SHORT FORM ORDER

COPY

INDEX No. 10-41055
CAL No. 14-00531MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 8-8-14
ADJ DATE
Mot. Seq. # 001 - MotD

LUCILLE KOZLOWSKI,

Plaintiff,

- against -

JOHN F. GALLAGHER, M.D. and GREAT SOUTH BAY SURGICAL ASSOCIATES AND VASCULAR LAB, LLP and SOUTHSIDE HOSPITAL,

Defendant.

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Upon the following papers numbered 1 to 19 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1-14; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 15-17; Replying Affidavits and supporting papers 18-19; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by defendants John F. Gallagher, M.D. and Great South Bay Surgical Associates and Vascular Lab, LLP, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted to the extent that the cause of action premised upon the lack of informed consent is dismissed, and that part of the motion for dismissal of the cause of action premised upon the defendant's alleged medical malpractice is denied.

In this medical malpractice action, Elizabeth Kozlowski seeks damages for personal injuries allegedly caused by the defendants' alleged negligent departures from the good and accepted standards of medical practice while providing her with care and treatment. On April 10, 2009, the plaintiff presented to Dr. Eugene Krauss, M.D. for an evaluation of her knees for possible knee replacement. She had a history of high blood pressure, high cholesterol, deep vein thrombosis, and known coronary artery disease which required angioplasty and stenting. Dr. Krauss noted that the plaintiff had diminished

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dorsalis pedis and posterior tibial pulse, and therefore referred her to defendant Dr. John Gallagher for vascular consultation and preoperative vascular clearance. Dr. Gallagher saw the plaintiff on October 5, 2009 and noted that the plaintiff had moderately severely venous stasis changes in both lower extremities upon standing. He ordered a Duplex scan which was performed on October 8, 2009, and which did not reveal any evidence of deep vein thrombosis or deep venous insufficiency in the lower extremities. Dr. Gallagher cleared the plaintiff for total left knee replacement surgery which was performed by Dr. Strauss on October 29, 2009. Dr Strauss used a tourniquet for 29 minutes during the procedure. On October 30, 2009, the plaintiff was diagnosed with an occlusion of her left popliteal artery and proximal posterior tibial artery. After a stat angiogram was performed, bypass graft was performed. On November 1, 2009, she had additional surgery for a four-compartment fasciotomy secondary to compartment syndrome, which left the plaintiff with foot drop in her left extremity, and an ulcer on her left heel. Causes of action for medical malpractice and lack of informed consent have been pleaded.

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 (***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 [2nd Dept 1981]).

In motion (001), the defendants submitted, inter alia, an attorney's affirmation; copies of the summons and complaint; defendants' answer and demands; plaintiffs' verified bill of particulars; copies of the deposition transcripts of plaintiff, Dr. Gallagher, and non-party Dr. Strauss; plaintiff's certified medical records for multiple admissions to Southside Hospital, Dr. Chernoff; uncertified medical records which are not in admissible form pursuant to CPLR 3212 and 4518; and the affidavits of Rajeev Dayal, M.D. and Elton Strauss, M.D.[1]

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[1]These affidavits are nearly identical for the first eleven pages and refer to medical journal articles and publications which have not been provided with the experts' affidavits. The general rule in New York is that an expert cannot base an opinion on facts he did not observe and which are not in evidence, and that expert testimony is limited to facts in evidence. (*see* ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]). Such publications are not in evidence and raise factual issues with regard to the impressions of defendants' experts and bases for their opinions.

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 [2nd Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420 [1999]). 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***, 224 AD2d 674, 638 NYS2d 700 [2nd Dept 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 [2nd Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2nd Dept 1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 690 NYS2d 762 [3d Dept 1999]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the 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 defendant's 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 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

Defendant Dr. John Gallagher testified that he first saw the plaintiff on October 5, 2009 on referral from Dr. Eugene Strauss. He did not at any time, before or after seeing the plaintiff, call or speak with Dr. Strauss, or obtain any of the plaintiff's medical records from plaintiff's health care providers. His note indicated the plaintiff had a history of deep vein thrombosis several years prior. He was not aware of the findings of diminished dorsalis pedis and posterior tibial pulses by Dr. Strauss and his physician's assistant when they saw the plaintiff prior to her referral to him. Dr. Gallagher testified that had he been aware of the diminished dorsalis pedis and posterior tibial pulses, he still would not have changed the course of his evaluation, examination, or testing.

