SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present: **HON. RANDY SUE MARBER**
JUSTICE TRIAL/IAS PART 10

_____X

LAURA CRUZ and LUIS CRUZ,

Plaintiffs,

-against-

Index No.: 608005/15
Motion Sequence…02
Motion Date…09/05/17

JAY NATHAN, M.D., ORTHOPEDIC ASSOCIATES OF GREAT NECK, LLP, and GLEN COVE HOSPITAL,

Defendants.

_____X

Papers Submitted:
Notice of Motion……x
Affirmation in Opposition……x
Plaintiff Expert Affirmation……x
Memo of Law in Opposition……x
Reply Affirmation……x

Upon the foregoing papers, the motion by the Defendants, JAY NATHAN, M.D. ("Dr. Nathan"), ORTHOPEDIC ASSOCIATES OF GREAT NECK, LLP ("Orthopedic Associates"), and GLEN COVE HOSPITAL (the "Hospital"), seeking an order pursuant to CPLR § 3212, granting them summary judgment dismissing the complaint, is determined as hereinafter provided.

In this medical malpractice action, the Plaintiff, LAURA CRUZ, seeks to recover for personal injuries allegedly resulting from the negligent care and post-operative treatment rendered by the Defendants relating to an open reduction internal fixation

("ORIF") of a left trimalleolar fracture with placement of screws, wire and a plate performed on January 24, 2014. The Plaintiff alleges that the Defendants improperly placed her in a splint following the ORIF surgery; failed to timely remove the splint post-operatively which led to swelling of the lower left extremity ultimately resulting in compartment syndrome requiring fasciotomies and consequential scarring; and failed to timely diagnose the compartment syndrome, but for which the Plaintiff would not have suffered permanent neurological injury. The pertinent facts are as follows.

On January 21, 2014, the Plaintiff, a 37-year-old female, presented to the Emergency Department of the Hospital with complaints of severe pain to her left ankle following a slip and fall accident on snow which occurred while the Plaintiff was shoveling snow at her place of employment. X-rays performed at the Hospital revealed acute medial malleolar and distal fibular fractures with possible posterior malleolar fracture and subluxation of the ankle joint. An emergency medicine attending physician, non-party Dr. Dinesh Verma, placed the Plaintiff's left ankle in a long posterior fiberglass splint, after which repeat x-rays showed no improvement in the bone deformity. Dr. Verma discharged the Plaintiff on the same day with instructions to remain non-weight bearing, use crutches to ambulate, and follow up with an orthopedic surgeon, the Defendant, Dr. Jay Nathan, within two (2) days for follow up care and further treatment.

On January 23, 2014, the Plaintiff presented to Dr. Nathan at Orthopedic Associates. Upon evaluation and review of the x-rays taken at the Hospital, Dr. Nathan's impression was a trimalleolar displaced ankle fracture with tibial talor joint subluxation despite closed reduction. Dr. Nathan recommended the Plaintiff to undergo ORIF of the

trimalleolar fracture. Dr. Nathan testified at his Examination Before Trial ("EBT") that the risks associated with the procedure, of which he normally advises patients, were death, need for additional surgery, lack of improvement, nerve or tendon injury, and infection. He further testified that compartment syndrome is a rare occurrence [*See* Nathan EBT Transcript at pp. 36-38, annexed to Defendants' Motion as Exhibit "G"]. The Plaintiff ultimately agreed to proceed with the surgery which was scheduled for the following day.

