O'Connell v St. Luke's Roosevelt Hosp. Ctr.
2017 NY Slip Op 32264(U)
October 23, 2017
Supreme Court, New York County
Docket Number: 805451/13
Judge: Joan A. Madden
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11
--X
JONATHAN O'CONNELL, INDEX NO. 805451/13

Plaintiff,

-against-

THE ST. LUKE'S ROOSEVELT HOSPITAL CENTER,

Defendant.
--X
JOAN A. MADDEN, J.:

In this action for medical malpractice, defendant The St. Luke's Roosevelt Hospital Center ("defendant hospital" or "St. Luke's Roosevelt Hospital") moves for summary judgment dismissing the complaint and plaintiff opposes.

On August 23, 2012, plaintiff was working for Con Edison and was injured when a heavy steel grate street cover fell on and crushed his right forearm. Plaintiff was taken by ambulance to the emergency room at defendant hospital, where he was treated for his injuries. Plaintiff alleges that defendant hospital was negligent in failing to timely diagnose and timely treat compartment syndrome in his right forearm, and as a result he suffered neurological damage and atrophy to his right forearm. Specifically plaintiff alleges the following departures from accepted medical practice: 1) defendant's administration of several doses of pain medication was contraindicated in making it more difficult to properly assess plaintiff's pain levels and numbness, thereby increasing the risk of a delayed diagnosis of compartment syndrome; 2) defendant admitted it should have known that plaintiff was at risk for developing acute compartment syndrome upon presentiment to the emergency department, but it did not suspect compartment syndrome until

approximately five hours later; 3) defendant failed to conduct proper tests including compartment pressure measurement and failed to examine his right forearm for tense muscle compartment with firm feelings; 4) defendant failed timely to diagnose compartment syndrome by not following the steps of a differential diagnosis and instead ignored the signs and symptoms of compartment syndrome that were exhibited upon initial assessment, i.e. pain out of proportion to injury and pain upon passive range of motion; 5) defendant failed to request an immediate surgical consultation; 6) defendant failed to perform frequent serial examinations and reassessments; 7) defendant failed to prevent the permanent and irreversible nerve damage caused by compartment syndrome; and 8) defendant prevented plaintiff from getting the proper and adequate treatment he required.

In support of its motion for summary judgment, defendant hospital submits an attorney's affirmation; a physician's affirmation from Robert J. Strauch, M.D., an orthopedic surgeon; the pleadings and the Verified Bill of Particulars; plaintiff's deposition testimony; the deposition testimony of defendant's employees, Dr. Amy Caggiula, M.D. and Dr. Jonathan Wassermann, M.D.; an IME report from Dr. Roger A. Bonomo, M.D., a neurologist; and plaintiff's records from defendant hospital. Defendant asserts that the hospital chart and physicians' testimony show that plaintiff was "properly worked up, diagnosed and treated for multiple fractures, lacerations and other collateral damage and developing compartmental syndrome via surgical intervention with the performance of a fasciotomy within hours of his presentation to the Emergency Department at St. Luke's Roosevelt Hospital on July 23, 2012." Defendant argues that "compartment syndrome is a condition that takes time to develop and demonstrate symptoms, must less consequences," and that at the time of surgery later that day, "the intra

operative medical findings by the orthopedic surgeon Dr. Alton Barron, conformed to there having been no adverse consequences attributable to compartment syndrome that occurred to that point," and those finding were "reaffirmed on subsequent wound exploration." Defendant argues that consistent with the foregoing is the fact that plaintiff returned to full time heavy labor for Con Edison, which he would not and could not have done if he had a "demonstrable impairment," and that he "has no muscle atrophy or neurologic disability."

In opposition, plaintiff submits an attorney's affirmation and affirmations from two separate orthopedic surgeons. Plaintiff objects that defendant's documents are not in admissible form, as the deposition transcripts are neither signed nor certified, and the IME report of Dr. Bonomo is not signed. Plaintiff also agues that defendant's medical affirmation is "conclusory and speculative," and that his own medical records, deposition testimony and physicians' affirmations, establish "multiple departures from the standard of care" that caused and contributed to his "progression and development of compartment syndrome and resultant nerve damage and sequelae."

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff, there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy the burden, a defendant in a medical malpractice action must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature. Id. Specifically, a defendant asserting that the treatment did not depart from accepted

medical standards must provide an expert opinion that is detailed, specific and factual in nature. See Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on the facts in the record or those personally known to the expert and defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hospital, 69 AD3d 403, 404 (1st Dept 2010). Defendant's expert opinion must "explain 'what defendant did and why.'" Id (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

Once the defendant makes a prima facie showing, the burden shifts plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez v. Prospect Hospital, 68 NY2d 320, 324-325 (1986). In a medical malpractice action, "to avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries." Roques v. Nobel, supra at 207. To meet this burden, "plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." Id. Where conflicting expert opinions are adequately supported by the record, summary judgment must be denied. See Frye v. Montefiore Medical Center, 70 AD3d 15 (1st Dept 2009); Cruz v. St Barnabas Hospital, 50 AD3d 382 (1st Dept 2008).

Applying the foregoing standards, the Court finds that defendant has satisfied its burden by submitting, *inter alia*, the affirmation of Dr. Strauch, an orthopedic surgeon, and the IME

report of Dr. Bonomo, a neurologist.[1] Dr. Strauch's opinion is based on his review of the pleadings, the "pertinent medical records and examination reports" and deposition testimony, together with his "experience, knowledge and training as a physician and orthopedic surgeon." He states that plaintiff presented to the Emergency Department at St. Luke's Roosevelt Hospital at approximately 10:47 a.m. on August 23, 2012 with a "post traumatic crush injury sustained to his right forearm a short time earlier that morning, but notably given the allegations involved, he did not at that time manifest compartment syndrome." Dr. Strauch explains that "[i]t is important to understand at the outset that such a condition is an evolving one with variable contributing factors, that when it occurs involves tissue swelling that can and typically does, develop over time and that surgical intervention is neither justified or appropriate in the absence of a tentative diagnosis that is typically based on the clinical symptomology." Dr. Strauch states that plaintiff "was assessed and found to be neurologically intact" and that the "treatment plan involving the administration of pain medication and prophylactic antibiotics, together with the performance of x-rays and pursuit of an orthopedic consult was formulated and implemented."

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[1]Plaintiff's objection to the admissibility of Dr. Bonomo's IME report is without merit. Although the copy of the report submitted with the motion is not signed, defendant's reply includes a signed copy of the report along with proof that the signed report was served on plaintiff's attorney on May 5, 2016, before defendant made the instant motion on June 17, 2016.

Plaintiff's objection to the admissibility of the deposition testimony is likewise without merit. In reply, defendant submits the signature page from plaintiff's deposition which contains plaintiff's signature. The unsigned but certified depositions of defendant's own witnesses, Dr. Caggiula and Dr. Wasserman, are admissible evidence for the purposes of defendant's summary judgment motion <u>See</u> <u>Sass v. TMT Restoration Consultants Ltd</u>, 100 AD3d 443 (1st Dept 2012); <u>Rodriguez v. Ryder Truck, Inc</u>, 91 AD3d 935 (2nd Dept 2012). In reply, defendant additionally shows that the transcripts were sent to those deponents for review and they failed to sign and return the transcripts within 60 days. The unsigned testimony, therefore, is in admissible form. <u>See</u> <u>Franzese v. Tanger Factory Outlet Centers, Inc</u>, 88 AD3d 763 (2nd Dept 2011).

He opines that such "steps were appropriate and in accordance with good and accepted practices." He states that x-rays were obtained and reviewed, and plaintiff "was diagnosed with fractures of both his right radius and ulna." He states that plaintiff was "throughly reevaluated at approximately 1PM," he "remained neurovascularly intact and orthopedic consult was being pursued," and "continued to be reassessed in the Emergency Department together with being administered the medications outlined above."

Dr. Strauch states that plaintiff "was seen by an orthopedist and surgery planned." He explains that "[l]ater that afternoon as the plaintiff continued to be seen, numbness was observed for the first time," and "[s]urgical consult was obtained shortly thereafter and plaintiff was thereafter transferred for surgery which was undertaken by orthopedic surgeon, Dr. Alton Barron and commenced at approximately 6:49 PM." He states that the "surgery addressed the plaintiff's fractures and developing compartment syndrome." He opines that "within a reasonable degree of medical certitude, the assessments and workup of this patient were appropriate and timely," as there "was no evidence of compartment syndrome until late afternoon that day" and "[u]nder the circumstances, the surgery that followed occurred both within a reasonable and acceptable timeframe and was in no way untimely."

Specifically, Dr. Strauch explains that "the most important factor in assessing the significance of the timing of surgery for any potential compartment syndrome is the intraoperative findings" and "[h]ere Dr. Barron's operative report for the procedure performed on August 23, 2012 documents solely healthy tissue being found on exploration," which "attests to the fact that while the plaintiff suffered injury as the result of his trauma, he did not, in contrast, suffer adverse consequences of compartment syndrome, whose hallmark is necrotic or

compromised tissue." Dr. Strauch further explains that the "follow-up procedures which were performed in accordance with good and accepted medical and orthopedic practice stemmed from the patient's initial injury and concomitants thereto and not from any departures from good and accepted medical practice or delays in treatment." He states that the "follow-up care and procedures as occurred on August 25, 2012 and August 29, 2012 are not at all uncommon and are thoroughly appropriate in the management of injuries of the nature sustained by this patient and should not be construed otherwise."

Dr. Strauch states that "the consistent and continued findings of healthy vital tissue during Dr. Barron's two aforementioned successive follow-up wound explorations attest to the patient not having suffered any adverse consequences of compartment syndrome," which is "compelling objective medical evidence that no injury was suffered by plaintiff as the result of any claimed departures." He states that "[p]ost surgical examination and findings including those of the independent neurological examination of Dr. Roger A. Bonomo performed on November 4, 2015, are consistent with the absence of permanent neurological compromise or disability, as well as the absence of claimed muscle atrophy." Dr. Strauch concludes that "defendant hospital through the actions of its physicians and staff at all times comported with standards of good and accepted medical practice," the "assessment and treatment plan was appropriate to the signs and symptoms presented and timely took into consideration any developments and additional symptoms that developed," and "[s]urgical intervention occurred in timely fashion such that the timing of same in no way adversely affected the patient."

Defendant's neurologist, Dr. Bonomo, examined plaintiff on November 4, 2015. In his report of the same date, Dr. Bonomo states that plaintiff is "34-year old, right-handed man who

says a grating cover fell on his right forearm just above the wrist at work on 8/23/12," and "was taken to the ER of St. Luke's Roosevelt Hospital where he was first treated with pain medication" and "developed numbness of his fingers and forearm while in the ER and fasciotomy was performed that day on the anterior forearm to treat compartment syndrome." Dr. Bonomo's report states that plaintiff "was in the hospital for a week in which he had more surgeries before the wound was closed the day before discharge," and that he "followed up with the surgeon and started physical therapy about 3 weeks after discharge." Dr. Bonomo reports that plaintiff "complains most of loss of power and mobility in right forearm and hand . . . [and] numbness on the forearm around the surgical scar." Dr. Bonomo reports that "[n]umbness in fingers comes and goes" and that he "gets pain radiating from right elbow to wrist on elbow flexion and extension, especially after being inactive for a while." The report states that plaintiff "takes no pain medication," his "[r]ight shoulder pain is provoked by pronation and supination of the forearm," and "[h]e does not identify anything that relieves the pain." Also, plaintiff "has slight neck pain at times, but does not associate that with the compartment syndrome" and "denies having similar problems before this accident." Dr. Bonomo states that plaintiff "had right wrist scaphold repair in 2003 and left wrist fusion and tendon transfer in '09."

Upon examination, Dr. Bonomo reports, *inter alia*, as follows: range of motion of the neck is "full and painless"; "cranial nerves 2-12 are normal; "no muscle atrophy with right forearm 0.5 cm greater in circumference than left"; "muscle strength and tone are normal"; "reflexes are active and equal"; "[s]ensation is normal except for report of increased sensitivity to pin over the right forearm scar and decreased sensitivity on the right hand in a glove pattern consistent with symptom magnification"; "mildly tender in muscles of right forearm, but not

right shoulder or neck"; "Tinel's is absent at right elbow and both wrists"; and "Phelen's sign is absent." Dr. Bonomo opines that "[t]his history and this neurologic exam are consistent with recovery after right forearm trauma and fasciotomy for impending compartment syndrome"; "no objective evidence of residual injury to any part of the nervous system or spine"; and "no neurologic disability or need for further diagnostic testing or treatment."

Based on the foregoing, defendant hospital has satisfied its prima facie burden for summary judgment. Although Dr. Strauch's affirmation lacks some detail, when considered together with Dr. Bonomo's IME report, defendant has made a sufficient showing that plaintiff does not suffer from any neurological injury, disability or atrophy attributable to compression syndrome.

Turning to plaintiff's opposition, the Court concludes that the expert affirmations from two orthopedic surgeons raise issues of fact for trial. Surgeon1 (affirmation 6 pages) states that based on his review of the defendant hospital records, the depositions, and defendant's expert affirmation and IME report, "as well as my knowledge, training and skill in the field of orthopedic surgery," defendant "departed from the standard of care in its treatment of Mr. O'Connell," and such departures "constituted competent producing causes of the development and progression of Mr. O'Connell's acute compartment syndrome and resultant nerve damage and sequelae."

Specifically, Surgeon1 opines that given plaintiff's "medical history – 30 years old and sustained a crush injury to his right forearm, including a fracture to the distal radium – Mr. O'Connell was at high risk of developing compartment syndrome." He states that given the "medical history alone, Defendant should have placed Mr. O'Connell on a high index of

suspicion for compartment syndrome upon his arrival to the emergency department" and given the symptoms exhibited upon initial assessment, defendant "should have recognized the developing compartment syndrome in plaintiff's upper extremity." He notes that compartment syndrome was not included in the diagnosis when plaintiff presented to the emergency room or "after the initial assessment, which revealed several signs of the developing compartment syndrome." He explains that the standard of care would have included "raised suspicion so as to alert Defendant to conduct frequent serial examinations with compartment pressure measurements every 30 to 45 minutes." Defendant, however, "did not document frequent serial examinations" and "never performed any compartment pressure measurements," and had it done so, "a timely diagnosis of compartment syndrome in Mr. O'Connell's right forearm would have been made, the surgery would have been performed earlier," and "treatment would have likely prevented any nerve damage from the compartment syndrome."

Surgeon1 explains that the "accuracy of physical examinations for diagnosing acute compartment syndrome is limited," so "close observation and frequent serial examinations using compartment pressure measurements are of great importance." He explains that it is "also of great importance for the physician to obtain accurate assessments of the patent's pain levels and numbness," so defendant's administration of "several doses of pain medication" complicated "accurate and timely identification" of plaintiff's pain level. He states that defendant's "choice of treatment – administering paid medication; no serial examinations; no serial compartment pressure measurements – all contributed to the delayed diagnosis of compartment syndrome" in plaintiff's right forearm and increased the "risk of danger" to plaintiff.

Surgeon1 states that defendant "further departed from the standard of care when it failed

to request immediate surgical consultation," as plaintiff was a patient at "high risk of developing compartment syndrome" and "his clinical findings were suggestive of compartment syndrome. He states that defendant's request for a surgical consultation approximately five (5) hours" after plaintiff's initial assessment, "was not timely."

Surgeon1 opines that "based on the fact that Mr. O'Connell's sensation in his right upper extremity was found to be intact in all modalities upon initial assessment, a timely diagnosis would have prevented the complications of acute compartment syndrome and improved his outcome." He states that "because Defendant departed from the standard of care, Mr. O'Connell's compartment syndrome was diagnosed too late to prevent nerve damage," which resulted in plaintiff sustaining "muscular neurologic deficits as well as weakness in his hand, with atrophy, restriction of motion, and numbness in his right upper extremity."

Surgeon1 further opines that defendant "failed to make a timely diagnosis" by failing "to conduct a proper differential diagnosis." He explains that defendant "failed to follow the first step of a differential diagnosis – gather all the information to make a list of all symptoms." He states that defendant "failed to gather information that would have been provided from a compartment pressure measurement," and "failed to test for any tense muscle compartment with a firm feeling in Mr. O'Connell's arm," explaining that "tense muscle compartment is a reliable indicator of compartment syndrome." He states that defendant also "failed to list all the possible causes of the symptoms that Mr. O'Connell exhibited upon initial assessment," and failed to "document diagnosis of compartment syndrome when it should have listed compartment syndrome on the top of its list because of the urgent danger that compartment syndrome poses." He explains that "compartment syndrome is urgently dangerous because it can quickly and

severely injure the patient." He opines that had defendant "properly followed the steps of a differential diagnosis, Mr. O'Connell's outcome from his injuries and complications from the compartment syndrome would have been improved."

Plaintiff submits a second expert affirmation from a separate orthopedic surgeon ("Surgeon2" with 5 page affirmation), who reviewed the St. Luke's medical records, the operative reports and defendant's expert affirmation. He opines that defendant departed from the standard of care in its treatment of plaintiff, and that such departures "constitute competent producing causes of the development and progression of Mr. O'Connell's acute compartment syndrome and resultant nerve damage and sequelae therefrom." He explains that "acute compartment syndrome most often develops soon after significant trauma, particularly trauma involving fractures," the forearm is a "common site" of compartment syndrome; and acute compartment syndrome "is more often seen in young men (under the age of 35) who suffer fractures of the distal radius." He states that plaintiff was 30 years old on the day of the accident when he sustained a crush injury to his right forearm, and based on those "facts alone, Mr. O'Connell was at high risk of developing acute compartment syndrome," and defendant should have placed him "on a high index of suspicion for compartment syndrome upon his arrival to the emergency department."

Surgeon2 explains that when a patient who is at high risk for developing compartment syndrome presents to the emergency department, "it is critical for the physician to conduct a careful and complete neurological examination of the extremity during the initial assessment and to accurately document the findings," and that the physician "must understand the limitations of isolated physical examinations in diagnosing and identifying acute compartment syndrome." He

explains that "relying solely on limited or few physical examinations can lead to inaccurate or delayed diagnosis of acute compartment syndrome," and for that reason "it is of great importance for the physician to maintain a high index of suspicion and conduct frequent serial examinations." He states that in plaintiff's case, "other than conducting a neurological examination upon initial assessment, the defendant did not perform any serial examinations or conduct compartment pressure measurements," and the failure to do so "were departures from the standard of care and increased the right of harm to Mr. O'Connell."

Surgeon2 explains that "[s]ome of the symptoms and examination findings suggestive of acute compartment syndrome include: pain out of proportion to the apparent injury (i.e. fracture); pain with passive range of motion of the affected compartment; tense muscle compartment with a firm feeling; and diminished sensation." He states that on initial assessment of plaintiff's right forearm, plaintiff reported pain at the highest level, 10 out of 10, and the physician's findings upon examination were noted as follows: "4 cm deep laceration to the volar surface of the right arm; good radial pulse; capillary refill less than two seconds; sensation was intact in all modalities; hematoma to the dorsal surface of the forearm; and pain with active and passive range of motion." Surgeon2 opines that based on those examination findings upon first assessment, plaintiff "was already showing signs of developing compartment syndrome," and at that time, defendant "should have suspected acute compartment syndrome" and "should have maintained a high index of suspicion and conducted frequent serial examinations or obtained compartment pressure measurements." Surgeon2 states that defendant failed to examine plaintiff's arm for "any tense muscle compartment (such an examination was performed for the first time approximately five (5) hours after this initial assessment)," and defendant's "failure to

recognize the developing compartment syndrome in plaintiff's forearm upon initial assessment" was another departure from the standard of care and that the "diagnosis of compartment syndrome was delayed because of these departures."

Surgeon2 further explains that if acute compartment syndrome is suspected in a patient "based on risk factors and clinical findings, then surgical consultation should be made with the potential intent of taking the patient to surgery based on the clinical picture." He states that measuring compartment pressures in patients at risk for developing acute compartment syndrome "involves no major complications," but not obtaining those pressure measurements "may lead to a missed diagnosis and permanent deformity or dysfunction of the extremity." He explains that the "limited accuracy of one physical examination for identifying acute compartment syndrome cannot be emphasized enough" and for that reason "it is so crucial to maintain a high index of suspicion and conduct frequent serial examinations in order to diagnose acute compartment syndrome with accuracy and timeliness." He explains that "[w]th early diagnosis and appropriate treatment, the complications of acute compartment syndrome can be prevented and normal function of the extremity can be maintained."

Surgeon2 notes that plaintiff's "sensation was found to be intact in all modalities upon initial assessment," which "indicates that Mr. O'Connell did not suffer nerve damage solely from the crush injury," and "it cannot be said that Mr. O'Connell's nerve damages was only from the crush injury and not from the compartment syndrome." He states that the fact that plaintiff's sensation was "intact upon initial assessment and then diminished almost five (5) hours later demonstrates that the evolving compartment syndrome was a substantial factor in causing Mr. O'Connell's nerve damage." He states that it is "incorrect to say that Mr. O'Connell did not

suffer any nerve damage based on the fact that the operative report documents solely healthy tissue being found on exploration,"as "the operative report only documents the condition of Mr. O'Connell's muscle tissue" and there is "no documentation" on the condition of plaintiff's "nerve tissue." He states that there is a "difference between muscle tissue and nerve tissue" and "the condition of Mr. O'Connell's muscle tissue cannot provide any indication as to the condition of Mr. O'Connell's nerve damage."

The foregoing conclusions of plaintiff's orthopedic surgeons that had defendant properly monitored plaintiff's condition it would have timely diagnosed and timely treated compartment syndrome in plaintiff's right forearm, and plaintiff would have had a more complete recovery without the resulting nerve damage and sequelae therefrom, are sufficient to rebut the contrary conclusions of defendant's orthopedic surgeon and examining neurologist that plaintiff was properly and timely treated for developing compartment syndrome and suffered no nerve damage or atrophy as a result of compartment syndrome. Given the experts' conflicting conclusions and the differences in their opinions as to the standard of care and the question of proximate cause, substantial issues of fact and credibility exist which can only be resolved at trial. See Frye v. Montefiore Medical Center, supra; Cruz v. St. Barnabas Hospital, supra. Defendant, therefore, is not entitled to summary judgment.

Accordingly, it is

ORDERED that defendant's motion for summary judgment is denied.

DATED: October 23, 2017

ENTER:

J.S.C.

HON. JOAN A. MADDEN
J.S.C.