymmetry that, according to the report, had not been present on prior studies. The ultrasound from the same day, taken, and as interpreted by, Kaufman, revealed an irregular shaped hypoechoic mass, with distinct margins measuring 6.2 cm by 4.0 cm by 4.0 cm in the right breast within an area of dense tissue at the 11:00 o'clock to 1:00 o'clock position, located 1 cm from the nipple. The ultrasound indicated that there was no evidence of malignancy in the left breast. In contrast to the studies undertaken from 2010 to 2014, and earlier in 2015, the BI-RADS category was "6 Known Biopsy-proven malignancy." At that point, Estabrook explained to the plaintiff that her plan was to perform a right breast lumpectomy with sentinel node biopsy on September 22, 2015.

After radiologic and sonographic confirmation, Estabrook performed the lumpectomy of the plaintiff's right breast at Manhattan Surgery Center on September 22, 2015. A surgical pathology analysis of the lumpectomy tissue, along with a sentinel node excision, documented a 7 cm mass that reflected a positive estrogen and progesterone receptor status, and metastatic disease to one out of two sample lymph nodes that had been excised. As Estabrook described

it, based on surgical and pathological findings referable to the lumpectomy, she decided to perform a wider re-excision on October 8, 2015 at the same site. On that date, Estabrook performed a right breast re-excision procedure. On October 12, 2015, Estabrook memorialized in the relevant chart that had she received the patient's Oncotype score of 22, which she characterized as an intermediate score, suggesting that the plaintiff's cancer was not going to recur, and thereafter advised the patient of her Oncotype Score by telephone.

On October 20, 2015, the plaintiff underwent a positron emission tomography (PET) scan, and when she next saw Estabrook on October 21, 2015, the PET scan results remained pending. According to Estabrook, at that time the plaintiff planned to follow up with medical oncologist Shanu Modi, M.D., at Memorial Sloan Kettering Cancer Center (MSKCC) for continuing treatment with radiation and chemotherapy. On November 6, 2015, the plaintiff presented to MSKCC for the administration of chemotherapy, but the medical staff there would not then administer it. Dr. Modi ordered an ultrasound and a large collection of tissue was observed, aspirated, and cultured, after which he prescribed the antibiotic Clindamycin to the plaintiff. The plaintiff visited Estabrook later that day, complaining of redness to her right breast. After examining the plaintiff, Estabrook reported observing the surgical scar, and erythema around the scar, in the right, close to the 12 o'clock position. Estabrook aspirated more fluid for a breast culture, which was negative for bacteria. When Estabrook next examined the plaintiff on November 16, 2015, she concluded that the plaintiff was much improved on antibiotics, and was receiving chemotherapy; she scheduled the plaintiff to return to see her in January 2016. The November 16, 2015 appointment, however, was the plaintiff's last visit with Estabrook.

The plaintiff underwent four rounds of chemotherapy at MSKCC, which was completed in February 2016, and then received radiation therapy. Specifically, Dr. Modi prescribed a course of treatment that included chemotherapy consisting of four rounds of Adriamycin and Cytoxan from October 23, 2015 through December 8, 2015, four doses of Taxol from December 23, 2015 through February 3, 2016, as well as radiation therapy that was administered from

February 24, 2016 through April 5, 2016. Beginning in 2016, Dr. Modi also prescribed a course of aromatase inhibitor therapy, beginning with Letrozole, and eventually switching to Anastrozole, which the plaintiff is still undergoing at present. As Estabrook characterized them, MSKCC's records indicated that the plaintiff's post-surgical treatments were completed as of May 2016. Estabrook further asserted that the plaintiff has evinced no evidence of a recurrence of cancer and has experienced no adverse post-treatment issues. The plaintiff testified at her deposition that, as a consequence of the chemotherapy, she suffered from cognitive impairment, commonly referred to as "chemo brain," as well as hot flashes, stiffness, bone pain, fatigue, flu like symptoms, and rashes, all of which she claimed had an adverse effect on her enjoyment of life while she underwent the treatment.

The plaintiff commenced this action on June 8, 2016.

III. THE PLAINTIFF'S CONTENTIONS

In her complaint, the plaintiff alleged that Estabrook failed properly to examine her, failed properly to interpret radiological studies, failed to provide proper follow-up examinations and treatment, including breast sonograms, and failed to perform a proper diagnostic workup so as to diagnose breast cancer in a timely fashion, thus delaying treatment of the cancer that ultimately was diagnosed. She further asserted that Estabrook did not obtain her fully informed consent to treatment because Estabrook failed to inform her of the seriousness and true nature of her condition. In addition, the plaintiff alleged that Estabrook violated Public Health Law § 2404-c, which requires mammogram reports to inform patients whose mammograms indicate the presence of dense breast tissue of the possibility of cancer and of the available opportunities for further examination and treatments. The plaintiff alleged that, as a consequence of Estabrook's wrongful acts, she was deprived of the opportunity for an earlier diagnosis and a better treatment outcome.

In her bill of particulars as to Estabrook, the plaintiff alleged that Estabrook departed from good and accepted medical practice in failing properly to interpret mammography studies,

in failing to recommend further breast imaging studies, in failing to perform proper breast examinations, in failing to perform proper follow-up evaluations, in failing to follow up with the results of existing mammography studies, and in failing to perform a breast ultrasound scan and repeat ultrasound scans. She also faulted Estabrook for failing to perform proper diagnostic tests and studies so as to diagnose her condition, failing to refer her for three-dimensional mammography, digital breast tomosynsthesis, spot films, and magnification studies, failing to inform her of the need for a sonogram due to the density of her breasts, failing to offer supplementary screening, and failing to adhere to proper breast density notification practices. In light of these alleged departures from good practice, the plaintiff further alleged in her bill of particulars that Estabrook delayed a proper diagnosis, thus failing to diagnose breast cancer and delaying proper treatment, and failed to refer her to an oncologist, thus causing her condition to worsen and deteriorate.

The plaintiff claimed in her bill of particulars that, as a consequence of Estabrook's alleged malpractice, she ultimately had to undergo a biopsy that was positive for malignancy, a lumpectomy that revealed invasive lobular carcinoma with one positive node and inadequate margins, further surgical intervention in the form of re-excision, and extensive periods of intravenous chemotherapy followed by radiation. She alleged that, during the course of her chemotherapy and radiation treatments, she experienced nausea, fatigue, mouth sores, hair loss, alteration in memory and concentration, inability to perform household chores, inability to participate in social and recreational activities, interference with her employment, loss of appetite, distortion of taste, shortness of breath, inability to drive during radiation, skin burning, discoloration, fatigue, and sensitivity of her skin to touch. The plaintiff further complained of difficulty sleeping and menopausal symptoms, including hot flashes. She also alleged in her bill of particulars that she suffered from scarring, asymmetry of her breasts with respect to size, shape. and nipple contour, including an indentation at her right breast surgical site, and decreased range of motion and weakness of her right arm. The plaintiff claimed that, as a

consequence of the cancer and treatment regiments, she continues to require treatment, including the administration of aromatase inhibitor medication and injections for osteoporosis, with resultant bone and joint pain.

In her bill of particulars as to Mount Sinai-St. Luke's Roosevelt Hospital, the plaintiff essentially reiterated the allegations that she made against Estabrook and, in effect, seeks to hold the hospital vicariously liable for Estabrook's alleged malpractice and other wrongdoing.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the Mount Sinai defendants submitted the pleadings, the bills of particulars, the plaintiff's supplemental bill of particulars, the transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, an attorney's affirmation, and the expert affirmation of breast surgeon Dana Monaco, M.D. The Mount Sinai defendants argued that they did not depart from good and accepted practice, that a lack of informed consent cause of action does not lie where the underlying medical malpractice claim is based on a failure to diagnose a medical condition, and that any claims arising from a failure to diagnose cancer between January 2010 and December 8, 2013 are time-barred.

In her affirmation, Dr. Monaco asserted that, in the first instance, Estabrook did not cause the plaintiff's cancer, and that neither Estabrook nor the hospital played any role in performing or interpreting the plaintiff's mammograms and sonograms. As she noted, these studies were primarily performed and interpreted by West Side's radiologists, including Kaufman and Dr. Maslin. Dr. Monaco averred that,

> "[a]s a breast surgeon, it was wholly appropriate and within the standard of care for a breast surgeon to adhere to the Board-Certified radiologists' interpretation of these studies and rely upon their interpretations. As a breast surgeon, Dr. Estabrook was entitled to rely upon reports from Board Certified radiologists from West Side Radiology, which always reported normal radiological findings up to the point of the patient being diagnosed with cancer in September of 2015."

Specifically, Dr. Monaco asserted that it was wholly appropriate, and well within the standard of care, for Estabrook to employ the several West Side radiologists' preliminary and final readings

of the mammograms to assess the plaintiff's breast health during her annual office visits, and appropriate to forego rereading the studies. In this regard, Dr. Monaco averred that there was no custom and practice, and no need, for the plaintiff to carry the same-day films from West Side up to Estabrook's office for further review.

Dr. Monaco explained that, in light of the repeated normal physical breast examinations and independent benign radiological studies, Estabrook did not have a duty to refer the plaintiff for any further studies, including, but not limited to, spot films, magnifications, breast ultrasound, or breast tomosynthesis, the latter of which she identified as equivalent to three-dimensional mammography. She further asserted that, based upon these benign, normal findings, Estabrook comported with the standard of care, and had no duty to refer the plaintiff to an oncologist or to order supplemental screenings. Dr. Monaco opined that it was appropriate for Estabrook to follow the recommendations, set forth in the radiologists' reports, to advise the plaintiff to return for yearly mammograms.

Dr. Monaco explained that, inasmuch as the findings reported by the West Side radiologists were always normal until September 2015, Estabrook had no duty to consult with the particular radiologist who performed the studies, but that when the mammogram and ultrasound were performed in contemplation for the excision surgery after cancer had been diagnosed in September 2015, it was wholly appropriate for Estabrook to speak with the radiologist, which she in fact did.

Dr. Monaco opined that since Estabrook is a breast surgeon, but not a radiologist or mammographer, she had no duty under Public Health Law § 2404-c to comply with statutorily mandated breast density notification practices, or to notify the plaintiff if she had dense breasts, since, as a breast surgeon, she would not be able to detect whether or not the patient's breasts were in fact dense. Rather, she concluded that Estabrook properly relied on the radiology reports regarding findings pertaining to the patient's breast density.

From a clinical perspective, Dr. Monaco rendered her opinion that Estabrook, at every visit, appropriately conducted examinations of the plaintiff's breasts, since she elicited appropriate past medical histories, performed examinations from every angle, and then correlated her findings with the results of the radiological studies. As Dr. Monaco characterized it, based on the totality of the examinations over a five-year period, there was never any indication to refer the plaintiff for any further workup or to provide the plaintiff with any referrals until the August 31, 2015 office visit. Dr. Monaco asserted that, at that visit, Estabrook appropriately reviewed the plaintiff's medical history, properly performed an examination, and palpated a new 3 cm by 2 cm right, upper inner quadrant breast mass. Dr. Monaco concluded that, at that time, Estabrook appropriately suspected that the plaintiff had either an abscess or cancer. She opined that Estabrook's examination, and differential diagnosis and assessment, were timely and appropriate, as the sudden onset of the mass was more indicative of an infection than cancer. Hence, Dr. Monaco asserted that it was appropriate for Estabrook to have the plaintiff complete a regimen of treatment with antibiotics, and to have her return on September 14, 2015 to reassess the mass. Inasmuch as the breast mass had not decreased when the plaintiff returned on September 14, 2015, Dr. Monaco concluded that Estabrook timely and properly performed an ultrasound and an ultrasound-guided core biopsy of the breast mass, and that when the surgical pathology report came back positive for an invasive lobular carcinoma of the right breast on September 16, 2015, Estabrook acted appropriately and comported with the standard of care by immediately contacting the plaintiff by telephone and advising her that her biopsy was positive for breast cancer. Dr. Monaco further concluded that Estabrook comported with the standard of care by instructing the plaintiff to return to her office the following day to undergo a mammogram and an ultrasound, and also to discuss surgery.

Dr. Monaco also opined that, after radiologic and sonographic confirmation of the presence of an invasive lobular carcinoma, Estabrook timely and appropriately performed a lumpectomy of the right breast at Manhattan Surgery Center on September 22, 2015 and that,

based on the post-operative findings, it was wholly appropriate and comported with the standard of care for Estabrook to follow up with a wider re-excision on October 8, 2015.

Ultimately, Dr. Monaco concluded that Estabrook did not cause or delay the diagnosis of cancer in any way and that, immediately after a mammogram documented a proven malignancy, Estabrook timely and appropriately comported with the standard of care by scheduling the patient for breast surgery. She expressly stated that nothing Estabrook did or did not do caused any harm to the plaintiff.

With respect to whether the action was commenced in a timely fashion against them, the Mount Sinai defendants argued that any claims arising from a failure to diagnose cancer between January 2010 and December 8, 2013 were time-barred. They contended that the continuous treatment doctrine was not applicable here because the Mount Sinai defendants were not treating the plaintiff for an identifiable, ongoing condition, but only provided annual diagnostic screening services. They further argued that CPLR 214-a(b)---which created a date-of-discovery rule for ascertaining when the limitations period for claims involving the failure to diagnose cancer begins to run---is Inapplicable because "[t]he law applies to acts, omissions, or failures occurring on or after January 31, 2018" (L 2018, ch 1, § 5), and the failures alleged to have occurred here involved mammograms taken in 2013, 2014, and 2015.

In opposition to the motion, the plaintiff relied on the same pleadings, bills of particulars, deposition transcripts, and medical records that the Mount Sinai defendants submitted. The plaintiff also submitted an attorney's affirmation, a statement of facts, a memorandum of law, and the expert affirmations of diagnostic radiologist Joan D. Goodman, M.D., and oncologist, hematologist, and internist Joseph Ramek, M.D.

Dr. Goodman asserted that, in addition to her extensive academic and hospital-oriented radiology practice, she also maintained a private diagnostic radiology practice from 1988 through 2013, primarily involving in women's imaging, and focusing on mammography, ultrasound, bone densitometry, and hysterosalpingograms, at which she saw approximately 20

patients per day. As Dr. Goodman explained it, her private practice involved not just the reading and interpretation of breast imaging and other radiologic studies, but the regular performance of physical examinations of patients who presented for breast evaluations, which she alleged was done for the purpose of clinically correlating her radiologic findings. As part of that clinical correlation, Dr. Goodman asserted that she had performed thousands of clinical breast examinations, including "countless" breast cancer screenings that "included a manual breast exam of the same type that Dr. Estabrook was performing serially on Ms. Gormley from 1998-2015." She averred that she had performed "countless such breast examinations" in hospital settings during her more than four-decade long career. Consequently, Dr. Goodman stated that she was "familiar with all aspects of performing clinical evaluations to assess for the presence of breast tumors, as well as standards of care pertinent to such evaluations, *on the part of both the physician performing a manual breast exam*, as well as the radiologist" (emphasis added).

Although Dr. Goodman's opinion primarily addressed the departures from accepted radiological practice that Kaufman allegedly committed, she also rendered an opinion as to whether Estabrook properly conducted physical examinations of the plaintiff's breast in 2013, 2014, and early 2015. After first concluding that focal asymmetry and architectural distortion were indeed apparent on the 2013, 2014, and 2015 mammography imaging, and stating that the imaging reflected that imaging was clear enough to reflect that the distortion had grown from one year to the next, and explaining what she had observed on the films to reach that conclusion, Dr. Goodman opined that, based on the size and characteristics of the abnormality, Estabrook should have recognized the tumor in the plaintiff's right breast upon palpation during both the 2013 and 2014 physical examinations, and the early 2015 examination. She explained that this area of focal asymmetry was a radiologic finding that "served to document the transition of the abnormal tissue" in the plaintiff's right breast from "merely benign calcifications . . . to the point where this cancer appears to have begun to grow." Dr. Goodman noted that surgical pathology from the lumpectomy performed on September 22, 2015 was consistent with that

conclusion, as that study reported calcifications within the carcinoma that had been evaluated by a pathologist.

Dr. Goodman asserted that,

> "when palpating a breast during a manual exam to assess such an area of focal asymmetry during a manual breast exam, the focal area of density within the breast that is creating the asymmetry on the films, should be apparent to the clinician performing the manual breast exam, as this tissue actually feels more dense and nodular, or 'lumpy' to the touch, than the tissue in the other quadrants of the same breast, as well as the patient's other breast, if present. Because the focus of dense breast tissue is only in one quadrant of the breast, this density is more noticeable to the touch.
>
> ". . . a tumor this size, that was big enough to be creating a radiologic finding of focal asymmetry on mammography, should have been palpable to Dr. Estabrook by the time the finding was visible on the serial mammograms beginning in 2013. . . . She would have and should have, as an experienced breast surgeon, been able to detect the presence of the area of density in the upper outer quadrant of the right breast, by this time, even in the absence of it being reported on prior mammogram reports. Dr. Estabrook should have had an index of suspicion requiring further imaging and investigation.
>
> "Had Dr. Estabrook detected this suspicious area of density, the applicable standard of care with respect to a patient such as Ms. Gormley who had a known history of dense breasts, would have required Dr. Estabrook to have ordered spot compression views, followed by sonography."

In this regard, Dr. Goodman concluded that Estabrook departed from the applicable standard of care, and that, as confirmed by Kaufman in his deposition testimony, Estabrook herself was free to order any additional breast studies that she believed were warranted, and was not limited to complete reliance on the West Side radiologic studies.

Dr. Goodman projected that, based upon a magnification factor of 25-30%, and her own measurements of the architectural distortion that she observed on the January 28, 2013, February 21, 2014, March 25, 2015, and September 17, 2015 mammograms, the tumor size would have been no more than approximately 4½ cm at the time of diagnosis had the cancer been diagnosed in 2013, rather than the 7 cm to which it had grown at the time of its removal. She also opined that February 21, 2014 represented the last chance for treatment of the tumor before the cancer progressed to stage 2B.

Dr. Ramek's opinion primarily was addressed to the issue of proximate cause. He explained that the genome for cancerous tumors is genetically unstable and that, over time, not only do malignant tumors grow in volume, they also develop additional genetic mutations, and generally grow to be more aggressive and more likely to behave unpredictably over time if left unchecked. As he framed it, the longer a cancer is allowed to grow, the more likely it is to become aggressive and result in a "crescendo of disease that can be challenging to effectively treat, if the cancer is treatable at all." Dr. Ramek asserted that.

> "[c]ancer is known within the field of Oncology to be an opportunistic growth of cells, and it is known to always be changing, based on molecular changes it can go through naturally. This means, that cancer cells can actually exploit the failure to detect them; the longer they are permitted to grow unabated, the more chances they have to mutate further and have a growth spurt."

He stated that this process was particularly true in a patient such as the plaintiff, who was undergoing hormone replacement therapy with estrogen and progesterone supplements, "in the face of a breast cancer that was estrogen receptor and progesterone receptor positive, meaning that the tumor that Ms. Gormley had, used estrogen and progesterone as fuel for growth." For this reason, Dr. Ramek concluded that, as soon as the plaintiff was diagnosed with invasive lobular carcinoma, she not only had to discontinue hormone replacement therapy, but effectively ended up on a regimen of aromatase inhibitors that was administered for the express purposes of *suppressing* estrogen and progesterone and slowing the growth of the cancer.

Dr. Ramek explained that, due to the nearly 32-month delay in diagnosing the plaintiff's cancer, the carcinoma continued to be able to feed off of her estrogen and progesterone supplements, a process reflected by the mammograms depicting a substantial growth in the architectural distortion between January 2013 and March 2015. As he characterized it, the tumor that was ultimately diagnosed was not just larger at the time of diagnosis, but also different in character due to molecular changes. Dr. Ramek agreed with Dr. Goodman's conclusion that February 2014 presented the last chance for this tumor to be diagnosed before the growth of the tumor began to increase at a rapid rate. In this respect, he explained that

tumors can have periods of slow growth, and other periods of rapid growth, depending on the unstable nature of the tumor genome. Dr. Ramek concluded that the plaintiff's tumor was in a period of rapid growth between February 21, 2014 and September 17, 2015, particularly between the mammograms taken on March 25, 2015 and September 17, 2015, but appeared to have been growing more slowly prior to 2014.

Based on his conclusion that the tumor experienced a "fast growth spurt," Dr. Ramek opined that the plaintiff could have avoided the spread of the cancer to the lymph node, which he conceded only had a modest metastatic deposit measuring 6 millimeters, and would have benefitted from a smaller tumor of approximately 4.5 cm instead of 7 cm, had the cancer been diagnosed on January 28, 2013, or even February 21, 2014. According to Dr. Ramek, "[t]his would have placed her cancer staging at a lower level than the Stage 2B she was determined to be at, at the time of the diagnosis in September of 2015."

In describing the adverse effects and damage that the purported delay in diagnosis caused or contributed to, Dr. Ramek explained that "[a] decrease in cancer staging, confers different benefits to any patient. First and foremost, the survivability rates for breast cancer, decrease as the staging increases." In other words, he stated that a delay in diagnosis of a cancer that results in a higher cancer staging, with the plaintiff, "decreases the baseline of her 5 and 10-year survivability rates by a measurable amount." He went on to assert that,

> "[w]ith the type of cancer that Ms. Gormley had, this translated to decreasing her from a survivability rate in the high 90s (which is essentially as close to a guarantee of a cure as one can get in Oncology), to a survivability rate in the mid-high 80s - a less desirable rate of survivability, in a cancer that tends to recur after year 5.
>
> "The increase in cancer staging, also increases her chance of a recurrence. Her Oncotype score, which is more essential for determining the likelihood of recurrence than is a Ki-67 score, came back as 22, indicating an intermediate chance of recurrence. The bigger the tumor, the bigger the chance it will recur."

Although Dr. Ramek recognized that the plaintiff "still would have undergone much of the same treatment had [the cancer] been diagnosed at an earlier date, her chances of recurrence or

survivability suffered by measurable amounts" due to tumor growth between January 2013 and September 2015. More particularly, Dr. Ramek opined that, by failing timely to diagnose the cancer, the defendants deprived the plaintiff of the only chance that she had to "potentially avoid the growth spurt that this cancerous tumor demonstrated between the 3/25/2015 and 9/17/2015 mammograms," and that, hence, the delay in diagnosis was a substantial factor in causing the injuries that the plaintiff is claiming here, specifically, in causing her cancer staging to increase unnecessarily, diminishing the plaintiff's life expectancy and survivability rates, and increasing her chance of the recurrence of cancer.

Neither Dr. Goodman nor Dr. Ramek provided an opinion as to whether any of Estabrook's examinations of the plaintiff between 2010 and 2012, or any failure to order additional scanning during that time period, departed or deviated from the applicable standards of care.

The plaintiff also argued that the monitoring of an abnormality to ascertain the presence or onset of a disease or condition may constitute "treatment" for purposes of tolling the statute of limitations under the continuous treatment doctrine. She contended that, inasmuch as the Mount Sinai defendants were monitoring dense breast tissue for adverse changes, including the possible onset of cancer, in light of both the tissue density and her ongoing hormone replacement therapy, the continuous treatment doctrine should apply to all annual breast examinations beginning in 2010. The plaintiff did not address the lack of informed consent cause of action, nor the viability of an implied private cause of action against the Mount Sinai defendants pursuant to Public Health Law § 2404-c, which imposes upon providers of mammography services certain notification requirements with respect to patients who exhibit dense breast tissue.

In reply, the Mount Sinai defendants submitted an attorney's affirmation, in which they reiterated their prior arguments with respect to their alleged deviations from accepted practice, and whether any such deviations proximately caused or contributed to any compensable injuries

or damage. In this respect, they asserted that the affirmations of the plaintiff's experts failed to raise a triable issue of fact as to either a deviation from good practice or proximate cause. They further argued that the opinions of both Dr. Goodman and Dr. Ramek were conclusory, speculative, and based on hindsight in any event, and that Dr. Goodman, as a radiologist, was not qualified to render an opinion as to whether Estabrook, a breast surgeon, deviated from good and accepted practice in the quality and propriety of her physical examinations. The Mount Sinai defendants also noted that the plaintiffs' experts did not address any departures that allegedly were committed between January 2010 and December 2012. In addition, the Mount Sinai defendants argued that the continuous treatment doctrine should not apply here, in that they only provided the plaintiff with routine breast cancer screening, and that the only conceivable "condition" that they continued to diagnose was dense breast tissue, which is statutorily defined as "not abnormal." They contended that, consequently, the presence of dense breast tissue did not support the plaintiff's argument that she fell within a recognized exception to the rule that routine screening and check-ups, unrelated to any existing, identifiable disease or condition, do not constitute continuous treatment.

V. SUMMARY JUDGMENT STANDARDS

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 his or her 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 (*see 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 his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her 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]).

Contrary to the plaintiff's contention, the Mount Sinai defendants' motion may not be denied solely on the ground that they declined to submit a statement of uncontested material facts. 22 NYCRR 202.8-g, referable to such statements, was amended on July 6, 2022 to make the movant's submission of a statement of undisputed facts optional, unless the court otherwise directs (*see* 22 NYCRR 202.8-g[a]). This court did not direct the parties to submit statements of uncontested facts or counter statements of fact.

A. STATUTE OF LIMITATIONS

In connection with 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 a triable issue of 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 MLB Sub I, LLC v Clark,* 201 AD3d 925, 927 [2d Dept 2022]; *Murray v Charap*, 150 AD3d 752 [2d Dept 2017]; *Precision Window Sys., Inc. v EMB Contr. Corp*., 149 AD3d 883, 884 [2d Dept 2017]; *Guzy v New York City*, 129 AD3d 614, 615 [1st Dept 2015]; *Williams v New York City Health & Hosps. Corp*., 84 AD3d 1358 [2d Dept 2011]; *Rakusin v Miano*, 84 AD3d 1051 [2d Dept 2011]). The plaintiff commenced this action on June 8, 2016. The Mount Sinai defendants established, prima facie, that all medical malpractice claims premised upon conduct that occurred prior to December 8, 2013, that is, two years and six months prior to the commencement of the action, were time-barred. To avoid dismissal of claims based on the Mount Sinai defendants' alleged departures from good practice antedating December 8, 2013, the plaintiff thus was required to raise a triable issue of fact as whether the statute of limitations had been tolled, an exception to the limitations period was applicable, or she actually commenced the action within the applicable limitations period. The plaintiff failed to do so.

The statute of limitations applicable to actions to recover for medical malpractice against a private health-care provider is two years and six months, 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 that statute 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 Appellate Division, First Department, has not adopted the bright-line rule articulated by the Appellate Division, Second Department, in decisions such as *Sherry v Queens Kidney Ctr*. (117 AD2d 663, 664 [2d Dept 1986]), which holds "that treatment is not considered continuous when the interval between treatments exceeds the period of limitation." Rather, the First Department has articulated a more nuanced rule that 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 the patient's condition (*Devadas v Niksarli*, 120 AD3d at 1006). 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])."

(*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).

The continuous treatment doctrine, however, does not apply to routine diagnostic examinations or assessments of a patient, even when conducted repeatedly over a period of time, when those examinations or assessments are unrelated to an identifiable condition that required treatment (*see Massie v Crawford*, 78 NY2d at 520; *Nykorchuck v Henriques*, 78 NY2d at 258-259; *Charalambakis v City of New York*, 46 NY2d 785, 787 [1978]). As explained by the Court of Appeals in *Massie v Crawford* (78 NY2d at 519, 520 [citations omitted]), the continuous treatment doctrine "does not contemplate circumstances where a patient initiates return visits

merely to have . . . her condition checked" because "the policy reasons underlying the continuous treatment doctrine do not justify the patient's delay in bringing suit in such circumstances." "In the absence of continuing efforts by a doctor to treat a particular condition, none of the policy reasons underlying the continuous treatment doctrine justify the patient's delay in bringing suit" (*Nykorchuck v Henriques*, 78 NY2d at 259; *see Creque v New York City Health & Hosps. Corp.*, 193 AD3d 542, 542 [1st Dept 2021] [isolated incidents of routine breast examinations could not be the basis for invoking a toll for continuous treatment, where there was no evidence that either plaintiff or defendant expected plaintiff to return for further treatment after any of her annual mammograms]). "That defendant might have negligently failed to diagnose her cancer does not toll the statute, since the failure to establish a course of treatment is not, in and of itself, a course of treatment for the purposes of tolling the statute" (*Creque v New York City Health & Hosps. Corp.*, 193 AD3d at 542).

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 court concludes that the Mount Sinai defendants made the necessary prima facie showing that many of the plaintiff's visits in which they allegedly failed to diagnose breast cancer occurred more than two years and six months prior to the June 8, 2016 commencement of this action, specifically, the examinations and screenings that Estabrook conducted in 2010, 2011, 2012, and, as most relevant to this dispute, on January 28, 2013.

The court notes that the First Department has recognized an exception to the rule removing "routine physical examinations" from the ambit of the continuous treatment doctrine in cases where there was "an agreement between physician and patient to continue observation of suspicious breast tissue," inasmuch as such continued observation "may constitute sufficient monitoring to support a finding of continuous treatment" (*Oksman v City of New York*, 271 AD2d 213, 215 [1st Dept 2000]; *see Young v New York City Health and Hosps. Corp.*, 91 NY2d 291, 296 [1998] [the monitoring of an abnormality to ascertain the presence or onset of a disease or

condition may constitute treatment for purposes of the continuous treatment doctrine]; *Cherise v Braff*, 50 AD3d 724, 726 [2d Dept 2008] [same]; *Prinz-Schwartz v Levitan*, 17 AD3d 175, 179 [1st Dept 2005] [finding triable issue of fact as to "whether the frequency and intensity of the monitoring of plaintiff's breasts rose to a level sufficient to qualify as continuous treatment" and "whether plaintiff was being monitored for a specific medical condition"]). The plaintiff, however, failed to raise a triable issue of fact as to whether her situation falls within that exception. Between January 2010 and January 2013, the only "condition" that the plaintiff presented to the Mount Sinai defendants was dense breast tissue, which is not, in an of itself, a condition that can be characterized as "suspicious" for any disease or "abnormal." In fact, the Legislature expressly has found that "[d]ense breast tissue is very common and is not abnormal," and noted only that "dense breast tissue can make it harder to find cancer on a mammogram and may also be *associated with an increased risk* of breast cancer" (Public Health Law § 2404-c [emphasis added]). During the period of time under consideration, the plaintiff's breasts repeatedly were diagnosed as BI-RADS Category 2 Benign, with "stable and benign" tissue. Undergoing annual breast examinations to ascertain whether this stable and benign status remained constant or had changed did not constitute an agreement to monitor tissue that was "suspicious" for any cancer, but only to monitor tissue that correlated with an increased risk of cancer (*see Reeps v BMW of N. America, LLC*, 2012 NY Slip Op 33030[U], *18, 2012 N.Y. Misc. LEXIS 5788, *26 [Sup Ct, N.Y. County, Dec. 16, 2012] ["It is a well-known scientific principle that 'association is not causation,' or 'correlation is not causation.' Courts are well aware of this principle, and sometimes expressly cite it"]).

The Mount Sinai defendants also correctly noted that CPLR 214-a(b)---which created a date of discovery rule for ascertaining when the limitations period for claims involving the failure to diagnose cancer begins to run---is Inapplicable because "[t]he law applies to acts, omissions, or failures occurring on or after January 31, 2018" (L 2018, ch 1, § 5), and the failures alleged to have occurred here involved mammograms taken in 2013, 2014, and 2015.

Accordingly, the Mount Sinai defendants must be awarded summary judgment dismissing, as time-barred, any medical malpractice claim that was premised upon alleged departures from good and accepted treatment and care that antedated December 8, 2013. This includes claims that they failed to diagnose breast cancer in connection with their January 28, 2013 examination and screening of the plaintiff.

B. MEDICAL MALPRACTICE BASED ON ALLEGED DEPARTURES FROM GOOD PRACTICE

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept

2019]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy his or her burden on a summary judgment motion, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice,

and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

Contrary to the Mount Sinai defendants' contention, Dr. Goodman, as a radiologist specializing in women's health issues, and who also had conducted thousands of physical breast examinations to screen patients for lumps, cancers, and other breast diseases, was qualified to render an opinion as to whether Estabrook departed from good and accepted medical practice in the manner in which she examined and palpated the patient's breast, in failing to recognize the presence of a mass, in thus failing to refer the plaintiff for ultrasound, sonogram, or other scanning procedures, and in failing timely to diagnose breast cancer. Similarly, the court rejects their contention that Dr. Ramek, as an oncologist, hematologist, and internist, is not qualified to render an opinion as to whether the delay in diagnosis here caused or contributed to the plaintiff's alleged injuries and damages.

The determination of whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court, the provident exercise of which will not be disturbed absent a serious mistake or an error of law (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]). The courts of this State repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247,1248 [4th Dept 2008]; *Julien v Physician's Hosp.*, 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox*

Hill Hosp., 161 AD2d 352, 355 [1st Dept 1990]). Nonetheless, a physician who is put forward by a party as an expert qualified to support or oppose a summary judgment motion must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was applicable (*see Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus,

> *"the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [at issue], whether acquired through his practice or studies or in some other way'* (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; *see also Atkins v Beth Abraham Health Servs.*, 133 AD3d 491 [1st Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.,* 126 AD3d 653 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg,* 44 AD3d 1018 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment])"

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]).

Consequently, where, as here, the physician proffering an allegedly expert affirmation demonstrates familiarity with, training in, and experience with certain aspects of the defendant's specialty, specifically, the manner and thoroughness of a physical breast examination and the sufficiency of the methods of palpation, or whether a delay in diagnosing cancer could increase the likelihood of recurrence or diminish life expectancy, he or she will be deemed to have the requisite experience, training, and knowledge necessary to render an opinion as to whether that defendant departed from standards of good practice that proximately caused injury to the

plaintiff (*see Fuller v Preis*, 35 NY2d at 431 [neurologist was permitted to give an opinion in the closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide]; *Humphrey v Jewish Hosp. & Med. Ctr*., 172 AD2d 494 [2d Dept 1991] [general surgeon was deemed to be qualified to render an opinion in the specialty of obstetrics and gynecology]; *Matter of Sang Moon Kim v Ambach*, 68 AD2d 986, 987 [3d Dept 1979] [opinion testimony of qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon committed during spinal surgery]; *Matter of Lincoln v New York City Health & Hosps. Corp*., 2018 NY Slip Op 34085[U], *5, 2018 NY Misc LEXIS 14236, *8 [Sup Ct, Bronx County, May 3, 2018] [internist is qualified to render opinion as to the standard of care governing medical care and treatment of patients who undergo breast examinations and breast imaging studies, despite not being a radiologist, oncologist, or breast surgeon]; *cf. Vargas v Bhalodkar,* 204 AD3d 556, 557 [1st Dept 2022] ["(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether [defendant] deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York*., 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that [defendant] departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai*, 179 AD3d 860 [2d Dept 2020] [general and vascular surgeon not qualified to render opinion as to orthopedics or family medicine]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *Steinberg v Lenox Hill Hosp*., 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation[,as h]e specializes in cardiovascular surgery, not neurology or ophthalmology [and] failed to 'profess the requisite personal knowledge' necessary to make a

determination on the issue of whether [an arterial] perforation was responsible for plaintiff's visual impairment"]).

With respect to the merits of their motion, the Mount Sinai defendants established, prima facie, that Estabrook not deviate from the applicable standard of care in the manner in which she examined and palpated the patient's breasts in 2014 and early 2015, the manner in which she made the diagnoses rendered after those two examinations, and in declining to refer the plaintiff for other scanning technologies prior to August 2015. They also made a prima facie showing that nothing that she did or failed to do caused or contributed to any injuries, as the plaintiff would have had to undergo the same treatment whether the cancer was detected on February 21, 2014 (or earlier), March 25, 2015, or in September 2015. The plaintiff, however, raised triable issues of fact as to whether Estabrook departed from good and accepted practice in failing to detect a mass upon palpation during the 2014 and early 2015 examinations, as the plaintiff's expert expressly concluded that, given the size of the mass---as the expert measured it upon review of the February 21, 2014 and March 25, 2015 mammograms---could and should not have been missed if a proper physical examination and proper palpation had been conducted. The plaintiff also raised triable issues of fact as to whether the failure to detect the mass in early 2014, thus allowing it to grow for at least 13 months, and the further failure to detect it in early 2015, thus allowing to grow for another 5 months, caused or contributed to an increased likelihood of recurrence and a decreased life expectancy. Although the court is dismissing claims arising from Estabrook's examinations that she conducted, and determinations that she rendered, prior to December 8, 2013, the court notes that the plaintiff's experts did not comment upon the examinations conducted in 2010, 2011, and 2012. Hence, in addition to dismissal of these latter claims on the ground that they were time-barred, the court also awards summary judgment to the Mount Sinai defendants dismissing them on the merits.

Consequently, Estabrook is not entitled to summary judgment dismissing so much of the medical malpractice cause of action against her as was premised upon her conduct subsequent to December 8, 2013, including the examinations of February 21, 2014 and March 25, 2015. "'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp*., 164 AD3d 1211, 1213 [2d Dept 2018]). Since Estabrook was a Mount Sinai-St. Luke's Roosevelt Hospital employee, summary judgment is also denied to the hospital to the extent that it was denied to Estabrook.

C. LACK OF INFORMED CONSENT

The elements of a cause of action to recover for lack of informed consent are:

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst*., 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

Nonetheless, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or

disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]).

The Mount Sinai defendants established, prima facie, their entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action insofar as asserted against them, and the plaintiff's experts did not raise a triable issue of fact in connection with whether any diagnostic procedure involved the invasion or disruption of the decedent's bodily integrity. Hence, summary judgment must be awarded to the Mount Sinai defendants dismissing the lack of informed consent cause of action insofar as asserted against them.

D. PUBLIC HEALTH LAW § 2404-c

The plaintiff purports to assert a cause of action against the Mount Sinai defendants for violating the provisions of Public Health Law § 2404-c. That statute, effective January 19, 2013, recites as follows:

> "Every provider of mammography services shall, if a patient's mammogram demonstrates dense breast tissue, provide notification to such patient that shall include, but not be limited to, the following information, in any summary of the mammography report sent, pursuant to the federal mammography quality standards act, to the patient:
>
> "Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with an increased risk of breast cancer.
>
> "This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your results was sent to your physician.

> "For the purposes of this section dense breast tissue shall mean heterogeneously dense or extremely dense tissue as defined in nationally recognized guidelines or systems for breast imaging reporting of mammography screening, including, but not limited to, the breast imaging reporting and data system of the American College of Radiology, and any equivalent new terms, as such guidelines or systems are updated."

In the first instance, the court agrees with the Mount Sinai defendants that Estabrook was not a "provider of mammography services" within the meaning of the statute, a term that refers to radiologists and other physicians who themselves perform the mammography itself. Such radiologists and those other physicians are the ones required to provide the patient with the statutory notification, which includes a notification that a report of the patient's results was "sent to your physician." Estabrook would be the physician to whom the results were sent, and not the provider of mammography services who was required to send the results to another physician. Hence, Estabrook was not required to provide the plaintiff with the statutory notification required by Public Health Law § 2404-c. Since the plaintiff did not address this issue in her opposition papers, the Mount Sinai defendants are entitled to summary judgment dismissing that cause of action insofar as asserted against them.

In any event, the court concludes that no private right of action may be implied to permit a plaintiff to recover damages for violating Public Health Law § 2404-c. "The availability of a private right of action for the violation of a statutory duty--as opposed to one grounded in common-law negligence--is not a new concept. When a statute itself expressly authorizes a private right of action, there is no need for further analysis. When a statute is silent, as it is here, courts have had to determine whether a private right of action may be fairly implied" (*Uhr v East Greenbush Cent. Sch. Dist*., 94 NY2d 32, 38 [1999]; *see Brian Hoxie's Painting Co. v Cato-Meridian Cent. School Dist.,* 76 NY2d 207, 211 [1990]). In *Burns Jackson Miller Summit & Spitzer v Lindner* (59 NY2d 314, 325 [1983]), the Court of Appeals articulated the standards that were synthesized into a three-part test in *Sheehy v Big Flats Community Day* (73 NY2d 629, 633-634 [1989]), which requires an inquiry into "(1) whether the plaintiff is one of the class for

whose particular benefit the statute was enacted; (2) whether recognition of a private right of action would promote the legislative purpose; and (3) whether creation of such a right would be consistent with the legislative scheme" (*see also Carrier v Salvation Army,* 88 NY2d 298, 302 [1996]; *Maimonides Med. Ctr. v First United Am. Life Ins. Co.,* 116 AD3d 207, 211 [2d Dept 2014]). The third factor has generally been deemed to be the most critical (s*ee Carrier v Salvation Army*, 88 NY2d at 302).

The purpose of Public Health Law § 2404-c is to provide information to patients who have been found, upon mammography, to have dense breast tissue. It thus is a information disclosure statute, that obligates radiologists to provide their patients with information concerning the importance and relevance of the presence of dense breast tissue, to advise those patients that they should be vigilant in monitoring any changes, and to let them know that there are other scanning technologies that can be employed to detect lumps in the breast. Neither the Senate nor the Assembly sponsors' memoranda suggest that the law is anything more than an information disclosure statute (*see* Sponsors' Mem, Senate Introducer Mem in Support, Bill Jacket L 2012, ch 265). As the Assembly sponsor noted in her memorandum,

> "[a]ccording to this bill, it is up to the patient with dense tissue and their physician, as it should be, to determine the next steps to be taken, if any. There are no specific recommendations in the notification for additional screening for breast cancer. . . "
>
> *****
>
> "This legislation does not impose significant requirements."

(Assembly Sponsor's Mem, Bill Jacket, L 2012, ch 265). In her memorandum recommending approval of the bill that ultimately was enacted into law, the Executive Deputy Commissioner of the New York State Department of Health noted that "the legislation would arm patients with additional information to help them, in consultation with their physician, to decide whether additional screening is necessary" (Letter from St Health Dept, July 23, 2012 at 2, Bill Jacket, L 2012, ch 265). A private right of action generally will not be implied into a statute that is enacted solely to compel a private actor to disclose certain information (*see Abdale v North Shore-Long*

Is. Jewish Health Sys., Inc., 49 Misc 3d 1027, 1036 [Queens County 2015] [declining to find an implied private right of action to enforce General Business Law § 899-aa, which mandates that that any person or business which conducts business in New York, and owns or licenses computerized data that includes certain private information, is required to disclose any breach of the security of the system to any resident of New York whose private information was, or is reasonably believed to have been, acquired by a person without valid authorization]; *cf. Fine v State of New York*, 10 Misc 3d 1075[A], 2005 NY Slip Op 52240[U], 2005 NY Misc LEXIS 3047 [Ct Claims, Nov. 15, 2005] [declining to find an implied private right of action to enforce Education Law § 6510(8), which requires that State Education Department files relating to investigation of professional misconduct be kept confidential]).

The court notes that, even though the plaintiff cannot assert an implied private right of action to enforce Public Health Law § 2404-c, to the extent that a radiologist's failure to provide the notifications required by the statute constituted a departure from the standard of care applicable to radiologists and providers of mammogram services, the plaintiff may assert any such alleged failure as a common-law medical malpractice claim (*see generally Stone v Gordon*, 211 AD2d 881, 881 [3d Dept 1995] ["The implied warranty of habitability provisions of Real Property Law § 235-b were not intended to create an alternative remedy to recover damages for personal injuries that are recoverable in a negligence action."]).

VI. CONCLUSION

In light of the foregoing, the motion of the defendants Alison Estabrook, M.D., and Mount Sinai-St. Luke's Roosevelt Hospital is granted to the extent that they are awarded summary judgment:

(a) dismissing, as time-barred, all medical malpractice claims asserted against them that are premised on their alleged departures from good and accepted medical practice occurring prior to December 8, 2013,

(b) dismissing the lack of informed consent cause of action insofar as asserted against them, and

(c) dismissing the Public Health Law § 2404-c cause of action insofar as asserted against them,

those claims and causes of action are dismissed, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

5/9/2024
DATE

JOHN J. KELLEY, J.S.C.

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