On January 24, 2014, the Plaintiff presented to the Hospital where she was admitted for surgery. Prior to the surgery, the Plaintiff signed a consent form entitled "Consent to Operative/Invasive/Diagnostic Procedures, Anesthesia/Sedation Analgesia", countersigned by Dr. Nathan [*See* Defendants' Exhibit "R"]. At 4:13 p.m., Dr. Nathan brought the Plaintiff to the operating room, assisted by Physician Assistant ("PA") Wojick. The operative report reflects that, intraoperatively, the Plaintiff was found to have a comminuted fracture in three major pieces requiring reduction and fixation with screws, wire and a plate. It is undisputed that the intraoperative films revealed that the fracture was appropriately reduced, with proper positioning of hardware with good alignment. After the wounds were closed and dressed, PA Wojick applied an "AO" left leg splint. Following the procedure, the Plaintiff was admitted to the PACU at 5:46 p.m. She was later transferred to the Medical/Surgical floor of the Hospital at 7:30 p.m.

The Plaintiff contends that upon admission for the surgery, discharge was anticipated the same day. However, due to the Plaintiff's complaints of pain following the surgery, a physician Order was issued admitting her to the hospital, directing elevation of her left foot above heart level, consults for physical therapy and occupational therapy, and

a pain management plan. Discharge was noted to be scheduled when the Plaintiff was comfortable on oral narcotics and cleared by physical therapy.

On January 25, 2014 at 10:10 a.m., the Plaintiff was examined by PA Wojick who noted "decreased sensation to touch at the top of [Plaintiff's] left foot secondary to edema." [*See* Excerpts of Hospital Chart, annexed to Plaintiffs' Opposition as Exhibit "B"]. The Plaintiff testified that she complained of pain throughout the day and was unable to be discharged from the hospital due to the inability to control pain with oral medications [*See* Plaintiff's EBT Transcript at pp. 69-74].

On January 26, 2014, the Plaintiff complained of worsened pain, and by the evening, her pain increased to a level of 8 out of 10. [*Id.* at pp. 74-77]. She was examined by PA Bell who noted that the Plaintiff's pain (which was a 10 out of 10) decreased to 5 out of 10 with administration of Toradol. PA Bell did not perform a sensory exam of the Plaintiff's toes.

On January 27, 2014, the Plaintiff complained of pain that was more severe than the day before, and a pressure sensation. The pain was not relieved with pain medications early that morning. At 8:00 a.m. on January 27, 2014, the Plaintiff was examined by PA Szabo who noted complaints of pain along the anterior and lateral aspects of the left ankle. PA Szabo further noted a decrease in dorsiflexion of the Plaintiff's left toes. At 11:00 a.m. the same day, the head nurse asked PA Alpy to examine the Plaintiff for worsening complaints of pain to her left ankle that was not subsiding with pain medication. Upon physical exam, the Plaintiff was unable to move her left great toe, representing loss of use of the Extensor Hallicus Longus tendon ("EHL"). PA Alpy also

observed swelling above the top portion of the splint. PA Alpy testified at her EBT that when she placed her fingers under the casting of the bottom portion of the splint, she found that it did "not appear to be tight"; although there is no record of same in the Hospital chart. At that time, PA Alpy decided to remove the splint and the cotton padding underneath in an attempt to relieve the Plaintiff's pain. PA Alpy's progress note reflects that she "notified Dr. Steinvurzel & Dr. Erlanger of patient's possibility to [rule out] compartment syndrome to left leg". She further noted that the pain medication was changed from Oxycodone to Dilaudid with minimal relief. PA Alpy documented that Dr. Erlanger was to obtain the Plaintiff's pressures [*See* Alpy EBT Transcript at pp. 27-32, annexed to Defendants' Motion as Exhibit "K"; *see also* Excerpts of Hospital Chart, annexed to Plaintiffs' Opposition as Exhibit "B"].

Dr. Erlanger was the on-call physician for Orthopedic Associates that day as Dr. Nathan was not available post-operatively due to a scheduled vacation on January 25th. Upon receiving the call from PA Alpy, Dr. Erlanger presented to the Hospital to evaluate the Plaintiff.

Prior to Dr. Erlanger's evaluation on January 27, 2014, the Plaintiff was not seen by a physician post-operatively.

A progress note by Dr. Erlanger at 12:20 p.m. on January 27, 2014 reflects that the Plaintiff developed increasing posterior pain culminating that morning. He noted that EHL was not present and had not been present since the surgery as per the PA. Physical examination revealed decreased range of motion of the Plaintiff's toes, decreased sensation, and severe pain on passive stretch. Dr. Erlanger's pressure measurements of the

anterior and lateral compartment of the left leg revealed elevated pressures as follows: anterior – distal third compartment at 70 mm Hg; middle third compartment at 19 mm Hg; and lateral middle third compartment at 17 mm Hg. The normal pressure range in a muscle compartment is between 10-12 mm Hg. Dr. Erlanger diagnosed the Plaintiff with compartment syndrome and explained that surgical intervention was necessary to release the pressure of the compartments by undergoing fasciotomies.

On January 27, 2014 at 3:05 p.m., Dr. Erlanger brought the Plaintiff to the operating room for intraoperative measurement of compartment pressures and fasciotomies. Intraoperative compartment pressures measured 120 mm Hg in the posterior compartment; 60 mm Hg in the lateral compartment; and 50 mm Hg in the anterior compartment. The operative report notes that the posterior compartment pressure was reduced from 120 mm Hg to 4 mm Hg following the fasciotomy.

Post-operatively, the Plaintiff's pain significantly improved to a level of 2 out of 10, but she still had limited range of motion of the left toes. The Plaintiff underwent PT and OT following the procedure and remained non-weightbearing. She also presented for a plastic surgery consult with Dr. Bruce Brewer, because the fasciotomy incisions remained open and would require skin grafting to close. The Plaintiff was discharged home on January 31, 2014.

On February 14, 2014, the Plaintiff underwent a debridement of medial and lateral open fasciotomy wounds of the left lower leg with application of split-thickness skin graft which was performed by Dr. Brewer at Winthrop University Hospital [*See* Winthrop Hospital Chart, annexed to Plaintiffs' Opposition as Exhibit "D"].

On February 25, 2015, the Plaintiff underwent surgical removal of the hardware at Syosset Hospital.

Subsequent orthopedic notes from February 2016 reflect that the Plaintiff walks with a limping gait, continued to exhibit limited range of motion in her left ankle, and loss of sensation in the dorsal proximal foot and anterior lower leg.

The Plaintiff testified that she has no feeling in her left lower extremity around the fasciotomy scars, her shin, and down to her foot. She further testified to diminished sensation of her left ankle joint to her toes on the top of the foot. The Plaintiff continues to walk with a limp, is unable to dance, wear high heels, play sports with her children, care for her grandchildren, or climb stairs without assistance. She also complains of resultant emotional sequelae from her fasciotomy scars.

The Plaintiff alleges in her Verified Bill of Particulars that the Defendants were negligent in their performance of the ORIF of her left trimalleolar fracture performed by Dr. Nathan; post-operative monitoring which resulted in the development of left lower extremity compartment syndrome; improper placement of the left lower extremity splint; applying the splint with excessive tightness; failing to timely diagnose compartment syndrome; and failing to timely perform the fasciotomies. Upon completion of the discovery and following the filing of the Note of Issue, the Defendants now move for summary judgment.

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medial practice, and (2) evidence that such departure was a proximate cause of injury (quotations and citations omitted)." [*Faicco v. Golub*, 91 A.D.3d

817, 818 (2d Dept. 2012)]. "Thus, [o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (quotations and citations omitted." [*Id.* at 817]. "In order to sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars (citations omitted)." [*Wall v. Flushing Hosp. Med. Ctr.*, 78 A.D.3d 1043, 1045 (2d Dept. 2010)].

Once a defendant has demonstrated his entitlement to summary judgment, "the burden shifts to the plaintiff to 'submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant . . . so as to demonstrate the existence of a triable issue of fact.' " [*Savage v. Quinn*, 91 A.D.3d 748, 749 (2d Dept. 2012), quoting *Alvarez v. Prospect Hosp.*, *supra* at p. 324 and citing *Stukas v. Streiter*, 83 A.D.3d 18 (2d Dept. 2011)].

In support of their motion, the Defendants submit the expert affirmation of Joel Buchalter, M.D. [*See* Buchalter Affirmation, undated, annexed to Defendants' Motion as Exhibit "A"[1]]. Dr. Buchalter opines, within a reasonable degree of medical certainty, that the Plaintiff's allegations are completely without merit or basis in fact as the care and treatment rendered to her by the Defendants in January 2014 was in accord with appropriate standards of care and did not cause or contribute to the injuries alleged. In pertinent part, Dr. Buchalter opines that "[a]pplication of a splint is necessary following open reduction and internal fixation to promote primary healing by keeping the ankle immobilized. Unlike casts, splints accommodate for swelling which is expected during the post-operative

[1] It is noted that Dr. Buchalter's Affirmation was not contained within the working copy of the motion papers in violation of Part 10 rules. The Court acquired the document by printing a copy from NYSECF.

period." [*Id.* at ¶ 29]. As to the claim that the splint was excessively tight, Dr. Buchalter opined that the Hospital chart is devoid of any complaints regarding the ankle splint; and there is no deposition testimony in this regard. He further attested that application of a splint following ORIF does not cause compartment syndrome. If the splint was applied in an excessively tight manner, Dr. Buchalter claims that signs and symptoms would present of left lower extremity ischemia including color changes, decreased pulses and prolonged capillary refill, and over time, the lower extremity could become gangrenous unless blood flow is restored. He also noted PA Alpy's deposition testimony that during her examination on January 27, 2014, she recalled having space to insert her fingers in the area between the distal portion of the splint and the Plaintiff's foot which establishes that the splint was not excessively tight. [*Id.* at ¶ 34].

Dr. Buchalter concludes, within a reasonable degree of medical certainty, that "the cause of [the Plaintiff's] compartment syndrome is attributable to orthopedic trauma from her comminuted, displaced trimalleolar fracture and is not secondary to the application of her splint." [*Id.* at ¶ 35].

Dr. Buchalter agrees that the Plaintiff suffered from acute compartment syndrome, which he describes as a limb-threatening condition that occurs when the tissue pressure within a closed muscle compartment exceeds the perfusion pressure. He explains that it most commonly occurs subsequent to a traumatic event, such as a fracture, and is a "known complication of orthopedic trauma that frequently occurs in the absence of negligence". He opines that "[t]here is no prophylaxis for compartment syndrome" and that "the only treatment…is to relieve the pressure in the compartment by performing a

fasciotomy…" [*Id.* at ¶32]. It is Dr. Buchalter's opinion that patients with acute compartment syndrome would present with signs and symptoms of pain, paresthesia (numbness), paralysis, pulselessness and prolonged capillary refill; and that "subjective complaints of pain in the absence of any of the above-referenced objective clinical findings is not indicative of compartment syndrome." [*Id.* at ¶ 33].

Dr. Buchalter finds that, in this matter, the documented complaints of post-operative pain on January 24, 2014 through January 26, 2014 were not diagnostic for compartment syndrome, and that the severe pain experienced by the Plaintiff is expected in the ordinary clinical course following a severe, displaced, comminuted trimalleolar fracture requiring [ORIF] with hardware" [*Id.* at ¶ 37].

The Defendants' expert further explains that there was no clinical indication to remove the Plaintiff's splint at any time prior to January 27, 2014, attesting that the decreased sensation found upon examination on January 25, 2014 "is an expected post-operative finding in light of edema." While Dr. Buchalter acknowledges PA Szabo's examination revealed "some decrease" in dorsiflexion, he opines that in response, "discharge was appropriately held". He then characterizes the Plaintiff's complaints of pain at 11:00 a.m. as "an acute onset of worsening pain that did not respond to intravenous narcotics along with loss of the majority of active left toe motion, representing loss of use of EHL", which, Dr. Buchalter admits, represented compartment syndrome. He continues that PA Alpy acted appropriately by taking down the Plaintiff's cast at that time and contacting the on-call physician, Dr. Erlanger, to obtain the compartment pressures "as Physician's Assistants are not trained to obtain compartment pressures." [*See* Defendants'

Exhibit "A" at ¶ 41].

Dr. Buchalter further concludes, within a reasonable degree of medical certainty, that there was no delay in diagnosing the Plaintiff's compartment syndrome, attesting that it represented an acute event "culminating on the morning of January 27, 2014..." He opines that, had there been a delay in diagnosis, muscle necrosis would have been evident during the fasciotomy performed by Dr. Erlanger at 3:05 p.m. on January 27, 2014. In support of this opinion, Dr. Buchalter relies upon the operative report which purportedly reflected that "the tissue in all compartments was found to be '***healthy with normal color, no purulent discharge and no evidence of necrosis***." [*Id.* at ¶ 36 (emphasis in original)]. Dr. Buchalter further opines that, "[t]he lack of necrotic tissue coupled with the highly elevated posterior compartment pressure of 120 mm Hg suggests that Ms. Cruz's compartment syndrome could not have been longstanding as tissue becomes necrotic within a period of hours at a pressure of 120 mm Hg." [*See* Defendants' Exhibit "A" at ¶ 43].

Based on the expert affirmation of Dr. Buchalter, the Defendants have established their entitlement to summary judgment dismissing the complaint against them thereby shifting the burden to the Plaintiffs to establish the existence of a material issue of fact.

In opposition, the Plaintiffs submit an expert affirmation of a board certified orthopedic surgeon[2]. Preliminarily, the Court notes that the Plaintiffs' expert does not contend any departure from the standard of care up to and including the ORIF performed

[2] The Plaintiffs' counsel has not disclosed the identity of the expert pursuant to *Marano v. Mercy Hospital*, 241 A.D.2d 48 (2d Dept. 1998), and has submitted an unredacted copy for the Court's *in camera* review.

by the Defendant, Dr. Nathan, other than his alleged failures pertaining to the claim for lack of informed consent. According to the Plaintiffs' expert, the claimed departures from good and accepted medical practice arise from Dr. Nathan's placement of a splint on the Plaintiff post-operatively and the remainder of the Defendants' post-operative care and treatment of the Plaintiff as discussed in further detail below.

The Plaintiffs' expert opines that there "was no medical indication to place a hard splint which would only be needed to stabilize the joint when the joint was stabilized internally with hardware." [*See* Plaintiffs' Expert Affirmation at pp. 9-10]. It is opined that the hard splint placed the Plaintiff at an increased risk for compartment syndrome due to limited ability for the leg to expand with the anticipated post-operative swelling, which was more likely to occur due to the administration of Lovenox, an anti-coagulent, for DVT prevention. Contrary to Dr. Buchalter's opinion – that splints, unlike casts, accommodate for swelling, and therefore the application of a splint postoperatively was appropriate – the Plaintiffs' expert opines that the splint "provided no benefit to her healing given the surgery". [*Id.* at pp. 12-13].

The Plaintiffs' expert further opines that the Defendants' failure to remove the cast prior to 11:00 a.m. on January 27, 2014 was also a departure from good and accepted medical practice. In contrast to Dr. Buchalter's opinion, the Plaintiffs' expert found the Plaintiff's complaints of pain disproportionate to the surgical procedure at issue and required the Defendants to undertake steps to determine the cause of the pain. This is especially so since discharge was originally intended to be the same day as the surgery. According to the Plaintiffs' expert, good and accepted medical practice required the inquiry

to begin with removal of the splint to perform a complete examination of the leg, including pulses, sensation and motor function.

The Plaintiffs' expert finds significant the decreased sensation noted by PA Wojcik on January 25, decreased dorsiflexion of the toes noted by PA Szabo at 8:00 a.m. on January 27, and the absence of EHL during the entire post-operative period as noted by Dr. Erlanger as indicative that the Plaintiff was suffering from a condition that required removal of the splint for appropriate testing and diagnosis. It is further opined that upon removal of the splint, the surgical site could have been easily protected with a cotton webril dressing which would not cause compression of the area.

The Plaintiffs' expert agrees that the ankle fracture made the Plaintiff susceptible to compartment syndrome, but disagrees with the Defendants' contention that it was an unavoidable consequence thereof. Timely removal of the splint, among other measures, could have prevented the development of compartment syndrome.

As for the Defendants' contention that the splint was not excessively tight, the Plaintiffs' expert opines that PA Alpy's ability to insert her fingers in the distal portion of the splint does not definitely establish that the splint was not excessively tight as the splint "could have room on the posterior side but be tight on the anterior side, or vice versa." [*Id.* at p. 13]. It is further noted that while PA Alpy testified to this at her deposition, no such occurrence is documented in the Hospital chart.

The physician for the Plaintiffs further finds that PA's Wojcik, Bell and Szabo failed to form a proper differential diagnosis and rule out compartment syndrome as the Plaintiff's symptoms which included pain, diminished sensation and impaired motor

function, are all indicative of compartment syndrome. The PA's are also claimed to have departed from good and accepted medical practice by failing to inform a supervising physician of the symptoms exhibited by the Plaintiff so that she could be further evaluated.

Upon review of Dr. Buchalter's affirmation, the Plaintiffs' expert points out that the operative report does not reflect that the tissue found in all compartments were "healthy with normal color, no purulent discharge and no evidence of necrosis". It is further noted that the operative report is devoid of any description of the tissue.

As to the intraoperative compartment pressures, the Plaintiffs' expert noted that normal pressure rangers between zero and 10 mm Hg; blood flow becomes compromised at pressures greater than 20 mm Hg; and muscle and nerve fibers are subject to ischemic necrosis at pressures greater than 30 mm Hg. As such, given the pressure of 50 mm Hg in the anterior compartment, 60 mm Hg in the lateral compartment, and 120 mm Hg in the lateral compartment, found by Dr. Erlanger on January 27, 2014, "it would have been impossible for [the Plaintiff] not to have sustained permanent injury to her left lower extremity as a result of the compartment syndrome." [*Id.* at p. 12].

As to the lack of informed consent claim, the Plaintiffs' expert attests that Dr. Nathan failed to obtain Mrs. Cruz's informed consent with regard to the placement of the splint post-operatively in that he failed to provide any information concerning its risks, benefits, and the alternatives of simply dressing the wound with cotton webril. It is further opined that a reasonably prudent person in the Plaintiff's position would have decided against placing the splint post-operatively if given appropriate information as it provided no benefit but instead, placed the patient at increased risk for developing compartment

syndrome.

The Plaintiffs' expert concludes, within a reasonable degree of medical certainty, that the Defendants' departures from good and accepted practice, as well as Dr. Nathan's failure to obtain the Plaintiff's informed consent, singularly and/or in combination, were a proximate cause and a substantial contributing factor of the Plaintiff's injuries, including the development of compartment syndrome which required her to undergo fasciotomies and skin graft, as well as consequential nerve damage resulting in altered sensation and the inability to engage in activities which she was able to preoperatively. It is further concluded that, "had a splint not been placed and/or had the splint been removed in a timely fashion, she would not have developed a compartment syndrome and would have been spared all the sequellae associated therewith." Lastly, the Plaintiffs' expert concludes that Dr. Nathan's failure to obtain informed consent "significantly diminished this patient's chances of a better outcome and/or the possibility of a better recovery, depriving her of a more favorable prognosis." [*Id.* at pp. 13-14].

In light of the Plaintiffs' expert's affirmation, the Court finds issues of fact exist thereby precluding summary judgment in favor of the Defendants on the Plaintiffs' claim for medical malpractice.

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions [*Feinberg v. Feit*, 23 A.D.3d 517, 519 (2d Dept. 2005)]. Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury [*See DiGeronimo v. Fuchs*, 101 A.D.3d 933, 936 [2d Dept. 2012)].

The Court finds unavailing the Defendants' arguments in reply that the "Plaintiff's expert's affirmation herein is rife with speculation and conclusory statements without reference to the medical record." Quite to the contrary, the Plaintiffs' expert unequivocally points out the specific departures while referencing the relevant portions of the Hospital chart. Indeed, the Defendants' own counsel concedes to the fact that Dr. Erlanger does not discuss the compartment tissue in the operative report as opined by Dr. Buchalter. In their reply, the Defendants attempt to correct the error by contending that the tissue is discussed in the discharge summary and the quote contained within Dr. Buchalter's expert affirmation was a typographical error stating "operative report" instead of "discharge summary" [*See* Defendants' Reply Affirmation at ¶ 20; fn. 1]. It bears noting, however, that while Dr. Erlanger's discharge summary references the intraoperative findings as including a discussion of the tissue ("the tissue was noted to be healthy with color normal and no purulent discharge"), the operative report itself makes no such reference.

Similarly lacking in merit is the theory that there was no clinical indication for earlier removal of the cast and for the Plaintiff's left lower extremity to be examined by a physician prior to January 27, 2014 – three days following the surgery. The Defendant, Dr. Nathan, concedes that he was scheduled for a vacation starting on January 25th (the day following the ORIF surgery) and had no further contact with the Plaintiff post-operatively. While Dr. Nathan testified that his partners from Orthopedic Associates were aware of the Plaintiff's surgery and subsequent hospitalization, the record is devoid of any evidence that any physician even attempted to follow-up with this patient until an emergent

situation arose on January 27th. Indeed, the Defendants' own expert concedes that PA's are not trained to obtain compartment pressures. Given the markedly elevated levels found by Dr. Erlanger intraoperatively, the Plaintiffs' expert successfully raises an issue of fact regarding whether there was a delay in diagnosing compartment syndrome. It will be for a jury to determine whether earlier testing of the Plaintiff's left lower extremity by a physician, as opined by the Plaintiffs' expert, would have resulted in a different, less injurious outcome for the Plaintiff.

Based on the conflicting expert affirmations proffered in this case, an issue of fact also exists as to whether compartment syndrome could have been diagnosed earlier or altogether prevented, thus avoiding permanent nerve damage to the Plaintiff's lower extremity. It is not within this Court's purview to decide, in the first instance, whether the splint should have been applied, and in the second instance, whether earlier removal and testing would have been the appropriate course of treatment in light of the signs and symptoms exhibited by the Plaintiff.

Here, the conflicting testimony of the parties' respective experts and the weight to be afforded are questions within the province of the jury. Thus, the Plaintiffs have established the existence of material issues of fact as to whether the Defendants' post-operative care and treatment of the Plaintiff was in accordance with accepted medical standards as well as whether such care was a proximate cause of her injuries.

A claim of lack of informed consent requires proof of three elements: 1) "failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits

involved"; 2) "a reasonably prudent person in the patient's position would not have undergone the treatment [if she] had been fully informed"; and 3) the procedure was the "proximate cause of the injury or condition for which recovery is sought." Public Health Law § 2805–d (1) & (3). "Thus, '[t]o establish a cause of action [to recover damages] for malpractice based on lack of informed consent, [a] 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 same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury (citations omitted)' " (*Walker v. St. Vincent Catholic Med. Centers*, 114 A.D.3d 669, 670 [2d Dept. 2014], quoting *Spano v. Bertocci*, 299 A.D.2d 335, 337-338 [2d Dept. 2002] [internal quotation marks omitted]). When seeking dismissal of a claim sounding in lack of informed consent, a defendant must establish that he or she "disclosed 'the risks, benefits and alternatives' of plaintiff's surgeries that would have been explored by a reasonable plastic surgeon under the same circumstances, [and] that a similarly situated patient, 'fully informed, would have elected ... to undergo the procedure or treatment (citations omitted)' " [*Conto v. Lynch*, 122 A.D.3d 1136, 1138 (3d Dept. 2014), quoting *Rivera v. Albany Med. Ctr. Hosp.*, 119 A.D.3d 1135, 1138 (3d Dept. 2014)]. "[E]ven in cases where the defendant fails to submit sufficient proof with respect to the other elements of an informed consent cause of action, the defendant may nevertheless establish entitlement to summary judgment by demonstrating

that any lack of informed consent was not the proximate cause of the plaintiff's injury (citations omitted)" [*Keeler v. Liberatore, M.d., CNY Obstetrics & Gynecology, P.C.*, 134 A.D.3d 1495, 1497 (4th Dept. 2015)]. "[A] generic consent form signed by the [patient] on the date of the procedure, as well as an operative report which summarized the information allegedly provided to the [patient]," standing alone, do not meet that burden. Rather, the defendant must "offer her deposition testimony, or that of any other person with knowledge, establishing the specific risks, benefits, and alternatives of which decedent allegedly was informed (citations omitted)" [*Rezvani v. Somnay*, 65 A.D.3d 537, 538-39 (2d Dept 2009)].

Preliminarily, the Court notes that the Defendants' expert, Dr. Buchalter, did not opine as to whether Dr. Nathan disclosed the risks, benefits and alternatives of the Plaintiff's post-operative care, including application of the AO splint, that would have been explored by a reasonable orthopedic surgeon under the same circumstances, or whether a similarly situated patient, fully informed, would have elected to such post-operative treatment. The consent form at issue here reflects the Plaintiff consented to the performance of the ORIF of the left ankle with application of the splint and generally that the risks of the procedure were explained to the Plaintiff. Dr. Nathan testified at his deposition that the consent form, which provides "the risks and benefits were discussed in great detail today", is part of the template language in the Hospital's electronic medical record program. However, Dr. Nathan had no recollection whether compartment syndrome was one of the risks discussed with the Plaintiff. Rather, he testified that, "by general sum and substance, when one has an acute fracture or risk of anesthesia, including death, no

improvement, additional surgery, necessary tendon or nerve injuries, infection, compartment syndrome is a rare occurrence". [*See* Nathan EBT Transcript at pp. 36-37].

Via the executed consent form which referenced the procedure and application of the splint, the defendants established their prima facie entitlement to judgment as a matter of law on the Plaintiff's lack of informed consent claim.

In opposition, however, the Plaintiffs' expert's opinions regarding Dr. Nathan's failure to fully inform the Plaintiff of the risks associated with the procedure and post-operative application of a splint, particularly compartment syndrome, as well as his failure to discuss possible alternatives and that such failures proximately caused the Plaintiff's injuries, sufficiently raise a question of fact. Moreover, given Dr. Buchalter's opinion that compartment syndrome is "a known complication of orthopedic trauma that frequently occurs in the absence of negligence", it would appear that a jury should resolve the question of whether the Plaintiff should have been advised of such risk. The Court further notes the inconsistency of Dr. Nathan's testimony that compartment syndrome is a "rare occurrence" with the opinion of the Defendants' expert in this regard.

Accordingly, it is hereby

ORDERED, that the motion by the Defendants, seeking an order pursuant to CPLR § 3212, granting them summary judgment dismissing the complaint, is **DENIED**.

Dated: Mineola, New York
October 25, 2017

ENTERED
OCT 31 2017
NASSAU COUNTY
COUNTY CLERK'S OFFICE

HON. RANDY SUE MARBER, J.S.C.

HON. RANDY SUE MARBER