

<b>Sharobeem v Smith</b>
2022 NY Slip Op 31880(U)
June 9, 2022
Supreme Court, New York County
Docket Number: Index No. 805445/2016
Judge: John J. Kelley
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**SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY**

**PRESENT: HON. JOHN J. KELLEY PART 56M**

*Justice*

-----X

JACKLIN SHAROBEEM and ESMAT SHAROBEEM,

Plaintiffs,

- v -

MARK L. SMITH, M.D., F.A.C.S., and BETH ISRAEL  
MEDICAL CENTER,

Defendants.

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INDEX NO. 805445/2016

MOTION DATE 03/23/2022

MOTION SEQ. NO. 001

**DECISION + ORDER ON  
MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 001) 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88

were read on this motion to/for

JUDGMENT - SUMMARY

In this action to recover damages for medical malpractice based on departures from good and accepted medical practice and lack of informed consent, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is denied.

In 2012, the plaintiff Jacklin Sharobeem (hereinafter the patient) was diagnosed with invasive ductal carcinoma of the left breast and, in 2013, with right breast cancer. She underwent a partial left-breast lumpectomy with radiation therapy and axillary node removal and a right-breast lumpectomy. The patient thereafter was placed on a regimen of Tamoxifen to treat and suppress the cancer. In the summer of 2014, the patient consulted with Dr. Christopher Mills and the defendant Mark L. Smith, M.D., F.A.C.S., contemplating a radical bilateral mastectomy and breast reconstruction surgery. On August 27, 2014, she met with Smith, a plastic surgeon, who recommended that she undergo deep inferior epigastric perforators (DIEP) flap surgery. On September 12, 2014, the patient underwent a preoperative

magnetic imaging angiography (MRA) of the abdomen and pelvis to evaluate the abdominal vasculature for surgical planning. Mills performed the mastectomy on September 29, 2014, and Smith performed the DIEP flap surgery on both September 29 and September 30, 2014, for a total of 18 hours of surgery. The patient, however, thereafter developed a hematoma in her left breast area. On October 1, 2014, the hematoma was drained and evacuated. On that same date, in an additional surgical procedure, the flap was removed due to nonviability. The patient thus did not have her left breast reconstructed. Although the patient was placed on antibiotics, she subsequently developed a breast skin infection that was treated during a subsequent admission to Beth Israel Hospital between October 8, 2014 and October 10, 2014.

The crux of the plaintiffs' claims, as set forth in their bill of particulars, is that the defendants negligently recommended that the patient undergo DIEP flap surgery despite the fact that the administration of Tamoxifen had been discontinued only two days prior to the surgery. They asserted that the recent continued administration of Tamoxifen left the patient in a hypercoaguable state when the operation was performed, that such increased clotting occluded the blood flow to the breast area, and that the occlusion of blood flow near the proposed anastomosis (the locus of the surgical connection of tissue) both increased the risks of that surgery and ultimately caused it to fail with respect to the patient's left breast, requiring the surgery to be reversed only one week later.

Specifically, the plaintiffs asserted that the radiation therapy that previously had been administered to the patient caused a skin condition that constituted a clinical sign of blood flow compromise in the left breast, and that the patient's pre-existing diabetes was not fully and properly considered when recommending either DIEP or transverse rectus abdominus myocutaneous (TRAM) flap breast reconstruction surgery. The plaintiffs further asserted that the patient's "flaps were not fully robust," indicating that they were not fully vascularized and pink, and thus were not fully supplied with blood, leaving them insufficient to support a successful DIEP flap surgery. They also contended that the defendants failed properly to

interpret the absence of Doppler signals from intraoperative ultrasound testing, claiming that they should have been interpreted as the lack of an adequate blood supply in and to the left breast. They also suggested that the defendants negligently switched the right and left breast sonogram leads, thus leading to a misreading of the actual level of blood flow to the left breast. The plaintiffs averred that the defendants departed from good and accepted practice by failing to abort to the reconstructive surgery because they should have recognized the absence of adequate blood flow and the insufficient viability of the flaps. In addition, the plaintiffs asserted that the defendants negligently failed to identify a hematoma during the surgery, and should have accounted for the precipitous decline in the patient's hemoglobin levels during surgery, which would have alerted them to the likelihood of diminished blood flow to her left breast area.

