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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: ALICE SCHLESINGER PART IA PART 16

Index Number : 116707/2006

OSTROV, DEBORAH

VS

ROZBRUCH, JACOB M.D.

Sequence Number : 002

SUMMARY JUDGMENT

INDEX NO. _____

MOTION DATE _____

MOTION SEQ. NO. _____

MOTION CAL. NO. _____

The following papers, numbered 1 to _____ were read on this motion to/for _____

| | PAPERS NUMBERED |
|---|---|
| Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ... | |
| Answering Affidavits — Exhibits | |
| Replying Affidavits | |

**Cross-Motion:** ☐ Yes ☒ No

Upon the foregoing papers, it is ordered that this motion for summary judgment by defendant Jacob Rozbruch, M.D. is granted in part and denied in part in accordance with the accompanying memorandum decision.

FILED

JAN 20 2011

NEW YORK
COUNTY CLERK'S OFFICE

JAN 14 2011

Dated: January 14, 2011

ALICE SCHLESINGER J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☐ FINAL DISPOSITION ☒ NON-FINAL DISPOSITION

Check if appropriate: DO NOT POST ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

----------X

DEBORAH OSTROV,

Plaintiff,

-against-

JACOB ROZBRUCH, M.D., and BETH ISRAEL MEDICAL CENTER,

Defendants.

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Index No. 110106
Motion Seq. No. 002

SCHLESINGER, J.:

Deborah Ostrov, the plaintiff, has had a number of orthopedic procedures with the defendant Jacob Rozbruch as her surgeon. The two first met on October 20, 1998, when Ms. Ostrov was referred to Dr. Rozbruch by her long-time primary care physician, Dr. Leonard Raifman. She had suffered a left tibia stress fracture that was healing but was still a cause of complaints for left foot pain and persistent left leg swelling.

On February 8, 2001, Dr. Rozbruch performed an open reduction of Ms. Ostrov's right elbow due to a fracture from a fall; on October 1, 2001, he performed a left total hip replacement; on October 13, 2003, he performed a right knee replacement; and on June 7, 2004, the doctor performed a left total knee replacement. It is this last surgery that forms the basis for Ms. Ostrov's complaint that the procedure was contraindicated and should not have been done. She was 73 years old at the time and has complained of extraordinary persistent swelling in her left leg from that point forward.

When this action was commenced, the plaintiff named Dr. Rozbruch and Beth Israel Medical Center, the site of the surgery, as defendants. With regard to her orthopedic surgeon, in addition to the claim of malpractice causing severe and permanent injury, Ms. Ostrov also claimed a lack of informed consent to this surgery.

At the completion of discovery, both defendants moved for summary judgment. In a decision dated July 12, 2010, I granted the hospital's motion but requested additional submissions, primarily from the opposing plaintiff, regarding the claims against the doctor. The rationale for this interim decision was that, while in the first instance I did find that Dr. Rozbruch had made out a prima facie case entitling him to the dismissal of the action based on multiple affirmations from non-party experts as to his surgical care and treatment (the submissions were from Dr. Donald Rich, an orthopedist, Dr. Larry Scher, a vascular surgeon, Dr. Raifman, plaintiff's before-mentioned primary care physician, and Dr. Andrew Turtel, her treating orthopedist), I also noted that the medicine involved was complicated and that, in fact, all the physicians heard from were still unclear as to precisely why the poor result had occurred. Further, I found that while the plaintiff's opposition, in the form of an affirmation from an orthopedist, did opine about departures, I was still concerned with the limited discussion provided by this physician as to precisely why this left knee replacement was contraindicated and also what was the mechanism of the injury. In other words, after the burden had shifted to the plaintiff, I was still unclear what specifically made this surgery ill advised and "how or why Ms. Ostrov's left leg deteriorated to the extent it allegedly did as a result of the left knee replacement." (See page 3 of my July 12, 2010 decision).

I then directed supplemental expert submissions from both sides "to clarify the medical opinions" so that I could "better understand the complex medical issues and determine whether issues of fact truly exist" (p 4). The plaintiff was to submit his papers first since the moving defendant was entitled to the last word of argument. I then received a new submission from counsel for Ms. Ostrov in the form of an extensive affidavit from a Board Certified surgeon who had completed a Fellowship in vascular surgery. This surgeon

identified himself/herself as having "extensive experience in evaluating patients for vascular issues related to prospective joint replacement surgery, as well as extensive experience in following post-operative patients who had undergone surgery and/or hip replacement surgery, for any vascular issues related thereto" (¶1 of this affidavit).

Strikingly, what I received from counsel for the defendant Dr. Rozbruch was an explosion of affirmations/ affidavits. Specifically, I heard from six doctors, five of whom were vascular surgeons and one of whom was an internist. Two were supplemental affirmations, the first from Dr. Scher, a surgeon, and the other from Dr. Raifman, Ms. Ostrov's long-time primary care physician. I also received one from the plaintiff's former treating vascular surgeon, Dr. Stephen Haveson, who had been mentioned before but never heard from. Finally, three were submitted from well- credentialed vascular surgeons who had been actively involved in the creation, development and revision of the Clinical-Etiology-Anatomy-Pathophysiology (CEAP) classification system. These physicians were Dr. Gregory Moneta, Dr. Robert Kistner, and Dr. Thomas Wakefield.

The plaintiff's surgeon/expert does agree with the plaintiff's prior orthopedic expert as to the existence of two departures. They are first, that the June 2004 left knee replacement was contraindicated because of Ms. Ostrov's recent history and clinical presentation, and second, that Dr. Rozbruch deviated from accepted medical/surgical standards by failing to obtain a clearance for this surgery from a vascular surgeon. The implicit assumption for this latter point is that a vascular surgeon under the circumstances would not have given such clearance.

However, included in the extensive response from the defense is an affirmation from Ms. Ostrov's former treating vascular surgeon, who, I must assume, would have been the

vascular surgeon to whom Ms. Ostrov would have been referred if Dr. Rozbruch had sought clearance from a vascular surgeon, instead of obtaining that clearance from Dr. Raifman, an internist. That vascular surgeon, Dr. Haveson, acknowledges that Ms. Ostrov did suffer from venous insufficiency, venous edema and chronic lymphedema. However, contrary to what plaintiff's expert opined, he would not have "scratched" the left knee replacement if he had been asked for a pre-operative consult/clearance. He says this is so because he believes that the left knee replacement was not contraindicated. He states that he would have cleared Ms. Ostrov for this surgery as there were no acute vascular symptoms at the time and she needed the surgery. Finally, her history did not preclude the knee replacement.

Since it must be assumed that Dr. Haveson is correct when he says he would have been the vascular surgeon consulted, and since he clearly opines that he would have provided clearance for the procedure, it follows, and I do so find, that the alleged deviation must fall.[1] Therefore, the arguably sole viable departure against Dr. Rozbruch concerns the claim that he should not have proceeded with the June 2005 left knee surgery in light of Ms. Ostrov's history, her clinical presentation, and the CEAP classification system, which plaintiff's expert in part relied upon in giving his opinion. This surgeon, before giving his opinion on the issues, states that he reviewed all the medical and legal records connected to this action, as well as the supporting affirmations submitted as part of the summary judgment papers. He also reviewed my interim decision and the concerns expressed therein.

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[1]If Dr. Haveson had in fact given the clearance, with presumably the same poor result, it may well be that he would have, under such circumstances, been a defendant along with Dr. Rozbruch in this action. But this is non-profitable speculation since the facts did not play out that way. Ms. Ostrov received the clearance from her internist.

For the first time in these motion papers, this surgeon refers to the "CEAP classification scoring system for chronic venous disorders." He indicates that CEAP stands for Clinical-Etiology-Anatomy-Pathophysiology and explains that it was established in 1994 by a committee of the American Venous Forum and endorsed by the Society for Vascular Surgery. He then explains that patients, pursuant to their clinical presentation and history, are rated under the CEAP system according to the severity of their vascular disease on a scale of zero to six, with six being the most severe.

The doctor then opines that in October of 1999, when seen by her vascular surgeon Dr. Haveson, Ms. Ostrov presented with significant varicose veins and mild incompetence of her perforator veins. It also was noted that the swelling in her left leg was due to a chronic venous insufficiency. The swelling indicated that edema was present. Putting these symptoms together, the surgeon then classifies Ms. Ostrov as a class 3 under the CEAP system, based upon her varicose veins and her edema.

In January of 2001, Dr. Haveson then noted that Ms. Ostrov had increasing stasis dermatitis (an inflammation of the skin) which, according to plaintiff's expert, escalated her classification to class 4. The expert states (at ¶7) that: "A class 4 under the CEAP classification system represents significant and severe vascular disease."

Dr. Rozbruch proceeded with a left hip replacement on October 1, 2001, but during the course of the patient's recovery at the hospital, she developed a deep vein thrombosis. Based on this development, the expert opines that it could not be expected that her CEAP classification would ever improve (¶8).

Dr. Rozbruch then performed a right knee replacement on October 13, 2003. As a consequence of this surgery, Ms. Ostrov developed another deep vein thrombosis, as

well as a full thickness pressure sore on her left heel. Her classification remained at a "4" "with significant, serious vascular disease" (¶9).

The expert then proceeds to explain the "big surgery" involved in a left knee replacement, such as the one performed here on June 7, 2004. He explains that the procedure involves taking out the entire knee joint and the distal femur, with dissection of soft tissue off of the joint and bone. This dissection interrupts the lymphatic flow in every patient. In Ms. Ostrov's case, with a pre-existing history of lymphedema,[2] this condition never resolved. Nor does this expert opine that the condition should have been expected to resolve in light of the patient's history. In fact, it did not resolve, and the extensive dissection contributed to increased venous reflux, another reason for the extensive swelling (¶¶ 12 and 13).

The surgeon then opines (at ¶14) "with a reasonable degree of medical certainty" that "Dr. Rozbruch departed from good and accepted surgical practice by performing the total left knee replacement upon Ms. Ostrov, in view of the plaintiff's severe chronic venous insufficiency and lymphedema." In this regard, the expert points out that Dr. Rozbruch himself testified that he would not operate on a patient with significant venous insufficiency (¶14).

The issue here is, pre-operatively, how serious were the plaintiff's circulatory problems and were the doctors attending to her, including the defendant, sufficiently on

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[2]Whether, when and by whom an actual diagnosis of lymphedema was made regarding this patient is the subject of some controversy. The defense position is that it is a diagnosis made by exclusion and here it was made after the June 2004 surgery, when no other explanation for the poor results other than lymphedema could be found. However, whether or not such an actual diagnosis was written in the records, the expert for Ms. Ostrov contends that she had all the characteristics of this condition.

notice of her condition to have them conclude that surgery was not the right course. Plaintiff's expert believes that there was enough symptomology present, specifically the combination of significant varicose veins, the compromise of Ms. Ostrov's perforator veins, the swelling of her left leg, the increasing stasis dermatitis, and a history of deep vein thrombosis, to have reached the conclusion that a surgical approach was wrong and that Dr. Rozbruch should have appreciated that and refrained from going ahead.

Further on in his affirmation, the surgeon gives his opinion as to the mechanism of the injury. He says that "her injuries herein resulted from the major soft tissue dissection performed during the removal of the knee joint and bone. The dissection in and of itself interrupted the lymphatic flow in an already severely compromised patient, resulting in increased, persistent swelling" (¶16).

As noted earlier, the defendant's opposition is extensive. The overall contention expressed by counsel (at ¶12) is that the opinions offered by plaintiff's expert are "not accepted within the medical community, factually unsupported and directly contradict Ms. Ostrov's deposition testimony." Counsel then divides his opposition into three basic parts. The first, which refers the Court to affirmations/affidavits from three prominent vascular surgeons – Dr. Gregory Moneta, Dr. Robert Kistner and Dr. Thomas Wakefield – attempts to show that the plaintiff's expert misconstrues the applicability and use of the CEAP classification system.

The second part refers to a supplemental affirmation from a surgeon, Dr. Larry Scher, that elaborates on his earlier opinion as to how Ms. Ostrov's diagnosis of lymphedema came to be. As stated earlier in this decision, it was a later diagnosis made by exclusion, after all other possible causes for her massive swelling following the left knee

replacement had been explored and rejected. Dr. Scher also points out that the medical records do not document significant swelling preoperatively and thus there was no basis for anticipating this result from the June 2004 surgery. He says that before this procedure, Ms. Ostrov only displayed mild intermittent swelling.

The third part of the opposition refers the Court to two additional affirmations, a second one from Ms. Ostrov's long-time internist Dr. Leonard Raifman, who did clear the plaintiff for the June 2004 surgery, and a first affirmation from Dr. Stephen Haveson, the plaintiff's vascular surgeon who was not given the opportunity to clear her for that surgery but states now, in reviewing the records, that he would have.[3] Dr. Raifman points out that a diagnosis of chronic lymphedema was made well after the June 7, 2004, knee surgery and was the eventual diagnosis given to her condition. However, the major portion of his affirmation is spent describing three subsequent right knee surgeries that the plaintiff underwent in 2007 and 2009, all of which he also gave clearance for. These surgeries were performed by someone other than the defendant here.

These subsequent surgeries appeared to be a powerful argument in favor of the disputed June 2004 left knee surgery despite the plaintiff's circulatory problems. It appeared to be a good counter-argument to plaintiff's position. Thus, I raised this point at oral argument. Contrary to what had been suggested, that the recent right knee surgeries had all occurred without incident, I was told that, in fact, more recently that same right leg had to be amputated! Thus, the counter-argument loses its appeal.

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[3]As indicated earlier, this affirmation by Dr. Haveson does succeed in the defense prevailing here on the claimed departure that a vascular surgeon should have been consulted preoperatively.

As to the CEAP classification, here too, oral argument proved to be informative and valuable. While it is true that the three vascular surgeons who supplied the affirmations/affidavits on behalf of the defendants did say that this CEAP classification "is not, should not, and never has been used as a risk stratification or venous severity classification system" and that it "has never been implemented as a means to establish a standard of care in terms of treatment or risk assessment" (¶5 from the affidavit of Dr. Gregory Moneta), these same three surgeons, along with many other vascular surgeons, co-authored a "Special Communication" from the American Forum in 2004 and published by the Society for Vascular Surgery, that said something distinctly different.[4]

The name of the Special Communication is "Revision of the CEAP Classification for Chronic Venous Disorders: Consensus Statement." Early in the article, the statement is made that since "diagnosis and treatment of CVD (chronic venous disorders) is developing rapidly, the need for an update of the classification logically follows." What comes next is new terminology and definitions and refinement of C categories (the "C" part of the acronym standing for "clinical"). Under the heading "Basic CEAP", appears the following:

> A new basic CEAP is offered here. Use of all components of CEAP is still encouraged. However, many use the C classification only, which is a modest advance beyond the previous classifications based solely on clinical appearance. Venous disease is complex, but can be described with the use of well-defined categorical descriptions. For the practicing physician CEAP can be a valuable instrument for correct diagnosis to guide treatment and assess prognosis.

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[4]Plaintiff's counsel presented this article to me at oral argument. I accepted it as it had been written by the three affirmants and was on the subject they had opined about.

This point is very similar to what plaintiff's expert said in his analysis of the CEAP classification and its use. Further, in the portion of the article entitled "Refinement of C Classes in CEAP", "edema" is given a class 3 rating, and changes in skin are given a class 4 rating. These ratings are also consistent with those ratings given by plaintiff's expert surgeon.

In summary, as stated earlier in my interim decision, I found that Dr. Rozbruch's motion papers, in the first instance, did establish a prima facie case entitling him to summary judgment. However, for the reasons discussed there and in this decision, I found that more information and elaboration was necessary before finally concluding whether or not plaintiff had met her burden to show the existence of factual issues sufficient to continue the action for trial.

I now find that plaintiff has done that, but only as to one claimed departure, whether the June 2005 total left knee replacement was contraindicated in light of what was known and could have been reasonably anticipated regarding plaintiff's venous disorder. While it may be the case that there was no documented diagnosis of chronic lymphedema before the June 2004 surgery, it is the plaintiff's position via her expert that the clinical picture before that surgery was sufficient to suggest such a disorder and the negative foreseeable consequences of going ahead with the major left knee replacement.

Accordingly, it is hereby

ORDERED that the motion by defendant Jacob Rozbruch, M.D., for summary judgment is denied as to the claimed departure that the June 2005 total left knee replacement was contraindicated; and it is further

ORDERED that the motion by defendant Jacob Rozbruch, M.D., for summary judgment is granted to the extent of severing and dismissing all other claimed departures, such as the failure to obtain clearance from a vascular surgeon (discussed herein), lack of informed consent, and negligence during the surgery. With regard to the latter two claims, plaintiff has failed to present sufficient proof to raise a triable issue of fact.

Dated: January 14, 2011

JAN 14 2011

J.S.C.

ALICE SCHLESINGER