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

PRESENT: LOBIS Justice PART 6

JACOBS, JILL, ETAL.

-v-

BHAVANA POTHURI, M.D., ETAL

INDEX NO. 100190/10

MOTION DATE 2/21/12

MOTION SEQ. NO. 02

MOTION CAL. NO.

The following papers, numbered 1 to 43 were read on this motion to/for dismiss.

	PAPERS NUMBERED
Notice of Motion/Order to Show Cause — Affidavits — Exhibits ...	1→29
Answering Affidavits — Exhibits	30→41
Replying Affidavits	42→43

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

FILED

MAY 18 2012

NEW YORK
COUNTY CLERK'S OFFICE

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION

Dated: 5/16/12

J.S.C.
JOAN B. LOBIS

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

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

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

----------X

JILL JACOBS,

Plaintiff,

Index No. 100190/10

-against-

Decision and Order

BHAVANA POTHURI, M.D., and NEW YORK UNIVERSITY HOSPITALS CENTER d/b/a NYU MEDICAL CENTER,

Defendants.

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JOAN B. LOBIS, J.S.C.:

Defendants Bhavana Pothuri, M.D., and New York University Langone Medical Center s/h/a "New York University Hospitals Center d/b/a NYU Medical Center" ("NYU") move, by order to show cause, for an order, pursuant to C.P.L.R. Rule 3212, granting them summary judgment dismissal of the action. Plaintiff Jill Jacobs opposes the motion.

This case arises out of Dr. Pothuri's performance of a total abdominal hysterectomy and bilateral salpingo-oophorectomy ("TAH/BSO") on the then 48-year old plaintiff. From August 2005 through the end of 2008, plaintiff's medical history was significant for an unchanged 5 centimeter uterine fibroid; instances of irregular menses; and perimenopausal mood swings. On December 30, 2008, plaintiff presented to her internist with complaints of right lower quadrant pain; the internist immediately referred plaintiff to the emergency department at NYU to rule out appendicitis. A computed tomography ("CT") pelvic scan showed that plaintiff had a 7 centimeter cystic uterine fibroid; a 3.3 centimeter right ovarian lesion; a probable 1.4 centimeter left ovarian growth; and free fluid. The radiologist's impression was that plaintiff had a large degenerating fibroid. Plaintiff's internist then referred plaintiff to Dr. Pothuri for further treatment of the fibroid.

Plaintiff first saw Dr. Pothuri on January 7, 2009. Dr. Pothuri reviewed the December 30, 2008 CT scan results. Plaintiff reported that her mother had ovarian cancer in her mid-40's that was cured with a hysterectomy. Plaintiff reported pelvic pain that was interfering with her ability to exercise (plaintiff is a dancer and a dance instructor). Plaintiff reported that she was taking Motrin but was still experiencing pain. Dr. Pothuri's examination revealed that plaintiff had a tender, enlarged uterus at 12-weeks' size. Dr Pothuri's impression was that plaintiff had a symptomatic fibroid uterus with rapid growth. Both parties testified that plaintiff desired immediate surgery. Dr. Pothuri offered plaintiff a surgical appointment the next day, likely due to a cancellation. Plaintiff testified that Dr. Pothuri told her that if she did not take the appointment for the next day, she would have to wait a month for the next appointment, though Dr. Pothuri testified that she can usually schedule a surgery within two weeks. Plaintiff accepted the next-day appointment and proceeded to undergo pre-admission testing.

On January 8, 2009, plaintiff presented to NYU for her procedure. Plaintiff discussed what the procedure would entail with Joanie Hope, M.D., a gynecology fellow working with Dr. Pothuri. Plaintiff then signed a consent form, which set forth that the procedure that was to be performed was a total abdominal hysterectomy; removal of tubes and ovaries; and possible staging procedure. The consent form was witnessed by Nurse Soraia Gonzalez, who worked in the preoperative area. Nurse Gonzalez also completed a "hand-off" sheet, which indicated that plaintiff verbalized to Nurse Gonzalez that the procedure that was about to be performed was a total abdominal hysterectomy.

Although Dr. Pothuri had no independent recollection of plaintiff's procedure, her operative report indicates that she performed a TAH/BSO. Specimens taken during the procedure were sent to pathology. The pathology report indicated that plaintiff did not have cancer. Plaintiff was discharged on January 11, 2009, with instructions to schedule an appointment with Dr. Pothuri.

Dr. Pothuri's notes reflect that plaintiff telephoned Dr. Pothuri on January 21, 2009, and reported a great appetite, "ok" bowels, and no fever. She saw Dr. Pothuri later that day. Dr. Pothuri's notes reflect that she examined plaintiff and found her to be doing well; that she discussed the pathology studies from the surgery with plaintiff; and that she referred plaintiff for follow-up gynecological care and a colonoscopy.

On February 27, 2009, plaintiff began treating with Gary London, M.D., in California, for a regimen of hormone replacement therapy. On March 30, 2009, plaintiff presented to David Feldman, M.D., a gastroenterologist. He noted that plaintiff had a well-healed scar in her pelvic region. On April 2, 2009, Dr. Feldman performed a colonoscopy on plaintiff, with no abnormal findings.

Plaintiff next saw Dr. Pothuri on May 29, 2009, for a postoperative check-up. Dr. Pothuri's notes reflect that plaintiff complained of abdominal swelling and reported dissatisfaction with her surgical scar. Dr. Pothuri examined plaintiff and found slight swelling of the right lower quadrant. Dr. Pothuri ordered a CT scan to rule out a hernia and referred plaintiff to a plastic surgeon regarding the scar. A CT scan performed on June 9, 2009, indicated that plaintiff had a small amount of nonspecific fluid adjacent to the ascending colon but did not indicate a hernia.

On July 14, 2009, plaintiff presented to Babak Dadvand, M.D., a plastic surgeon in California. She complained of fullness in the lower right quadrant for six months. Dr. Dadvand's notes reflect that he examined plaintiff and found a soft abdomen and a well-healed low transverse incision. He found a hernia defect measuring 3x2.5 centimeters superior and lateral to the right aspect of the incision. Dr. Dadvand's notes reflect that it was "unclear [to him] as to why [plaintiff] would have a hernia defect in this area as it is superior to and lateral to her incision. This is most likely an abdominal wall hernia[.]" He recommended that plaintiff undergo exploration and repair. On December 14, 2009, Dr. Dadvand performed the hernia surgery. His findings were "right lower quadrant incisional hernia versus muscle tear, no intra-abdominal component, extensive scarring in the lower midline with a rectus diastasis in the midline." Dr. Dadvand repaired the hernia and the midline diastasis.

The parties' testimony varied greatly with respect to their understanding of what procedure Dr. Pothuri was going to perform on January 8, 2009, and why. Dr. Pothuri testified that on January 7, 2009, plaintiff agreed to undergo a TAH/BSO after Dr. Pothuri presented plaintiff with her options. Dr. Pothuri testified that a hysterectomy is the standard of care to treat a 48-year-old patient with plaintiff's symptoms and condition, for whom fertility is not important due to age. She testified that although a myomectomy is one option, it is not the standard of care. Dr. Pothuri testified that it was standard for her to instruct a patient such as plaintiff that she had a symptomatic uterus with pain; that she would benefit from a hysterectomy; that a myomectomy was not an option, given the absence of fertility concerns; and that a myomectomy has a greater risk of requiring a blood transfusion and morbidity. Dr. Pothuri further testified that she discussed with plaintiff the options of ultrasound fibroid destruction or uterine artery embolization, but that—due to the size of her

uterus and fibroid, the likelihood that these two procedures would have lower success, and the possibility of cancer—surgical management was the preferred route of treatment for plaintiff. Dr. Pothuri testified that plaintiff was informed that if a malignancy was found, a staging procedure would be performed, but that there was no way to determine a malignancy prior to surgery.

In contrast, plaintiff testified that at the first appointment, Dr. Pothuri told her that she did not have time to discuss the surgery and that Dr. Pothuri never explained how she would remove the cyst. Plaintiff could not recall how it was explained to her that the cyst would be removed, though she recalled that she knew that the cyst would not be removed laparoscopically. Plaintiff testified that on January 8, 2009, Dr. Hope informed her that the procedure entailed opening her up, removing the cyst, and performing a biopsy for cancer; she testified that Dr. Hope told her that a hysterectomy would only be performed if it was determined that she had cancer. Plaintiff further testified that the possibility of cancer and a hysterectomy was raised for the first time during her preoperative discussion with Dr. Hope and that she could recall nothing else about the conversation that she had with Dr. Hope after the possibility of cancer was raised. Plaintiff's boyfriend, who was present while Dr. Hope was talking to plaintiff, testified that Dr. Hope told plaintiff that a hysterectomy would only be done if cancer was found. Plaintiff testified that it was her understanding that if cancer were not detected, the cyst would simply be removed, and that she consented to the hysterectomy on the consent form because she was under the impression that it would only be performed in the event that she had cancer. She testified that she was unaware that a hysterectomy would be performed either way.

Dr. Hope was not deposed, but defendants annexed an affidavit from her to their motion papers. Dr. Hope sets forth that she reviewed plaintiff's hospital records from NYU and that she is certain that she followed her custom and practice in discussing consent with plaintiff. She states that on January 8, 2009, she had a detailed discussion with plaintiff about the planned surgery and the "Consent for Surgery" form that plaintiff signed. Dr. Hope states that plaintiff was scheduled for a total abdominal hysterectomy and bilateral removal of the fallopian tubes and the ovaries. She states that once plaintiff checked in, she began the informed consent discussion by asking plaintiff why she was in the hospital and what her understanding was of the procedure about to be performed. She sets forth that she conveyed a clear message to plaintiff, using lay language, that her uterus, tubes, and ovaries were to be surgically removed. Additionally, Dr. Hope avers that other hospital staff repeated this information to plaintiff and asked her questions about the surgery.

Dr. Hope states that she conveyed to plaintiff the risks of the TAH/BSO, such as bleeding, infection, blood clot, damage to organs in the surgical field, wound complications, allergic reaction to anesthesia, and death; the benefits of such procedure, including removal of the uterine mass, possible relief of pain, diagnosis of any existing gynecological cancer, prevention of any uterine, ovarian, or tubal cancer, and cancer staging if cancer were found; and the alternative of not undergoing the surgery. Dr. Hope asserts that if plaintiff had any hesitation or if plaintiff had limited her consent to only the removal of the uterine fibroid, the surgery would have been cancelled. Dr. Hope explains that she discussed with plaintiff that the procedure could be limited to only the TAH/BSO, or if cancer were detected and confirmed, Dr. Pothuri could proceed to remove lymph nodes in order to determine the stage of the cancer. Dr. Hope sets forth that plaintiff consented to the removal of lymph nodes if cancer were found. Dr. Hope reiterates: "the Consent for Surgery

specifically documents that [plaintiff] gave her consent for a '**total abdominal hysterectomy, removal of tubes and ovaries, possible staging procedure**' because [plaintiff] personally gave her consent to me for those procedures to be done by [Dr. Pothuri] at NYU on January 8, 2009." (Emphasis in original).

Aside from Dr. Hope's discussion with plaintiff, Dr. Pothuri testified that prior to a procedure, it is customary for her to discuss with the patient in the preoperative area the surgery she will perform and to confirm that the patient understands what she is undergoing and has no further questions. Also, Nurse Gonzalez was deposed and she testified that it is customary for her to confirm with patients what kind of surgery they are going to have and to check their consent form to make sure it matches the surgery written on the operating room schedule.

As to the issue of whether plaintiff was informed that a TAH/BSO would cause early-onset menopause, Dr. Pothuri testified that her standard practice is to discuss the effects of a hysterectomy in terms of it causing menopause, though she had no independent recollection of this discussion with plaintiff. Dr. Pothuri testified that she would have discussed the need for hormone replacement therapy with plaintiff during the initial office visit and the postoperative check-up when she instructed plaintiff to follow-up with a gynecologist. In contrast, plaintiff testified that the possibility of early-onset menopause being caused by the hysterectomy was never mentioned to her because she was never informed that she was going to have a hysterectomy. Plaintiff testified that it was not until May 29, 2009, that Dr. Pothuri first mentioned that plaintiff might want to consult with a hormone doctor because she would be going into menopause due to the hysterectomy. According to plaintiff's recollection, Dr. Pothuri never mentioned early-onset menopause until more

than four months after the TAH/BSO was performed and three months after she started receiving hormone treatment from Dr. London in California.

Plaintiff commenced this action by the filing of a summons and complaint on January 7, 2010. Her causes of action sound in medical malpractice, lack of informed consent, and negligent hiring and/or retention (only as against NYU). The essential allegations in plaintiff's bills of particulars are that Dr. Pothuri departed from the standard of care in failing to perform the proper diagnostic tests prior to the hysterectomy; performing the hysterectomy negligently; failing to advise plaintiff of the risks, benefits, and alternatives (including a myomectomy) of the planned surgery or the hysterectomy; failing to fully inform plaintiff that the surgical procedure that she would be undergoing was a hysterectomy, with sufficient clarity and time for plaintiff to be able to make an informed decision; and failing to diagnose and repair plaintiff's bilateral hernia. As against NYU, plaintiff claims that NYU is liable for Dr. Pothuri on the basis of respondeat superior and for its employees' independent negligence. The departures alleged against NYU are nearly identical to those alleged against Dr. Pothuri, with the exception of an allegation that NYU departed from the standard of care in failing to follow standard and accepted medical, nursing, hospital, and surgical skill. Plaintiff claims that her injuries include, inter alia, undergoing an unnecessary hysterectomy; early-onset menopause; pain and suffering; bilateral hernia; impaired mobility and permanent impairment of ability to exercise; depression; and the need for further surgeries.

Defendants now seek summary judgment. As established by the Court of Appeals in Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) and Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 (1985), and as has recently been reiterated by the First Department, it is

"a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that [he or she] is entitled to judgment as a matter of law." Ostrov v. Rozbruch, 91 A.D.3d 147, 152 (1st Dep't 2012), citing Winegrad, 64 N.Y.2d at 853. In a malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010) (citations omitted). Once the movant meets this burden, it is incumbent upon the opposing party to proffer evidence sufficient to establish the existence of a material issue of fact requiring a trial. Ostrov, 91 A.D.3d at 152, citing Alvarez, 68 N.Y.2d at 324. In medical malpractice actions, expert medical testimony is the sine qua non for demonstrating either the absence or the existence of material issues of fact pertaining to an alleged departure from accepted medical practice or proximate cause.

Defendants assert that the care rendered was at all times consistent with good and accepted medical practice and did not proximately cause the injuries alleged by plaintiff. Further, they assert that plaintiff's informed consent claim is without merit and should be dismissed as a matter of law. Defendants maintain that plaintiff was informed of the foreseeable risks, benefits, and alternatives of the treatment rendered, and that a reasonably prudent patient would not have declined to undergo the TAH/BSO had she been informed of the potential complications. They argue that plaintiff will be unable to refute the consent form that she signed or to show that a reasonable person, informed of the risk, would have opted against the procedure.

With their motion, defendants submit an affirmation from Gary L. Goldberg, M.D., a physician licensed to practice medicine in New York and board certified in obstetrics and gynecology and gynecologic oncology. Based on his review of the litigation documents and medical records, his own experience, and Dr. Hope's affidavit, Dr. Goldberg opines, to a reasonable degree of medical certainty, that defendants' care and treatment was at all times appropriate and within the standards of care, and that nothing they did or did not do proximately caused plaintiff's alleged injuries. He avers that for a patient who is shortly going to be 49 years old, with a long-standing history of pelvic pain from a fibroid uterus, and with questionable recent rapid growth of a uterine lesion, the standard of care calls for a hysterectomy to remove the uterus. Dr. Goldberg further sets forth that plaintiff had a long history of chronic pelvic pain, an ovarian cyst, and direct maternal history of ovarian cancer, so she required removal of her ovaries to prevent ovarian cancer and potentially relieve the chronic pain. Therefore, Dr. Goldberg opines that the treatment plan for a patient in plaintiff's circumstances called for a TAH/BSO and that Dr. Pothuri's treatment plan was consistent with good and accepted medical standards.

Dr. Goldberg maintains that a myomectomy is a high-risk procedure by which the surgeon dissects the fibroids from the uterus and tediously reconstructs the uterus in an attempt to preserve fertility. He asserts that the risks of myomectomy are a high chance the fibroids will regrow and an increased risk of hemorrhage. He avers that a myomectomy is only offered to women of child-bearing age who have a vested interest in maintaining fertility. Dr. Goldberg sets forth that plaintiff was not a candidate for a myomectomy because she was nearly 49 years old, was peri-menopausal, had a family history of cancer, had a large uterine fibroid with rapid growth, and had an ovarian cyst. Dr. Goldberg maintains that another option, uterine artery embolization ("UAE"),

carries the same risk of recurrence as with a myomectomy. He avers that UAE is contraindicated for a patient with pelvic pain and for a patient with a history of cancer since it does not rule out cancer. Dr. Goldberg states that for a patient like plaintiff, the only alternative to a TAH/BSO was to manage her fibroids and pain with medication.

Dr. Goldberg opines that Dr. Pothuri's surgery was performed skillfully, successfully, and without complications, and that no cancer was found. A CT scan taken on June 9, 2009, showed no evidence of a hernia; thus, Dr. Goldberg opines, Dr. Pothuri's conclusion on May 20, 2009, that plaintiff did not have an incisional hernia, was appropriate. Having reviewed Dr. Dadvand's records, Dr. Goldberg opines that plaintiff may not have experienced a hernia at all, or if she did, it somehow occurred after the June 9, 2009 CT scan. He opines, to a reasonable degree of medical certainty, that plaintiff's later abdominal defect was not caused by Dr. Pothuri's treatment.

Dr. Goldberg sets forth that Dr. Hope's affidavit, the deposition testimony, and the hospital records reflect that defendants obtained plaintiff's consent to the TAH/BSO in accordance with the standard of care. Dr. Goldberg opines that plaintiff executed a sufficient consent form; that the material risks, benefits, and alternatives were sufficiently stated to plaintiff prior to the surgery; and that a reasonably prudent person in plaintiff's position would have undergone the surgery at issue. He points out that neither the hospital chart nor Dr. Pothuri's treatment notes contain any references to comments from plaintiff, before or after the surgery, that she did not consent to the hysterectomy.

In opposition, plaintiff argues that sufficient evidence exists to show that there are unresolved questions of fact as to whether defendants adequately disclosed the risks, benefits, and alternatives for the treatment of plaintiff's uterine fibroids; whether a reasonably prudent patient in plaintiff's position would have undergone a TAH/BSO had she been fully informed that she was a candidate for a myomectomy; and whether defendants' negligence proximately caused plaintiff's injuries. Plaintiff maintains that, absent a finding of cancer, she did not give her informed consent to a TAH/BSO to treat her uterine fibroid because she was neither told that she was a candidate for a myomectomy nor that the removal of her ovaries would cause early-onset menopause.

Plaintiff submits an affidavit from Herbert A. Goldfarb, M.D., who sets forth that he is board certified in obstetrics and gynecology and laser surgery. Dr. Goldfarb sets forth that he reviewed the litigation materials, the medical records, and the affidavits and affirmations annexed to defendants' motion. He explains that a fibroid is a muscular growth in a woman's uterus that develops into cancer only in very rare cases, and that having a fibroid does not increase a woman's chances of getting uterine or ovarian cancer. Dr. Goldfarb sets forth that a fibroid can cause pain and heavy menses, and that when a fibroid outgrows its blood supply and degenerates, it may cause acute pain. Dr. Goldfarb states that fibroids grow slowly and usually shrink after menopause by as much as 60 percent. He states that treatment options for fibroids include monitoring, medication, and surgery. He states that pelvic examinations and ultrasounds can be used to track the growth of a fibroid. He states that conservative treatment for acute fibroid degeneration includes antibiotics, anti-inflammatories, pain medication, and bed rest. Of the surgical options, Dr. Goldfarb states that one option is a myomectomy, during which the fibroid is removed without removing the healthy parts of the uterus. Dr. Goldfarb opines that compared to a TAH/BSO, a myomectomy—where the

uterus, ovaries, and fallopian tubes are not removed—is a less invasive treatment, has fewer complications, and has less risk of intra-operative blood loss, infection, and visceral injury. Dr. Goldfarb maintains that a 7 centimeter fibroid is not a large fibroid, that surgical removal of a 7 centimeter fibroid is not challenging for an experienced gynecological surgeon, and that a 7 centimeter fibroid can even be removed laparoscopically.

Dr. Goldfarb opines that in December 2008, plaintiff's acute pain was due to fibroid degeneration and standard conservative treatment was appropriate. He contends that when Dr. Pothuri saw plaintiff on January 7, 2009, she immediately scheduled plaintiff for surgery without offering her standard conservative treatment, without giving her a full explanation of her alternative surgical options and their risks and benefits, and without giving her adequate time to make a knowledgeable decision. Based on plaintiff's testimony that she did not know the difference between a cyst and a fibroid and that she thought her "cyst" would simply be removed and biopsied, Dr. Goldberg opines that defendants never fully explained to plaintiff her medical diagnosis nor the treatment alternatives for her uterine fibroid. He opines that based on the evidence, it was plaintiff's understanding that Dr. Pothuri would be removing her uterine fibroid and that this is the procedure that she expected and consented to.

In contrast to Dr. Pothuri's and Dr. Goldberg's opinions that plaintiff was never a candidate for a myomectomy, Dr. Goldfarb opines that plaintiff was a candidate for a myomectomy, and that a reasonable practitioner would have advised a patient such as plaintiff of the option of a myomectomy, the benefits of a myomectomy (preserving the uterus), and the risks of a myomectomy (excessive bleeding and possible conversion to hysterectomy). He further opines that a patient such

as plaintiff would have selected a myomectomy if that option and all other options had been presented to her. Dr. Goldfarb opines, to a reasonable degree of medical certainty, that defendants' failure to explain the alternatives, risks, and benefits of all the surgical options—a myomectomy, a hysterectomy without removal of the ovaries and fallopian tubes, and TAH/BSO—with sufficient time and clarity, was a departure from good and accepted medical practice and was the proximate cause of plaintiff's injuries.

Dr. Goldfarb opines that it was a departure from good and accepted medical practice to perform a TAH/BSO rather than a myomectomy. He maintains that defendants' emphasis on the risk that the fibroid could be cancerous was inaccurate because there were no suspicious or malignant findings pre-operatively. Dr. Goldfarb opines that a reasonable practitioner under similar circumstances would have advised plaintiff of the remote likelihood that her uterine fibroid would turn out to be cancerous and that the 3 centimeter follicular cyst on her right ovary was a normal finding. Dr. Goldfarb states that under prevailing standards of care, removal of a woman's ovaries is unnecessary for treating uterine fibroids. If Dr. Pothuri was concerned about plaintiff's mother's history of ovarian cancer, she could have performed the BRCA1 gene test on plaintiff as an alternative to removing her ovaries. Additionally, a frozen sample could have been taken during the surgical procedure. However, Dr. Goldfarb asserts, these options were not presented to plaintiff. Dr. Goldfarb further opines that the evidence shows that plaintiff was not adequately advised that both her ovaries would be removed and that she would experience sudden-onset menopause as a result.

Dr. Goldfarb opines that as a result of defendants' negligence, plaintiff experienced early-onset menopause, abdominal muscle weakness and damage, scarring, a hernia, the need for additional surgery, and depression. He opines that the hernia defect and weakened abdominal walls resulted from Dr. Pothuri's negligent performance of the open total abdominal hysterectomy.

Plaintiff submits her own affidavit, in which she states that she thought that Dr. Pothuri would be removing only her cyst; that she understood that she would have a hysterectomy only if Dr. Pothuri found cancer; that had she been fully informed of the alternatives, risks, and benefits of the TAH/BSO, she would not have consented to the procedure; that she was not informed that her ovaries would be removed or that their removal would cause early-onset menopause; that she would not have signed the consent form for a TAH/BSO had she been clearly informed that all her normal and healthy reproductive organs would be removed regardless of whether cancer was found or not; that had the option of a myomectomy been offered and fully described to her, she would have consented to a myomectomy; and that had she been advised that the removal of the fibroid could be accomplished laparoscopically, with a smaller incision and shorter recovery, she would have elected to undergo laparoscopic surgery.

Plaintiff's essential claim for medical malpractice is that, given the circumstances, Dr. Pothuri's decision to perform a TAH/BSO in order to treat her fibroid was improper, i.e., that Dr. Pothuri's treatment plan departed from good and accepted medical practice. Defendants submitted evidence sufficient to establish a prima facie entitlement to summary judgment on this issue by offering expert testimony that Dr. Pothuri's plan and treatment was not only proper but was plaintiff's only legitimate option, as the only other course of treatment for a patient in plaintiff's

circumstances was management with medication, which plaintiff did not desire. As to the other options discussed above, defendants provided sufficient expert opinion evidence that they were too risky or inappropriate to be considered viable treatment options. Dr. Pothuri, herself, testified that she did not believe a myomectomy was appropriate for plaintiff and that, as part of her standard practice, she would have informed plaintiff that a myomectomy was not an option given that plaintiff did not have fertility concerns. However, plaintiff has raised an issue of fact by submitting expert opinion evidence that a myomectomy was a viable option for a patient in plaintiff's position. Although there is no real dispute that, as an isolated event, the hysterectomy was not performed in a negligent manner (Dr. Goldfarb's opinion as to the hysterectomy being negligently performed was wholly conclusory), there are real questions of fact as to whether Dr. Pothuri departed from the standard of care by presenting a hysterectomy or continued management with non-narcotic pain medication as plaintiff's only two options, and then by carrying out the TAH/BSO. As there are issues of fact regarding the appropriateness of the treatment plan, there are necessarily issues of fact as to whether that treatment caused plaintiff to undergo an unnecessary TAH/BSO and early-onset menopause.

As to plaintiff's claim for lack of informed consent, in moving for summary judgment dismissal of such a claim, a defendant must demonstrate the absence of any factual disputes as to (1) whether plaintiff was informed of the alternatives to, and the foreseeable risks and benefits of, the proposed procedure, and (2) whether a reasonably prudent patient would not have declined to undergo the proposed treatment had he or she been so fully informed. Koi Hou Chan v. Yeung, 66 A.D.3d 642, 644 (1st Dep't 2009); Pub. Health L. § 2805-d. The alternatives and foreseeable risks and benefits are defined as those which "a reasonable . . . practitioner under similar circumstances

would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation." Pub. Health L. § 2805-d(1).

Defendants established their prima facie entitlement dismissal of plaintiff's cause of action for lack of informed consent by offering the consent form that plaintiff signed and the testimony of Dr. Pothuri, Nurse Gonzalez, and Dr. Hope, showing that defendants' custom and practice included discussions with plaintiff about the alternatives to, and risks and benefits of, the TAH/BSO. In opposition, plaintiff raised issues of fact as to whether she was informed that the TAH/BSO would cause early-onset menopause and whether she correctly understood the procedure that was about to be performed. Moreover, one of the contested issues is whether defendants should have given plaintiff the option of a myomectomy, so there is an issue of fact as to whether plaintiff was adequately informed of the alternatives to the TAH/BSO. Accordingly, it is hereby

ORDERED that defendants' motion is denied in its entirety; and it is further

ORDERED that the parties shall appear for a pretrial conference on May 29, 2012, at 9:30 a.m.

Dated: May 16, 2012

ENTER:

JOAN B. LOBIS, J.S.C.