The plaintiffs also contended that the defendants did not obtain the patient's fully informed consent to the DIEP flap surgery because they did not explain to her that they might be proceeding without an adequate blood supply or flow, did not explain the risks of proceeding without such a flow, and did not inform her of the possible need to employ tissue expanders during the operation, let alone obtain her consent to employ those expanders. They further asserted that the defendants failed to advise the patient that it might be necessary to close the surgical site without creating a flap if there were not an adequate blood supply or source that could be identified.

The plaintiffs alleged that, as a consequence of undergoing the DIEP flap procedure in the absence of adequate blood flow, and the concomitant occlusion or thrombosis of the venous outflow anastomosis, the patient developed a hematoma in her left breast area that had to be evacuated on October 1, 2014, and was caused to undergo an additional surgical procedure on that date as well to remove the DIEP left-breast flap due to nonviability. They further alleged that, as a consequence, the patient's left breast could not be reconstructed in the most optimal fashion.

In support of their motion, the defendants submitted the pleadings, the bill of particulars, the relevant medical records, and the parties' deposition transcripts, along with the expert affirmation of Evan Garfein, M.D., a board-certified plastic surgeon.

Dr. Garfein opined that the defendants' examination, treatment, and care of the patient satisfied the standard of care applicable to plastic and breast reconstruction surgery. He asserted that the patient presented "highly unusual intrinsic anatomic blood vessel anatomy" that Smith only first encountered intra-operatively during the DIEP flap procedure on September 29, 2014, and that, consequently, even the establishment of an anastomosis was difficult and complicated. Dr. Garfein concluded that DIEP flap surgery was indeed indicated, given the patient's "body habitus, her native breast size, and her history of radiation therapy," all of which "support[ed] use of autologous reconstruction with the DIEP flap" in this case. He asserted that the patient "had adequate abdominal tissue to support autologous reconstruction." He further opined that the length of time to complete the surgery and "the eventual thrombosis of the anastomosis" were not indicia of departures from good and accepted medical practice.

As Dr. Garfein explained it, in DIEP flap surgery,

"excess skin and fat tissue from the patient's lower abdomen is surgically transplanted to the chest and sculpted to recreate the shape of the lost breast(s). The tissue is perfused by perforators, usually from the deep inferior epigastric artery and vein, that travel through (perforate) the rectus abdominis muscle and supply blood to this abdominal 'flap.' During the procedure, these vessels are divided in the abdomen and reattached to an artery and vein in the chest. Prior to the procedure, a magnetic resonance angiography (MRA) is usually performed to visualize and confirm that the patient has viable perforating blood vessels in her abdominal flap to allow for this tissue to be used as a flap. Most patients have multiple perforators that supply blood to the abdominal tissue flap. DIEP flap procedures require special surgical training and a specialization in microsurgery on the part of the surgeon.

"In contrast to artificial tissue expanders or implants, DIEP flap breast reconstruction offers the benefit of recreating the breast with the patient's own tissue (autologous) and usually does not require revision or replacement of implants. There are also significant advantages to a DIEP flap surgery relative to other reconstructive techniques such as transverse rectus abdomininal myocutaneous (TRAM) flap or latissimus dorsi flap procedures, as those procedures are more invasive since they involve removal of a significant volume of muscle (rectus abdominal or latissimus dorsi muscle) which adversely affects

a patient's core strength and stability and can result in a longer and more difficult recovery. In contrast, the DIEP flap procedure preserves the patient's rectus abdominal muscle and its fascial covering completely, usually does not require a surgical mesh to support the abdominal wall and results in fewer long-term complications such as post-operative hernia, pain and muscle weakness."