Dr. Gallagher identified the plaintiff's risk factors for arterial disease, high blood pressure, elevated cholesterol, coronary artery disease, arterial angioplasty, and stenting. She was also on two antiplatelet medications. He was aware that the plaintiff had all these conditions, except for the high cholesterol, and was unaware that she actually had five stents placed with multiple arteries involved. He felt that her history of high blood pressure and coronary artery disease made her more likely to have arterial disease at her age, as compared to the general population. He stated that a vascular condition means both venous and arterial condition. Because the plaintiff had a cardiologist, he focused his attention to questions relating to significant venous disease or peripheral vascular disease. He did not speak to her cardiologist.

Dr. Gallagher stated that based upon the plaintiff's age, high blood pressure, symptomatic coronary artery disease treated with angiography and stenting, he had a high degree of suspicion that she had peripheral vascular disease. He stated he performs a complete physical examination, and if it is totally normal, he has then ruled out significant peripheral arterial disease. Thus, he stated, there is no need to do any noninvasive studies. He indicated, however, that some patients with peripheral vascular disease can present with normal pulses. He described the examination which he did and stated that the examination was entirely normal. He manually examined her pulses. He used the Doppler during the venous exam and evaluated the arterial system at the same time. He did not perform PVR, pulse volume recordings, or ABI, ankle-brachial index, as such testing was not necessary because the physical examination was normal. Such testing, he stated, would have been redundant.

Dr. Gallagher was aware that the knee replacement surgery would involve the use of a tourniquet. Risks associated with the tourniquet, if the tourniquet is put on for too long, or if the pressure is too high, are that it can cause vascular damage and lead to problems once the tourniquet is let down. If a patient has significant vascular disease, a tourniquet could cause problems even if it is not on for too long or the pressure is not too high. Relating to the finding that the plaintiff had moderately severe venous stasis changes in both extremities, meant she had venous insufficiency which can result in ulcers and other difficult problems. He told the plaintiff and her daughter that she needed a Duplex scan to investigate the status of the vessels from the groin to the ankles to assess or diagnose abnormalities in the venous system. The Duplex scan was done on October 8, 2009 by his technician. He testified that there was no evidence of deep vein thrombosis, so he gave clearance for the plaintiff's knee replacement surgery. The Duplex study, he stated, was primarily to evaluate the plaintiff's venous system.

Dr. Gallagher stated that in 2008, he was no longer a partner in Great South Bay Surgical Associates, but was a partner in the separate entity of Bay Shore Noninvasive Vascular Lab or Great South Bay Noninvasive Vascular Lab, LLC. He was not sure which. He interpreted vascular studies for Great South Bay Surgical Associates, in which he was not a partner, and submitted a report as a partner of the Vascular Lab. The plaintiff's report concerning her Duplex scan was typed by the technician who performed the exam. He signed the report after he reviewed the study and agreed with the findings. He then testified that the plaintiff was in a hurry so he dictated his note right after the vascular exam after reviewing the images and discussing it with the technician.

Plaintiff's surgeon, Dr. Eugene Krauss stated that prior to the plaintiff's surgery, it was noted by him and his physician's assistant that the plaintiff had diminished pedal pulses, that she was taking Plavix, and she was under the care of a cardiologist. He indicated that a patient with coronary artery disease may very well have peripheral vascular disease. One of the determinations he has used, in the over 10,000 knee replacement surgeries he has done, is to determine if the patient is medically healthy enough for surgery. Only a small number of patients are sent to a vascular surgeon for preoperative clearance. He sent the plaintiff for vascular surgical clearance due to the finding of diminished peripheral dorsalis pedis and posterior tibialis pulses, her history of cardiac disease with stent placement, and of deep vein thrombosis or blood clots. He noted that she also had swelling in her leg which could have been due to low blood flow. He felt she was predisposed to peripheral vascular disease.

Dr. Eugene Strauss, when asked if an arterial occlusion is a known risk of the knee replacement procedure, answered that "vascular issues around knee replacement surgery are known possible

complications." He stated that vascular issues include blood clots, occlusions, and vascular injuries. He continued that he uses the tourniquet with knee replacement surgery around 30 to 40 minutes on the average. He stated that tourniquet times under an hour are not correlated with vascular occlusions. The plaintiff's tourniquet was turned on at 12:15 and turned down at 12:44 p.m. With a tourniquet time of 29 minutes, he would not expect vascular complications unless there was an underlying vascular problem. He stated that there are times that knee replacement is done without a tourniquet, and those are the cases where the vascular surgeon has specifically given instruction not to use a tourniquet. He stated that the vascular surgeon is the expert on whether to use the tourniquet. Dr. Strauss testified that Dr. Gallagher did not recommend that the tourniquet not be used during the plaintiff's knee replacement surgery. Dr. Eugene Strauss stated that it was up to the vascular surgeon to give preoperative clearance and advise whether or not the plaintiff could have the surgery, and whether or not the tourniquet could be used.

Defendants' expert, Dr. Rajeev Dayal, avers that he is licensed to practice medicine in New York State and is board certified in general surgery with an added qualification in vascular surgery. He indicated that while various medical records he reviewed are not certified as complete, they appear credible. However, medical records must be certified pursuant to CPLR 4518 (c). It is Dr. Gayal's opinion within a reasonable degree of medical certainty that Dr. Gallagher did not depart from the accepted standards of good medical, surgical, or vascular surgical practice, and that no negligent act that Dr. Gallagher may have done, and nothing that he failed to do, was a substantial factor in causing the plaintiff's alleged injuries.

Dr. Dayal discussed the plaintiff's medical history of atherosclerotic cardiac disease and coronary artery stenting, however, he failed to mention plaintiff's history of deep vein thrombosis. He continued that the plaintiff presented to Dr. Eugene Krauss on April 10, 2009, with painful arthritis in her knees. When Dr. Krauss and his physician's assistant noted diminished pulses in the plaintiff's feet, he referred her to Dr. Gallagher for evaluation of her vascular status prior to performing any contemplated knee replacement surgery. Upon vascular clearance of the plaintiff for knee replacement surgery by Dr. Gallagher, Dr. Krauss, relying upon Dr. Gallagher's clearance, performed a total left knee replacement on October 29, 2009, after obtaining informed consent from the plaintiff. Dr. Strauss advised plaintiff of the risks of the surgery, including vascular injuries and problems, blood clots, occlusions, and infection. He indicated that Dr. Gallagher's clearance note stated that the plaintiff had normal peripheral pulses, and that Dr. Krauss was sufficiently reassured, and felt that his own prior impression of diminished pulses was inaccurate. Dr. Krauss, thereafter, employed his usual and customary operative technique of applying a tourniquet, though Dr. Dayal does not indicate the location of the tourniquet, or the amount of pressure employed with the tourniquet. Dr. Dayal does not indicate the area of the arterial occlusion suffered by the plaintiff in relation to the area where the tourniquet was placed. Dr. Dayal stated that had Dr. Gallagher advised against use of the tourniquet, Dr. Krauss would not have employed the same. He also indicated that Dr. Krauss performed eleven total knee replacements on October 29, 2009.

Dr. Dayal continued that postoperatively, until the early morning of October 30, 2009, pulses were palpated in the plaintiff's left foot, but it then became pulseless. An arteriogram showed a distinct arterial blockage in the Hunter's Canal of the left femoral artery. Several surgeries were performed subsequently to re-vascularize the plaintiff's left leg and foot, and to treat the wound complications of the revascularization surgery. Dr. Dayal stated he did not discuss the timing and techniques of the diagnosis and operative treatment of plaintiff's left leg arterial occlusion and subsequent course in

Southside Hospital, as these matters are not relevant to Dr. Gallagher's participation in the care of the plaintiff. However, Dr. Dayal does not opine that timing and techniques of the diagnosis and operative treatment of the left arterial occlusion did not contribute to plaintiff's injuries, including foot drop, and the need for subsequent surgeries and procedures. This raises factual issues with regard to proximate cause and plaintiff's claimed injuries.

Dr. Dayal stated that Dr. Gallagher's examination included an evaluation of both arterial and venous circulations, including history and listening for arterial bruits over the carotid arteries, the area of the abdominal aorta, the iliac vessels in the lower abdomen, and over the femoral vessels which were soft on palpation. Femoral, popliteal, dorsalis pedis, and posterior tibial pulses were 2+ bilaterally, and normal. Dr. Gallagher also ordered Doppler color flow examination of the blood vessels in the plaintiff's legs, including the arteries and veins, and reviewed the report of the examining technician, as well as the images obtained during the Doppler study, and discussed the specific findings with the vascular technician. Dr. Gallagher signed off on the study and concluded that the plaintiff had a normal vascular examination and scan, that she had no evidence of peripheral artery disease in her legs, and that no further examination and testing were necessary. Dr. Dayal stated that Dr. Gallagher was aware that tests such as arteriogram, ABI (arterial brachial index), and PVR (pulse volume recordings) were available. However, Dr. Gallagher did not order those tests because he obtained a normal evaluation, and because there was a lack of diminished peripheral pulses which would have indicated the presence of peripheral arterial disease. Dr. Dayal did not set forth the standard of care to rule out peripheral arterial disease, and he did not indicate that he reviewed the Duplex images.

Dr. Dayal opined that a physician proposing an invasive medical procedure is required to obtain informed consent from the patient, and a physician need not obtain informed consent for a procedure to be performed by another physician. He also opined that there is no need, medically or ethically, to provide informed consent when a patient requests specific treatment which does not involve invasive procedures, and there are no reasonably foreseeable risks. Additionally, Dr. Dayal set forth that Dr. Krauss provided informed consent for the surgical procedure for left knee replacement. Dr. Dayal continued that vascular occlusion can occur in the absence of negligence by the treating physician and is a known risk of the procedure. He further opined that vascular clearance is not a guarantee that a patient is free of vascular disease, as vascular clearance is merely a medical opinion based on reasonable medical judgment that the patient's existing vascular status is sufficiently stable to allow the proposed surgery to be performed.

While Dr. Dayal refers to a particular study in a publication that arterial occlusion is a complication of knee replacement, such publication has not been provided with the moving papers, and Dr. Dayal does not state the publication is authoratative. This raises factual issues and also leaves this court to speculate as to the full contents of the article. Dr. Dayal stated that the article also indicated that arterial vascular occlusion can occur with or without use of a tourniquet during surgery, but occurrence of deep vein thrombosis is increased by use of the tourniquet, which the plaintiff did not have. Dr. Dayal opined that even if Dr. Gallagher had suggested that a tourniquet not be used, it would not have made a difference as there is no evidence that the use of the tourniquet during the surgery caused the arterial occlusion suffered by the plaintiff. Thus, opined Dr. Dayal, Dr. Gallagher's clearance was not the proximate cause of the plaintiff's arterial occlusion and the damages she suffered as a result of the complication. However, this raises factual issues as Dr. Dayal does not set forth the basis for this

opinion by setting forth the location of the tourniquet in relation to the site of the arterial occlusion, or the presence of severe arterial peripheral disease found immediately after the knee replacement surgery.

Dr. Dayal continued that Dr. Gallagher conformed to the standard of care for vascular clearance by careful examination of the plaintiff, and the use of a Doppler venous arterial study. Dr. Dayal stated that Dr. Gallagher found that there was no femoral bruit, which is a valid and effective predictor (along with normal pulsations) that peripheral arterial disease was not present, as supported by literature and the study which Dr. Dayal did not provide in support of his opinion. He continued that the gold standard for predicting arterial disease would be a pre-operative arteriogram, which has significant dangers and complications. He state that it is not suitable for the plaintiff as a screening or clearance test, even though she had risk factors for peripheral arterial disease. Dr. Dayal, again relying on medical literature not provided to this court, stated that even if the plaintiff had such testing and revascularization surgery following a finding of arterial disease, vascular occlusion can still occur. However, he does not indicate whether the study reveals such vascular occlusion occurs in the revascularized vessel or another vessel, however. He added that there is no evidence that ABI or PVR study would have shown different results than those studies performed by Dr. Gallagher. He stated that Dr. Gallagher utilized three separate and effective examinations to come to his medical conclusion that the plaintiff's vascular status was adequate for the contemplated surgery, and that he used his own best judgment and practice comporting with other peer physicians. While Dr. Eugene Strauss testified that vascular injury could be a complication of knee replacement surgery, Dr. Dayal does not discuss or rule out whether vascular injury was the cause of plaintiff's arterial occlusion, either from the tourniquet or other means.

Dr. Elton Strauss, defendants second expert, averred that he is licensed to practice medicine in New York and is board certified in orthopedic surgery. He opined that there is no evidence that Dr. Gallagher departed from the standard of good and accepted medical or vascular surgical practice, and there is no negligent act by Dr. Gallagher, or nothing that he failed to do, which was a substantial factor in causing the plaintiff's alleged injuries. The first eleven pages of Dr. Strauss' affidavit are essentially identical to Dr. Dayal's affidavit. It is noted that Dr. Strauss does not set forth the bases for his expertise in vascular standards of care and practice. He stated that he concurs with Dr. Eugene Strauss' testimony that vascular events, such as blood clots or arterial occlusions, are known complications of the knee replacement surgery performed on the plaintiff. It is noted that Dr. Eugene Krauss also indicated that vascular injury is a complication, however, Dr. Elton Strauss does not comment on vascular injury or opine that the plaintiff did not suffer a vascular injury in the instant action.

Expert Strauss stated that the postoperative arteriogram study indicated that the plaintiff had an occlusion in her left femoral artery which presumably caused her left foot to become pulseless postoperatively. He cannot ascertain from the record whether the occlusion was the result of plaque formation in the femoral artery or the result, of an embolism from a distant vessel, or whether the occlusion was caused by some other event or occurrence. It is noted in the operative report of October 30, 2009, that there was occluded inflow to the tibioperoneal trunk with severe, chronic atherosclerotic disease. Dr. Elton Strauss does not address the issue of severe, chronic atherosclerotic disease and whether or not this condition should have been ruled in or out by Dr. Gallagher during his evaluation of the plaintiff, in light of the plaintiff's past history. Nor does he opine with regard to the standard of care for vascular testing, and how the moving defendant comported with such standards.

Dr. Elton Strauss opined, as an orthopedic surgeon, that arterial occlusions can occur in the absence of negligence by the treating physician or the physician who clears the patient as a candidate for surgery. He also opined that an arterial occlusion can occur in the operated leg whether or not a tourniquet is used. Dr. Elton Strauss also referred to the same article referred to by Dr. Dayal, which has not been provided to this court. Again, relying on the same article, Dr. Elton Strauss opined that there is no evidence that had Dr. Gallagher suggested that a tourniquet not be used, and had a tourniquet not been used, that it would not have made any difference in the fact that the plaintiff suffered an arterial occlusion. Dr. Elton Strauss stated that there is evidence that Dr. Eugene Krauss relied upon the vascular clearance to suggest modifications in his operative use of a tourniquet. However, he does not indicate what that evidence is and how the use of the tourniquet was modified. He does not set forth why the operative use of the tourniquet was modified, and what risks plaintiff's surgeon was attempting to avoid with the modification.

It is noted that neither of defendants' experts offers an opinion concerning whether or not the tourniquet should have been used, and what Dr. Gallagher's recommendation should have been. Nor do they mention if there are increased risks for vascular occlusion with use of a tourniquet in an 85 year old patient with a cardiac history with stent placement, decreased dorsal pedis and posterior tibial pulses, and leg swelling prior to knee replacement surgery. Based upon the foregoing, Dr. Elton's Strauss' and Dr. Dayal's conclusory opinions raise factual issues concerning the defendants' alleged negligent departures from good and accepted standards of care, and proximate cause of plaintiff's injuries, which preclude summary dismissal of the cause of action premised upon the alleged medical malpractice by the moving defendants.

The plaintiff submitted the redacted affirmation of her expert in opposition to defendants' motion. However, the redacted version of the expert affidavit submitted by plaintiff lacks evidentiary value (***Marano v Mercy Hospital***, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). "A party may successfully oppose a summary judgment motion without disclosing the names of the party's expert witnesses. In opposition to such a motion the party defending against a summary judgment motion may serve the movant with a redacted copy of its expert's affirmation as long as an unredacted original is provided to the court for its in camera inspection (***Marano v Mercy Hospital***, supra). This procedure preserves the confidentiality of the name of plaintiff's medical expert while also preserving plaintiff's obligation in opposing defendant's motion, in that by submitting a redacted affirmation and by offering the original to the court for in camera inspection, plaintiff has opposed the motion with evidence in admissible form (***Rubenstein v Columbia Presbyterian Medical Center***, 139 Misc.2d 349, 527 NYS2d 680 [N. Y. County 1988]).

A copy of the affirmation with the expert's name and signature have not been provided to this court under separate cover. Accordingly, plaintiff's expert affirmation is not in admissible form and is insufficient to raise a triable issue of fact as to the defendants' alleged malpractice ***(Rose v Horton Medical Center***, 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]), even if the defendants had demonstrated prima facie entitlement to summary dismissal of the complaint, which they did not.

In reviewing the plaintiff's expert's affidavit, it is determined that, if it were in admissible form, it would raise factual issues to preclude summary judgment. Plaintiff's expert opined that Dr. Gallagher

deviated from accepted standards of medical care in failing to perform an appropriate vascular evaluation and by improperly clearing the plaintiff for her total knee replacement surgery. Given the patient's history of deep vein thrombosis, it was appropriate for defendant Gallagher to focus on her venous condition during the evaluation, however, because the plaintiff presented at very high risk for peripheral arterial disease, which was not the focus of Dr. Gallagher's vascular evaluation, the plaintiff would never have been cleared for surgery if she had been properly evaluated.

Plaintiff's expert stated that plaintiff's history of high blood pressure, high cholesterol, and known coronary artery disease requiring angioplasty and stenting, placed the patient at significant high risk for peripheral arterial disease, more so than a patient without such history. Plaintiff's expert opined that Dr. Gallagher's evaluation of the plaintiff did not show appropriate recognition for that history. He opined that Dr. Gallagher departed from the standard of care in failing to perform ABIs and PVRs, non invasive studies, which more accurately and with greater sensitivity, evaluate a patient for arterial disease, arterial occlusion, and arterial compromise, which could present problems in the planned surgery. The plaintiff's expert continued that in assessing the risk/benefit analysis, these noninvasive tests involved no risk to the plaintiff and would have potentially provided great benefit to the plaintiff, as they would have demonstrated she had significant arterial disease. This would have either contraindicated the surgery, contraindicated the application of a tourniquet which was applied for 29 minutes, or lead to arterial bypass surgery being performed prior to the knee replacement surgery. These departures, stated plaintiff's expert, were individually and collectively the proximate cause of the patient's injuries.

The plaintiff's expert also opined that the tourniquet thrombosed the plaintiff's leg and caused a complete occlusion of what was probably an already compromised narrow vessel. In the immediate postoperative period, it was diagnosed that the plaintiff had severe chronic peripheral disease which did not happen overnight, pre-existed the surgery, and was not diagnosed. Had Dr. Gallagher appreciated the plaintiff's significant history of risk for peripheral arterial disease, and performed the noninvasive aforementioned studies, the plaintiff's peripheral artery disease would have been diagnosed, and Dr. Gallagher could have made Dr. Krauss aware of the same. However, Dr. Gallagher departed from the standard of care and cleared the plaintiff preoperatively for the knee replacement surgery, without addressing the plaintiff's peripheral vascular disease. Had that disease been addressed preoperatively, the plaintiff would not have suffered the dire and castastrophic consequences she did.

In that it has been determined that there were no invasive procedures performed by the moving defendants on the plaintiff, the cause of action, premised upon the alleged failure of Dr. Gallagher and his group to provide informed consent for the testing he performed, fails. Public Health Law § 2805-d sets forth, in pertinent part, that the "right of action to recover for medical...malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body....For a cause of action therefore, it must be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought" (***Johnson v New York City Health & Hospitals Corp***, 2008 NY Slip Op 32016(U) [Sup Ct, New York County 2008]).

To establish a cause of action for malpractice based on lack of informed consent, the plaintiff must prove (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 sane position would not have undergone the treatment if he or she had been fully informed, and (3) tht the lack of informed consent is a proximate cause of the injury (***Rezvani v Somnay, M.D.***, 24 Misc 3d 1240[A], 2008 NY Slip Op 52692[U] [Sup Ct, Kings County 2008]). The non-invasive Duplex study, performed at the request of Dr. Gallagher by his technician, did not require informed consent as there was no invasion or disruption of the integrity of the body. There has been no testimony that there were known risks for the procedure and no factual issue has been raised concerning risks associated with the procedures performed by Dr. Gallagher. Importantly, the plaintiff does not claim an injury proximately caused by the Duplex study or Dr. Gallagher's examination.

Accordingly, that part of motion (001) for dismissal of the cause of action premised upon the failure of the moving defendants to provide informed consent is granted, and that part of motion (001) for dismissal of the negligence cause of action is denied.

Dated: 9-30-14

Hon. Debra P. Hecht

A.J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION