Murray v Charap
2013 NY Slip Op 31975(U)
August 12, 2013
Supreme Court, Suffolk County
Docket Number: 06-22728
Judge: Jerry Garguilo
Republished from New York State Unified Court System's E-Courts Service. Search E-Courts (http://www.nycourts.gov/ecourts) for any additional information on this case.
This opinion is uncorrected and not selected for official publication.

[* 1]

COPY

SHORT FORM ORDER

INDEX No. 06-22728
CAL No. 12-00952MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 47 - SUFFOLK COUNTY

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 10-17-12
ADJ. DATE 7-17-13
Mot. Seq. # 002 - MD

---X

WALDEMAR MURRAY and VIVIAN MURRAY,

Plaintiffs,

- against -

MITCHELL CHARAP, M.D.,

Defendant.

---X

CHRISTOPHER S. OLSEN, ESQ.
Attorney for Plaintiffs
199 East Main Street, P.O. Box 1576
Smithtown, New York 11787

HEIDELL, PITTONI, MURPHY & BACH, LLP
Attorney for Defendant
1050 Franklin Avenue, Suite 408
Garden City, New York 11530

Upon the following papers numbered 1 to 60 read on this motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 16; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 17-51 (no affidavit of service); Replying Affidavits and supporting papers 52-57; Other sur-reply- 58-60 ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the part of motion (002) by defendant, Mitchell Charap, M.D., pursuant to CPLR 3211(a)(5) which seeks dismissal of any of plaintiff's claims of medical malpractice and lack of informed consent alleged to have occurred prior to February 17, 2004 on the grounds that the statute of limitations expired prior to commencement of the action is denied; and that part of the motion pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him on the basis he did not depart from good and accepted standards of care and treatment, that he provided informed consent, and that he did not proximately cause the plaintiff's alleged injuries is denied.

In this medical malpractice action, the plaintiffs seek damages for personal injuries alleged to have been suffered by Waldemar Murray from September 1993 through and including March 31, 2004, while under the care and treatment of defendant Mitchell Charap, M.D. Causes of action have been asserted for medical malpractice by the defendant premised upon the alleged negligent departures from the good and accepted standards of medical care and practice by defendant Charap, lack of informed consent, and a derivative claim on behalf of Vivian Murray, plaintiff's spouse. It is alleged, inter alia, that the defendant failed to diagnose, test, treat, or consider the plaintiff's signs and symptoms of elevated lipids and blood sugar, failed to refer the plaintiff to the appropriate doctors for appropriate care and treatment, and permitting and causing the plaintiff to suffer coronary artery disease (CAD), occluded coronary arteries, and cardiac arrest.

Defendant Charap seeks summary judgment dismissing the complaint on the basis that any treatment rendered to the plaintiff prior to February 17, 2004 is time barred as it occurred more than two and one-half years prior to the expiration of the statute of limitations; that even if there is no bar by the statute of limitations, that he did not depart from good and accepted standards of care and treatment; he did not proximately cause the plaintiff's alleged injuries; and he provided proper informed consent.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this application, defendant Charap has submitted, inter alia, an attorney's affirmation; the affirmation of defendant's expert Dr. Bardes; copies of the summons and complaint; answer; plaintiff's verified and supplemental verified bills of particulars; uncertified copies of medical records from Faculty Practice Radiology, pharmacy records and North Shore University Hospital of July 17, 2005 which are not in admissible form; and transcripts of the examinations before trial which do not comport with the font size required by CPLR 2101(a) as to: Waldemar Murray dated October 10, 2008, January 9, 2009, and April 10 2010 which are also unsigned but certified, Vivian Murray dated October 4, 2008, January 9, 2009, which are also unsigned but certified, and April 30, 2010 which is signed and certified, Mitchell Charap which is unsigned and uncertified but is considered as adopted as accurate by the moving defendant (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]), and non-party Bibi Rakeia Maharaja which is unsigned and is not considered (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]).[1] Medical records are required to be submitted in admissible form which requires that they be certified pursuant to CPLR 3212 and 4518 (***Friends of Animals v Associated Fur Mfrs., supra***). Expert testimony is limited to facts in evidence (*see also* ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]). None of medical records are in admissible form to be considered on a motion for summary judgment and are thus not in evidence.

---

[1] The transcripts provided by the moving defendant are barely legible in addition to not being in admissible form. CPLR 2101 requires papers to be no less than ten point font size.