Dr. Garfein thus asserted that it was within the standard of care for a plastic surgeon to recommend DIEP flap surgery as one of several options for breast reconstruction, and that it was not a departure from good practice to recommend it, or to prefer or employ one such method over several others.

Contrary to the allegations set forth in the plaintiffs' bill of particulars, Dr. Garfein attested that, inasmuch as "radiation therapy causes fibrotic damage, stiffness, wound healing problems and scarring to the breast skin," those factors militate against "achieving a successful implant-based reconstruction," as implants are "associated with a higher infection rate than autologous reconstruction" such as DIEP flap surgery. Consequently, he concluded that, in light of that fact, as well as the patient's initial large breast size, "it was better to use an autologous flap rather than an implant or tissue expander in this case." In fact, he stated that, contrary to the plaintiffs' contentions "[p]rior radiation therapy is a significant indication for use of a DIEP flap and many patients that have received such therapy undergo this flap procedure under the standard of care." In any event, Dr. Garfein stated that "the complications that the patient encountered were not, in any way, related to or attributable to her prior radiation therapy."

Dr. Garfein concluded that, although the patient's prior history of diabetes, hypertension, and a prior cesarean section increased the risk of the procedure, they were not contraindications to proceeding with a DIEP flap surgery.

With respect to the plaintiffs' contentions regarding the patient's Tamoxifen therapy, Dr. Garfein asserted that

"Tamoxifen is thought to be mildly associated with an increased risk of deep venous thrombosis during surgery, but there is no standard or consensus in the literature as to when Tamoxifen should be discontinued prior to surgery. Further, many studies find that Tamoxifen presents no risks to patients undergoing microsurgery. Nonetheless, in this case, Tamoxifen was discontinued 48 hours

prior to her DIEP flap surgery which is within the standard of care. Further, the patient received subcutaneous Heparin, 5000 units, intraoperatively on September 29, 2014, which was followed by an additional 1,000 bolus and a 100 unit per hour drip. She was also given Toradol, 30 mg IV prior to the microsurgical anastomosis. Ultimately, given the anti-coagulation medication that she was on, the complications that arose during the procedure were not due to a D[EEP] V[ein] T[hrombosis] or Tamoxifen, *but, as explained below, [it was] the patient's anatomic irregularities [that] resulted in microvascular thrombosis.*"

(emphasis added). Specifically, Dr. Garfein explained that, on September 29, 2014, Smith, upon harvesting the flap in the course of the surgery, observed that the patient's left deep inferior epigastric artery was not supplying blood to the left abdominal flap. As he phrased it, "[e]ssentially, these arteries did not connect with the perforator artery and therefore, could not be used as in-flow to the flap." Dr. Garfein asserted that this presented a "very unusual and rare intrinsic anatomic abnormality" that was not clearly visualized on the pre-operative magnetic resonance angiogram and, thus "could not be predicted or prevented." As Dr. Garfein explained it, "despite appropriate pre-operative radiographic work-up, sometimes the vascular anatomy encountered intraoperatively necessitates altering the pre-operative plan," the very situation that he asserted was present in the patient's case.

As Dr. Garfein continued,

"Here, the left abdominal flap received its dominant blood supply from the superior epigastric arteries that run inferiorly from the chest to the abdomen. These arteries connected with the perforating artery going into the flap. The superior epigastric artery is not used for free tissue transfer due to its long course within the substance of the rectus abdominis muscle.

"Further, the dominant venous outflow from the abdominal flap tissue is typically handled by the deep inferior and, sometimes, the superficial inferior epigastric veins. With Ms. Sharobeem, however, the superficial inferior epigastric vein was not available, due either to native anatomic variability or to a prior Pfannenstiel incision from her cesarean section. As such, the deep inferior epigastric veins were the only remaining option for venous outflow.

"Essentially, plaintiff's arterial and venous vasculature to the left flap were coming from directions opposite to the norm, an anomaly which could not be appreciated on the pre-operative MRA. Normally, the arterial inflow and venous outflow vessels run together. This required changing the operative plan."

He explained that, if the abdominal flap tissue could not be transferred to the breast, it must be discarded, and it cannot be reused or reinserted into the abdomen. Dr. Garfein further explained that, because of the patient's unusual anatomy, only a limited length of the superior epigastric artery and deep inferior epigastric vein could be taken without devascularizing and cutting through the entire abdominal muscle.

Dr. Garfein nonetheless concluded that aborting the procedure was neither indicated nor within the appropriate standard of care, as the optimal procedure was to utilize the patient's autologous tissue. He opined that Smith accomplished this goal by employing the patient's thoracodorsal vessels as the recipient vessels in her chest so as to best match the small caliber of the DIEP flap artery and vein. As he explained it, "Smith dissected these vessels to provide increased length to perfuse the flap, reach the perforator vessels in the DIEP flap and obtain a better size match for the smaller vessels intrinsic to this patient's left abdominal flap." In describing this "plan B," Dr. Garfein reported that

"Dr. Smith was able to perform a functional arterial anastomosis between the arterial perforator of the flap and the thoracodorsal artery. However, the patient's deep inferior epigastric vein was significantly larger than the much smaller thoracodorsal vein. Therefore, Dr. Smith then utilized a vein graft from the patient's forearm to provide an intermediate vessel to attempt to connect the thoracodorsal and deep inferior epigastric vein with the use of two different sized couplers. After tenuous outflow was observed following this connection, Dr. Smith removed the smaller coupler and hand-sewed an anastomosis between the vein graft and the thoracodorsal vein. A near infrared angiography device was employed three times on the left breast skin paddle and showed a patent arterial and venous anastomosis on the left side. Ischemia time was only 1 hour and 32 minutes which is both reasonable and acceptable, and at the completion of the case, the flap appeared to be well perfused."

In other words, Dr. Garfein concluded that this work-around did not cause an unreasonably long occlusion or loss of blood flow to the flap or the anastomosis, that is, the portion of tissue that became connected by virtue of the surgery.

Dr. Garfein also opined that there was no medical basis for any claim that the patient should not have been taken to the recovery room following the completion of surgery on September 30, 2014.

Dr. Garfein further rejected several contentions made in connection with the plaintiffs' expert disclosure. He averred that references to the "left inferior pedicle" or a cesarean section are unclear and inscrutable, and that

"[t]o the extent that plaintiff's expert is claiming that Dr. Smith should have used the deep inferior epigastric system, those vessels were not viable, as already explained. Had these vessels been available on the left side, Dr. Smith would have used them just like he used them in performing transfer of the right abdominal flap to the right post-mastectomy defect without any complications."

Dr. Garfein took issue with the plaintiffs' contention that Smith "failed to fully evaluate both the right and left pedicles before division of the pedicles." As he explained it, the sequence in which Smith performed the operation had no impact on ischemic time. Moreover, Dr. Garfein rejected the plaintiffs' contention that Smith improperly chose to anastomose the vessels to the thoracodorsal system rather than the internal mammary system, explaining that it is well within the standard of care "to utilize the thoracodorsal vessels as recipient," as "the thoracodorsal vessels are often smaller in diameter than the internal mammary vessels and, therefore, were the best available option for inflow or recipient vessels" for the small caliber vessels that were available to Smith by virtue of the patient's anatomic irregularities. He noted that it was "imperative" for Smith to attempt an anastomosis between the abdominal flap and the thoracodorsal vessels once the tissue was harvested.

Based on his review of the relevant records, Dr. Garfein, recounted that, at her preoperative meeting with Smith, the patient discussed the risks and benefits of DIEP versus TRAM treatment, and expressed her preference for the DIEP flap surgery. According to Dr. Garfein, Smith was able to hear the patient's perforating vessels with an ultrasound Doppler probe, which further supported his determination to proceed with DIEP flap surgery. Dr. Garfein concluded that relevant documentation established that Smith properly explained to the patient all of the risks associated that were with that procedure, including those that were more likely to occur due to the patient's history of hypertension and diabetes, including

"bleeding, infection, delayed healing, loss of tissue due to inadequate blood supply, unsightly scars, changes in or loss of sensation, pain, asymmetry, pressure sores, nerve injury, fluid collection, change in tissue consistency, inability to breast feed, need for further surgery, need to remove the nipples, and additional imaging."

Dr. Garfein further reported that, in a note dated September 5, 2014, Dr. Christopher Mills documented that he had a lengthy conversation with plaintiffs regarding the patient's options, and that the patient was shown photographs and diagrams relating to the anticipated surgery. The patient executed a written consent form both on August 27, 2014 and September 29, 2014. He further stated that Smith need not have obtained a separate consent with respect to the forearm vein graft or any other aspect of the DIEP flap procedure on September 29, 2014, as permission to perform any ancillary procedure necessary to effectuate the surgery was implied in the broad written consent given to undertake all necessary procedures.

In opposition to the defendants' motion, the plaintiffs relied upon the same pleadings, bills of particulars, deposition transcripts, and medical records, as well as the affirmation of a board-certified plastic surgeon and editor of a major peer-reviewed plastic surgery journal, who opined that the defendants did, in fact, depart from good and accepted practice, and that the departure proximately caused the patient to sustain injuries.

The plaintiff's expert asserted that the standard of care in a case such as the patient's required the discontinuation of Tamoxifen at least 14 days prior to the mastectomy and breast reduction surgery, and that the discontinuation only 48 hours prior to the surgery constituted a departure from the standard of care. He or she expressly disagreed with Dr. Garfein's statement that there was no medical consensus as to how long prior to surgery that the Tamoxifen should have been discontinued prior to surgery. As the expert phrased it, "[i]t is my opinion that there is a consensus in the relevant medical community that the risk of thrombosis increases with Tamoxifen use and the generally accepted standard of care is to discontinue Tamoxifen for 2 to 3 weeks in advance of a major procedure." The expert concluded that the thrombosis resulted from the recent, regular administration of Tamoxifen to the patient, and that

it was "one of the reasons that the left breast flap in this case failed, and Dr. Smith's deviation from accepted standards of medical care in this respect proximately caused thrombosis, left breast flap failure, and related injuries suffered by the plaintiff."

The expert asserted that he or she reviewed, in detail, the literature attached as an exhibit to the defendants' motion papers, compared it to other literature, and concluded that Dr. Garfein did not specifically reference any of the articles in his affirmation, but simply attached them to the motion papers. The plaintiff's expert expressly opined that, based on significant distinguishing factors---including the small sample size, the delays between the mastectomies and the reconstructive surgeries that were considered, and the types of reconstructive surgeries studied therein---those articles were not instructive as to the relevant and applicable standard of care in any event. The plaintiff's expert also challenged the reliability of non-peer reviewed studies submitted by the defendants for the same reasons, and noted that, in any event, some of them concluded that Tamoxifen should be discontinued *one month* prior to surgery to avoid blood occlusion and thrombosis. As the expert explained it, at least one article cited by the defendants expressly recommended an "individualized approach to preoperative cessation" of Tamoxifen "where each patient's risk factor profile is examined thoroughly before the decision to withhold therapy is made," and that, in this case, the patient presented with significantly increased risk factors for thrombosis and thromboembolism, as compared to the general population, based on her age, cancer diagnosis, radiation therapy, and type II diabetes. The expert concluded that a 48-hour cessation was "woefully insufficient and a departure from accepted standards of medical care in this patient."

The expert retained by the plaintiffs further opined that, contrary to Dr. Garfein's conclusions, the mere use of anti-coagulents such as Heparin and Toradol during the patient's procedure did not mitigate Smith's negligent failure to discontinue the administration of Tamoxifen in a seasonable manner, as "[a]nticoagulant therapy is not guaranteed

to abolish microvascular thrombosis in this type of surgery.” The expert thus concluded that the defendants’ failure to consider the patient’s specific risk factors in advance of her extensive and lengthy surgery, and their failure to discontinue the administration of Tamoxifen at least 14 days prior to surgery, were departures that proximately caused and substantially contributed to her postoperative complication of venous thrombosis and the failure of the left breast flap due to lack of blood flow and death of tissue.

The plaintiffs’ expert also concluded that Smith deviated from good and accepted medical practice with respect to his pre-surgical evaluation, his surgical technique, and his failure to create a plan of treatment that provided for an alternative method of performing the surgery if circulatory issues were encountered with the left breast. The expert further opined that the defendants prematurely transferred the patient to the recovery room and failed timely to diagnose a post-operative hematoma.

With respect to the type of surgery that the defendants recommended to the patient, the plaintiffs’ expert stated that

“Contrary to Dr. Garfein’s assertions, it is my opinion that the choice of a DIEP was not ‘indisputably indicated’ or the ‘best option’ for this particular patient, especially one of an ipsilateral nature (same side), given that Dr. Smith was well-aware of an anatomic anomaly on the left prior to the September 29, 2014 breast reconstruction surgery. There are a host of other means of performing an autologous breast reconstruction, all or many of which are much simpler, and would have had a greater success rate in this particular patient given the special circumstances noted on the pre-operative MRA, and encountered intraoperatively with blood flow in the blood vessels in the left thoracic/chest and in the abdominal flap.”

As the expert explained it, while Smith was performing the surgery, he identified the blood supply to the right breast and placed the flap, but that when Smith turned his attention to the left breast, he discovered that there was no pulse in the pedicle into the perforator. The expert reported that Smith himself stated in a post-operative report that the dominant blood supply was coming from the upper system rather than the expected lower system, and that Smith conceded in his deposition testimony that he thus needed to alter his surgical approach.

The expert concluded that Smith should have evaluated and operated on the left breast first, given the history of radiation therapy to the left breast and the findings of the September 12, 2014 abdominal and pelvic MRA, which showed that the vasculature and blood supply/drainage from the left vascular pedicles had an unusual intrinsic blood vessel anatomy. The expert asserted that, based on the patient's history and the MRA findings, it was a departure from good medical practice *not* to evaluate and operate on the left breast first. In fact, the expert contradicted Dr. Garfein's conclusion that Smith first encountered or became aware of unusual anatomy only during the DIEP flap procedure; rather, the expert noted that the pre-operative September 12, 2014 MRA report reflected a difficulty in visualizing the arterial inflow to the dominant perforator, and stated that the arterial inflow to the dominant perforator in the left vascular pedicle "presumably arises from a medial column branch," thus corroborating that that difficulty in visualization. The expert thus rejected Dr. Garfein's conclusion that the anomaly of the arterial and venous vasculature to the left flap coming from opposite directions from the norm could not be appreciated on the pre-operative MRA. In this regard, the plaintiffs' expert also expressly rejected Dr. Garfein's opinion that the sequencing of left and right breast surgical activity, including the sequence in which the flaps were harvested, had no effect on the time within which the left side could develop and reveal ischemia; rather, the expert asserted that the sequencing was critical in light of the prior radiation and surgery administered to the left breast, which required attending first to the left breast to comport with the standard of care.

The expert further referred to Smith's own operative notes, in which Smith referenced the portion of the preoperative MRA report that revealed problems with the left vascular pedicle, specifically, that there was difficulty in visualizing the arterial inflow to the one dominant perforator on the patient's left side. Hence, the expert concluded that, even prior to the breast reconstruction surgery, Smith knew that the left side of the patient's abdominal flap presented an anatomic anomaly and could be problematic for ipsilateral left breast reconstruction.

Moreover, the expert concluded that, in light of this knowledge, Smith should have, but did not,

develop a contingency plan to address the situation that actually occurred, namely, that there was insufficient blood flow to the patient's left side to support a DIEP flap procedure on the left breast. As the plaintiff's expert further opined,

"While plaintiff agreed to a DIEP, Dr. Smith should have had plans in place to select another option intra-operatively when every vein graft and anastomosis was clotting or failing during the surgery, since at that point there was an expected high failure rate of the DIEP based on the sequence of events during surgery. The Consent allowed Dr. Smith to choose another option and states: 'and all related and/or necessary procedures', yet Dr. Smith did not have a reliable or appropriate contingency plan in place, which was a deviation and substantial cause of the left breast flap failure and related injuries."

The plaintiff's expert vigorously disagreed with Dr. Garfein's opinion that, in this case, it was a mere exercise of rational medical judgment to recommend and opt for DIEP flap surgery, as opposed to TRAM or Latissimus flap surgeries. He or she stated that

"[t]his is not a matter of a surgeon using his professional judgment to select between viable treatment options. I opine that for this particular patient, the DIEP flap was not an appropriate choice compared to other autologous flap methods based on the documented pre-operative MRA findings detailed above and the significant intra-operative complications, including vein graft and anastomosis clotting and failure during the surgery."

The plaintiff's expert continued that

"[a]mple time and appropriate options, within accepted standards of medical care, were readily available to Dr. Smith, the treating surgeon, well before the failure of the left breast flap. An appropriate method of reconstruction in this case would have been to reconstruct the non-radiated right breast with an alloplastic tissue expander/implant and reconstruct the radiated left breast by using the viable abdominal tissue from the right side for an autologous reconstruction. Significantly, Dr. Garfein notes the transfer of the right abdominal flap as being without difficulty. I opine that this same flap should have been utilized on the contralateral left side, given the problems on the left side, and Dr. Smith's failure to do this was a deviation from accepted standards of medical care."

In addition, the plaintiffs' expert explained that Smith should have explored the artery inferiorly to identify where and how it was obstructed, which he failed to do, and that Dr. Garfein, in rendering his opinion, failed to consider an obstruction due to scar tissue. The expert concluded that it was a departure from accepted standards of medical care for Smith to have failed to explore and identify the cause of the lack of blood flow, that he should have utilized the

patient's existing cesarean section scar by dissecting out the inferior pedicle down to the scar, and that this departure led to the employment of a poor surgical technique that, in turn, resulted in thrombosis and failure of the left breast flap.

The plaintiffs' retained expert further concluded that Smith improperly chose to anastomose the vessels to the thoracodorsal system rather than to the internal mammary system, and that Smith's choice was a deviation from accepted standards of medical care, as the utilization of the thoracodorsal vascular system in an already problematic DIEP transfer led to the sacrifice of key blood vessels that otherwise would have allowed a latissimus dorsi muscle transfer pedicled flap on the very vessels that he sacrificed. The expert opined that this latter flap alone would have achieved autologous breast reconstruction on the left side.

In light of what the plaintiffs' expert characterized as the excessive length of an 18-hour-long surgery that should only have taken 5 to 6 hours, he or she further opined that it was a departure from good practice to send the patient directly to the recovery room after the surgery was completed. According to the expert, Smith's operative report conceded that there were several indicia of an inadequate blood supply flowing to the left flap and, as such, he should have removed the left flap, closed the skin, and told the patient's family that he could only complete a right-side reconstruction despite his efforts, and that the patient should have been closely monitored post-operatively, which was not done. The expert concluded that this departure was a substantial factor in contributing to the patient's injuries.

The plaintiffs' expert also concluded that the defendants failed to obtain the patient's fully informed consent for the breast reconstructive surgery, as Smith failed to offer and discuss contingency plans with the patient and her family in light of the pre-operative MRA findings, or even to discuss those findings of anatomical anomalies with the patient. According to the expert, alternative methods for reconstruction of the left breast, including alternative surgical techniques, such as the placement of a tissue expander, should have been discussed with the patient in advance, but were not, and that Smith should have discussed contingency plans in

the event that an unremarkable completion of the intended procedure was not possible, as in the case of problems in identifying an acceptable blood supply. The expert averred that, had the patient been provided with the parameters and treatment options, while she might have made an informed choice and insisted on a DIEP flap procedure rather than other autologous reconstruction methods, but might also have selected the option of no reconstruction in the event that a viable reconstruction with the autologous tissue was not possible. "However, the failure to provide adequate informed consent denied plaintiff an opportunity to make a fully informed choice." The expert rejected Dr. Garfein's statement that the inclusion, on the written consent form, of permission to undertake "all related and/or necessary procedures," along with a related disclaimer, was sufficient to obtain the necessary informed consent to the procedure actually undertaken in this matter, particularly in light of the patient's medical history and known risk factors.

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see CPLR* 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie

showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

“The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even ‘arguable’” (*De Paris v Women’s Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; see *Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff’s case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

“To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff’s injury” (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (see *McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; see generally *Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (see *Roques v Noble*, 73 AD3d

at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Where the expert's

"ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; see *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

In connection with the claim that the defendants departed from accepted medical practice, they established their prima facie entitlement to judgment as a matter of law with their submissions, including Dr. Garfein's affirmation. Nonetheless, the affirmation of the plaintiffs' retained expert raised a triable issue of fact as to whether the defendants' determination to recommend and proceed with DIEP flap surgery constituted a departure from good and accepted practice in light of the patient's medical history and known anatomical anomalies, both of which increased the likelihood of failure due to ischemia. The plaintiffs further raised a triable issue of fact as to whether the defendants departed from good and accepted care in connection with some of the intraoperative decisions that Smith made concerning the sequencing of various tasks, the determination to create an anastomosis employing particular blood vessels, and the failure either to abort the left-side DIEP flap procedure or remove the left flap after incipient or apparent failure, as well as the post-operative determination to transfer the patient directly to the recovery room after surgery rather than retaining her in the operating room after the failure should have become apparent. The plaintiffs also raised a triable issue of fact as to whether the post-operative care rendered between September 30, 2014, and October 1, 2014 comported with the applicable standard of care.

Hence, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action premised upon departures from good and accepted practice must be denied.

The elements of a cause of action for lack of informed consent are

"(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”

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; see *Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a “non-emergency treatment, procedure or surgery” or “a diagnostic procedure which involved invasion or disruption of the integrity of the body” (Public Health Law § 2805-d[2]).

“The mere fact that the plaintiff signed a consent form does not establish the defendants’ prima facie entitlement to judgment as a matter of law” (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (see *Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

Although the defendants established, prima facie, that they provided the patient and her family with information concerning foreseeable risks and benefits of DIEP flap surgery, the affirmation of the plaintiffs’ expert raised a triable issue of fact as to whether the defendants fully informed the patient of likely ischemic problems arising from her medical history and risk factors, of anticipated problems that would have to be addressed while she was anesthetized, and of the likelihood of success or failure of the procedure in connection with her left breast, as compared with other autologous and non-autologous breast reconstruction methods. The court agrees with the plaintiffs that the vague language included in the written consent form was not sufficient


to provide the patient with the extent of information she needed to provide her fully informed consent to any specific alternative surgical technique that the defendants employed here.

Accordingly, it is

ORDERED that the defendants' motion for summary judgment dismissing the complaint is denied.

This constitutes the Decision and Order of the court.

6/9/2022  
DATE

  
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JOHN J. KELLEY, J.S.C.

CHECK ONE:

CASE DISPOSED

GRANTED

SETTLE ORDER

INCLUDES TRANSFER/REASSIGN

DENIED

NON-FINAL DISPOSITION

GRANTED IN PART

SUBMIT ORDER

FIDUCIARY APPOINTMENT

OTHER

REFERENCE

APPLICATION:

CHECK IF APPROPRIATE: