State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: January 28, 2021

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531007

JUDITH GOLDSCHMIDT, as
Executor of the Estate of
HARRY BAKER, Deceased,
Respondent,

v

MEMORANDUM AND ORDER

CORTLAND REGIONAL MEDICAL
CENTER, INC., et al.,
Appellants.

Calendar Date: January 11, 2021

Before: Lynch, J.P., Clark, Pritzker and Colangelo, JJ.

Levene Gouldin & Thompson, LLP, Vestal (Justin L. Salkin of counsel), for Cortland Regional Medical Center, Inc., appellant.

Aswad & Ingraham, LLP, Binghamton (Mary E. Saitta of counsel), for Lynn Cunningham and another, appellants.

Gale, Gale & Hunt, LLC, Fayetteville (Kevin T. Hunt of counsel), for Kirwin G. Gibbs and another, appellants.

Coughlin & Gerhart, LLP, Binghamton (Rachel A. Abbott of counsel), for respondent.

Pritzker, J.

Appeals (1) from an order of the Supreme Court (Tait, J.), entered September 30, 2019 in Broome County, which, among other things, denied defendants' motions for summary judgment dismissing the amended complaint, and (2) from an order of said court, entered January 16, 2020 in Broome County, which, upon reargument, adhered to its prior decision.

On January 12, 2012, Harry Baker (hereinafter decedent) went to the emergency department at defendant Cortland Regional Medical Center, Inc. (hereinafter CRMC) with complaints of dizziness. Defendant Kirwin G. Gibbs, a radiologist, interpreted the results of a chest X ray performed on decedent as presenting a "[q]uestionable" nodule, but "[o]therwise unremarkable." Gibbs did, however, order a CT scan to be performed that same day (hereinafter the January 12, 2012 scan), which he also interpreted to show a mass that he diagnosed as "likely benign." Gibbs recommended that a follow-up CT scan be performed in one month but, at the suggestion of defendant Lynn Cunningham, decedent's primary care provider, a second CT scan was performed 11 days later (hereinafter the January 23, 2012 scan). Gibbs interpreted this scan as showing the mass to be "[u]nchanged" suggesting "benign etiology" and recommended another CT scan in two months.

In April 2012, a third CT scan was performed (hereinafter the April 2012 scan), which Gibbs again interpreted as favoring "benign etiology." Gibbs recommended continued monitoring, including a follow-up CT scan suggested in three months. In July 2012, decedent again went to the emergency department of CRMC, this time complaining of shortness of breath. A chest X ray was performed (hereinafter the July 2012 X ray) and interpreted by another physician, Andrew Lewis, who noted the mass and recommended decedent continue further evaluation pursuant to his current schedule for CT scan monitoring. The next CT scan, performed in August 2012 (hereinafter the August 2012 scan), was interpreted by Gibbs, who found the original mass to be unchanged and a new, small mass in a different area

of the lungs. Gibbs concluded that both masses were "likely of benign etiology" and recommended another CT scan in six months. Subsequently, in September 2012, decedent sought a second opinion from a pulmonologist who diagnosed the mass as lung cancer and scheduled a lobectomy to remove it and conduct biopsies of the surrounding lymph nodes. Following the lobectomy and chemotherapy, decedent entered remission. However, his lung cancer returned in January 2014 and quickly metastasized to his brain. Despite further treatment, decedent died from the cancer in January 2015.

Prior to his death, in December 2014, decedent initiated the present medical malpractice action alleging that defendants – Cunningham and her employer, defendant Cortland Medical Associates, P.C. (hereinafter collectively referred to as the Cunningham defendants); Gibbs and his employer, defendant Cortland Memorial Radiology, P.C. (hereinafter collectively referred to as the Gibbs defendants); and CRMC – deviated from standards of medical care and that the deviation was the proximate cause of the cancer spreading throughout his lungs and to his brain. Following decedent's death, Supreme Court issued an order substituting plaintiff, as executor of decedent's estate, as the named plaintiff. Plaintiff simultaneously submitted an amended complaint reflecting this change and defendants thereafter joined issue.

In November 2018, defendants separately moved for summary judgment dismissing the amended complaint. Plaintiff opposed all such motions. In a September 2019 order, Supreme Court denied the motions for summary judgment with the exception that, if the continuous treatment doctrine is found to be inapplicable, then any claims against the Gibbs defendants and CRMC arising after July 27, 2012 would be dismissed for lack of causation. Thereafter, the Gibbs defendants and CRMC both moved for reargument seeking dismissal of all claims relating to treatment on and after July 27, 2012, which plaintiff opposed. In a January 2020 order, Supreme Court granted reargument and adhered to the September 2019 order with a clarification regarding the extent to which the July 2012 X ray and the August

2012 scan could be discussed at trial and reserving the right to rule on evidentiary issues at that time. Defendants appeal from the September 2019 order, and the Gibbs defendants and CRMC also appeal from the January 2020 order.

Turning first to the Cunningham defendants, there is no dispute that they met their initial burden of establishing prima facie entitlement to summary judgment. Thus, the burden shifted to plaintiff to present expert medical opinion evidence that there was a deviation from the accepted standard of care and that this departure was a proximate cause of the cancer spreading throughout decedent's lungs and to his brain (see Butler v Cayuga Med. Ctr., 158 AD3d 868, 874 [2018]; Longtemps v Oliva, 110 AD3d 1316, 1318 [2013]). To that end, the Cunningham defendants assert that plaintiff failed to meet her shifted burden because her expert was not qualified to opine on the standard of care for family medicine and, even if he was, his opinions were conclusory, speculative and not supported by competent evidence.

To meet her shifted burden, plaintiff proffered an affidavit of Mark Levin, an oncologist, who is licensed in both New York and New Jersey and is, among other things, certified by the American Board of Internal Medicine and the American Board of Quality Assurance and Utilization Review. Although his specialty and the majority of his experience in the medical field is as an oncologist and hematologist, Levin averred that he is "knowledgeable with respect to the standards of treatment and practice applicable to primary care physicians." Given Cunningham's familiarity with decedent's long history of smoking and positive family history for lung cancer, and calling upon his education and experience as an oncologist and internist, Levin opined to a reasonable degree of medical certainty that Cunningham breached her standard of care as a primary physician by, among other things, "failing to immediately refer [decedent] to a specialist such as a pulmonologist," by "failing to immediately order a biopsy of the mass" in his lung and again failing to order a biopsy after the April 2012 scan revealed that the mass had increased in size.

We agree with Supreme Court that Levin is qualified to opine on the standards applicable to a primary care physician and that he laid a sufficient foundation to render his opinion reliable. "A medical expert does not have to be a specialist in the same field as a defendant doctor" (Frank v Smith, 127 AD3d 1301, 1303 [2015] [citations omitted]). Although the absence of the same specialty could perhaps impact the weight to be given to the opinion, it does not render it inadmissible (see Bell v Ellis Hosp., 50 AD3d 1240, 1242 [2008]). Here, despite Levin having not practiced in the field of family medicine, his experience as an oncologist, taken together with his board certifications and the nature of this action as an alleged failure to timely diagnose cancer, there is a sufficient basis to infer that his opinion is reliable (see Carter v Tana, 68 AD3d 1577, 1580 [2009]; Bell v Ellis Hosp., 50 AD3d at 1242; compare Postlethwaite v United Health Servs. Hosps., 5 AD3d 892, 895-896 [2004]). Thus, Supreme Court correctly found that Levin was qualified to furnish an expert opinion as to the standard of care. Moreover, given that Levin's affidavit is "detailed and supported by reference to and discussion of relevant medical records and testimony," we do not find it to be conclusory or speculative and, accordingly, find that Levin's affidavit is sufficient to raise an issue of triable fact (see Frank v Smith, 127 AD3d at 1303; Carter v Tana, 68 AD3d at 1579-1580).

We now turn to the Gibbs defendants and CRMC who claim that plaintiff's action is untimely because the continuous treatment doctrine does not apply. "An action for medical . . . malpractice must be commenced within two years and six months of the act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure" (CPLR former 214-a).[1] Plaintiff does not challenge

[1] In January 2018, after the commencement of this action, CPLR 214-a was amended to add a provision allowing for an action based upon the alleged negligent failure to diagnose cancer to be brought within two years and six months of the date that the plaintiff knew or reasonably should have known of the alleged negligence (see CPLR 214-a [b] [i], as amended by L 2018, ch 1).

Supreme Court's determination that both the Gibbs defendants and CRMC established prima facie entitlement to summary judgment, as the summons and complaint were filed more than two years and six months after the January 12, 2012 scan, the January 23, 2012 scan and the April 2012 scan (see Shultis v Patel, 163 AD3d 1342, 1342-1343 [2018]). Thus, the burden shifted to plaintiff to raise an issue of fact as to whether the continuous treatment doctrine tolled the statute of limitations (see id.).

"While medical malpractice claims generally accrue at the time the malpractice is committed, the continuous treatment doctrine provides that 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, [the] accrual comes only at the end of the treatment" (Hauss v Community Care Physicians, P.C., 119 AD3d 1037, 1038 [2014] [internal quotation marks and citations omitted]; see Borgia v City of New York, 12 NY2d 151, 155 [1962]). "Although treatment does not necessarily end upon a patient's last visit to the doctor, further treatment must be in some way 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, or in conformance with the periodic appointments which characterized the treatment in the immediate past" (Waring v Kingston Diagnostic Radiology Ctr., 13 AD3d 1024, 1026 [2004] [internal quotation marks, brackets and citation omitted]; see Aulita v Chang, 44 AD3d 1206, 1208 [2007]). "Generally, where a diagnostic service . . . renders discrete, intermittent, medical services, this will not be considered continuous treatment" (Elkin v Goodman, 285 AD2d 484, 486 [2001] [citations omitted]). However, "the continuous treatment toll may apply to a diagnostician where periodic diagnostic examinations are prescribed as part of ongoing care for a plaintiff's existing condition and are explicitly anticipated by physician and patient alike" (Waring v Kingston Diagnostic Radiology Ctr., 13 AD3d at 1026 [internal quotation marks, brackets and citation omitted]).

To meet her shifted burden, plaintiff proffered evidence that, after each scan, Gibbs recommended that decedent return for regular follow-up scans at specific intervals. At her deposition, Cunningham testified that, when she ordered the January 23, 2012 scan to be done with and without contrast, Gibbs had a technician relay to Cunningham that he did not want to use contrast on the patient and requested a new order without contrast. In her notes, Cunningham memorialized that Gibbs conveyed his belief that the mass in decedent's lung was "a pneumonia, period" and recommended a "plain CT to follow up only." As a result, Cunningham changed the order to a CT without contrast. Subsequently, following the April 2012 scan, Cunningham noted that Gibbs recommended that decedent engage in "serial" CT scan follow-up because "there is a concern for developing cancer."

We agree with Supreme Court that plaintiff met her shifted burden of establishing a question of fact that the continuous treatment doctrine tolled the statute of limitations. The record demonstrates that periodic scans were not only contemplated by Gibbs, Cunningham and decedent, but they were also planned and executed (compare Kaufmann v Fulop, 47 AD3d 682, 684 [2008]; Waring v Kingston Diagnostic Radiology Ctr., 13 AD3d at 1026). This anticipated and continuous monitoring is also evident by Gibbs' repeated comparisons of current scans with decedent's previous scans, which CRMC retained on file (see Elkin v Goodman, 285 AD2d at 486). Although it is true that successive comparisons of scans alone do not render treatment by a radiologist continuous, it is clear from Cunningham's testimony that decedent, who Cunningham described as "reluctant to engage in health care," trusted and relied upon Gibbs' reports of the scans and his continued indications that the mass was likely benign (see Swift v Colman, 196 AD2d 150, 153 [1994]; compare Noack v Symenow, 132 AD2d 965, 966 [1987]). As such, given that decedent's scans were scheduled and explicitly anticipated as part of ongoing care to monitor decedent's condition, a question of fact remains as to whether the continuous treatment doctrine applies (see Elkin v Goodman, 285

AD2d at 486; compare Kaufmann v Fulop, 47 AD3d at 684; Noack v Symenow, 132 AD2d at 966).

Finally, we reach CRMC and the Gibbs defendants' contention that, if the continuous treatment doctrine applies, all claims arising from the July 2012 X ray and August 2012 scan still must be dismissed as plaintiff failed to raise a question of fact as to proximate cause connected with these images. This contention misconstrues the gravamen of plaintiff's complaint. To that end, plaintiff is alleging, specific to these defendants, that Gibbs' entire course of treatment, beginning on January 12, 2012 and ending on approximately August 10, 2012, deviated from accepted standards of medical care and that, because of said deviation, decedent's chance for survival decreased (see generally Clune v Moore, 142 AD3d 1330, 1331-1332 [2016]; Goldberg v Horowitz, 73 AD3d 691, 694 [2010]). Plaintiff does not, as the Gibbs defendants and CRMC appear to be arguing, allege separate claims based upon each separate scan or X ray that was done. In fact, plaintiff has conceded that, if it is determined that the continuous treatment doctrine does not apply, plaintiff's claims against the Gibbs defendants and CRMC cannot stand, as any claims related to the January 12, 2012 scan, the January 23, 2012 scan and the April 2012 scan are time-barred. Moreover, the time period that elapsed between the July 2012 X ray and the diagnosis of the cancer in September 2012 was not causative, in and of itself, of the cancer's metastasis. As such, Supreme Court properly denied the motions for summary judgment filed by the Gibbs defendants and CRMC. Defendants' remaining contentions, to the extent not specifically addressed, have been examined and found to lack merit.

Lynch, J.P., Clark and Colangelo, JJ., concur.

ORDERED that the orders are affirmed, with costs.

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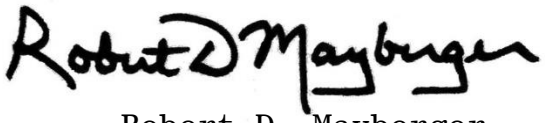

Robert D. Mayberger
Clerk of the Court