At an IAS Term, Part 43 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 8th day of September, 2009.

P R E S E N T:

HON. MARK I. PARTNOW,

Justice.

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OLGA KURKOVA, et ano.,

Plaintiffs,

- against -

Index No. 24131/04

NEW YORK UNIVERSITY MEDICAL CENTER, et ano.,

Defendants.

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The following papers numbered 1 to 7 read on this motion:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1 - 4
Opposing Affidavits (Affirmations)	5 - 6
Reply Affidavits (Affirmations)	7
Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers in this action by plaintiffs Olga Kurkova (plaintiff) and Semyon Kurkov (collectively, plaintiffs) to recover damages for medical malpractice, negligence, and lack of informed consent, defendants NYU Hospital Center sued herein as New York University Medical Center (NYU) and Jafar J. Jafar, M.D. (Dr. Jafar)

(collectively, defendants) move for summary judgment dismissing plaintiffs' complaint as against them.

On October 17, 2002, plaintiff, who was then 53 years old, was brought by ambulance to the emergency room at Coney Island Hospital unresponsive with non-reactive pupils and left hemiplegia. Plaintiff was diagnosed with a right frontal intra-cerebral hematoma. On that day, an emergency right frontal intra-cerebral craniotomy was performed for evacuation of the intra-cerebral hematoma. Notably, during that procedure, an inverted horseshoe scalp incision and a frontal bur hole were made, and a frontal bone flap was elevated. Upon completion of the evacuation of the hematoma, the bone flap was reapplied, plaintiff's scalp was approximated with vicryl, and her skin closed with staples. Plaintiff remained hospitalized at Coney Island Hospital until her transfer to Peninsula Hospital Center for rehabilitation on October 28, 2002.

Plaintiff received physical and occupational therapy at Peninsula Hospital, and was discharged at the end of December 2002. At that time, plaintiff was able to ambulate without devices and to perform self-care, but required some supervision.

In January 2003, plaintiff presented to Dr. Lybov Moysik, a neurologist, complaining of heaviness in her head, dizziness, feeling weak, and tiring easily. Dr. Moysik noted that plaintiff still had a frontal lobe hematoma. Plaintiff presented to Dr. Jafar, a neurosurgeon, on January 14, 2003, after being referred to him by Dr. Moysik. Dr. Jafar's records indicate that on the first visit, plaintiff made complaints of weakness with memory retention

problems. Dr. Jafar noted that plaintiff's October 2002 MRI revealed a right frontal basal hemorrhage prior to her craniotomy at Coney Island Hospital. Dr. Jafar's recommendation was to obtain information from Coney Island Hospital, a new MRI, and a cerebral angiography.

Dr. Jafar saw plaintiff again on February 4, 2003. At that time, Dr. Jafar noted that plaintiff had meningitis at age 12 and no history of trauma before her right frontal hematoma and subsequent surgery. Dr. Jafar further noted that plaintiff was complaining of occasional frontal headaches.

On March 19, 2003, plaintiff was admitted to NYU as an outpatient for treatment by Dr. Peter Nelson, a neuroradiology interventional specialist. Dr. Jafar had referred plaintiff to Dr. Nelson for a cerebral angiography, which Dr. Nelson performed. Dr. Nelson reported that the angiogram revealed a mixed brain/dural arterial venous fistula malformation localized to the anteromedial right frontal lobe. Dr. Nelson further reported that the lesion was supplied primarily though orbital branches of the right anterior cerebral artery (ACA) with additional contribution through the ethmoidal divisions of both ophthalmic arteries contributing to the anterior falcial arcade.

Dr. Jafar saw plaintiff again on March 25, 2003, after she had undergone the angiogram. Dr. Jafar's notes stated that he explained to plaintiff and her adult son, Oleksander Kurkov (plaintiffs' son), who acted as plaintiff's translator (since plaintiff speaks Russian), that the angiogram showed that she had a Grade I arteriovenous malformation

(AVM) in the frontal medial basal area fed by ACA and ethmoid arteries. Dr. Jafar's notes also stated that he explained to plaintiff and her son the advantages of surgery, the alternative of embolization by Gamma Knife, and doing nothing. Dr. Jafar's notes further stated that he explained to them the complications of surgery, which included but were not limited to infection, loss of smell, cerebrospinal fluid (CSF) leak, hemorrhage, stroke, and even death. Dr. Jafar additionally noted that all questions were answered and that plaintiff wanted to proceed with the surgery which was tentatively scheduled for the next week.

On March 29, 2003, plaintiff presented to the emergency room at NYU with an acute onset sudden headache. A CT scan of plaintiff's head was performed, revealing post-operative changes of the right frontal lobe.

On March 30, 2003, plaintiff signed a consent for craniotomy for research of AVM. The consent form states that "[t]he nature and purpose of the operation and/or procedures, the necessity therefor, the possible alternative methods of treatment, the risks involved and the possibility of complication in the treatment of my condition has been fully explained to me and I understand the same."

On March 31, 2003, Dr. Jafar performed a right bifrontal craniotomy and stereotactic computer-assisted microsurgical resection of AVM with autologous pericranial dural grafting and obliteration of the frontal sinus of plaintiff at NYU. Plaintiff tolerated the procedure very well. In the Operation Summary, dictated on March 31, 2003 and transcribed on April 11, 2003, under the section entitled Operative Comments, Dr. Jafar indicates that "[a]fter an

extensive discussion with the family and son, and explaining the advantages of the surgery, the alternatives, as well as the complications [,plaintiff] wanted to proceed with the surgery." The antibiotic Ancef (Cefazolin) 1 gram IVPB had been administered to plaintiff pre-operatively at 8:15 A.M. prior to the incision at 8:47 A.M., and plaintiff received an additional three doses of Ancef (Cefazolin) one gram at eight-hour intervals post-operatively.

On April 1, 2003, plaintiff underwent a post-surgical angiogram, which showed that the entire AVM was removed/obliterated. Plaintiff also underwent a post-operative CT scan, which was consistent with a successful surgery with no residual AVM. During the post-operative course, the wound was noted to be clean, dry, and intact, and plaintiff remained afebrile. On April 14, 2003, plaintiff was discharged from NYU to her home. On that date, plaintiff's bifrontal craniotomy staples were noted to be clean, dry, and intact, with a boggy flap. In addition, plaintiff's white blood count was within normal limits at 6.8 on that date.

On April 19, 2003, plaintiff saw Dr. Jafar in his office, and he noted that plaintiff was on Dilantin (an anti-seizure medication), the wound was well-healed, and there was no CSF leak. Dr. Jafar indicated, in his note, that plaintiff was to return to his office in six weeks.

According to plaintiff, on May 6, 2003, she awakened and saw that she had bags and swelling under her eyes and she called Dr. Jafar, who told her to go to the emergency room at NYU (Plaintiff's Dep. Transcript at 78-79). According to Dr. Jafar, he received a telephone call from plaintiff on the afternoon of May 6, 2003, and she told him that the day before, her forehead had swelled up suddenly and acutely (Dr. Jafar's Dep. Transcript at 66-

67). Dr. Jafar claims that he told plaintiff to come to his office immediately, and when he saw her in the office with swelling and puffiness on her forehead and the periorbital area, he immediately sent her to the emergency room at NYU.

Plaintiff was admitted to NYU from the emergency room in May 6, 2003 for erythema and swelling at the former surgical site. At NYU, plaintiff had a CT scan of her head, which revealed pansinusitis, and infection. A tap of the fluid collection over plaintiff's forehead revealed the presence of gram positive rods. Plaintiff was started on Vancomycin (an antibiotic), and an infectious disease consult was called. Dr. Louie, the infectious disease specialist, added Zosyn and Cleocin to plaintiff's regimen and a PICC line was inserted.

According to Dr. Jafar's neurosurgery attending note in the NYU records dated May 12, 2003 at 1:00 P.M., he had spoken with Dr. Louie, who believed plaintiff's skull flap was infected and needed to be removed, and that the infection could not be eradicated unless that was done. According to Dr. Jafar, he explained to plaintiff with her son present as a translator that she had an infection in the bone in her forehead, that he did not believe it would be possible to eradicate it with medication alone, and that the best treatment for her was to have the bone in her forehead removed in order to totally obliterate the infection (Dr. Jafar's Dep. Transcript at 75-76). After Dr. Jafar discussed the risk with plaintiff that if she did not have the surgery, the infection could spread to her brain, plaintiff agreed to have the surgery (Plaintiff's Dep. Transcript at 84-85). Plaintiff signed a consent form for the surgery.

On May 12, 2003, plaintiff underwent the removal of infected bone flap, autologous fat and rectus graft harvesting and repair of the frontal sinus for frontal sinusitis with intracranial extension and skull osteomyelitis by Dr. Jafar at NYU. Plaintiff tolerated the procedure well. Plaintiff was discharged to Haym Solomon Home for Nursing and Rehabilitation on May 23, 2003, where she remained through June 27, 2003. During her admission there, plaintiff received antibiotic therapy with Zosyn and Cleocin. Plaintiff was discharged to her home on June 27, 2003. Plaintiff discontinued antibiotics on June 28, 2003.

Plaintiff saw Dr. Jafar on July 1, 2003 and again on October 14, 2003. Plaintiff's wound from the operation was depressed and clean. Plaintiff saw Dr. Jafar again on November 11, 2003. at which time he made plans for a titanium implant to cover plaintiff's frontal bony defect.

On March 1, 2004, plaintiff underwent a large cranioplasty at NYU for her bifrontal skull defect. Plaintiff tolerated the procedure well and was discharged from NYU on March 2, 2004.

Dr. Jafar saw plaintiff again on May 11, 2004, at which time he noted that plaintiff's wound was well-healed with no sign of infection, and the sutures were removed. Dr. Jafar noted an excellent cosmetic result. Plaintiff's last office visit with Dr. Jafar was on May 11, 2004, at which time he noted that plaintiff was on no medications, made no complaints, and that her wound was well-healed without any signs of infection.

Plaintiffs filed this action on July 30, 2004 against NYU and Dr. Jafar. Plaintiffs' complaint alleges four causes of action. Plaintiff's first cause of action alleges that Dr. Jafar's medical care, diagnosis, and treatment of her were not in accordance with accepted standards of medical care. Plaintiff's second cause of action asserts that NYU was negligent in hiring and supervising medical personnel who were careless, unskillful, and negligent, and who did not posses the requisite knowledge and skill of medical professionals in the community. Plaintiff's third cause of action alleges a claim of lack of informed consent against defendants. In the fourth cause of action, plaintiff's husband, Semyon Kurkov, asserts a claim for loss of consortium. Defendants served their answer on or about September 3, 2004. Discovery has been completed, and plaintiffs have filed their note of issue.

Defendants, in support of their instant motion, assert that plaintiffs cannot establish a prima facie case of medical malpractice against them. "To establish a prima facie case of liability in a medical malpractice action, a plaintiff must prove (1) the standard of care at the facility [or locality] where the treatment occurred, (2) that the defendant breached that standard of care, and (3) that the breach was the proximate cause of the [plaintiff's] injury" (*Elliot v Long Is. Home, Ltd.*, 12 AD3d 481, 482 [2004]; *see also Flanagan v Catskill Regional Med. Ctr.*, __ AD3d __, 2009 NY Slip Op 06161, *2 [2009]; *Deadwyler v North Shore Univ. Hosp. at Plainview*, 55 AD3d 789, 781 [2008]; *Pace v Janus*, 291 AD2d 436, 436 [2002]; *Berger v Becker*, 272 AD2d 565, 565 [2000]).

