Navarrete v Del Pizzo
2026 NY Slip Op 31804(U)
April 24, 2026
Supreme Court, New York County
Docket Number: Index No. 805345/2017
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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SANDRA NAVARRETE and ELIZABETH DALY, as Co-Executors of the Estate of GARY SILBERMAN, deceased,

Plaintiffs,

- v -

JOSEPH DEL PIZZO, M.D., THE NEW YORK AND PRESBYTERIAN HOSPITAL, and THE NEW YORK-PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805345/2017

MOTION DATE 04/30/2026

MOTION SEQ. NO. 003

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 003) 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and lack of informed consent, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiffs oppose the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the lack of informed consent cause of action, and the motion is otherwise denied.

The crux of the plaintiffs' claim is that the defendants committed malpractice between October 27, 2009 and July 20, 2016 in the course of treating and providing postoperative care to their decedent, Gary Silberman. In their bill of particulars addressed to the defendant urologist Joseph Del Pizzo, M.D., as well as their bills of particulars addressed to the defendant hospitals The New York and Presbyterian Hospital and The New York-Presbyterian Hospital[1] (together

[1] The plaintiff commenced this action against "The New York and Presbyterian Hospital" and "The New York-Presbyterian Hospital." It is the court's understanding that the latter refers to the hospital located at

NYPH), they asserted that Del Pizzo departed from good and accepted medical and surgical practice by failing properly to monitor the decedent subsequent to an October 27, 2009 nephrectomy that he performed, in failing timely to perform annual check-ups, in failing timely to recommend and obtain appropriate radiology reports, and in failing to obtain and properly review subsequent postoperative radiology reports that were undertaken. They further alleged that Del Pizzo failed to take proper cognizance of the two hypoechoic lesions on the decedent's left kidney that were depicted on a May 1, 2015 radiological study and, thus, failed to prevent the metastasis of the decedent's renal cancer, and to prescribe a proper course of treatment therefor. The plaintiffs also faulted Del Pizzo for failing to recommend proper postoperative surveillance of the decedent's renal cancer, including a failure to take proper cognizance of the results of renal ultrasound scanning that was undertaken, or to recommend that the decedent undergo a computed tomography (CT) scan. They asserted that, as a consequence of these departures, the decedent was caused not only to sustain metastatic kidney cancer and lymph node metastasis, but was compelled to undergo an open left radical nephrectomy, with excision of multiple left retroperitoneal masses and chemotherapy, neither of which otherwise would have been indicated. The plaintiff additionally alleged that the decedent sustained related injuries to his pancreas, the need for multiple serial interventional radiology drainages, multiple endoscopic retrograde cholangiopancreatographies (ERCPs), and placement of a gastronomy tube. According to the plaintiffs, all of these conditions and additional procedures caused the decedent to sustain epigastric pain, abdominal scarring, blood clots, nausea, vomiting, and diarrhea. They claimed that the departures from good and accepted practice diminished the decedent's survival rate and life expectancy, leaving him with a permanent fear of recurrence of

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West 168th Street between Fort Washington Avenue and Broadway in Manhattan, while the former refers to the totality of the entity created by the merger of The New York-Presbyterian Hospital and Weill Cornell Medical Center. Regardless of the status of either of the named entities, for the purposes of this action, they will together be referred to as "NYPH" where required, and the court will refer to "Weill Cornell" where appropriate.

cancer, fear of exacerbation of the cancer when it recurred, and fear of death, along with additional physical pain and suffering, as well as a permanent inability to work and permanent loss of enjoyment of life.

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 Flanders v Goodfellow,* 44 NY3d 57, 62-63 [2025]; *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]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that 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, but 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]).

"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]). Moreover, 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 Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally 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]; *see generally Kristie M. v. Mercy Hosp. of Buffalo,* 240 AD3d 1228 [4th Dept 2025]; *Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, 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]; *Jones v Ricciardelli*, 40 AD3d 935, 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 the burden on a summary judgment motion, 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, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 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; *Luu v Paskowski*, 57 AD3d 856, 857 [2d Dept 2008]; *see also Kristal R. v Nichter,* 115 AD3d 409, 411-412 [1st Dept 2014]; *Bacani v Rosenberg*, 74 AD3d 500, 501-502 [1st Dept 2010]). 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 also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *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).

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]). 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]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d 619, 620 [3d Dept 1999], quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a physician, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the [medical] procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]). Expert testimony, however, is not necessary with respect to the issue of whether a reasonably prudent person, fully informed, would not have consented to the treatment (*see Gray v Williams*, 108 AD3d 1085, 1086-1087 [4th Dept 2013]; *Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept

2000]; *Hardt v LaTrenta*, 251 AD2d 174, 174 [1st Dept 1998]; *Osorio v Brauner*, 242 AD2d 511, 511-512 [1st Dept 1997]). "'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy the burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, were discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]). In any event, "[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.

In support of their motion, the defendants submitted, among other things, the pleadings, the plaintiffs' bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, a statement of allegedly undisputed material facts, a memorandum of law, an attorney's affirmation, and the expert affirmations of urologist Jeffrey Cadeddu, M.D., urologic oncologist M. Dror Michaelson, M.D., and abdominal radiologist Victoria Chernyak, M.D.

Dr. Cadeddu first provided a relevant history of the decedent's condition and treatment. As he explained it, on August 16, 2009, the decedent presented to the NYPH emergency department, complaining of left groin pain radiating to his left flank. A CT scan undertaken there on August 24, 2009, which had been ordered by Del Pizzo, depicted a 5-millimeter (mm) distal left ureteral kidney stone and a left renal mass measuring 2.7 centimeters (cm) by 2.5 cm that was suspicious for neoplasm. The relevant chart reflected that the decedent presented for an

initial visit at the Weill Cornell urology clinic (the clinic) on October 9, 2009, where he was seen by Del Pizzo and resident Christopher Barbieri, M.D., with the former counseling the decedent with respect to options for treatment of the mass, including laparoscopic or open excision and active surveillance. The decedent opted to proceed with a laparoscopic partial nephrectomy. On October 27, 2009, Del Pizzo performed a laparoscopic-assisted robotic left partial nephrectomy upon the decedent, with assistance from urologist Peter Stahl, M.D. As Dr. Cadeddu explained it, during the surgery, the mass was found to be adherent to the decedent's diaphragm, but was successfully dissected off of it, and that pathologists who examined the mass postoperatively concluded that it was a chromophobe renal cell carcinoma. Dr. Cadeddu asserted that Drs. Stahl and Del Pizzo reported that the tumor had extended through the decedent's kidney capsule and abutted the perinephric adipose tissue, but did not actually "involve" that tissue, while the surgical margin was negative for carcinoma. The decedent was discharged to his home on October 30, 2009.

According to Dr. Cadeddu, the decedent presented to the clinic for a postoperative follow-up appointment on November 11, 2009, where he was seen and examined by Dr. Barbieri and attending urologist Gilbert Wise, M.D. Dr. Cadeddu asserted that a physical examination of the decedent that was undertaken on that date was unremarkable, with Drs. Barbieri and Wise reporting that the decedent was doing well and that his pain had abated somewhat, while they provided him with an "excellent prognosis," directing him to return to the clinic in three months, and undergo a CT scan in six months. Dr. Cadeddu asserted that Del Pizzo was not present at or involved with this appointment. He further averred that the decedent did not return to the clinic for a follow-up visit, and did not undergo the CT scan as directed, instead waiting more than two years, until July 27, 2012, to contact Del Pizzo and the clinic, at which time the decedent requested that Del Pizzo order a renal scan.

In response to the decedent's July 27, 2012 request, Del Pizzo's office placed an order for a CT scan of the decedent's abdomen and pelvis, which was performed at Zwanger-Pesiri

Radiology on August 15, 2012, after which the radiologists delivered a report to Del Pizzo, who reviewed it. According to Dr. Cadeddu, the CT scan report noted postoperative changes along the lateral aspect of the decedent's left kidney, an associated tiny nodularity that was suspected to have been generated postoperatively, and a tiny hypodense focus in the lower pole of the left kidney that was too small to characterize.

On April 24, 2013, the decedent presented to internist Mary Mattheos, M.D., complaining of nausea, diarrhea, bloating, and gas. As Dr. Cadeddu explained it, an abdominal sonogram taken on April 26, 2013 showed a heterogenous lesion in the mid-pole of the decedent's left kidney, upon which Dr. Mattheos referred the decedent to a gastroenterologist. Nonetheless, the decedent returned to see Dr. Mattheos on May 6, 2013, after his symptoms worsened, upon which she referred the decedent to a urologist other than Del Pizzo. On May 13, 2013, the decedent presented to urologist Aaron Woodall, M.D., at Suffolk Urology Association, who recorded the decedent's history of laparoscopic partial nephrectomy, reviewed the April 26, 2013 ultrasound scan, and recommended that the decedent submit to a follow-up CT scan or sonogram. On the same day as his visit with Dr. Woodall, the decedent called Del Pizzo's office to discuss his recent sonogram, as well as Dr. Woodall's suggestion that he might need surgery for a renal cyst. On May 14, 2013, Del Pizzo returned the decedent's call and left him message, while also leaving a message for Dr. Woodall. On May 17, 2013, the decedent again called Del Pizzo's office, spoke with the latter's receptionist, and explained that he wanted to speak with Del Pizzo about the results of an outside magnetic resonance imaging (MRI) scan that the decedent had undergone. After the message was forwarded to Del Pizzo, he reviewed the MRI report that same day, and returned the decedent's call, asking the latter to send him the actual MRI images so that he could review them, and told the decedent to undergo a repeat MRI scan or a positron emission tomography (PET) scan six months hence to ensure stability. According to Dr. Cadeddu's interpretation of the relevant medical records and deposition testimony, the decedent did not contact Del Pizzo until August 22, 2013, on which date the decedent called Del

Pizzo's office and spoke with a receptionist, who sent Del Pizzo a message, informing the doctor that the decedent wanted to speak with him about a recent emergency department presentation. Del Pizzo allegedly spoke with the decedent later that day, and again discussed the May 16, 2013 MRI results, thereupon formulating a plan for the decedent to undergo a repeat MRI scan in one to two months, and explaining that, if the renal mass were enlarging, the decedent was to schedule a PET scan and/or biopsy.

Del Pizzo purportedly did not have contact with the decedent until May 5, 2015, when the decedent called his office, spoke with his receptionist, and explained that he wanted to discuss recent ultrasound results with Del Pizzo. After leaving a message for the decedent that day, the decedent did not again call Del Pizzo until May 11, 2015, when the decedent again spoke with a receptionist, upon which Del Pizzo returned the call later that day, but had to leave a voicemail message, which the decedent purportedly did not return.

On July 7, 2015, the decedent called Del Pizzo to inform the latter that he was not feeling well and to request a CT scan, a request to which Del Pizzo acceded, after which the decedent underwent such a scan at Zwanger-Pesiri Radiology. According to Dr. Cadeddu, the resulting radiology report indicated that there were multiple new left perinephric masses that were "worrisome" for recurrent and metastatic hypernephroma. Dr. Cadeddu explained that Del Pizzo called the radiologist on July 8, 2016, who confirmed that the masses had not been identified on prior scans, after which Del Pizzo contacted the decedent, and directed the decedent to obtain a copy of the study and bring it to NYPH for review. Dr. Cadeddu averred that, on July 19, 2016, the decedent presented to the NYPH emergency department with complaints of dysuria and left flank pain for the prior three days, informing emergency room personnel that he had undergone a CT scan two weeks earlier that showed a 5 cm midpole left renal mass, in addition to multiple left perinephric masses measuring as large as 8 cm, which he had been told were concerning for metastatic disease. NYPH admitted the decedent to its inpatient facilities, where the decedent underwent a left thoracoabdominal radical nephrectomy

on July 20, 2016, with excision of multiple left retroperitoneal masses, excision of the diaphragm, and the placement of a chest tube, which was performed by urologist and urologic oncologist Douglas Scherr, M.D. Pathology reports indicated the presence of metastatic renal cell carcinoma, chromophobe type.

On September 12, 2016, the decedent underwent an ERCP that revealed a pancreatic duct tail leak, with pancreatic fluid collection, upon which surgeons placed a biliary stent and pigtail drain. According to Dr. Cadeddu, on February 27, 2017, an abdominal and thoracic CT scan of the decedent revealed the presence of left supraclavicular lymphadenopathy, which he concluded likely represented metastasis. On January 2, 2019, the decedent underwent another CT scan of the abdomen and pelvis, this time at Memorial Sloan Kettering Cancer Center (MSKCC), which reportedly showed multiple left retroperitoneal, abdominopelvic, and left rectus sheath masses consistent with metastases, while a January 8, 2019 MRI showed multiple left retroperitoneal, abdominopelvic, and left rectus sheath masses, which oncologist Deaglan McHugh, M.D., characterized as unequivocal metastatic progression of primary renal carcinoma. The decedent died on July 26, 2020 from complications of renal cell carcinoma.

Dr. Cadeddu opined that the treatments that Del Pizzo rendered to the decedent were appropriate, and that his subsequent treatment recommendations were consistent with the applicable standards of care. More specifically, he concluded that Del Pizzo's recommendation that the decedent undergo a left ureteroscopy/holmium laser lithotripsy, with cystoscopy and ureteral stent placement, was appropriate in light of the CT scan depicting a 5 mm distal left ureteral stone, and that Del Pizzo properly performed this procedure. In this respect, Dr. Cadeddu asserted that the stone was successfully fragmented by the laser, and all fragments were retrieved and subsequently biopsied, while there were no complications associated with the procedure, and the ureteral stent was thereafter successfully removed on August 26, 2009. He additionally concluded that Del Pizzo appropriately performed the October 27, 2009 laparoscopic assisted left partial nephrectomy, and that there were no complications associated

with that surgery. As he explained it, the mass was adherent to the diaphragm, but Del Pizzo successfully dissected it off of the decedent's diaphragm, while pathology studies showed that the entire mass was removed, since the surgical margin was negative for carcinoma.

Dr. Cadeddu stated that the pathology studies revealed the mass that was removed in 2009 was a chromophobe renal cell carcinoma that had not metastasized and that, consequently, the prognosis for a patient such as the patient, who had undergone a successful resection, was "excellent." As he described it, it is exceedingly rare for chromophobe renal cell carcinoma to recur and that, in light of the decedent's prognosis and uneventful postoperative course, it was appropriate for clinic personnel to recommend that he return to the clinic three months after the surgery, and to undergo a follow-up CT scan six months after the surgery. According to Dr. Cadeddu, at that juncture, simple monitoring would have been the proper approach for the future care of the decedent.

Dr. Cadeddu noted that Del Pizzo did not see the decedent in the clinic after the latter was discharged from NYPH following the October 27, 2009 partial nephrectomy, explaining that, inasmuch as the surgery had been successfully completed, and the decedent was not experiencing any postoperative complications, follow-up monitoring was arranged with the clinic, which Dr. Cadeddu characterized as a "reasonable" approach. Moreover, he approved of Del Pizzo's conduct in ordering the August 15, 2012 CT scan upon the decedent's request, made almost three years after the nephrectomy, noting that the imaging report of the scan did, in fact, reveal postoperative changes, but that it did not contain any concerning findings that warranted further workup and treatment. Hence, Dr. Cadeddu concluded that further immediate action was not necessary. He further explained that Del Pizzo properly scanned the CT report into the appropriate electronic medical records system, so that it could be accessed by clinic personnel, and recommended that the decedent follow up with those medical providers.

According to Dr. Cadeddu, Del Pizzo did not again interact with the decedent until May 13, 2013, when the latter called Del Pizzo for a second opinion regarding treatment that had

been recommended by Dr. Woodall. Dr. Cadeddu concluded that Del Pizzo appropriately recommended that the decedent undergo an MRI for further evaluation of a possible renal cyst, explaining that an MRI is more sensitive than a CT scan and, therefore, provides a better images of the relevant structures. He further noted that, after this conversation, Del Pizzo called Dr. Woodall's office, and left a message confirming with Dr. Woodall's receptionist that the decedent was Dr. Woodall's patient. Dr. Cadeddu stated that, at that point, it was "understandable" for Del Pizzo to have concluded that Dr. Woodall, rather than Del Pizzo, was the decedent's primary treating urologist going forward. In any event, he averred that Del Pizzo, upon reviewing the MRI report, properly spoke with the decedent and asked or a copy of the May 16, 2013 MRI films. He attested that Del Pizzo's recommendation that the decedent obtain a repeat MRI or PET scan in six months scan was appropriate, particularly since Del Pizzo had, at that point, been unable to review the MRI films. In any event, Dr. Cadeddu asserted that the findings set forth in the MRI report indicated that the images "were non-specific and largely suggestive of post-operative changes." Hence, he concluded that it was perfectly reasonable, based on the MRI report only, for Del Pizzo to concur with the radiologist and recommend only further monitoring. Upon reiterating his opinion that the recurrence of chromophobe renal cell carcinoma is incredibly rare, and that the likelihood of a recurrence requiring intervention is very low, it was reasonable for Del Pizzo to have recommended a repeat MRI in six months.

Dr. Cadeddu further opined that, after the decedent waited an additional three years to contact Del Pizzo, the latter properly reviewed an early July 2016 CT imaging report on July 8, 2016, appropriately called the reviewing radiologist to confirm that the masses had not been identified on the previous scans, and correctly requested copies of the film. As Dr. Cadeddu framed the issue, upon "[u]nderstanding the severity and urgency of the situation," Del Pizzo also properly requested that the decedent obtain a copy of the films and bring them to Del Pizzo's office, upon which Del Pizzo reviewed the CT images and presented the case

at an oncology conference, which yielded a consensus that additional surgery was indicated. Specifically, he explained that the decedent's new masses extended to the diaphragm, and that Dr. Scherr thus would need to perform an open procedure. Dr. Cadeddu concluded that Del Pizzo acted promptly and appropriately once informed of the findings of the CT scan report, and thus was able to provide the decedent with a recommended treatment plan when the two of them spoke on the phone on July 11, 2016, which was only four days after the CT scan was performed. He opined that "[t]here was absolutely no delay with respect to the diagnosis or treatment of Mr. Silberman's cancer recurrence after Dr. Del Pizzo became aware of a possible recurrence upon receipt of the CT report," and that the treatment plan that Del Pizzo recommended to the decedent was well within the standard of care, since Del Pizzo did not simply refer the decedent to other physicians for further workup, but instead took it upon himself to consult with oncologists in order to prepare a treatment plan as quickly as possible.

In any event, Dr. Cadeddu opined that earlier diagnosis of the recurrence of the decedent's renal cancer would not have negated the need for additional surgical resection. As he explained it, once cancer is suspected, the standard of care is to have it surgically removed so that the concerning mass can be submitted for pathology analysis. Moreover, he averred that the decision to perform a laparoscopic or open procedure is exclusively within the purview of the operating surgeon, who, in this case, was Dr. Scherr. Dr. Cadeddu further concluded that it was reasonable for Dr. Scherr to perform an open procedure, given the location of the tumor and involvement of the diaphragm, the fact that it was a recurrence, and the likelihood of adhesions. He conceded, however, that, once the decision was made by Dr. Scherr to perform an open procedure, there was an inherent risk of damage to the organs in the surgical field, including the pancreas, and he asserted that "[i]njury to the pancreatic duct was a possibility and known and accepted complication of removing the kidney regardless of when the surgery was performed." Dr. Cadeddu explained that, in this respect, there were substantial adhesions

present in the operating field during Dr. Scherr's surgery that complicated the procedure. He stated that it was highly likely that,

> "given the absence of any documentation of Dr. Scherr removing nodules or masses from the pancreas, that the pancreatic duct injury occurred when the adhesions were being taken down. These adhesions would have been present whether Mr. Silberman underwent surgery in 2016 or years earlier,"

explaining that adhesions are bands of scar tissue that can form after surgery, even if the surgery is uncomplicated and performed properly. He concluded that the adhesions that were found during the July 2016 surgery were a result of the October 27, 2009 surgery and, therefore, would have developed shortly after that earlier surgery, and would have been present whether the decedent underwent surgical resection in 2012 or 2016. Dr. Cadeddu thus asserted that any alleged delay in diagnosis of the recurrence of the decedent's renal cell carcinoma did not affect the surgical treatment rendered to the decedent, and did not cause the subsequent pancreatic duct injury that ultimately was addressed on September 12, 2016.

Dr. Michaelson also opined that the treatment that the defendants rendered to the decedent was at all times within the standard of care. After recounting the decedent's medical history, he concluded that Del Pizzo properly performed the October 27, 2009 laparoscopic assisted left partial nephrectomy, agreed with Dr. Cadeddu that there were no complications associated with the surgery, and stated that pathology studies indicated that the entire mass was removed, inasmuch as the surgical margin was negative for carcinoma. He concurred with Dr. Cadeddu's opinion that the mass was a chromophobe renal cell carcinoma, and agreed with Dr. Cadeddu that the likelihood of recurrence was slight, calculating it as less than 5%. Dr. Michaelson thus expressly agreed with Dr. Cadeddu's opinion that it thus was appropriate for clinic medical personnel to recommend that the decedent return to the clinic in three months and undergo a follow-up CT scan in six months, since monitoring would be the proper approach going forward and would have satisfied the standard of care, while radiation and chemotherapy were not appropriate treatment options for localized renal cell carcinoma.

According to Dr. Michaelson, chromophobe cell carcinoma is easily treatable if it is diagnosed while it is still contained within the kidney, as it was in the decedent's case. He asserted that, generally, the mass can be removed surgically, and that removal is more often than not completely curative. Dr. Michaelson averred that, in the decedent's case, in which the mass was contained entirely within the kidney, and had been successfully resected, with pathology studies showing clean margins, "the likelihood of metastases or recurrence of chromophobe cell carcinoma was less than 5%." Moreover, he stated that the 2012 CT scan showed no evidence of metastases or recurrence and, therefore, required no action. Since, however, the May 16, 2013 imaging revealed enhancing nodules, which were suspicious for metastatic disease, Dr. Michaelson concluded that Del Pizzo appropriately recommended a follow-up scan in six months, consistent with the reviewing radiologist's recommendation. He further noted that Del Pizzo reminded the decedent on August 22, 2013 of the need for the follow-up study, and also advised the decedent that he might need a PET scan and/or biopsy if there were an enlargement of the masses, recommendations that Dr. Michaelson described as appropriate. He further noted that the decedent failed to follow those recommendations.

Dr. Michaelson asserted that, ultimately, the decedent's recurrent chromophobe renal cell carcinoma already was incurable by the time that the decedent underwent the May 16, 2013 MRI scan. As he explained it, despite undergoing a radical nephrectomy, areas of metastatic disease will remain in an individual with metastatic renal cell carcinoma. Thus, according to Dr. Michaelson, by May 16, 2013, the decedent's cancer had spread beyond the kidney and into the retroperitoneum, rendering surgical resection non-curative. He stated that, given the lack of effective systemic therapy for chromophobe renal cell carcinoma, the cancer was incurable as of May 2013. Dr. Michaelson thus concluded that, even had the decedent begun receiving treatment for a recurrence in 2013, the outcome of his illness would not have changed since, once chromophobe renal cell carcinoma has spread beyond the kidney, it is generally incurable, as chemotherapy has proven to be ineffective.

As Dr. Michaelson described it, systemic therapies such as such as Opdivo, Cabrometyx, Avastin, and Affinitor can be administered to patients such as the decedent for palliative purposes, but none is curative for metastatic renal cell carcinoma, but may still be administered with the hope that they might have some positive effect. He also asserted that such tumors are unresponsive to radiation. Dr. Michaelson ultimately concluded that, although the treatment rendered and recommended by Del Pizzo to the decedent was within the standard of care, "there was nothing that Dr. Del Pizzo could have done to prevent the progression of Mr. Silberman's disease, and his subsequent injuries, including pancreatitis," and that nothing that Del Pizzo did or did not do proximately caused the progression of the decedent's cancer.

Dr. Chernyak agreed with Drs. Cadeddu and Michaelson that the May 16, 2013 MRI scan that the decedent underwent depicted a recurrence of the decedent's chromophobe renal cell carcinoma. She asserted that the scan reflected the presence of at least nine recurrences in the perirenal space to the left of the decedent's left kidney, and concluded that the location of these recurrences in the fat surrounding the kidney indicated that, at the time of the MRI, the cancer was no longer confined to the left kidney, and had therefore metastasized. She expressly concluded that neither the August 2009 nor the August 2012 scans had shown evidence of cancer recurrence or metastases and that, consequently, the recurrence must have arisen between August 2012 and May 2013. She further opined that the follow-up radiology studies that Del Pizzo recommended to the decedent were at all times consistent with the standard of care, and conformed with the radiologists' recommendations.

More specifically, Dr. Chernyak asserted that the 2012 CT scan did not reveal any concerning findings and that, therefore, an immediate change to the recommended routine surveillance was not necessary. Nonetheless, she explained that, when Del Pizzo noted the enhancing soft tissue structures described in the May 16, 2013 MRI report, he recommended a repeat MRI in six months, and a possible PET scan and/or biopsy in the future, recommendations that she characterized as "consistent with the reviewing radiologist's

recommendations, and well within the standard of care for monitoring potential recurrences of chromophobe renal carcinoma from a radiographic perspective."

In addition, the defendants argued that any claims for malpractice arising from the allegedly negligent postoperative surveillance of the decedent from October 27, 2009 through July 8, 2014 were barred by the applicable two-year-and-six month limitations period set forth in CPLR 214-a, since there was no continuous treatment by the defendants during that period of time that would have tolled the limitations period. Hence, they contended that the only claims that were timely asserted by the plaintiff were for acts of negligence that occurred on or after March 15, 2015, which was the date two years and six months prior to the September 15, 2017 commencement date of this action. Specifically, they argued that the mere fact that Del Pizzo reviewed radiological imaging scans between October 27, 2009 and July 8, 2014 did not constitute "treatment" within the meaning of CPLR 214-a.

In opposition to the defendants' motion, the plaintiffs relied on many of the same documents that the defendants had submitted, and also submitted additional medical records, an audit trail referable to the defendants' electronic medical records, a response to the defendants' statement of material facts, a memorandum of law, an attorney's affirmation, and the expert 44-page, 82-footnoted affirmation of a board-certified urologist with experience in urological oncology, and an expert affirmation of a board-certified radiologist.

The urologist reiterated the decedent's medical history in granular detail, and included long quotations from relevant medical records. The history that this expert recounted was essentially the same as that described by the defendants' experts, although the plaintiffs' expert also noted that the March 22, 2017 chart from MSKCC described, in more detail, the injury that the decedent sustained to his pancreas during the final resection surgery, noting that it required a total of six endoscopic procedures, necessitating serial readmissions for a period of over three months postoperatively, with the decedent suffering significant deconditioning and the loss of 50 pounds. The MSKCC chart reported that the decedent eventually recovered and had been

placed under the care of medical oncologist Scott Tagawa, M.D., at Weill Cornell. That chart further reported that a February 27, 2017 CT scan revealed the presence of a 2.4 cm left cervical mass, a 3 cm mass between the sigmoid colon and the right seminal vesicle, and, incidentally, a pulmonary embolus and left iliac deep vein thrombosis. In addition, the chart indicated that MSKCC oncologist Martin Voss, M.D., elected to place the decedent under active surveillance in lieu of performing resection or a biopsy of the two newly identified masses, or in starting systematic treatment, because the decedent was still recovering from his many months in the hospital undergoing numerous procedures. The plaintiffs' urologist further noted that, on March 5, 2019, the decedent was, in fact, started on systemic therapy, consisting of the administration of Opdivo and Cabometyx, which was later switched to Avastin and Afinitor, but that the decedent died approximately 18 months thereafter.

The plaintiffs' retained urologist concluded that the defendants departed from good and accepted medical practice in providing insufficient care to the decedent from October 27, 2009 through July 20, 2016, and that their departures were a proximate cause of, and a substantial factor in, amongst other things, the delay in the decedent's ability to obtain proper postoperative surveillance radiology, the delay in an appropriate diagnosis of the recurrence of the decedent's cancer, the delay in providing the appropriate treatment for that recurrence, and the continued progression of the decedent's cancer, which led to his pancreatic tail injury, the need for additional surgery and procedures, the need for further presentations and hospitalizations, physical disabilities, his extensive pain and suffering, and ultimately, his death.

The urologist explained that chromophobe renal cell carcinoma is the third most common pathological type of renal cell carcinoma, is often diagnosed incidentally on radiology studies, and typically has a better prognosis than other renal cell carcinomas. This expert asserted that most persons suffering from chromophobe renal cell carcinoma are completely asymptomatic when they are diagnosed, but, if they do present symptoms, the disease typically presents as lower back or flank pain or hematuria. According to the plaintiffs' urologist, in

addition to radiological studies, urinalysis and blood testing can aid in diagnosing chromophobe renal cell carcinoma, while definitive diagnosis of the disease can be made via surgical excision of the tissue during a partial or radical nephrectomy, or a biopsy of the tissue. and that, in both cases, the tissue is sent to a pathology laboratory to confirm the diagnosis. The plaintiffs' urologist asserted that, when chromophobe renal cell carcinoma metastasizes, possible symptoms could include bone pain, weight loss, fever, cough, and/or leg swelling.

The plaintiffs' urologist asserted that patients with chromophobe renal cell carcinoma typically are diagnosed at an earlier stage than those with other subtypes of renal cell carcinoma because chromophobe renal cell carcinoma is an "indolent" cancer, with a growth rate of approximately about 0.38 cm to 0.5 cm per year. The expert asserted that, although the disease is typically indolent, it nonetheless can recur, progress, metastasize, and cause death, and, thus, patients with chromophobe renal cell carcinoma require postoperative surveillance for the duration of their lives. The urologist further concluded that, with or without lymph node involvement, surgery is the "gold standard" of treatment for patients who have been diagnosed with Stage 1, 2, or 3 chromophobe renal cell carcinoma, and that, depending on the size of the cancer and the expertise of the surgeon, the surgery can be a partial or radical nephrectomy, but that, for those suffering from Stage 4 chromophobe renal cell carcinoma, surgery will not cure the disease, but can only mitigate its symptoms. As the expert framed the issue, for those who have been diagnosed with Stage 4 chromophobe renal cell carcinoma, in addition to surgery, systemic therapy can be employed in an attempt to slow the tumor's growth and perhaps extend the patient's life.

Contrary to the defendants' contention, the plaintiffs' radiologist, relying upon the decedent's deposition testimony, asserted that, upon the decedent's October 30, 2009 discharge from NYPH following the October 27, 2009 surgery, Del Pizzo directed the decedent to follow up with Del Pizzo himself, and not the clinic, and that the decedent did, in fact, follow up with Del Pizzo, who formulated a postoperative surveillance plan consisting of yearly scans,

unless Del Pizzo indicated otherwise. The expert, adverting to the relevant chart, rejected Del Pizzo's contrary testimony to the effect that the decedent did not remain his patient, and opined that, even had primary responsibility for the decedent's care been transferred to the clinic, the physician-patient relationship between the decedent and Del Pizzo had not been severed thereby. Rather, the plaintiffs' urologist asserted that Del Pizzo, as the surgeon, should indeed have discussed and documented a detailed postoperative surveillance plan, and that any failure to formulate a more detailed plan constituted a departure from good and accepted medical practice. In this respect, the expert opined that, if Del Pizzo indeed intended to transfer the decedent's treatment to the clinic "it was incumbent on Dr. DelPizzo to explicitly document the transfer of Gary's care (e.g., office note, referral slip, etc.), and to confirm that both the Clinic and Gary understood that to be the case," and that Del Pizzo's failure to document this arrangement was a departure from good and accepted medical practice, as was NYPH's failure clearly to articulate a postoperative surveillance plan.

The expert urologist additionally opined that NYPH departed from good and accepted medical practice for failing affirmatively to schedule the decedent's three-month follow-up visit at the latter's November 11, 2009 visit, and for failing to order the CT scan on a date six months after the November visit. Instead of leaving it to the decedent himself, the expert explained that, had NYPH ordered these future visits, it would, at the very least, have provided control dates for the clinic to reference so that, in the event that the decedent missed any of those dates, the clinic would have known to contact the decedent for rescheduling. In this respect, the plaintiffs' urologist explained that the scheduling of a postoperative CT scan is "imperative for a cancer patient because it provides a postsurgical baseline from which to compare future surveillance scans." Instead, the expert stated that, the failure to schedule the follow-up postoperative visit and the CT scan the proper "postoperative surveillance" of the decedent "unnecessarily slipped through the cracks."

In any event, the plaintiffs' retained urologist expressly disagreed with Dr. Cadeddu that it was appropriate for the clinic merely to "recommend" that the decedent return in three months and undergo a follow-up CT scan in six months. As the expert described this issue,

> "[f]irst, Dr. Barbieri's note and Dr. Wise's note have conflicting plans as it pertains to a follow-up CT scan. Dr. Wise, the Attending, simply wrote to follow up in 3 months, while the Resident, Dr. Barbieri, wrote 'RTC after 3 months, CT scan in 6 months.' Second, there is no proof that either plan was communicated to Gary (i.e., no orders, no subsequent missed appointment letters, no phone calls, and no testimony from either doctor). As mentioned, *it was incumbent on the Clinic to schedule both the visit in 3 months and the CT scan in 6 months to ensure that, at minimum, there was a control date for Gary's treatment.* While recurrence of chromophobe renal cell carcinoma is very low (5-10%) after a Stage 1 diagnosis, it is more likely to recur after partial nephrectomy than radical nephrectomy, and the rate of recurrence is never 0% (i.e., it requires continued postoperative surveillance for life with the frequency of the scans changing over time based on the radiology findings or lack thereof). It was a departure from good and accepted medical practice, for NYPH, Dr. Del Pizzo, and the Clinic to allow Gary's postoperative surveillance to slip through the cracks. Given that all parties had Gary's contact information, they should have ensured that Gary was either going to follow up with them or not"

(emphasis added). The expert explicitly concluded that each of the 2009 departures that was identified was a proximate cause of, and a substantial factor in, all of the delays, attendant failures to diagnose recurrent renal cancer, and the several surgeries necessary to address it.

With respect to the defendants' engagement with the decedent in May and June 2010, the plaintiffs' retained urologist pointed out that, upon reviewing the audit trail of the decedent's chart, it was apparent that Del Pizzo had then accessed the chart, and thereupon reviewed the Tumor, Node and Metastasis (TNM) Staging Sheet, which identified Del Pizzo as the decedent's "Managing Physician." The expert asserted that, despite reviewing the sheet, Del Pizzo failed to do anything in furtherance of the decedent's postoperative surveillance plan and also failed to review the remainder of the chart in order to review the decedent's actual postoperative surveillance history. The plaintiffs' urologist further asserted that Del Pizzo failed to schedule a follow-up visit with the decedent, failed to order the decedent's baseline postsurgical abdominal CT that had been referenced the November 11, 2009 note, and failed to provide the decedent with a prescription to obtain such a scan. The plaintiffs' expert urologist opined that these

failures constituted departures from good and accepted medical practice. According to this expert, if Del Pizzo actually believed that the decedent were a patient of the clinic, rather than his personal patient, upon reviewing the TNM Staging Sheet, he should have alerted the clinic to the existence of the sheet, thereupon forwarded it to the clinic, and thereafter confirmed with the clinic that the decedent's postoperative care was under the clinic's auspices. The expert opined that these failures also constituted departures from good and accepted medical practice. According to the expert urologist, the decedent's chart "was accessed again multiple times after that in 2010, but neither Dr. DelPizzo nor the Clinic did anything in furtherance of" the decedent's postoperative surveillance plan, such as dispatching a missed appointment letter, scheduling an appointment, initiating telephone calls, or ordering or prescribing CT/MRI scans. The urologist similarly characterized these omissions as departures from good and accepted medical practice that proximately caused the decedent's delay in obtaining postoperative surveillance radiology, in obtaining a diagnosis of the recurrence of his cancer, and in obtaining appropriate treatment for the recurrence, as well as a proximate cause of the continued progression of his cancer, all of which, according to the expert, led to his pancreatic tail injury, the need for additional surgery, the need for further presentations and hospitalizations, the onset and exacerbation of the decedent's physical disabilities, and "his extensive pain and suffering, which culminated in his untimely demise."

According to the plaintiffs' expert urologist, in May 2011, Del Pizzo, but not the clinic, accessed the decedent's chart, but nonetheless failed to contact the decedent for any reason. The expert explained that, inasmuch as Del Pizzo was the operative surgeon, and, according to NYPH, the managing physician, this failure was a departure from good and accepted medical practice. The expert asserted that, if DelPizzo were seeking "to incorrectly shift the blame onto the Clinic, [then] NYPH, likewise, failed to call" the decedent about any missed visit and failed to take the required steps, as described above, or properly to implement the decedent's postoperative surveillance plan, despite the fact that the decedent was by then two years

removed from the surgery, without any evidence of that a baseline postsurgical imaging scan had been undertaken. If that were the case, the expert nonetheless concluded that NYPH itself would be responsible for these failures. The expert expressly asserted that these departures were a proximate cause of the injuries that he described in connection with the departures identified in connection with 2009 and 2010.

As the expert described it, inasmuch as Del Pizzo finally placed an order for the decedent to undergo an abdominal and pelvic CT with contrast on July 27, 2012, with a diagnosis of "malignant neoplasm of kidney, except pelvis," Del Pizzo indeed maintained a continuing physician-patient relationship with the decedent. Notably, the plaintiffs' urologist asserted that Del Pizzo ordered the CT scan without ever having spoken with the decedent or reviewing his chart. Hence, the expert concluded that Del Pizzo could not have known what, if any, complaints that the decedent had at that time, such as hematuria, weight loss, or pain, whether the decedent had undergone any radiology scans since August 2009 through July 27, 2012, or if the decedent was treating with any other urologist at that time. According to the plaintiffs' expert urologist, Del Pizzo's failure to speak with or conduct an in-person visit with the decedent were departures from good and accepted medical practice. In this respect, the expert reiterated that, if Del Pizzo thought that the decedent had been the patient only of the clinic, Del Pizzo should have personally discussed that issue with the decedent in 2012, which would have ensured that there was no misunderstanding as to who the decedent would be following up with for continued postoperative surveillance. The urologist averred that, if the clinic was, in fact, the appropriate follow-up provider, Del Pizzo should have confirmed it with the clinic or with Marina Peralta, the person who allegedly referred the decedent to the clinic.

With respect to the issue of whether it was Del Pizzo or clinic personnel who were responsible for the generation and implementation of the postoperative surveillance plan, the plaintiffs' expert noted that, although Del Pizzo claimed that he agreed to place the order for a CT scan in 2012, Del Pizzo then told his secretary to refer the decedent back to the clinic, but

nonetheless concededly reviewed the CT report himself several weeks later, and also admitted that he never contacted the decedent to review the report. The plaintiffs' expert concluded that Del Pizzo's failure to alert the clinic both before and after ordering the scan was a departure from good and accepted medical practice, particularly because the CT report recited findings that warranted closer examination and follow up.

As the plaintiffs' expert explained it, each potential CT finding should have been viewed "in context with heightened clinical suspicion especially given that the highest rate of recurrence is within the first few years after surgical resection," as Del Pizzo himself conceded. According to the expert urologist, the findings of concern included scattered sub-centimeter retroperitoneal lymph nodes, a 0.5 cm hypodense lesion in the lower pole of the left kidney, and tiny nodularity, which, although they required surveillance at shorter intervals, neither Del Pizzo nor anyone from the clinic called the decedent after August 15, 2012, when the results of the CT scan were reported. The expert further disagreed with Dr. Cadeddu that Del Pizzo *properly* scanned the CT report into the medical record system so that it could be accessed by personnel at the clinic, since the system did not automatically alert the clinic that the report had been uploaded. With respect to the results themselves, the plaintiffs' expert explicitly disagreed with Dr. Cadeddu that the report reflected only anticipated postoperative changes since where, as here, there is a questionable finding, depending on what the finding is, good and accepted medical practice requires closer follow up in the form either of repeat radiology studies at shorter intervals, a biopsy of the questionable finding, or surgery associated along the superior-posterior aspect of the left kidney. The plaintiffs' expert noted that, inasmuch as there were no baseline imaging studies of the decedent's kidney, the reading radiologist and, hence, both Del Pizzo and clinic personnel, could and should not have "presumed" that most of the findings reflected postoperative changes. Rather, the expert contended that it was incumbent upon Del Pizzo to obtain the images underlying the CT report, and to review and discuss the findings with the reading radiologist, Elliot D. Kalker, M.D., so that Del Pizzo could provide Dr. Kalker with the

context of the decedent's condition and treatment to ensure that the reading was accurate. In any event, the expert opined that Del Pizzo should have informed the decedent about "the potentially questionable findings" identified in the CT report and thereupon recommended and ordered an MRI scan to be conducted within three to six months to ascertain whether there was growth or enhancement of the lesion. The plaintiffs' expert urologist characterized the defendants' failures in these respects to be departures from good and accepted practice that proximately caused the development and spread of the decedent's cancer.

The plaintiffs' expert urologist expressly disagreed with Dr. Chernyak's opinion that Del Pizzo's recommendations for follow-up radiology studies were consistent with the standard of care. In this respect, the expert rejected Dr. Chernyak's conclusion that, although there were no findings of concern contained in the 2012 CT report, the evidence of metastatic, incurable cancer on the 2013 MRI scan was the first time that such findings were appropriate. Rather, the plaintiff's urologist opined that the findings set forth in the August 15, 2012 CT report

> "showed evidence of recurrent kidney cancer that was concerning for Stage 3 cancer based on the 0.5 cm hypodense lesion in the lower pole of the left kidney (axial image 62 series 3) and the tiny nodularity associated along the superior-posterior aspect (image 37 series 3). These findings were concerning for cancer recurrence and spread to adjacent lymph nodes, but not for cancer spread to surrounding organs (i.e., Stage 3 not Stage 4)."

As the expert explained it, at that juncture, solely with surgical intervention, a patient's 3-year survival rate was 90% to 95%, the 5-year survival rate was 80% to 90%, and the 10-year survival rate was 60% to 70%, while, if systemic therapy also had been initiated at that time, the 3-year survival rate was 95% to 98%, the 5-year survival rate was 88% to 94%, and the 10-year survival rate was 70% to 80%.

The plaintiffs' expert conceded that, after the decedent underwent an abdominal ultrasound scan at the direction of his primary care physician in early 2013, Del Pizzo appropriately ordered an MRI scan, which resulted in a May 16, 2013 MRI report, but that Del Pizzo departed from good and accepted practice by failing to order the films of the July 2012 CT

scan that had yielded the August 15, 2012 report, in order to compare them with the May 16, 2013 MRI report. The expert further asserted that Del Pizzo should have contacted Negar Dayani, M.D., the radiologist who read the May 2013 MRI scan and prepared the May 16, 2013 report, in order to discuss whether any changes were the result of cancer recurrence or metastasis, thereupon discussed the findings with the decedent, and then ordered an immediate CT-guided biopsy or a PET scan. As the expert interpreted the May 16, 2013 report, it indicated that there was

> "evidence of recurrent kidney cancer that was concerning for Stage 3 cancer based on (1) the 1.3 x 0.8 cm small ovoid structure (seen on series 4 image 14); (2) 0.8 cm soft tissue structure abutting the crus of the diaphragm (previously visualized on the 2012 CT); (3) tiny additional soft tissue structures in the retroperitoneum (seen on series 100); (4) 0.5 cm cysts in the upper pole of the left kidney; (5) 0.7 x 0.6 cm structure in the upper pole of the kidney; and (6) a small 0.8 cm lesion in mid pole of kidney."

According to the expert, this not only was evidence of growth of the cancer, but enhancement as well, which was concerning for cancer growth and spread to adjacent lymph nodes, albeit not to surrounding organs. The urologist explained that, inasmuch as this established that the decedent was then suffering from Stage 3 cancer, either surgical intervention only, or surgical intervention plus systemic therapy, would have maintained the 3-year, 5-year, and 10-year survival rates as previously described. The expert characterized Del Pizzo's omissions in this respect as departures from accepted practice that proximately caused the decedent's injuries.

In connection with the issue of whether Del Pizzo was continuously treating the decedent at this juncture, the plaintiffs' retained urologist expressly disagreed with Dr. Cadeddu's opinion that it was "understandable" for Del Pizzo to have concluded that Dr. Woodall was the decedent's primary treating urologist going forward. The expert asserted that the evidence in the record belies that opinion, inasmuch as the decedent saw Dr. Woodall once on May 13, 2013, and never saw him again after that visit, while Dr. Woodall himself wrote a note on May 15, 2013 specifically stating that Del Pizzo was arranging for the decedent's care at that time. Moreover, the expert noted that, on May 16, 2013, the decedent underwent the

MRI scan that had been ordered by Del Pizzo, and that, on May 17, 2013, Del Pizzo discussed the MRI results with the decedent, did not forward the results to Dr. Woodall, and did not direct the decedent to return to see Dr. Woodall. Moreover, the expert asserted that Del Pizzo "admittedly" did not refer the decedent to the clinic in 2013, characterizing the contrary statements by the defendants' experts as "factually inaccurate."

Although the plaintiffs' urologist agreed with Dr. Cadeddu that it would have been appropriate for Del Pizzo to have requested the decedent to provide him with the May 16, 2013 MRI films, the urologist noted that the decedent testified that contrary to Del Pizzo's testimony, Del Pizzo never asked for them. The expert faulted Del Pizzo for failing to ensure that the latter obtained the films. The plaintiffs' retained urologist also explicitly disagreed with the defendants' experts that it was appropriate for Del Pizzo to have recommended either a repeat MRI or a PET scan within six months because the records reflected that Del Pizzo was deciding between the two modes of imaging, depending on what the May 16, 2013 imaging actually depicted; rather, the expert opined that, regardless of whether Del Pizzo obtained and reviewed the MRI films themselves, he should have immediately ordered a CT-guided biopsy or a PET scan, based solely on the MRI report. Del Pizzo's failure to do so was, according to the urologist, a departure from good and accepted medical practice that was a proximate cause of the decedent's injuries that arose from spread of the cancer. More specifically, the expert criticized, as internally inconsistent, Dr. Michaelson's opinion, joined in by Drs. Cadeddu and Chernyak, that directing the decedent to wait until mid-November 2013 to undergo an MRI or PET scan was appropriate, since Dr. Michaelson had conceded that, by May 16, 2013, chromophobe renal cell carcinoma had recurred and spread to the point where it was incurable. The expert opined that such a six-month wait gave the decedent's cancer time to continue to grow and spread, thereby making it harder to treat, either surgically or with systemic therapy, and that, based on Dr. Michaelson's opinion that the cancer had indeed recurred and spread, the

standard of care at that juncture required the defendants surgically to remove the kidney and the masses and lesions, and to discuss systemic therapy.

According to the plaintiffs' urologist, when the decedent called Del Pizzo in August 2013, which was within the window of the radiologist's recommended follow up, Del Pizzo "once again failed to appreciate that the change in radiology findings seen on the May 16, 2013 MRI that raised concern for recurrence and potential regional metastasis and required an immediate CT-guided biopsy or PET scan." The expert stated that Del Pizzo's continued failure at this juncture to order a CT-guided biopsy or PET scan, obtain the May 16, 2013 MRI images, or inquire why the decedent presented the Good Samaritan Hospital emergency room were departures from good and accepted medical practice that proximately caused the decedent's injuries.

The plaintiffs' retained urologist further faulted Del Pizzo for his failure to take any additional action after obtaining the results of the decedent's July 6, 2014 postoperative surveillance ultrasound scan from the decedent's primary care physician on September 5, 2014. The expert opined that Del Pizzo, in reviewing the report, improperly presumed that, since the questionable findings on the May 16, 2013 MRI scan were not observed on the July 6, 2014 abdominal ultrasound scan, or mentioned in the ultrasound report, the abnormalities either resolved or constituted anticipated postsurgical changes. As the urologist explained it, an ultrasound is user-dependent and less reliable than CT and MRI scans for identifying lesions smaller than 3 cm, and, thus, an ultrasound scan is not something a physician should rely upon in following cancer patients, particularly where, as here, the patient has had abnormal findings on a CT or MRI scan. The urologist asserted that Del Pizzo should have reviewed the decedent's chart at that time, inclusive of the prior radiology reports, and contacted the decedent to ascertain the decedent's physical condition. Once again, the expert concluded that Del Pizzo should have ordered an immediate CT-guided biopsy or a PET scan or, "at the very least, he should have immediately ordered Gary an MRI to determine growth, enhancement, or the stability of the 2013 findings." The expert characterized Del Pizzo's failures in these

respects as a departure from good practice that proximately caused the decedent's injuries. With respect to the treatment and surveillance of the decedent during 2014, the plaintiffs' expert pointed out that neither Dr. Cadeddu nor Dr. Michaelson rendered an opinion concerning Del Pizzo's conduct and, thus, did not establish, prima facie, that Del Pizzo did not depart from good practice over the course of that year.

On May 1, 2015, the decedent underwent another ultrasound scan at the direction of his primary care physician. According to the plaintiffs' expert, on April 30, 2015, Del Pizzo ordered a chest x-ray and a renal sonogram for the decedent but, despite placing those orders, Del Pizzo conceded that he did not know if any other physician had been following the decedent in connection with postoperative surveillance, did not know if any other tests had been conducted, and did not know if any other workup had been performed. The plaintiffs' urologist concluded that Del Pizzo's failure to obtain that information constituted a departure from good and accepted medical practice because, had Del Pizzo obtained that information, he would have known that the decedent was only treating with Del Pizzo in connection with his renal cancer and that, other than the ultrasound scans, the decedent had not undergone any other postoperative surveillance since May 16, 2013. According to the plaintiffs' expert, such knowledge should have prompted Del Pizzo to order a contrast-enhanced CT or MRI in 2015, which Del Pizzo purportedly admitted would have been the next step after his review of the 2014 ultrasound report one year earlier. The expert averred that, instead, when Del Pizzo reviewed the abdominal ultrasound report in 2014, he spoke to the decedent, and simply filed the report away. The plaintiffs' retained urologist asserted that the May 1, 2015 ultrasound report identified two hypoechoic lesions of questionable etiology, respectively measuring 2.3 cm by 1.8 cm by 2.1 cm and 1.8 cm by 1.5 cm by 2.0 cm, which had not been noted on the 2014 ultrasound scan, and that these findings should have been a "red flag" for Del Pizzo to suspect possible recurrence and potential regional metastasis, since they were located within the left upper quadrant medial to the spleen and anterior to the left kidney. As the expert framed the

issue, these new findings of questionable etiology required follow up, and required Del Pizzo to inquire of the decedent whether the latter was experiencing any new symptoms such as pain, weight loss, or hematuria. According to the expert urologist, Del Pizzo "should have highlighted the concerning abdominal ultrasound findings with Gary. To have not done that, in light of the questionable findings in the Report, was a departure from good and accepted medical practice," as was Del Pizzo's continuing failure immediately to order a CT-guided biopsy or PET scan, or, at the very least, a contrast-enhanced CT or MRI scan, to further define the qualities and characteristics of these new lesions. The expert asserted that these departures proximately caused the delays that led to the exacerbation of the decedent's cancer and the necessity of the surgery in which his pancreatic injury was incurred. As with Del Pizzo's alleged departures from good practice during 2014, the plaintiffs' expert noted that neither Dr. Cadeddu nor Dr. Michaelson opined that Del Pizzo adhered to the standard of care during 2015.

As the plaintiffs' expert urologist recounted it, on April 19, 2016, the decedent called Del Pizzo's office, and, on April 28, 2016, Peralta placed orders for an abdominal CT scan, a chest x-ray, and a basic metabolic panel, mailing the decedent prescriptions for the CT scan and metabolic panel testing on June 13, 2016. The decedent underwent an abdominal CT scan on July 7, 2016, which, according to the plaintiffs' expert, revealed the following pertinent findings:

> "Kidneys: Alobulated enhancing and partially calcified lesion extending from the midpole posterolaterally measuring greater than 5 cm. Within the left perinephric fat there were multiple masses measuring up to 8cm in maximum diameter extending superiorly to the level of the diaphragm. Additional nodules are noted adjacent to the spleen both anteriorly and laterally at the level of the upper pole. The mass is extending inferiorly below the level of the kidney adjacent to the psoas muscle."

According to the plaintiffs' expert urologist, these findings indicated that a primary lesion was located in the left kidney, measuring 5 cm, and that multiple masses were located within the fat surrounding the left kidney that extended upward to the diaphragm, measuring up to 8 cm in maximum diameter. Additionally, the expert explained that there were nodules present both in front and to the side of the spleen, which were situated at the level of the upper pole of the

decedent's left kidney. The plaintiffs' expert expressly disagreed with Dr. Cadeddu's opinion that this was the first clear evidence of cancer recurrence. The relevant hospital chart reflected that, on July 20, 2016, Dr. Scherr performed a left thoracoabdominal radical nephrectomy, with excision of multiple left retroperitoneal masses, excision of diaphragm, and placement of a chest tube, while the surgical pathology report indicated recurrent chromophobe renal carcinoma, which had spread to the five regional lymph nodes, although distant metastasis was not evaluated. The cancer was characterized as Stage 4 cancer-pT4, which the expert explained is diagnosed when a tumor invades beyond Gerota's fascia, pN1, meaning that the cancer had spread to regional lymph nodes, and pMx0, denoting no distant metastasis at that juncture. The plaintiffs' expert averred that, inasmuch as the decedent was diagnosed with Stage 4 cancer in 2016, and that only surgery had been performed, without any systemic therapy, the decedent's his 3-year survival rate by that time had decreased to 50% to 65%, his 5-year survival rate had decreased to 35% to 50%, and his 10-year survival rate had decreased to 20% to 30%.

The plaintiffs' expert urologist noted that, during the July 20, 2016 surgery, Dr. Scherr intentionally dissected the decedent's diaphragm, but that his pancreatic tail was injured, with the injury not being discovered or repaired intraoperatively. The expert specifically disagreed with Dr. Cadeddu's opinion that the decedent's pancreatic tail injury "was caused during lysis of Gary's adhesions, and that the injury would have occurred whether the surgery occurred in 2012, 2013, 2014, or 2015 because the adhesions were a result of the 2009 surgery." Rather, the plaintiffs' urologist concluded that, had Del Pizzo timely diagnosed and treated the cancer recurrence in late 2012 or early 2013, the cancer would have been easier to surgically excise, and the pancreatic tail injury would have been less likely since, by allowing the cancer to grow and spread until 2016, the decedent's pancreatic tail was placed at an increased risk for injury during the surgery. As the expert further explained it, the risk was increased because, as metastatic lesions grow and get bigger, they become harder and firmer, and they stick to surrounding structures, making surgical excision increasingly difficult. The expert urologist

concluded that this course of growth of the lesions, in combination with the presence of already existing adhesions, further increased the risk of surgical complications. The expert again expressly opined the presence of adhesions caused by the 2009 surgery, standing alone, was not responsible for the increased risk to the decedent's pancreas presented by the 2016 surgery. In this respect, the expert noted that Dr. Scherr performed an open procedure, and his operative report failed to identify adhesions located in the area of the pancreatic tail, or that adhesions were lysed thereat. Moreover, the expert explained that, given the anatomical location of the pancreatic tail, the mobilization of the decedent's, organs, including the spleen, and the dissection of nodules at or near the spleen, which were smaller in 2013, as well as lesions around the kidney, which had grown since 2013, led to the pancreatic tail injury.

The plaintiffs' retained expert urologist further asserted that, based on a review of the surgical pathology report, the nodule that invaded the Gerota's fascia progressed, at its greatest extent, to 0.7 cm, which, along with the rate of growth of the cancerous tissue, led the expert to conclude the decedent's cancer had become Stage 4 in early 2015. The expert alleged that, by 2016, since the lesions had spread in front and to the side of the spleen at the level of the upper pole of the left kidney, and these organs are located near the tail of the pancreas, the risk of injury to the pancreatic tail had increased due to that spread.

The plaintiffs' retained expert radiologist expressly disagreed with Dr. Chernyak's opinions that the August 15, 2012 abdominal-pelvic CT scan "did not show concerning findings, and therefore immediate change to the recommended routine surveillance was not necessary," and that the August 15, 2012 abdominal-pelvic CT scan did not reveal any finding of cancer recurrence or metastases. Rather, the radiologist concluded that this scan revealed an irregularly contoured soft-tissue density adjacent to the lateral aspect of the left kidney and that, while that finding may have represented anticipated postoperative conditions, "it cannot be presumed postsurgical until proven otherwise, particularly given the history of malignant neoplasm of the kidney." The radiologist further asserted that this scan also revealed a few

small retroperitoneal nodular soft tissue densities superior to the left kidney and posterior to the spleen, which had not been present on the preoperative August 24, 2009 abdominal-pelvic CT, and, therefore, were "worrisome for tumor recurrence and/or metastatic disease." Hence, the plaintiffs' retained radiologist opined that the standard of care required additional follow-up imaging within a short period of time after August 15, 2012, and expressly disagreed with Dr. Chernyak's opinion that "immediate change to the recommended routine surveillance was not necessary."

The plaintiffs' retained radiologist further opined that the May 16, 2013 abdominal MRI scan revealed the growth of, and increase in the number of, the small retroperitoneal nodular soft tissue densities, superior to the left kidney and posterior to the spleen, that had been identified the August 15, 2012 abdominal-pelvic CT scan. The radiologist characterized this development as "highly worrisome" for interval progression of tumor recurrence and/or metastatic disease.

The plaintiffs' retained radiologist explained that, when a reading radiologist reports that there are no prior studies for comparison, "it behooves the ordering physician to contact the radiologist to inform him/her that there are prior studies for comparison," thus concluding that Del Pizzo should have contacted Dr. Dayani to inform the latter that there were prior studies for comparison, to discuss the findings, and to discuss whether there was a possibility of tumor recurrence. Hence, the radiologist opined that Del Pizzo departed from good and accepted medical practice by failing to contact Dr. Dayani to discuss not only the May 16, 2013 CT scan, but the August 15, 2012 CT scan as well.

In reply, the defendants submitted an attorney's affirmation, in which counsel reiterated the defendants' contention that claims premised upon care or treatment rendered between October 27, 2009 and July 8, 2014, or any failure to order diagnostic testing during that interval, were time-barred. In addition, she argued that Del Pizzo did not formulate a postoperative surveillance plan in 2009, and was not responsible for doing so. More generally, she contended

that the plaintiffs failed to raise a triable issue of fact in opposition to the defendants' prima facie showing of entitlement to judgment as a matter of law because the opinions of the plaintiffs' experts were conclusory, speculative, and not supported by the medical records. Furthermore, she contended that

> "Plaintiffs' expert's baseless claims that the patient was not properly followed between 2009 and 2012 is false. The evidence shows that on November 11, 2009, Mr. Silberman was told to return to the NYPH urology clinic in three months and undergo a CT scan in six months, but did not. . . . Indeed, Mr. Silberman did not seek further treatment from Dr. Del Pizzo or NYPH until July 27, 2012 when he asked for assistance in obtaining imaging. . . . Plaintiffs' entire theory of liability is based on Mr. Silberman's testimony, which. . . is unreliable. Moreover, because Mr. Silberman testified that he knew he was supposed to return for studies for five years, there is no issue of fact with respect to the follow-up treatment. The defendants' plan met the standard of care, Mr. Silberman simply refused to follow it."

The court concludes that the defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including the three expert affirmations that they presented to the court. The court, however, rejects their contention that the opinions of the plaintiffs' experts were conclusory, speculative, or unsupported by medical records or testimony. The court concludes that the opinions of the plaintiffs' experts were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the decedent (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to whether Del Pizzo failed properly to follow up with the decedent, failed timely to order appropriate diagnostic testing between 2009 and 2015, and failed to communicate with the clinic, and, thus, thwarted the decedent in obtaining appropriate surgical or systemic treatment for his renal cancer. The plaintiffs' expert further raised a triable issue of fact as to whether the decedent "simply refused to follow" a postoperative surveillance plan, or whether it was the defendants' obligation to aggressively follow up with the decedent to assure that diagnostic testing was undertaken at appropriate intervals. The plaintiffs' experts further raised triable issues of fact as to whether the departures that they identified caused or contributed to a delay in diagnosis and treatment, thus contributing

to the growth of untreated cancer, the decrease in the decedent's life expectancy, and the need for surgery that was riskier than surgery that might have been performed earlier had the defendants timely tested for and diagnosed the decedent's cancer. It is well settled that a battle of experts, such as presented here, raises credibility issues which must be resolved by a fact finder and which preclude summary judgment (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 25). The court rejects the defendants' contention that the decedent's deposition testimony was incredible as a matter of law, or even unworthy of belief. A court determining a summary judgment motion may not assess the credibility of lay or expert witnesses (*see Grasso v Nassau County,* 180 AD3d 1008, 1012 [2d Dept 2020] [defendants' contention that plaintiff's expert "misstated facts from the record" is an issue "as to the expert's credibility that should be resolved by a jury"]; *Torgersen v A&F Black Creek Realty, LLC*, 158 AD3d 1042, 1044 [3d Dept 2018]). In deciding a summary judgment motion, "the court may not determine credibility or otherwise resolve factual issues for its sole function is one of issue-finding, not issue-determination" (*Hammond v State of New York*, 157 AD2d 391, 393 [1st Dept 1990] [citations omitted]; *see Capelin Assocs. v Globe Mfg. Corp*., 34 NY2d 338, 341 [1974]; *Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957]). The exception to this rule, as propounded by the defendants (*see Carthen v Sherman*, 169 AD3d 416, 417 [1st Dept 2019]) is not applicable to the decedent's deposition testimony. The court notes that the entries in a medical chart, or the absence of entries, is not sacrosanct, and cannot, standing alone dispositively resolve a disputed issue (*see Cabrera v Golden*, 231 AD3d 149, 156 [1st Dept 2024]; *E.K. v Tovar*, 185 AD3d 803, 805 [2d Dept 2020]; *Melendez v Parkchester Med. Servs., P.C.*, 76 AD3d 927, 928 [1st Dept 2010]; *Cerny v Williams*, 32 AD3d 881, 884 [2d Dept 2006]; *Krapivka v Maimonides Med. Ctr*., 119 AD2d 801, 801-802 [2d Dept 1986]).

Moreover, the court concludes that the defendants are not entitled to summary judgment dismissing, as time-barred, those of the plaintiffs' claims that were based upon conduct occurring between October 27, 2009 and July 8, 2014. On a motion for summary judgment

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

The statute of limitations applicable to actions to recover for medical malpractice against a private health-care provider is 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 CPLR 214-a posits that the limitations period "does not begin to run until the end of the course of treatment when the course of treatment which includes the wrongful acts or omissions has run continuously and is *related to the same original condition or complaint*" (*Nykorchuck v Henriques*, 78 NY2d 255, 258 [1991] [internal quotation marks omitted] [emphasis added]; *see Massie v Crawford*, 78 NY2d 516, 519 [1991]; *McDermott v Torre*, 56 NY2d 399, 405 [1982]; *Borgia v City of New York*, 12 NY2d 151, 155 [1962]; *Jajoute v New York City Health & Hosps. Corp*., 242 AD2d 674, 676 [1st Dept 1997]).

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

> "[W]here the action is based upon the alleged negligent failure to diagnose cancer or a malignant tumor, whether by act or omission, the action may be commenced within two years and six months of the later of either
>
> (i) when the person knows or reasonably should have known of such alleged negligent act or omission and knows or reasonably should have known that such alleged negligent act or omission has caused injury, provided, that such action shall be commenced no later than seven years from such alleged negligent act or omission."

This provision of CPLR 214-a, however, applies only to acts, omissions, or failures occurring on or after January 31, 2018, and to causes of action that accrued after July 31, 2015 (*see* L 2018, ch 1, §§ 5-6; *McKinnon v North Shore-Long Is. Jewish Health Sys. Labs.*, 187 AD3d 890, 891 [2d Dept 2020]). Nonetheless, although the omissions that are the subject of this action occurred before January 31, 2018, the Legislature also enacted a revival provision, so that claims based on negligent failure to diagnose cancer or a malignant tumor that became time-barred after March 31, 2017 could be commenced by July 31, 2018, but no longer than seven years after the alleged negligent omissions (*see* L 2018, ch 1, §§ 5-6; *Mula v Sasson*, 181 AD3d 686, 687 [2d Dept 2020]). The defendants' alleged failures timely and appropriately to diagnose the decedent's renal cancer, which arose from the defendants' alleged failures to order appropriate testing in a timely manner, allegedly occurred on numerous occasions between 2010 and 2014. Even if the continuous treatment doctrine were inapplicable, claims arising from allegedly negligent conduct during that interval became time-barred after March 31, 2017 and, hence, the plaintiffs had until July 31, 2018 to interpose those claims against the defendants. This action was commenced on September 15, 2017, which was both prior to July 31, 2018 and less than seven years after the alleged omissions that occurred between September 15, 2010 and July 8, 2014. Hence, claims arising during that period were timely interposed regardless of whether the continuous treatment doctrine is applicable or inapplicable.

With respect to all of the negligent conduct allegedly occurring from October 27, 2009 (the date of the initial surgery) until March 15, 2015 (the date two years and six months prior to the plaintiffs' commencement of this action), the plaintiffs argued in their opposition papers that the continuous treatment doctrine is applicable for several reasons. They asserted that Del Pizzo did, in fact, assume the responsibility for developing a postoperative surveillance plan in late 2009, since the medical records demonstrated that, despite his contention that he had handed off that responsibility to the clinic, the clinic apparently never was informed that the

development of such a plan became its responsibility. Moreover, the plaintiffs contended that Del Pizzo did not merely access the decedent's chart for his own edification in May and June 2010, and again in 2011, but did so in his capacity as the admitted "managing physician" of the decedent's care, a capacity recognized by NYPH. Hence, they argued that the physician-patient relationship was not severed between October 27, 2009 and 2011. Furthermore, they pointed out that, on July 27, 2012, Del Pizzo affirmatively ordered certain imaging on the decedent's behalf, and that, although the mode of imaging may have been improper, Del Pizzo continued to order imaging during 2013, 2014, and 2015, and continued to review ultrasound scans that were performed under the aegis of the decedent's primary care physician. In addition, the facts underlying the decedent's one visit and one telephone call with Dr. Woodall present a sharp dispute as to whether Dr. Woodall ever became the decedent's treating urologist.

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

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

(*id*. at 1006). The Court ruled that, where such a situation obtains,

> "[c]ases such as *Clayton v Memorial Hosp. for Cancer & Allied Diseases* (58 AD3d 548 [1st Dept 2009]) are inapplicable . . . , to the extent they reiterate that 'continuous treatment exists "when further treatment is explicitly anticipated by

> both physician and patient as manifested in the form of a regularly scheduled appointment for the near future, agreed upon during that last visit, in conformance with the periodic appointments which characterized the treatment in the immediate past"' (58 AD3d at 549, quoting *Richardson v Orentreich*, 64 NY2d at 898-899)"

(*id*. at 1007). Nonetheless, where there is an absence of objective evidence demonstrating "continuous trust and confidence" between the patient and physician, the continuous treatment doctrine cannot be invoked (*see Rizk v Cohen*, 73 NY2d at 104-105; *De Peralta v Presbyterian Hosp.*, 121 AD2d 346, 349 [1st Dept 1986]; *see also McSheffrey v Helou*, 172 AD2d 728, 729 [2d Dept 1991]). Applying the First Department's articulation of the law, as this court must (*see D'Alessandro v Carro*, 123 AD3d 1, 6 [1st Dept 2014]), the plaintiffs have raised triable issues of fact as to whether the decedent reasonably believed that his physician-patient relationship with Del Pizzo continued following the October 27, 2009 surgery, despite the occasional lapse of a few months, that the physician-patient relationship with Del Pizzo had never been severed, that there was no appreciable improvement in his condition, and that his condition actually deteriorated over the course of his treatment by Del Pizzo and NYPH. Hence, the plaintiffs raised triable issues of fact as to whether the continuous treatment was applicable, so as to toll the limitations period from October 27, 2009 until March 15, 2015. Consequently, that branch of the defendants' motion which was for summary judgment dismissing the medical malpractice cause of action must be denied.

The defendants, however, established that the plaintiffs' claims all revolve around alleged failures to timely and appropriately follow up with the decedent's care, failures to order appropriate imaging studies, and concomitant failures to diagnose the decedent's renal cancer, leading to a delay in treatment and the necessity of high-risk surgery. In opposition, the plaintiffs did not address the issue. Since a lack of informed consent claim is inapplicable to a failure to diagnose, summary judgment must be awarded to the defendants dismissing the lack of informed consent cause of action.

The defendants' remaining contentions are without merit.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action, that cause of action is dismissed, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the attorneys for the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on May 7, 2026, at 11:45 a.m., at which time they shall be prepared to discuss resolution of the action, the scheduling of a future two-hour, mediation-style settlement conference, and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

4/24/2026
DATE

JOHN J. KELLEY, J.S.C.

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