SHORT FORM ORDER

INDEX No. 09-6364
CAL. No. 11-01838MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 32 - SUFFOLK COUNTY

PRESENT:

Hon. W. GERARD ASHER
Justice of the Supreme Court

MOTION DATE 2-7-12
ADJ. DATE 4-17-12
Mot. Seq. # 002 - MD

DAISY VAZQUEZ,	:	SALENGER, SACK, SCHWARTZ & KIMMEL
	:	Attorney for Plaintiff
Plaintiff,	:	233 Broadway, Suite 950
	:	New York, New York 10279
- against -	:	
	:	AARONSON RAPPAPORT FEINSTEIN &
CRAIG S. RADNAY, M.D., and SOUTHSIDE HOSPITAL,	:	DEUTSCH, LLP
	:	Attorney for Defendants
	:	600 Third Avenue
Defendants.	:	New York, New York 10016

Upon the following papers numbered 1 to 26 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (002) 1-13 ; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 14-22 ; Replying Affidavits and supporting papers 23-26 ; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by the defendants Craig S. Radnay, M.D. and Southside Hospital pursuant to CPLR 3212 for summary judgment dismissing the complaint is denied.

In this action for medical malpractice, the plaintiff, Daisy Vazquez, seeks damages for personal injury she allegedly sustained as a result of the negligence of the defendants Craig S. Radnay, M.D. and Southside Hospital. The plaintiff asserts that she was under the care and treatment of the defendant Craig S. Radnay from approximately September 1, 2007 through about April 12, 2008, and received treatment at defendant Southside Hospital from April 9, 2008 through April 12, 2008. The plaintiff alleges that the defendants departed from good and accepted standards of medical care during her treatment for knee replacement surgery, and that as a result of those departures, defendants caused damage to her popliteal vein and artery, resulting in an above the knee amputation of her right leg. The plaintiff further alleges the defendants failed to properly and timely diagnose and treat her, failed to provide her with proper informed consent, and negligently hired employees and staff who provided care and treatment at defendant hospital.

The proponent of 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. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]***; Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [1994]). In a medical malpractice action, the moving defendant's papers must set forth everything that the defendant does during the treatment of the patient and indicate that the treatment is not the proximate cause of the patient's complaints. A defendant meets this burden by establishing, as a matter of law, that there was no duty of care breached to the patient (***Kleinert et al v Begum,*** 144 AD2d 645, 535 NYS2d 43 [2d Dept 1988]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.,*** 7 AD3d 759, 776 NYS2d 907 [2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.,*** 242 AD2d 282, 660 NYS2d 739 [1997]).

In support of motion (002), the defendants have submitted, inter alia, an attorney's affirmation; the affirmation of the defendants' expert physician Paul Brief, M.D.; a copy of the summons and complaint, defendants' respective answers and plaintiff's verified bill of particulars; copies of uncertified medical and hospital records; the transcript of the examination before trial of Craig S. Radnay dated December 13, 2010; a certified copy of portions of the plaintiff's medical records dated December 4, 2008; and an uncertified partial record from February 19, 2009. The uncertified and partial medical records are not in admissible form pursuant to CPLR 3212. In any event, even if the plaintiff's medical records were in admissible form,

the defendants have failed to establish prima facie entitlement to summary judgment dismissing the complaint.

Dr. Radnay testified to his pre-operative care and treatment of Daisy Vazquez, a then thirty-four year old woman, and stated he informed her of multiple treatment options, and on May 12, 2008, she opted to have the total knee replacement due to chronic pain. Dr. Radnay testified to the effect that he explained to the plaintiff the risks and complications associated with a total knee replacement, and that she was at a higher risk for complications, including arterial injury, due to her osteonecrosis, some deformation of her bone, and multiple prior surgical arthroscopic procedures. Although he did not know how many procedures were previously done, he did not request those prior medical records. He advised that the risk of injury to the popliteal artery is a rare complication, approximately less than one percent, and that amputation was also a risk. After the surgery on April 9, 2008, he was notified at 5:00 p.m. by a recovery room nurse and a physician's assistant that the patient's foot was cold and pulseless. He did not recall checking her pulses upon completion of surgery, and testified that in April 2008, it was not his custom and practice to do so after completing a total knee replacement. He attended the plaintiff and conducted a Doppler examination for the dorsalis pedis pulse and posterior tibialis pulse. Based upon his findings, he immediately loosened the dressings and flexed her knee, but he still did not obtain a pulse. He immediately called for a vascular surgical consult.

Dr. Radnay testified that when he saw the plaintiff after 5:00 p.m., he advised her that he was concerned about a possible injury to the blood vessels and that further testing and consultation was necessary. Upon arrival of the vascular surgeons, Dr. Melman and Dr. LaRosa, they discussed a possible arterial injury and the need to return her to surgery. He was not involved in that surgery or the subsequent vascular surgery. He stated that Dr. Melman advised the plaintiff that she had a very high chance of losing her right lower extremity and that the popliteal artery appeared to have been lacerated. He also was advised that there was a thrombus in the artery proximal to the injury, but the nerve was intact. The muscle looked viable. Dr. Radnay stated that his own concern was that the injury occurred during the knee replacement, during the cutting of the proximal tibia from the anterior to posterior. He continued it could have possibly been due to some of the contractures, and when addressing the patella component, or when bringing the leg into extension, some injury to the vessel could have occurred. Intraoperatively, there was no reason to believe there was a complication. He also mentioned that possible bone spicules or something sharp, may have lacerated the vessels, or that the artery may have gone into spasm and clotted, but not bled, during surgery. He stated that he will never know for sure what caused the injury as there were no signs of injury during the procedure. The most likely cause was during the cut of the proximal tibia which is done with a saw blade. He continued that the posterior aspect of the proximal tibia is palpable with the saw, but the tip of the saw blade at the back is not always completely visualized, so the cutting is done "through a feel and then completed with the use of an osteotome to get a nice smooth cut."

When Dr. Radnay performed the total knee replacement, he was assisted by two physician assistants who worked under his direction. They assisted typically with soft tissue retraction, and did not usually employ any instrumentalities other than retractors. He testified that the plaintiff's anatomy was unique due to the flexion contracture at the knee, and the presence of osteonecrosis involving not only the joint but diffusely involving the femur and tibia. He continued that the procedure required instrumentation beyond the standard total knee replacement as she required stems on both the femur and the tibia in addition to wedge augmentation on the femur. He continued that intraoperatively, the procedure progressed as

planned. Although he did not know how long the procedure lasted, he noted that the tourniquet was applied at 12:27 p.m., released at 14:27, and then reinflated at 15:04 until 15:44. When he was ready to plant the implants, which had been available at the beginning of the case, the operating room did not have all the implants available. Thus, there was a delay in obtaining the implants.

Dr. Radnay further testified that on April 10, 2008, Dr. Melman and Dr. Wodicka performed a femoral to distal popliteal bypass surgery to prevent recurrent thrombosis secondary to external compression from the knee prosthesis on the previous repair. He continued that the plaintiff had good pulses on April 11, 2008, but the following day, she had slightly increased lower extremity swelling, edema, and the right foot was cooler than the left. On April 12, 2008, she was again taken to surgery due to a loss of Dopplerable signals. Thereafter, she was transferred to Lennox Hill Hospital, a tertiary care facility, to deal with her multiple needs, including grafting to the wound and plastic surgery, and infectious disease consult and treatment. On April 13, 2008, she underwent additional wound irrigation and debridement, as well as advancing or flapping muscle to help cover the bypass graft. She remained at Lennox Hill through June 5, 2008, and was thereafter admitted to a facility in Port Jefferson for care and treatment and rehabilitation. He learned that the plaintiff eventually had an amputation, but he had no opinion concerning whether or not the injury to the popliteal artery was a cause for her amputation.

Defendants' expert Paul Brief, M.D. affirmed that he is board certified in orthopedic surgery and is licensed to practice medicine in New York State. He set forth that he has performed numerous total knee replacement surgeries over the past forty years. He itemized the records and materials which he reviewed. He opined with a reasonable degree of medical certainty that all treatment rendered by the defendants was performed within the standard of good and accepted medical care, and that it was not the proximate cause of the plaintiff's injuries. He continued that Daisy Vasquez came under the care and treatment of Craig Radnay, M.D on September 26, 2007, presenting with a long standing history of bilateral knee pain, greater on the right. Over a twenty-year period, she underwent multiple recurrent patella subluxation, numerous injections, arthroscopic debridement, physical therapy, bracing and anti-inflammatory medications. Dr. Radnay's assessment was that of bilateral recurrent patellar subluxation with medial compartment arthritis and possible avascular necrosis of the medial and lateral femoral condyle. The treatment plan was to continue the anti-inflammatory medication and physical therapy.

Dr. Brief continued that when the plaintiff returned to Dr. Radnay on October 17, 2007, MRI studies revealed osteonecrosis throughout the entire distal femur and proximal tibia. Dr. Radnay discussed total knee replacement with the plaintiff, although he did not recommend it at the time. On March 12, 2008, the plaintiff presented with an interest in total knee replacement surgery of her right knee. Diagnostic studies at the time revealed changes consistent with avascular necrosis and notable joint space obliteration with medial joint space narrowing, more pronounced in the right knee. Dr. Brief set forth the informed consent provided by Dr. Radnay and stated that she was at an increased risk for complications due to the areas of osteonecrosis, deformation of her bone, multiple arthroscopies. He continued that she was further at risk for arterial complication of less than 1%, delayed wound healing, persistent pain, arterial injury, thrombosis, further surgery, amputation, and death. On April 9, 2008, the plaintiff was admitted to Southside Hospital for the right total knee replacement.

Dr. Brief stated that Dr. Radnay completed the total right knee arthroplasty surgery at about 4:30 p.m. on April 9, 2008. After surgery, Dr. Radnay was notified by the recovery room nurse, and his

physician's assistant, that the plaintiff's right foot was noted to be cold and white without palpable pulses. Dr. Radnay evaluated the plaintiff, and conducted Doppler study of the dorsalis pedis pulse and the posterior tibial pulse. The pulses were not palpable and could not be ascertained with Doppler examination. The plaintiff was seen at about 5:30 p.m. by Dr. Melman and Dr. LaRosa. who were called in on a vascular surgery consult by Dr. Radnay. An arterial Doppler revealed a lack of blood flow in the mid popliteal artery, which required urgent surgery. There was a high chance of loss of the right lower extremity. Dr. Brief stated that informed consent was obtained, and at 6:10 p.m. an arteriogram was performed revealing a traumatic arteriovenous fistula. A three compartment fasciotomy was performed. The popliteal artery was found to be divided completely at the level of the popliteal fossa and was repaired with a reversed greater saphenous vein interposition graft harvested from the left leg, providing excellent pulsatile flow to the right leg. However, on April 10, 2008, the plaintiff was found to have decreased pulses in the right foot with increased skin coldness. She was returned to the operating room where the right popliteal artery was incised and a thrombectomy performed, along with a right popliteal artery bypass. Post-operatively, there were Dopplerable pulses throughout the dorsalis pedis.

Thereafter, Dr. Radnay called infectious disease, hematology and critical care consultations. On the morning of April 12, 2008, the plaintiff had a gradual disappearance of previously audible pulses at the ankle with mottling of the right foot and decreased sensation due to compression within her right leg. She was taken to the operating room by Dr. Melman and Dr. LaRosa for exploration of the wound, extension of the fasciotomy, and chemical and mechanical thrombectomies of the right anterior tibial and posterior tibial arteries. The wound was only partially closed to cover the bypass, and the lower part of the leg could not be covered or closed. She was transferred to Lenox Hill Hospital for closure of the wound. Strong Dopplerable pulses were present through the dorsalis posterior tibialis arteries at the time of her discharge and upon admission to Lenox Hill Hospital.

On April 13, 2008, the plaintiff was transferred from Dr. Radnay's care into the critical care service under Dr. Mina, an attending physician. Irrigation and debridement of the wound was performed and a muscle flap was advanced to the exposed vascular graft. Pulses remained good throughout the admission. On December 4, 2008, she was admitted to Southside Hospital for multiple right lower extremity infections, ulcerations, cellulitis and MRSA infection. On February 19, 2009, she was admitted again to Southside Hospital for chronic cellulitis and ulcers which never healed. On February 22, 2009, the plaintiff elected to undergo an above the knee amputation for ischemia of the right lower extremity, non-healing wounds, and chronic pain syndrome.

It is Dr. Brief's opinion that the care and treatment rendered by defendants Radnay and Southside Hospital comported with good and accepted medical standards, and that the plaintiff was informed of all the known risks and potential complications as well as the benefits and alternatives to the procedure. Dr. Brief continued that Dr. Radnay discussed and fully explained the risks and potential complications, as well as the option of total knee replacement surgery, and only after conservative treatment did he recommend total right knee replacement. The plaintiff was advised of a 1% chance of arterial complication from the surgery. Dr. Brief opined that Dr. Radnay provided informed consent on three separate occasions, gave a full explanation of any risks and potential complications, and advised that she had a higher risk for complications due to her prior history. Dr. Brief described the knee replacement surgery performed by Dr. Radnay, with the assistance of two physician's assistants. He opined that it was proper to have the physician's assistants assist him during the surgery, and that the procedure was properly performed,

providing proper alignment and stable full range of flexion and extension. Appropriate sized components were used; appropriate bone dissections and resections were performed. Dr. Brief opined that it was his opinion that in April 2008, it was not the standard of care to check a patient's pedal pulses upon completion of a total knee replacement procedure, and that Dr. Radnay's decision to not check the plaintiff's pulses was within Dr. Radnay's sound discretion, and not a departure from the standard of care.

Dr. Brief stated that post-operatively, Dr. Radnay was notified immediately by the recovery room nurse at Southside Hospital and his physician's assistant that the plaintiff's right foot was cold and white without palpable pulses, and that within thirty minutes, he performed an evaluation of the her foot and immediately called a vascular surgery consult, which was performed within thirty minutes. About forty minutes later, the plaintiff was returned to the operating room for an arteriogram. Dr. Brief stated that the staff at Southside Hospital promptly recognized the absence of palpable pulses and promptly reported to Dr. Radnay, and he, the hospital staff, and the consultants, timely and appropriately responded. He continued that the arterial complication sustained by the plaintiff, the injury to the popliteal artery and arteriovenous fistula, are rare but well-recognized potential risks of a total knee replacement, and that such complications are not a result of medical malpractice.

Dr. Brief continued that the blood clots, or thrombi which formed in every vascular graft that was attempted, reoccurred in spite of multiple efforts at treatment, including mechanical and chemical thrombectomies, and that thrombi are a well-known complication of total knee replacement surgery, of which the plaintiff was advised. He stated that the plaintiff developed hypercoagulability which caused thrombosis of all surgical attempts for popliteal artery grafting, and attempts to reestablish proper circulation to the right leg. Dr. Brief opined that it was the hypercoagulability which caused the recurrent thrombosis and the failure of the popliteal artery grafting procedures, requiring the plaintiff to undergo an above the knee amputation, a known risk of total knee replacement. Thus, opined Dr. Brief, the above the knee amputation of the plaintiff's right leg was not causally related to any alleged malpractice. The plaintiff's reaction to the vascular graft surgery was the result of an unfortunate host response and not due to any medical malpractice or negligence on the part of Dr. Radnay or the Southside Hospital staff. Dr. Brief continued that the acts of the defendants did not constitute a departure from good and accepted standards of medical malpractice, and that there was nothing that they did or did not do which proximately caused the injuries complained of by the plaintiff.

In opposing this application, the plaintiff has submitted, inter alia, the affirmation[1] of her expert physician who is a physician licensed to practice medicine in New Jersey and is board certified in orthopedic surgery. The plaintiff's expert set forth the materials and records reviewed and rendered an opinion based upon a reasonable degree of medical certainty. He set forth the plaintiff's course of treatment during her hospitalizations and the complications which developed during her stay. It is the plaintiff's expert opinion that Dr. Radnay departed from good and accepted medical practice by failing to properly perform a knee replacement on the plaintiff. The plaintiff's expert's affidavit raises multiple factual issues which preclude summary judgment. The defendant's expert did not establish that Dr. Radnay properly identified and protected the popliteal artery and popliteal veins from trauma caused by either the surgical saw, or the retractors. The plaintiff's expert raised factual issues concerning the alleged departure from the

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[1]Although designated an affirmation, the plaintiff's expert has submitted an affidavit for an out-of-state physician which is properly notarized and deemed to be an affidavit.

good and accepted standards of care by Dr. Radnay in causing damage to the neurovascular bundle, and further departure by not ascertaining whether the plaintiff had a dorsalis pedis pulse in her right foot upon completion of surgery, given her known increased risks for injury and her unusual anatomical presentation.

The plaintiff's expert stated that Dr. Melman's handwritten operative report noted that the plaintiff has a severely ischemic right leg caused by "complete transection of the right mid-popliteal artery." He continued that Dr. Radnay testified that Dr. Melman advised him that the injury to the popliteal artery was in the posterior aspect of the knee and that it looked lacerated. Dr. Radnay then testified that most likely the injury occurred during the cut of the proximal tibia as that procedure is done with a saw blade from anterior to posterior and that he does not routinely visualize the artery, vein, or nerve during the replacement, and did not see any increased bleeding. The plaintiff's expert opined that the popliteal artery and veins, and the neurovascular bundle containing these vessels, must be identified and protected from surgical trauma, and that the failure to take cognizance of the anatomical location and protect the neurovascular bundles was a cause of the plaintiff's amputation, pain and suffering. He continued that the defendant injured three separate structures during the procedure, one popliteal artery and two popliteal veins, and that a laparatomy pad should have been placed to separate the retractors from the neurovascular bundle, and that the retractors must be carefully placed.

The plaintiff's expert continued that the tourniquet is applied to the leg during surgery to permit better visualization to the operative field. When the tourniquet is used, the surgeon may be unaware if small vessels are cut. However, upon release of the tourniquet, any vessels that are cut would bleed and should be immediately identified and treated. The tourniquet should be released prior to closure of the operative site to allow the surgeon to identify potential bleeding and afford the patient the best opportunity for recovery. During the surgery, the tourniquet was inflated twice, once for approximately two hours, and then a second time until completion of surgery. The plaintiff's expert stated that the damage to the popliteal artery and vein occurred after the second inflation of the tourniquet. Given the fact that the popliteal artery was divided completely, and two popliteal veins were also divided, there would have been profuse bleeding noted after the first release of the tourniquet. If the tourniquet were released prior to closure of the operative site, bleeding from the three traumatized vessels would have been profuse and resulted in immediate treatment and the best chance for the plaintiff's recovery. Thus, opined the plaintiff's expert, the damage to the plaintiff's artery and veins were traumatic injuries most likely caused by direct trauma from either the use of retractors or by a direct cut by a surgical saw. Either mechanism of trauma to the popliteal artery and two popliteal veins constitutes a departure from good and accepted medical practice.

Plaintiff's expert continued that retractors are used during the entire procedure and are utilized to pull muscles away from the operative site, improving the surgeon's visual field. He stated that Dr. Radnay testified that the two physician assistants assisted during surgery with soft tissue retraction. The plaintiff's expert continued that if a retractor, which is periodically moved during surgery to give the surgeon a different operative view, is moved too aggressively, injuries to arteries and veins, like those suffered by the plaintiff, are likely to occur. Due to the widespread damage to both the popliteal artery and popliteal veins, a retractor injury is a likely cause. The plaintiff's expert opined that the failure of the hospital staff to properly place the retractor resulting in this injury constituted a departure from good and accepted medical practice.

Alternatively, opined the plaintiff's expert, the damage to the popliteal artery and two veins occurred during the cut of the proximal tibia as testified to by Dr. Radnay. Cutting an artery and two veins indicates that the surgeon was using an improper technique and failed to feel that the saw had cut through the bone. This can occur when the surgeon does not have control of the surgical saw. The plaintiff's expert opined that Dr. Radnay exerted too much pressure upon the surgical saw, and pushed too hard, and that the saw passed through the bone, and at least a half inch further to the popliteal artery and two popliteal veins, causing a complete severing of the artery and veins, constituting a departure from good and accepted medical practice. He continued that Dr. Radnay and Southside Hospital staff did not take cognizance of the anatomical location and protect the neurovascular bundle leading to widespread damage to the plaintiff's vascular system.

The plaintiff's expert opined that it was a further departure from good and accepted medicine for Dr. Radnay or the hospital staff to fail to check the plaintiff's dorsalis pedis pulse at the conclusion of surgery. The earlier the diagnosis of any damage, the better the outcome for the patient. Here, the plaintiff's damages were not diagnosed until she was transferred to PACU, which decreased her chances for a successful repair without the need for amputation. The plaintiff's expert stated that it was not the standard of care to check a patient's dorsalis pedis pulse at the completion of the surgery. Dr. Radnay testified that the plaintiff was at an increased risk for surgical complications and bleeding. The operative report stated that she had a "unique anatomy". Thus, the plaintiff, was not an ordinary patient, and therefore, it was a departure for Dr. Radnay to fail to check her dorsalis pedis pulse at the completion of the operation.

The plaintiff's expert stated that the defense has argued that the "complication" suffered by the plaintiff was a risk of the surgery, however, the plaintiff's expert continued that it cannot be said that the defendant properly protected the popliteal artery and veins. In medicine, he continued, one cannot categorize something as a risk of the procedure if one has not taken all steps to prevent such damage. The operative report does not indicate that the neurovascular bundle was identified and protected. Although a physician may discuss the risks and complications with a patient, it does not insulate a physician from any complication during the surgery. The physician must take proper steps to protect the neurovascular bundle, and if he fails to do so, the complication is then not a risk of the procedure. The plaintiff's expert opined that the aforementioned departures from the good and accepted standards of medical practice were a direct cause of the plaintiff's amputation above the knee.

In view of the foregoing, the defendants' motion (002) for summary judgment dismissing the complaint is denied.

Dated: July 10, 2012

W. Gerard Asher
J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**