A party moving for summary judgment must make a prima facie showing of its entitlement to judgment as a matter of law by submitting evidence sufficient to demonstrate

the absence of any material issues of fact (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). "Once this showing has been made,. . . the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez*, 68 NY2d at 324; *see also Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]).

"In a medical malpractice action, a plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he [or she] was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact" (*Alvarez*, 68 NY2d at 324; *see also Fileccia v Massepequa Gen. Hosp.*, 63 NY2d 639, 640 [1984], *affg* 99 AD2d 796, 796 [1984]). "General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [the] defendant physician's summary judgment motion" (*Alvarez*, 68 NY2d at 325; *see also Flanagan*, 2009 NY Slip Op 06161, * 2; *Luu v Paskowski*, 57 AD3d 856, 857 [2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2007]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2003]).

In support of their motion, defendants have submitted plaintiff's medical records, which set forth, in detail, all of the medical care and treatment rendered to plaintiff. Defendants have also submitted Dr. Jafar's deposition testimony, plaintiff's deposition testimony, and plaintiffs' son's deposition testimony, which describe the facts and

circumstances regarding the medical care, diagnosis, and treatment of plaintiff by Dr. Jafar at NYU.

In addition, defendants have submitted the expert affidavit of George DiGiacinto, M.D., who is board certified in the speciality of neurosurgery. Dr. DiGiacinto opines, within a reasonable degree of medical certainty, that all of the care rendered to plaintiff by defendants was within accepted standards of neurosurgical practice and that the claimed departures did not proximately cause plaintiff's injuries. Dr. DiGiacinto sets forth that the initial surgery was indicated to remove the AVM in plaintiff since she had a prior hemorrhage and could re-bleed. Dr. DiGiacinto also asserts that the approach Dr. Jafar used through the large sinuses during the surgical procedure at NYU was a necessity and within good and accepted neurosurgical practice. Dr. DiGiacinto opines that once plaintiff developed an infection, Dr. Jafar acted properly and appropriately in performing surgery to remove the bone flap. Dr. DiGiacinto also states that Dr. Jafar properly and appropriately performed a cranioplasty on plaintiff. Dr. DiGiacinto additionally opines that the staff at NYU did not depart in any way from accepted standards of care with regard to the care and treatment of plaintiff during each admission to NYU in March 2003, May 2003, and March 2004.

Defendants have also submitted the expert affidavit of Dial Hewlett, M.D., who is board certified in the speciality of infectious disease. Dr. Hewlett opines, within a reasonable degree of medical certainty, that the care and treatment rendered to plaintiff was in accordance with good and accepted infectious disease/medical practice as it existed during

the dates at issue. Dr. Hewlett opines that plaintiff received the appropriate antibiotic therapy during her initial course at NYU by receiving Cefazolin at 8:15 A.M. on March 31, 2003 which continued through April 1, 2003. Dr. Hewlett explains that the guidelines for prophylactic antibiotics are to give the first dose before a surgical incision is made, and then to continue the antibiotics for 24-48 hours after the surgery. Dr. Hewlett points out that here, the antibiotic therapy was prophylactic only, as opposed to being given for infection, and, therefore, plaintiff did not require any more than the three doses of antibiotics that she received post-operatively over a 24-hour period.

Dr. Hewlett asserts that plaintiff's infection was caused by the organism propriano bacter acne, which is an organism normally found on healthy skin. Dr. Hewlett explains that an opening between plaintiff's scalp and skull was created by the surgical procedure, and there was a microscopic channel from plaintiff's scalp to the frontal sinus. Dr. Hewlett states the organism propriano bacter acne entered into a closed sinus, where the neurosurgery was performed, and acted as an opportunistic pathogen, causing infection. Dr. Hewlett opines that plaintiff developed an acute frontal sinusitis because the sinus was adjacent to the bone flap, and that is why plaintiff's bone flap was infected.

Dr. Hewlett explains that this was not an infection smoldering for four weeks, but one which developed quickly due to an irritation at the incision site which caused the bacteria to enter. Dr. Hewlett further explains that plaintiff had no symptoms for a prolonged time because this type of infection develops quickly and symptoms can develop in a matter of hours. Dr. Hewlett opines that if plaintiff had an infection related to what Dr. Jafar or the

staff at NYU did during the initial surgery, she would have developed symptoms prior to May 5, 2005 and would not have remained without any symptoms of infection from April 4, 2003 until May 5, 2003. Dr. Hewlett also opines that when plaintiff came back to Dr. Jafar complaining of swelling, Dr. Jafar acted properly and appropriately in removing the bone flap and giving plaintiff antibiotic therapy to eradicate plaintiff's infection.

Defendants, by the foregoing submissions, have made a prima facie showing that they did not depart from the accepted standard of care (*see Abalola v Flower Hosp.*, 44 AD3d 522, 522 [2007]; *Elliot*, 12 AD3d at 482). The burden thus shifted to plaintiffs to produce evidentiary proof in admissible form establishing the existence of a material question of fact (*see Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). Expert testimony must be presented by the plaintiff to show that defendants' conduct constituted a deviation from accepted standards of medical care and to establish proximate cause (*see Deadwyler*, 55 AD3d at 781; *Nichols v Stamer*, 49 AD3d 832, 833 [2008]; *Pace*, 291 AD2d at 436; *Berger*, 272 AD2d at 565; *Lyons v McCauley*, 252 AD2d 516, 517 [1998]).

While plaintiffs have submitted the redacted affirmation of their medical expert, a physician, such medical expert does not assert that Dr. Jafar committed medical malpractice in his treatment of plaintiff or in his performance of the craniotomy for resection of plaintiff's AVM. Plaintiffs' medical expert does not state that there was any fault with the surgery itself. Significantly, plaintiffs' medical expert does not opine that plaintiff developed the infection due to any negligence or medical malpractice on the part of Dr. Jafar or that plaintiff should have received antibiotics for a longer period of time post-operatively to

prevent an infection. Plaintiffs' expert does not dispute or challenge the opinion of Dr. Hewlett that Dr. Jafar acted properly in giving plaintiff a prophylactic course of antibiotics from March 31, 2003 through April 1, 2003 and that this was in accord with proper medical standards.

Thus, there is no triable issue of fact raised by plaintiff with respect to her first cause of action, which alleges medical malpractice by Dr. Jafar due to his alleged negligence in his care, diagnosis, and treatment of her. Dismissal of plaintiff's first cause of action is, therefore, required (*see* CPLR 3212 [b]; *Alvarez*, 68 NY2d at 324-325).

With respect to plaintiff's second cause of action as against NYU, plaintiffs' medical expert and plaintiffs' attorney do not raise any triable issue of fact in response to NYU's prima facie showing (by defendants' submissions, including Dr. DiGiacinto's expert affidavit) that NYU and its staff were not negligent in any way and did not depart from the requisite standard of care. Thus, summary judgment dismissing plaintiff's second cause of action is warranted (*see* CPLR 3212 [b]; *Alvarez*, 68 NY2d at 324-325; *Flanagan*, 2009 NY Slip Op 06161, *3).

Plaintiffs' opposition papers, including their medical expert's affirmation, focus solely upon plaintiff's third cause of action which alleges a lack of informed consent. Plaintiff's third cause of action to recover damages for lack of informed consent is governed by Public Health Law § 2805-d. In order to recover damages for lack of informed consent, a plaintiff must establish, pursuant to Public Health Law § 2805-d, that: "'(1) the defendant physician failed to disclose the material risks, benefits, and alternatives to the contemplated medical

procedure which a reasonable medical practitioner "under similar circumstances would have disclosed, in a manner permitting the [plaintiff] to make a knowledgeable evaluation,"and (2) "a reasonably prudent person in the [plaintiff's] position would not have undergone the procedure if he or she had been fully informed"'" (*Rodriguez v New York City Health & Hosps. Corp.*, 50 AD3d 464, 465 [2008], quoting *Dunlop v Sivaraman*, 272 AD2d 570, 570-571 [2000], quoting Public Health Law § 2805-d [1], [3]; *see also Spano v Bertocci*, 299 AD2d 335, 337-338 [2002]; *DeRosa v Kaali*, 240 AD2d 534, 535 [1997]; *Tibodeau v Keeley*, 208 AD2d 610, 612 [1994]; *Innucci v Bauersachs*, 201 AD2d 460, 460 [1994]; *Evans v Holleran*, 198 AD2d 473, 474 [1993]).

Plaintiff concedes that she signed the consent form for the craniotomy for resection of AVM (which is annexed as an exhibit herein) (Plaintiff's Dep. Transcript at 68-69) (*see Luu*, 57 AD3d at 858). Plaintiff argues, however, that the information disclosed to her about the risks inherent in the craniotomy were qualitatively insufficient.

It is well established that "[t]he alleged qualitative insufficiency of the consent must be supported by expert medical testimony" (*Davis v Nassau Ophthalmic Servs.*, 232 AD2d 358, 359 [1996]; *see also Rodriguez*, 50 AD3d at 464; *Gardner v Wider*, 32 AD3d 728, 730 [2006]; *Evans*, 198 AD2d at 474). "Where a plaintiff fails to adduce expert testimony establishing that the information disclosed to the patient about the risks inherent in the procedure is qualitatively insufficient, the cause of action for medical malpractice based on lack of informed consent must be dismissed" (*Rodriguez,* 50 AD3d at 465; *see also Gardner*, 32 AD3d at 730; *Evans*, 198 AD2d at 474). Such dismissal is also mandated where the

plaintiff "fail[s] to prove that a reasonably prudent person in [his or] her position would not have undergone the procedure had [he or] she been fully informed of the risks of the procedure" (*Rodriguez*, 50 AD3d at 465; *see also Dickstein v Dogali*, 303 AD2d 443, 444 [2003]; *DeRosa*, 240 AD2d at 535; *Tibodeau*, 208 AD2d at 612; *Innucci*, 201 AD2d at 460; *Evans*, 198 AD2d at 474).

Here, while plaintiff, at her deposition, denied that Dr. Jafar discussed with her that one of the risks of the surgery could be an infection (Plaintiff's Dep. Transcript at 61) and plaintiffs' son testified, at his deposition, that Dr. Jafar did not discuss the risk of infection (Plaintiffs' Son's Dep. Transcript at 40), plaintiffs, in their opposition papers, do not raise the argument that the consent given was insufficient due to any failure to disclose the risk of infection. Indeed, plaintiffs' medical expert concedes, in his affirmation, that Dr. Jafar's medical records do, in fact, include the note indicating that "he explained . . . the complications of . . . surgery, which included . . . infection." Dr. Jafar also testified, at his deposition, that he discussed the risk of infection with plaintiff, as indicated in his March 25, 2003 medical note (Dr. Jafar's Dep. Transcript at 48, 132). In addition, Dr. DiGiacinto, in his expert affidavit, states his opinion, within a reasonable degree of medical certainty, that Dr. Jafar obtained a proper informed consent for the surgery, which detailed infection as a risk.

Plaintiffs' medical expert concedes that plaintiff was informed by Dr. Jafar of the embolization procedure by Gamma Knife. In fact, plaintiffs' medical expert quotes Dr. Jafar's March 25, 2003 handwritten medical note, noting that Dr. Jafar specifically stated that

he explained the alternative embolization by Gamma Knife to plaintiff. Plaintiffs' medical expert, however, argues that plaintiff was not "fully" informed that the embolization procedure by Gamma Knife was a safer, less invasive procedure.

Plaintiffs' medical expert explains that embolization (endovascular occlusion) of an AVM is an alternative method to surgical removal, depending on the structure of the feeding vessels. Plaintiffs' medical expert notes that embolization is a minimally invasive procedure of interventional radiology, where a catheter is inserted from the inguinal area to the brain and the malformation is obstructed by injection of material through the catheter.

Plaintiffs' medical expert opines that the initial surgery performed by Dr. Jafar at NYU was not indicated for plaintiff. Plaintiffs' medical expert states that Dr. Jafar "did not fully inform plaintiff of the scientifically advanced less invasive option of embolization by Gamma Knife as he recommended radical open craniotomy for all Grades of AVM in all circumstances of patient presentation, including patients who are relatively asymptomatic." Plaintiffs' medical expert asserts that plaintiff should have been fully informed about the embolization by Gamma Knife procedure versus surgery.

Plaintiffs' medical expert further asserts that there was no reason not to initially undergo the embolization by Gamma Knife procedure since if one or more of the less serious complications of that procedure occurred, plaintiff could then have undergone the more radical, dangerous brain surgery. Plaintiffs' medical expert opines that, therefore, a reasonably prudent person in plaintiff's position would not have consented to radical brain surgery had she been fully informed of the alternative of embolization by Gamma Knife.

Plaintiffs' medical expert further opines that the failure by Dr. Jafar to fully inform plaintiff regarding the alternative treatment of embolization by Gamma Knife was a deviation from good and accepted medical practice which was a substantial factor in bringing about the removal of plaintiff's forehead bone flap.

Plaintiffs' medical expert's assertions, however, are belied by the evidence in this case. Plaintiffs' son, who testified that he acted as plaintiff's translator and was present at her visits to Dr. Jafar (*see* Plaintiffs' Son's Dep. Transcript at 29-40), specifically testified that Dr. Jafar gave plaintiff "basically two options" which were the "minimal invasive procedure involving going into her blood vessels with a little tube and gluing the passage" or "having . . . actual surgery to remove th[e] AVM" (*Id.* at 36-37). Thus, plaintiffs' son's deposition testimony shows that Dr. Jafar had informed him and plaintiff that the embolization procedure was less invasive. Indeed, plaintiffs' son even used the words "minimal invasive" when describing the procedure during his deposition testimony (*id.*). There is no evidence offered by plaintiff that she was not fully informed of the less invasive nature of the procedure of embolization by Gamma Knife or that the consent given by her was qualitatively insufficient.

Moreover, plaintiffs have failed to present evidence establishing that an informed, reasonably prudent person in plaintiff's position would not have consented to and undergone the craniotomy if she had been fully informed of the risks of the procedure (*see Rodriguez*, 50 AD3d at 465; *DeRosa*, 240 AD2d at 534; *Tibodeau*, 208 AD2d at 612; *Innucci,* 201 AD2d at 460; *Evans*, 198 AD2d at 474; *Hylick v Halweil*, 112 AD2d 400, 401-402 [1985]).

Plaintiff did not testify that if she had known more about the risks of the surgery versus embolization by Gamma Knife, she would not have undergone the procedure (*see Rodriguez*, 50 AD3d at 466). In fact, plaintiff testified that Dr. Jafar had explained to her that if she did not undergo the surgery, it was possible that a stroke could reoccur (Plaintiff's Dep. Transcript at 60, 65).

Dr. Jafar, at his deposition, testified that surgery was the best treatment for plaintiff's Grade I AVM (Dr. Jafar's Dep. Transcript at 50-53). Dr. Jafar stated that "the most efficacious treatment for an AVM that had hemorrhaged, a Grade I . . . is surgery [b]ecause you take out the AVM and you are rid of it" (*Id.* at 130). He explained that with surgery, the AVM "won't come back," whereas with Gamma Knife, you are not a hundred percent sure" (*id.*). Dr. Jafar indicated that embolization by Gamma Knife does not work right away, but, rather, it takes one to two years for the Gamma Knife to obliterate the AVM, and that, during that time, the AVM can reemerge (*id.*).

Additionally, Dr. DiGiacinto, in his expert affidavit, opined, to a reasonable degree of medical certainty, that "surgery to remove the AVM was indicated for [plaintiff], and that [embolization by G]amma [K]nife . . . or doing nothing were not good options for her." Dr. DiGiacinto explains that embolization by Gamma Knife would not have been the best treatment for plaintiff as the AVM could re-emerge, and it would take one or two year to obliterate the AVM, during which time a re-bleed could occur."

Plaintiffs' son, at his deposition, also testified that Dr. Jafar discussed with him that plaintiff was at risk of another stroke if nothing were done, with the possibility of recovery from a second stroke being minimal (Plaintiffs' Son's Dep. Transcript at 36). Plaintiffs' son

further testified that Dr. Jafar informed them that with embolization, there was a "considerable risk that [plaintiff] might lose her sight"(*Id.* at 38, 40-41). Plaintiffs' son stated that plaintiff did not give Dr. Jafar her answer of which option she was taking the same day that it was discussed with her, but that she first discussed her options with him and his father (*Id.* at 40). Plaintiffs' son also testified that the reason that after such discussion, plaintiff ultimately decided to go through with the surgery was because it would eliminate the risk of a stroke happening again (*Id.* at 39-40) and due to the risk of losing her sight with the embolization procedure (*Id.* at 41).

While plaintiffs' medical expert opines that there was no cause not to initially undergo the embolization by Gamma Knife procedure and only if complications occurred with the embolization by Gamma Knife procedure should plaintiff have undergone the more radical brain surgery, plaintiffs' medical expert ignores and fails to address the fact that plaintiff had a Grade I AVM that had previously hemorrhaged and that if she went forward with embolization by Gamma Knife, it could have taken one to two years for that to work, during which time there was a risk that she could re-bleed and have a another stroke and that the possibility of her recovering from that stroke would have been minimal. In this regard, it is noted that plaintiffs' expert never obtained or reviewed any of plaintiff's CT scans, MRIs, and angiograms since plaintiffs withdrew their cross motion which sought to strike defendants' answer for failing to provide them with these diagnostic films and plaintiffs never picked up these films from defendants. It is also noted that plaintiffs' medical expert does not indicate that he is a neurosurgeon or neurologist.

Thus, in view of the fact that plaintiff had a Grade I AVM that had previously hemorrhaged and for which she had previously required rehabilitation to recover, given the risk of a re-bleed and stroke with embolization by Gamma Knife as well as the potential risk of a loss of vision with that procedure, it cannot be said that any reasonable person in plaintiff's position would have opted for that procedure and would not have undergone the craniotomy (*see Rodriguez*, 50 AD3d at 465; *DeRosa,* 240 AD2d at 534; *Innucci*, 201 AD3d at 460; *Evans*, 198 AD2d at 472; *Hylick*, 112 AD2d at 401-402). Consequently, inasmuch as plaintiffs have failed to raise a triable question of fact as to the lack of informed consent, summary judgment dismissing plaintiff's third cause of action is mandated (*see* CPLR 3212 [b]; *Feliciano v New York City Health & Hosps. Corp.*, 62 AD3d 537, 538 [2009]; *Brown v Bauman*, 61 AD3d 540, 541 [2009]; *Luu*, 57 AD3d at 858).

As noted above, the fourth cause of action of plaintiffs' complaint asserts a claim of loss of consortium by plaintiff's husband. Since plaintiff's claims as against defendants are dismissed, plaintiff's husband's loss of consortium claim, which is a derivative claim, must also be dismissed (*see Flanagan*, 2009 NY Slip Op 06161,*3; *James v Middletown Community Health Ctr.*, 278 AD2d 280, 282 [2000]; *Hazel v Montefiore Med. Ctr.*, 243 AD2d 344, 345 [1997]; *Clarke v Mikhail*, 238 AD2d 538, 538 [1997]).

Accordingly, defendants' motion for summary judgment dismissing plaintiffs' complaint as against them, is granted.

This constitutes the decision, order, and judgment of the court.

ENTER

J. S. C.

HON. MARK C. DANIELS J.S.C.