[* 3]

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

It is determined that even if the defendant's moving papers were in admissible form and legally sufficient, that the defendant has not demonstrated prima facie entitlement to summary judgment dismissing the complaint.

Waldemar Murray testified that he had previously been under the care of Dr. Marks who diagnosed him with asthma for which an inhaler was prescribed, and told him his cholesterol level was high. He went to Dr. Kana, a pulmonologist for his asthma. He was referred to Dr. Charap by Dr. Marks. Dr. Charap first saw him for shortness of breath, light heatedness, and pain in the chest and legs at night while lying down. The shortness of breath was precipitated by exercise, and sometimes occurred when he was sitting down. He also experienced profuse sweating. Dr. Charap continued to prescribe the inhaler, and prescribed no other medication. He did not see Dr. Charap or any other physician from 1993 through 1995. Dr. Charap told him to exercise but never told him to change his diet. He saw Dr. Charap on January 13, 2000, May 31, 2001, and April 1, 2004, and was told he had asthma. Dr. Charap ordered his prescriptions for his inhalers and Lipitor.

Murray testified that all his visits with Dr. Charap lasted five to ten minutes. From September 30, 1993 through April 1, 2004, he had blood drawn at his yearly exams. Prior to 2004, he never saw a cardiologist, was never advised that he had a heart murmur, and was never put on a low fat diet. Murray continued that in 2005, Dr. Klein told him he had diabetes, which was the first time any doctor told him that. Dr. Charap started him on Lipitor for his cholesterol, but did not tell him he had diabetes. In 2005, he checked his own blood sugar because he was not feeling well, and his sugar level was 297. He called Dr. Klein for an immediate appointment and was sent to a cardiologist where a cardiogram, echo cardiogram, and nuclear stress test were performed. He stated he failed the stress test. He was also seen by Dr. Keith, the cardiologist, who set him up for a cardiac catheterization at North Shore Hospital for quadruple bypass surgery, which he had done. Murray testified that he no longer went to Dr. Charap thereafter.

Vivian Murray testified to the extent that she has been employed for twenty seven years as a receptionist by Dr. Porges, an ob/gyn physician at NYU Medical Center. Her husband, Waldemar Murray, had been treating with Dr. Marks, but they felt that he had no compassion and switched to Dr. Charap, who treated him for asthma and high cholesterol, but never advised him that he had diabetes. In 2005, he switched to Dr. Klein who diagnosed her husband as having diabetes and placed him on medication. Prior to 2005, she did not suspect that her husband had diabetes. He left Dr. Klein's care as they felt he was abrupt and he did not want Vivian Murray interfering with his treatment of her husband. She continued that when her husband started treating with Dr. Khanna, they were told her husband was not asthmatic. Mrs. Murray testified that her husband last saw Dr. Charap in 2004.

Mitchell Charap testified to the extent that he became employed by the NYU School of Medicine in 1982, and from 1982 through 2004, was a solo practitioner, with office hours three days a week from 1993 forward. He first saw Waldemar Murray on September 28, 1993, for a check up, as he was changing physicians. An EKG was obtained and revealed normal results. He did not order a stress test as, stress tests are ordered when a patient has symptoms reflective of ischemic heart disease. History revealed that Murray's father died of atherosclerotic heart disease, ASHD. The plaintiff had a history of smoking and belonged to Alcohol Anonymous. Defendant Charap's impression of Murray was that of healthy but overweight man, however, he did not record the plaintiff's weight. He learned from the plaintiff that he had asthma and high cholesterol or lipids. Charap ordered the records from the plaintiff's prior physician, Dr. Marks, a pulmonologist, and ordered blood work which showed total cholesterol of 306, HDL 361, triglycerides 199, and LDL 190. Dr. Marks' record showed that results of the blood work for December 4, 1991, December 30, 1991, and noted the lipids were improved and the blood sugar was borderline. Dr. Charap did not order medication for him, but wanted him to continue his diet which had helped to lower his cholesterol levels. He stated that there was no available evidence in 1993 that the drugs used to lower cholesterol were appropriate for Mr. Murray, and the other available drugs were ineffective. The primary prevention trials that used statins were not available until 1995.

Dr. Charap testified that when the plaintiff returned to his office on September 28, 1995, physical examination revealed diffused asthma for which he prescribed a steroid inhaler, Azmacort and ordered a CBC, chem 12, electrolytes, and prostate specific antigen, liver tests, and HDL cholesterol. The abnormalities were the total cholesterol of 311, the uric acid of 7.8, and the HDL cholesterol of 34. He was aware then, and in 2005, that the HDL of 34 was a positive cardiac risk factor. He testified that Niacin or Nicotinic acid could have been ordered for the low HDL, but he felt the diet, exercise and statins would lower the lipid profile significant and improve his glucose. On October 17, 1995, Dr. Charap saw the plaintiff and started him on Pravachol (Pravastatin) 20 mg. to lower the lipids. He referred him to a nutritionist as he was an increased risk for atherosclerotic heart disease. He was to return in six to eight weeks for a lipid check however, he did not return until April 8, 1998. Dr. Charap testified that he did not recall, but thought he might have continued to refill the Pravachol during that time. He added that secretaries sometimes ordered the refills, or the plaintiff's wife, who worked at NYU, might have ordered the renewals, as she also ordered blood tests for him through Dr. Porges' account on March 25, 1998, July 13, 1998 and again in 2001. He thought that Mevacor 20 mg. may have been substituted by the pharmacy for Pravachol. Laboratory work was obtained on March 24, 1998, and the plaintiff was seen on April 8, 1998. His glucose was noted to be 157, higher than the previous level, and the triglycerides were lower at 351. Dr. Charap did not obtain an EKG although this was a regular visit, as there were no indications or clinical symptoms indicating that one was necessary. His impression was diabetes mellitus type II, mixed hyperlipidemia. Lipitor, diet, and exercise/light walking, were ordered. Dr. Charap stated that although he

diagnosed the plaintiff with diabetes mellitus type II, that this was incorrect as the plaintiff did not meet the criteria for diabetes for the transition period as two fasting specimens of 140 or higher were needed, as well as a glucose tolerance test with a glucose over 200.

Dr. Charap continued that on July 13, 1998, the glucose was markedly lower at 119 but still higher than normal and there was an increase in the SGPT. The cholesterol dropped to 209. Triglycerides dropped and the HDL remained the same, and the calculated LDL lowered significantly. Thereafter, the plaintiff did not return until January 13, 2000 despite his repeated requests to the plaintiff and his wife to come in. He testified that during that time, he may have reordered the plaintiff's medications as he felt it was more important for the patient to be on the medication if he could not make it to the office. He assumed that Mr. Murray was not taking his medication and following his instructions, as indicated by the laboratory results. Dr. Charap's impression on January 13, 2000, was a resolving upper respiratory infection with wheezing noted in the left base of the lung. Dr. Charap testified that shortness of breath and wheezing could be representative of congestive heart failure. He did not employ the use of a methacholine challenge test. If the patient had congestive heart failure, the chest x-ray in 2000 would have showed an enlarged heart and vascular redistribution, and the plaintiff's chest x-ray was normal. He then stated that the heart would not always show up as enlarged and that a history of atherosclerotic heart disease could cause heart failure. He found no murmur. He considered signs and symptoms of heart disease as angina, prior myocardial infarction, abnormal EKG, or stroke.

Dr. Charap testified that he next saw the plaintiff on May 23, 2001. Dr. Charap testified that in 2001, the hemoglobin AIC was not a criteria for diabetes mellitus. He did not think Mr. Murray had diabetes at that time, and he could not recall whether or not he told him that. On May 22, 2001, his blood work was done for his office visit from Dr. Porges' office, consisting of a CBC with differential, comprehensive metabolic, lipid profile and PSA. The glucose was elevated to 128 which Dr. Charap stated was just a reflection of his glucose intolerance, a precursor to diabetes mellitus type II. His lipids were markedly improved, and he needed to stay on the Lipitor. Diet and exercise were an appropriate approach to treating the blood sugar elevation, but he stated that the plaintiff was not exercising, although he did not document it. A routine EKG was not taken as he had no symptoms. On April 1, 2004, Dr. Charap noted that the plaintiff had not returned for two years, and had no weight loss. However, no weights were recorded in Dr. Charap's notes which indicated that the plaintiff was not exercising, and that he was started on statins. His impression was that of stable asthma for three months, increased lipids, type II diabetes as his blood sugar was 331. He did not order home glucose monitoring as he felt that if he could get him to diet, that his sugar would come down.

Defendant Charap's expert, Charles Bardes, M.D. set forth in his affirmation that he is a physician licensed to practice medicine in New York State and that he is board certified in internal medicine, and practices as a primary care physician in internal medicine. Dr. Bardes set forth the materials and records which he reviewed, and stated with a reasonable degree of medical certainty that the care and treatment rendered to Waldemar Murray by defendant Charap was consistent with accepted standards of medical practice and did not cause or contribute to any of the injuries alleged by the plaintiff. He added that defendant Chara's management of the plaintiff's diabetes and elevated cholesterol was within the accepted and prevailing standard of care at the time, and that there is no causal relationship between the alleged departures and the injuries claimed. He further stated that defendant Charap was not negligent by not ordering serial EKGs or by not weighing and recording the plaintiff's weight or other information at each visit, or by not referring the plaintiff to an endocrinologist.

Dr. Bardes stated that the plaintiff first saw defendant Charap on September 30, 1993 for a comprehensive routine medical evaluation and presented with a history of asthma treated by Dr. Clement Marks, a pulmonologist. An EKG was normal, as was the physical examination. The labs, however, revealed a high density lipoprotein (HDL) of 36 which was within normal limits, a cholesterol level of 306 (normal 120-200); triglyceride level of 399 (normal 30-190), and a low density lipoprotein (LDL) of 190 (normal 65-175), and his glucose was 105 (normal 70-110). Defendant also obtained the lab results from Dr. Marks from December 1991, and in comparing those results with the values he obtained, and stated the results show improvement, so defendant planned to have the plaintiff continue with his "improved" diet. Dr. Bardes stated that this was appropriate, as was the asking the plaintiff to return every three to four months. He continued that "statin" medications for elevated cholesterol were not the standard of care for this clinical situation in 1993, however, he does not set forth the standard of care. Dr. Bardes stated that because the plaintiff came to the defendant with a history of asthma, that the defendant appropriately relied upon that diagnosis and had no reason to suspect that the diagnosis was not accurate or that asthma needed to be ruled out.

The plaintiff's second visit with the defendant was September 28, 1995 for an exacerbation of asthma with coughing, wheezing, dyspnea on exertion for four months, which the plaintiff was treating with Proventil, apparently ordered by his prior physician. Defendant Charap's diagnosis was that of diffuse asthma for which Azmacort was appropriately prescribed. Dr. Bardes stated that coughing and wheezing is not typically associated with cardiovascular disease, and that the plaintiff did not require an EKG, cardiac intervention, or to have his weight recorded. This visit was not an annual visit, stated Dr. Bardes, and therefore the defendant only addressed the plaintiff's chief complaints. Blood work revealed a cholesterol level of 311 and an HDL of 34. Dr. Bardes does not indicate that the defendant ordered or obtained the triglycerides or low density lipoprotein which were previously elevated. Per the defendant's request, the plaintiff returned on October 17, 1995 at which time the defendant documented that he discussed the plaintiff's elevated cholesterol levels in that they were a risk factor for cardiovascular (coronary artery disease), and that he needed to have his labs followed every three months. Pravachol was prescribed to treat the plaintiff's elevated cholesterol. Dr. Bardes stated that it appeared that Mevcor was given and that it was indicated to control cholesterol levels, as recommended by the medical community by October 1995. Dr. Bardes stated there was no evidence of diabetes at this time.

Dr. Bardes continued that the plaintiff did not return to Dr. Charap until April 8, 1998. On March 24, 1998, blood work was drawn prior to the office visit of April 8, 1998. The results were sent to Dr. Porges, the NYU physician for whom the plaintiff's wife worked, which suggested to Dr. Charap that the blood work had been drawn through Dr. Porges' office. The labs indicated the plaintiff's glucose was 157, HDL 29, cholesterol 284, and triglycerides 551, all elevated. Dr. Bardes stated the LDL was normal, but he does not provide the value. When the plaintiff presented to Dr. Charap on April 8, 1998, his impression was that the plaintiff had developed type II diabetes and mixed hyperlipidemia. Medication was changed from Mevacor to Lipitor, diet and exercise were discussed, which treatment Dr. Bardes stated was consistent with the standard of care. However, he stated, Dr. Charap felt that the plaintiff did not meet the strict criteria for diabetes, although the glucose level was suggestive of diabetes. He continued that the plaintiff was not harmed by this impression.

On January 13, 2000, the plaintiff returned to Dr. Charap with a five day history of cough with bloody mucous and a fever. Defendant ordered a chest x-ray which Dr. Bardes stated was "clear." The plaintiff was diagnosed with an upper respiratory infection and prescribed a bronchodilator, Albuterol.

Blood work reveler that the glucose was 159mg/dl; HDL low at 31; cholesterol level 196; and triglyceride level 235. Dr. Bardes stated that the glucose level Dr. Charap indicated that the plaintiff was not exercising or following a proper diet. The plaintiff was instructed to exercise, follow his diet, and take medication as directed, consistent with the standard of care. He added that no other treatment was indicated. It is noted, however, Dr. Bardes has not set forth the standard of care to determine whether this advice was correct. On May 22, 2001, the plaintiff's labs showed glucose was 128, just moderately elevated over the fasting level, but Dr. Bardes did not know if this was a fasting specimen. The plaintiff was seen by the defendant on May 23, 2001. His next visit was April 1, 2004, which Dr. Bardes states was a three year gap in routine followup or annual physical examinations. He continued that the standard of care did not require the defendant to pursue the plaintiff for care. However, 22 prescriptions for Lipitor and 11 prescriptions for Proventil inhalers were filled between May 23, 2001 and April 1, 2004, with Dr. Charap as the ordering physician, despite the plaintiff not returning for visits to the defendant. Dr. Bardes stated that although the plaintiff claims that this was a departure from the standard of care to renew the prescriptions without seeing the plaintiff, the plaintiff benefitted from the use of the statins, and it was the plaintiff's responsibility to undergo routine physician examinations, thus, the defendant's renewal of the statins was entirely consistent with the standard of care.

Dr. Bardes stated that April 1, 2004 was the plaintiff's final visit with the defendant since May 23, 2001, during which time the defendant did not lose any weight and was admittedly not exercising. The defendant noted a history of Type II diabetes and no exacerbation of the asthma. Lab work from March 31, 2004 revealed a glucose of 217, consistent with criteria for diabetes. The cholesterol was elevated to 303 and triglycerides to 458. HDL was low at 29. The defendant called the plaintiff's wife and told her that the plaintiff should resume his Lipitor as directed, and work on his diet and exercise. He stated that Dr. Charap did not order medication for the diabetes as, in the past, diet and exercise reduced the glucose level. Although a check up was ordered in three months, the plaintiff never returned. Dr. Bardes stated that it was not until one year later from April 1, 2004, that there was any documented complaint of chest pain suggestive of a cardiovascular etiology when cardiac work up revealed 4 vessel coronary disease, for which the plaintiff had cardiac bypass surgery on July 12, 2005. The plaintiff's total cholesterol of 233 and triglyceride of 385 indicated to Dr. Bardes that the plaintiff was not following medical advice regarding statins or diet and exercise. It was Dr. Bardes further opinion that it was the plaintiff's lifestyle, diet, and non-compliance with medical directions, not the treatment rendered by the defendant, that necessitated CABG (coronary artery bypass grafting) surgery. Dr. Bardes also opined that the defendant's care and treatment was compliant with the guidelines published by the National Institute of Health, however, those guidelines have not been provided.

It is determined that Dr. Bardes' opinions are broad, conclusory and unsupported by the standard of care at the time that the plaintiff was under the care and treatment of Dr. Charap with regard to the diagnosis and management of asthma, diabetes and hyperlipidemia. Dr. Bardes merely stated that Dr. Charap complied with the standard of care, but he did not state the standards to demonstrate such compliance. Dr. Bardes did not state the basis upon which the diagnosis of asthma was made by the defendant to substantiate such diagnosis, and if there were any other conditions which should have been considered in a differential diagnosis and ruled out. While Dr. Bardes indicated that the plaintiff was diagnosed with diabetes mellitus type II in 1998, he did not indicate what further diagnostic testing was ordered to determine whether the elevated sugars were continuing, or to treat the condition, or to refer the plaintiff to an endocrinologist for further testing or management of the diabetes. He did not set forth the

standard of care to demonstrate compliance with the same for the diagnosis, treatment, or management of diabetes mellitus type II.

As to the treatment provided for the hyperlipidemia, Dr. Bardes stated that it was not until one year later after the last visit of April 1, 2004, that there was any documented complaint of chest pain suggestive of a cardiovascular etiology when a cardiac workup revealed 4 vessel coronary disease, for which the plaintiff had cardiac bypass surgery on July 12, 2005. However, Dr. Bardes did not address the standard of care for the treating hyperlipidemia and monitoring and preventing progression of the coronary artery disease to the extent requiring bypass surgery. Dr. Bardes did not rule out that the plaintiff's shortness of breath upon exertion was related to any cardiac condition and was due solely to asthma, which asthma the plaintiff testified was later ruled out after he left Dr. Charap's care and treatment.

Dr. Bardes stated that 22 prescriptions for Lipitor and 11 prescriptions for Proventil inhalers between May 23, 2001 and April 1, 2004 were filled, with Dr. Charap as the ordering physician, despite the plaintiff not returning for visits to the defendant. Dr. Bardes stated that although the plaintiff claims that this was a departure from the standard of care to renew the prescriptions without seeing the plaintiff, the plaintiff benefitted from the use of the statins. Dr. Bardes did not dispute this was a departure from the standard of care. Dr. Bardes did not comment on whether the plaintiff was benefitted by the Proventil. Thus, even if the defendant's moving papers were in admissible form, the defendant has not established prima facie entitlement to summary judgment dismissing the complaint on the basis that the defendant did not depart from the accepted standards of medical care and practice, and that his care and treatment was not the proximate cause of the plaintiff's alleged injuries. Dr. Bardes has not addressed the issue of informed consent.

Based upon the foregoing, the burden has not shifted to the plaintiff to raise a factual issue to preclude summary judgment. It is noted that the plaintiff's expert affirmation is unsigned and is not in admissible form, however, plaintiffs have provided an unredacted signature page for the expert affirmation to this court as required. The medical exhibits have not been certified. Deposition transcripts are double-sided and are not bound on the side as required, and do not comport with font size requirements (22 NYCRR 202.5. CPLR 2101 (a)). However, in reviewing plaintiff's expert's affirmation, triable issues of fact which preclude summary judgment have been raised, which would preclude summary judgment dismissing the complaint even if both the moving papers, and plaintiff's opposing papers, were all in admissible form. Although the defendant objects to the court considering plaintiff's expert affirmation on the basis that the same was provided after the filing of the note of issue, the failure of a party to disclose its experts pursuant to CPLR 3101(d)(i) prior to the filing of a note of issue and certificate of readiness does not divest a court of the discretion to consider an affirmation or affidavit submitted by that party's experts in the context of a timely motion for summary judgment, as CPLR 3101 (d)(i) imposes no deadline or bar to expert testimony for noncompliance (***Rivers v Birnbaum***, 102 AD3d 26, 953 NYS2d 232 [2d Dept 2012]). Plaintiff has also provided copies of each expert's curriculum vitae, which are returned to plaintiffs under separate cover along with the expert affirmation signature pages.

Plaintiff's expert has raised factual issues concerning various departures from good and accepted standards of care by defendant Charap, including, but not limited to, Dr. Charap's failure to properly document the plaintiff's complaints; failure to timely institute appropriate dietary and pharmacological treatment for dyslipidemia, including proper monitoring and evaluation; failure to diagnose and appropriately treat hyperglycemia/pre-diabetes with oral hypoglycemic agents and monitoring, diet and

education. Plaintiff's expert set forth the various care and treatment rendered by Dr. Charap to the plaintiff. He set forth the standard of care and described how the defendant departed from the standard of care in treating the plaintiff. He set forth a description of the various disease conditions suffered by the plaintiff, risks associated with those conditions, and the appropriate treatment relative to each condition. The plaintiff's expert also set forth the relationship between elevated blood sugars and plasma lipids and lipoprotein concentrations and the increased risk for cardiovascular disease, which the plaintiff suffered, and which the plaintiff's expert stated were improperly treated and diagnosed. These factual issues preclude summary judgment from being granted to the defendant as to both departures and proximate cause.

Accordingly, that part of motion (002) which seeks dismissal of the complaint on the basis that the defendant did not depart from the standard of care and did not proximately cause any of the injuries claimed by the plaintiffs, and that informed consent was provided to the plaintiff, is denied.

Turning to that part of motion (002) which seeks dismissal of that part of the complaint relative to treatment rendered to the plaintiff prior to February 17, 2004 on the grounds that the statute of limitations expired prior to commencement of the action is considered as follows.

As set forth in ***Gomez v Katz***, 61 AD3d 108, 874 NYS2d 162 [2d Dept 2009], pursuant to CPLR 214-a, an action for medical malpractice must be commenced within two years and six months of the act, omission or failure complained of. However, the statute has a built-in toll that delays the running of the limitations period where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission, or failure. Under the continuous treatment doctrine, the 2 ½ year period does not begin to run until the end of the course of treatment, when the course of treatment which includes the wrongful acts or omissions has run continuously and is related to the same original condition or complaint. The underlying premise of the continuous treatment doctrine is that the doctor-patient relationship is marked by continuing trust and confidence and that the patient should not be put to the disadvantage of questioning the doctor's skill in the midst of treatment, since the commencement of litigation during ongoing treatment necessarily interrupts the course of treatment itself. Implicitly, the doctrine also recognizes that treating physicians are in the best position to identify their own malpractice and to rectify their negligent acts or omissions.

The court continued that the continuous treatment doctrine applicable to medical malpractice actions contains three principal elements. The first is that the plaintiff continued to seek, and in fact obtained, an actual course of treatment from the defendant physician during the relevant period. The term, course of treatment, speaks to affirmative and ongoing conduct by the physician such as surgery, therapy, or the prescription of medications. A mere continuation of a general doctor-patient relationship does not qualify as a course of treatment for purposes of the statutory toll. Similarly, continuing efforts to arrive at a diagnosis fall short of a course of treatment, as does a physician's failure to properly diagnose a condition that prevents treatment altogether.

The second element of the continuous treatment doctrine applicable to medical malpractice actions is that the course of treatment provided by the physician be for the same conditions or complaints underlying the plaintiff's medical malpractice claim.

The third element of the continuous treatment doctrine applicable to medical malpractice actions is that the physician's treatment be deemed continuous. Continuity of treatment is often found to exist when

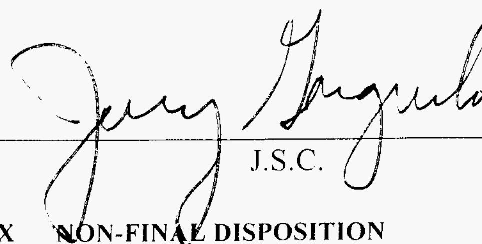
further treatment is explicitly anticipated by both physician and patient as manifested in the form of a regularly scheduled appointment for the near future, agreed upon during the last visit, in conformance with the periodic appointments which characterized the treatment in the immediate past. The law recognizes, however, that a discharge by a physician does not preclude application of the continuous treatment toll if the patient timely initiates a return visit to complain about and seek further treatment for conditions related to the earlier treatment.

This action was commenced by the filing of the summons and complaint on August 17, 2006. The last date of treatment of the plaintiff by defendant Charap was on April 1, 2004. Thus, the treatment rendered on April 1, 2004 was within the applicable two and one-half year statute of limitations set forth in CPLR 214-a for the same conditions, and the complaint was timely filed. Thus, dismissal is denied on the issue that the action was not timely commenced within the applicable statute of limitations.

The last date of treatment prior to April 1, 2004 was May 22, 2001, two years and eleven months earlier. Regardless of the absence of physical or personal contact between the plaintiff and the defendant in the interim, where the physician and patient reasonably intended the patient's uninterrupted reliance upon the physician's observation, directions, concern, and responsibility for overseeing the patient's progress, the requirement for continuous care and treatment for the purpose of the statue of limitations is certainly satisfied (***Richardson v Orentreich***, 64 NY2d 896, 487 NYS2d 731 [1985]; ***Balaban v Bachrach***, 2011 NY Slip Op 32734(U) [Sup Ct, New York County 2011]). Here, it is determined as a matter of law that the plaintiff's relationship with defendant Charap did not cease between May 22, 2001 and April 1, 2004. The testimony by defendant, and echoed by Dr. Bardes, established that during this nearly three year gap in treatment with office visits with the defendant, the plaintiff was provided with 22 prescriptions for Lipitor and 11 prescriptions for Proventil inhalers, with Dr. Charap as the ordering physician, despite the plaintiff not returning for visits to the defendant. It is apparent that there was an ongoing and continuing physician-patient relationship wherein the plaintiff was being treated by the defendant for the same conditions for the purpose of satisfying the statute of limitations (*see* ***Stilloe v Contini***, 190 AD2d 419, 599 NYS2d 194 [3d Dept 1993]).

Accordingly, that part of motion (002) which seeks dismissal of that part of the complaint relative to treatment rendered to the plaintiff prior to February 17, 2004 on the grounds that the statute of limitations expired prior to commencement of the action is denied.

Dated: 8/12/13



J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**