

Gardiner v Zilberstein

2025 NY Slip Op 31317(U)

April 7, 2025

Supreme Court, Kings County

Docket Number: Index No. 523002/2020

Judge: Ellen M. Spodek

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At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 7th day of April 2025

PRESENT:

HON. ELLEN M. SPODEK, Justice

-----X
COLLEEN GARDINER,

Plaintiff,

-against-

INGA ZILBERSTEIN, M.D., and INGA ZILBERSTEIN, M.D., PLLC

Defendants
-----X

DECISION AND ORDER

Index No. 523002/2020

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Defendants INGA ZILBERSTEIN, M.D., and INGA ZILBERSTEIN, M.D., PLLC ., move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiff opposes the motion.

Plaintiff, at the age of 34, first saw defendant Dr. Zilberstein on August 23, 2017, with a complaint of spotting between periods for three months. Plaintiff had a prior history of an endometrial polyp which was surgically removed. Dr. Zilberstein performed a breast exam, which was normal. Plaintiff provided her family history to Dr. Zilberstein, which showed that 1) her mother was diagnosed with breast cancer at the age of 60; 2) her maternal grandmother was diagnosed with skin cancer and breast cancer; 3) her maternal

great-aunt was diagnosed with breast cancer; and 4) her maternal second cousin was diagnosed with breast and bladder cancer. Dr. Zilberstein's plan was to perform a transvaginal/pelvic sonogram so she could assess the reason for spotting between periods and also evaluate the presence and size of the endometrial polyp. She also arranged to obtain two different genetic tests, "My Risks" and "Horizon". Dr. Zilberstein testified that the reason she ordered the "MyRisk" test was because it is "the test that's ordered for [a] patient who have [sic] strong family history of cancer or interested in the test." Mot. Exh. J at p 46 .

Dr. Zilberstein drew blood for the genetic tests and ordered the transvaginal sonogram to be performed at Rosetta Radiology. She also prescribed a prenatal vitamin, Vitapearl. She directed the plaintiff to return in six months to evaluate the polyp and do a fertility workup.

Plaintiff had the transvaginal sonogram on August 29. Dr. Zilberstein testified that the report showed a small polyp. Exh. J at pg. 53.

On or about September 7, 2017, Dr. Zilberstein received the Horizon test results, which showed that there were two genetic abnormalities, specifically carrier traits for Krabbe Disease and the Zellweger Spectrum Disorder. Dr. Zilberstein testified that "[t]he significance of those findings are that if her partner is a carrier for the same traits, then a fetus, a child, may have [a] twenty-five percent chance of having a disease...." Mot. Exh. J at pg. 54. Dr. Zilberstein left a message for the plaintiff on September 14 regarding the test results.

On September 15, plaintiff returned to see Dr. Zilberstein to discuss becoming pregnant. Dr. Zilberstein reviewed the Horizon results with the plaintiff and plaintiff discussed the possibility of having the uterine polyp removed.

Dr. Zilberstein received the MyRisk test results on or around September 24. The test results showed that the plaintiff had a 1.1% risk over the next 5 years of developing breast cancer and a 42.7% risk over her lifetime of developing breast cancer, classifying this as an elevated risk. The results also included a calculation under the "Tyrer-Cuzick breast cancer risk calculation" which showed a remaining lifetime breast cancer risk of 30.4% and a 5-year breast cancer risk of 0.7%. The recommendations included continued clinical follow ups every six to twelve months, annual mammograms at ten years younger than the earliest diagnosis in the family, annual breast MRI at ten years younger than the earliest diagnosis in the family and other risk reduction strategies based on the individual.¹

Dr. Zilberstein called the plaintiff on October 4, and the call was returned on October 18, when the plaintiff was made aware of the MyRisk test results. Dr. Zilberstein testified that she would have discussed all of the results with the plaintiff and advised her to perform self-examinations of the breast and to undergo a baseline mammogram at age 40. Mot. Exh. J at pgs. 107-109. Dr. Zilberstein testified that based on the MyRisk test results, she considered the plaintiff to be "a high risk, lifetime risk, and lower risk, average risk within the next five years." Id. at pg. 109. The plaintiff testified that when she saw the 42.7% lifetime risk of breast cancer, she asked Dr. Zilberstein "Should I get a

¹ The recommendations are based on the NCCN (National Comprehensive Cancer Network) Clinical Practice Guidelines in Oncology Breast Cancer Screening and Diagnosis which can be found at www.nccn.org.

mammogram? Should I be having regular mammograms?" Mot. Exh. I at pg 131. The plaintiff testified that Dr. Zilberstein told her that she was too young and there was no need to have a mammogram at that time. Id. The plaintiff testified that "I wanted a mammogram if...if she thought it was necessary." Id. at pg 132.

The plaintiff next saw Dr. Zilberstein on December 15 due to the continued bleeding between periods. The plaintiff testified that "I didn't have any concerns about my breasts at that time aside from the sebaceous cyst."² Id. at pg. 115. The plaintiff told Dr. Zilberstein she wanted the polyp removed, and after performing another sonogram on December 21, the polyp was removed on January 12, 2018 by Dr. Zilberstein. The polyp tested negative for cancer.

Plaintiff returned to see Dr. Zilberstein on January 29 for her post surgery follow-up, where Dr. Zilberstein advised the plaintiff that she should return in six months for a check-up.

Plaintiff's next visit with Dr. Zilberstein was on June 29, 2018, where she reported finding a mass in her left breast. Dr. Zilberstein ordered a mammogram and breast ultrasound. She noted in the chart "Left Breast Lower Medial 3 x 3 cm. mobile non-tender mass (? Cyst?)." Mot. Exh. H at p. 103.

The mammogram was performed at Rosetta Radiology on July 10. The report showed "BIRADS Category 5 – Highly Suggestive of Malignancy – Appropriate Action Should be Taken." Id. at 105. Dr. Zilberstein was made aware of the findings on July 11.

Plaintiff underwent an ultrasound guided core biopsy on July 13. The report

² On June 1, the plaintiff had a benign epidermoid cyst in her right breast removed at Schweiger Dermatology.

showed “Invasive Moderately Differentiated Duct Carcinoma (12 mm in greatest microscopic dimension), and Ductal Carcinoma in situ, intermediate grade, solid type associated with necrosis and calcifications.” Mot. Exh. H at pg. 108.

On August 9, plaintiff underwent a partial left mastectomy and lymph node dissection at Memorial Hospital performed by Surgeon Hiram Cody, MD. The post surgery report showed the mass measured 2.4 cm and the pathology report showed that 3/4 of the plaintiff’s lymph nodes were positive for cancer with the tumor estrogen receptor positive, progesterone receptor negative and HER-2 receptor positive with extensive lymphovascular invasion. Mot. Exh. O at pg. 191-198. Plaintiff received chemotherapy and underwent a lymph node transplant procedure.

Defendants submit the affidavit of Dr. Nancy Lebowitz, a board certified doctor of obstetrics and gynecology. Dr. Lebowitz opined that Dr. Zilberstein did not depart from the standard of care in the treatment and care rendered to the plaintiff and the care and treatment she provided was not the proximate cause of any of plaintiff’s injuries. She opined that Dr. Zilberstein did not depart from the standard of care in following the recommendations provided with the MyRisk test. Dr. Lebowitz states “There are myriad “Guidelines” put out by varying organizations as to breast cancer screening for patients at “high risk” of developing breast cancer – which this patient was NOT. The Guidelines vary in their recommendations, and no one set of guidelines defines the standard of care for when to obtain screening.” Mot. Exh. A. at pg 12. Dr. Lebowitz noted that MyRisk classified plaintiff at an elevated cancer risk and not a high cancer risk. She states that “[t]here is no issue that the patient was at high risk for lifetime development of breast cancer. There is also no issue that she was not at high risk for developing breast cancer

within the next five years. The patient's 5-year risk of getting breast cancer was 1.1%." Reply Exh. V. at pg. 2. She notes that the NCCN guidelines in 2017 (which is what MyRisk based their recommendations on) were based on an article from October 2010 in the Journal of the National Comprehensive Cancer Network, titled Clinical Assessment of Breast Cancer Risk Based on Family History, which discusses the "management of patients unaffected by hereditary breast cancer syndromes with 20% or greater lifetime breast cancer risk." The article states with regard to "Management Of Patients Unaffected by Hereditary Breast Cancer Syndromes With 20% or Greater Lifetime Breast Cancer Risk" as follows: "If a patient returns from cancer genetic risk assessment and is not found to be affected by hereditary breast cancer syndrome but has a significant family history of breast cancer, her risk can be estimated using one of the risk assessment models described in table 2 (The Gail, Claus, and Tyrer-Cuzick)." "Typically, breast screening in these women should begin 10 years earlier than the earliest breast cancer diagnosis, but no later than 40 years of age." Id. at pg. 13. Dr. Lebowitz states that "[th]ere is simply no consensus in the medical community or medical literature as to the year at which screening should be commenced for a patient with Mrs. Gardiner's risk assessment." Id. at pg. 14. She opines that Dr. Zilberstein followed the guidelines at the time, as they did not recommend annual MRI/Mammograms until 10 years earlier than the youngest family member diagnosed, and not later than 40. Dr. Lebowitz notes that the screening guidelines of Memorial Sloan Kettering Cancer Center, (which is where the plaintiff received her cancer care and treatment) provide that annual mammograms for patients at high risk for development of breast cancer should commence "no later than 10 years before the youngest age that a close blood relative was diagnosed with cancer. Do not

start earlier than age 25.” The plaintiff’s five year risk of getting breast cancer was 1.1 %. As the myriad guidelines had different timelines for when to begin screening, she notes that the standard of care did not require a mammogram or other imaging for plaintiff before the age of 40.

Plaintiff opposed the motion for summary judgment and submitted the affidavits of a board-certified general surgeon and a board certified doctor in obstetrics and gynecology. Plaintiff’s expert surgeon opined that if the plaintiff had been referred for screening either after her initial visit with Dr. Zilberstein or after the MyRisk test results were received, “the standard of care required recommendation and an order for a mammogram at that time. Given her risk profile, the standard of care would have dictated the initiation of regular mammography earlier than the general population.” Aff. In Opp. Exh. 1 at pg. 9. The expert goes on to opine that “If a mammogram had been performed following the MyRisk assessment it is more likely that not that the imaging would have detected the cancer at an earlier stage.” Id. The expert states that based on the natural progression of breast cancer that it is reasonable to conclude that the cancer would have been discovered prior to it reaching Stage III, and if the plaintiff had been referred for a mammogram earlier, she would have had a better prognosis for five year cancer survival, at 90%, as opposed to the 68% survival rate she had from Stage III. Id. at pg. 9-10. According to plaintiff’s expert surgeon, the strong family history of cancer and the elevated risk score suggest that there is a higher likelihood that the tumor was undetected due to the lack of timely imaging. Id. The expert opines that if the plaintiff had been referred for a mammogram after her initial visit with Dr. Zilberstein, “it is more likely than not that the imaging would have revealed a tumor in the range of 1.5 to 2 cm in size, corresponding

to Stage IIA breast cancer, irrespective of the density of the breast.” Id. The expert further asserts that if the plaintiff had been referred for a mammogram after the MyRisk test results were received, (which was six months before the eventual diagnosis) “it is more likely than not that the imaging would have detected a tumor of slightly larger size, still under 5 cm, with involvement of 1-3 nearby lymph nodes. This would correspond to a Stage IIB diagnosis.” Id. at pg. 11.

Plaintiff’s expert doctor opined that the plaintiff should have been flagged as a high risk patient and referred to a general surgeon for breast cancer screening. Aff. In Opp. Exh. 2 at pg. 4. The expert opines that the failure to refer the plaintiff for a mammogram after her initial visit or subsequent visits to Dr. Zilberstein, despite the plaintiff requesting a referral, is a departure from the standard of care. Id. This failure “directly contributed to the delayed diagnosis of her cancer at a more advanced stage...limited her treatment options but also worsened her overall prognosis.” Id. Plaintiff’s expert doctor asserts that defendants’ expert overlooked the significant family history and elevated risk scores by stating that there is no consensus in the screening guidelines for patients with the profile of plaintiff. Id, at pg. 6. Plaintiff’s expert doctor opined that the standard of care for a gynecologist with a patient with significant family histories and an elevated risk required referral to a specialist for breast cancer screening and management and the failure by Dr. Zilberstein to make such a referral was a departure. Id, at pg. 6-7.

DISCUSSION

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was

not the proximate cause of the alleged injuries. *Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v Streiter*, 83 AD3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Brinkley v. Nassau Health Care Corp.*, supra; *Fritz v. Burman*, 107 A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. City of New York*, 99 AD3d 673, 675 (2d Dept. 2012); *Bezerman v. Bailine*, 95 AD3d 1153, 1154 (2d Dept. 2012); *Stukas v. Streiter*, at 24. A plaintiff succeeds in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused plaintiff's injury. *Contreras v Adeyemi*, 102 AD3d 720, 721 (2d Dept. 2013); *Gillespie v New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Semel v Guzman*, 84 AD3d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas*, at 24.

After oral argument and a review of the papers, the Court finds that the defendants have sustained their burden of showing that they did not depart from good and accepted medical standards of care. The burden then shifted to plaintiff to provide evidence to the Court that the defendants did in fact deviate from the accepted standards of medical care, raising a triable issue of fact. The Court finds that plaintiff has not sustained her burden. "Where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment." *Díaz v. New York Downtown Hosp.*, 99 NY2d 542 (2002).

Plaintiff's expert surgeon opinion was speculative in stating that "If a mammogram had been performed following the MyRisk assessment it is more likely than not that the imaging would have detected the cancer at an earlier stage" and "it is more likely than not that the imaging would have revealed a tumor in the range of 1.5 to 2 cm in size, corresponding to Stage IIA breast cancer, irrespective of the density of the breast." Aff. In Opp. Exh. 1 at pg. 9-10. Plaintiff's expert surgeon continued to speculate when they said "Had Ms. Gardiner been referred and undergone a mammogram following her initial visit, which should have occurred approximately nine months prior to her eventual diagnosis, it is more likely than not that the imaging would have revealed a tumor in the range of 1.5 to 2 cm in size, corresponding to Stage IIA breast cancer, irrespective of the density of the breast. At this stage, the cancer would have been invasive but still confined to the breast tissue, with limited or no lymph node involvement. The earlier detection at this stage would have offered a significantly better prognosis, with a five-year survival rate of approximately 90%." Id. at pg. 10. This is purely conclusory. Saying that screening after the initial visit or after the MyRisk assessment more likely than not would have found the tumor at an earlier stage is clearly speculative, as there is nothing to say that the tumor would have been there to find. At the time that plaintiff first visited Dr. Zilberstein, the NCCN screening guidelines did not call for plaintiff to be referred for screening. The recommendations with the MyRisk assessment also did not call for screening at that time. The plaintiff's five-year risk of developing cancer was 1.1% according to the MyRisk assessment. The NCCN screening guidelines at the time of the MyRisk assessment, as well as at the time of plaintiff's visits with Dr. Zilberstein, stated that for women who have a lifetime risk greater than 20% as defined by models that are largely dependent on family

history and are asymptomatic, the annual screening mammogram should begin 10 years prior to the youngest family member but not prior to age 30. Mot. Exh. S at pg. 7. The Memorial Sloan Kettering Cancer Center Breast Cancer Screening Guidelines also state that annual mammograms for patients at high risk for development of breast cancer should commence “no later than 10 years before the youngest age that a close blood relative was diagnosed with cancer. Do not start earlier than age 25.” Reply Exh. W at pg. 2. Plaintiff did not present to Dr. Zilberstein with any breast symptoms until June 29, 2018, when Dr. Zilberstein immediately referred her for a mammogram. The Court finds that the defendants complied with the screening guidelines in place at the time of the plaintiff’s care and treatment from defendants. Plaintiff’s conclusory expert opinions using hindsight to say that plaintiff should have been referred for screening at a time that the screening guidelines and the low five-year risk did not call for it, cannot be used to raise a triable issue of fact. “In opposition, the plaintiffs failed to raise a triable issue of fact, as their expert’s opinion....was conclusory, speculative, and based largely on hindsight reasoning.” *Ortiz v. Wyckoff Heights Med. Ctr., et al*, 149 AD 3d 1093, 1095 (2d. Dept. 2017).

Plaintiff’s expert surgeon states that the standard of care was “to initiat[e] regular mammography earlier than the general population.” Aff. In Opp. Exh. 1 at pg. 9. Plaintiff fails to provide any evidence or support for what is considered “earlier than the general population.” What is the standard of care for the general population and how does it differ from this case? What would be earlier? Plaintiff cannot create an issue of fact for a departure from the standard of care that is unsupported by citation to any medical authority.

Plaintiff alleges that Dr. Zilberstein should have referred the plaintiff to a breast surgeon, a general surgeon or another specialist for further treatment at the time of her first visit with Dr. Zilberstein and especially after the MyRisk test results were received. The Court finds that neither the complaint, the Bill of Particulars (“BP”) nor the Supplemental BP specifically mention claims for failure to refer to a general surgeon, specialist or other specialist. Plaintiff’s BP alleges claims for “failing to promptly, properly, timely and urgently refer and follow the plaintiff radiologically and clinically” and “in failing to promptly, properly, timely and urgently refer the plaintiff to a radiologist, oncologist and breast surgeon” on page 4 of the Bill of Particulars. Mot. Exh. D. “A plaintiff cannot, for the first time in opposition to a motion for summary judgment, raise a new or materially different theory of recovery against a party from those pleaded in the complaint and the bill of particulars” *Anonymous v. Gleason, M.D., et al.*, 175 AD 3d 614, 617 (2d Dept. 2019).

As to plaintiff’s claim for failure to refer to a breast surgeon, nowhere in the plaintiffs’ expert opinions does it state what the standard of care is for referral to a breast surgeon. The plaintiff’s expert surgeon states that a surgeon would have referred the plaintiff for a mammogram. Plaintiff’s OB/GYN expert states that “the gynecologist standard of care involves identifying high risk patients and ensuring that they receive appropriate referrals for further evaluation and screening.” Aff. In Opp. Exh. 2 at pg 4. Nowhere do the plaintiff’s experts cite to support for their claim that the standard of care required referral to a breast surgeon at the time of plaintiff’s visits to Dr. Zilberstein and upon receiving the MyRisk test results. The NCCN Guidelines for 2018, (which the MyRisk test results base their recommendations upon) do not state that such a referral is

required. Mot. Exh. S at pg. 8.³ Plaintiff does not provide any support for her claim that the standard of care required a referral to a breast surgeon at the time of her first visit to Dr. Zilberstein or upon the receipt of the MyRisk test results. It is speculative to say that a referral to a breast surgeon would have led to the plaintiff being sent for a mammogram. Such speculation is insufficient to raise a triable issue of fact.

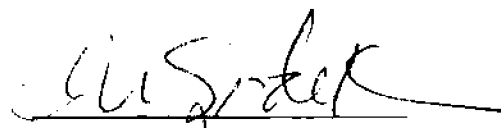
As to the lack of informed consent claims, plaintiff does not mention them at all in her Affirmation in Opposition, and therefore the claims must be dismissed.

CONCLUSION

As the Court found that plaintiff's expert affidavits were speculative and conclusory, plaintiff has failed to sustain her burden to raise a triable issue of fact. Defendants motion for summary judgment is granted and the complaint is dismissed against the defendants.

This constitutes the decision and order of the Court.

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³ The 2024 NCCN Guidelines state to consider referral to a breast specialist as appropriate. See Mot. Exh. T at pg. 12. These were not the guidelines at the time of the alleged claims in this case.