Ferrone v Beth Israel Hosp.
2020 NY Slip Op 30371(U)
January 7, 2020
Supreme Court, New York County
Docket Number: 805630/2015
Judge: George J. Silver
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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AUSTIN FERRONE,

Plaintiff,

Index No. 805630/2015
Motion Seq. 001

-v-

DECISION & ORDER

BETH ISRAEL HOSPITAL, and
PAUL THOMPSON, D.O.,

Defendants.

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GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendants MOUNT SINAI BETH ISRAEL s/h/a "BETH ISRAEL HOSPITAL" ("Beth Israel") and PAUL THOMPSON, D.O. ("Dr. Thompson" collectively "defendants"), move for summary judgment. Plaintiff AUSTIN FERRONE ("plaintiff") opposes the motion. For the reasons discussed below, the court grants the motion in part, and denies it as to separate aspects discussed herein.

Plaintiff, then nineteen-years-old, fell on ice and fractured his ankle. He was scheduled to undergo an open reduction and internal fixation of his left ankle on March 11, 2013 by non-party, Dr. Christopher Hubbard ("Dr. Hubbard"). Dr. Thompson was the assigned anesthesiologist for plaintiff's surgery.

On March 11, 2013, prior to the surgery, Dr. Thompson met with plaintiff, and completed an anesthesia pre-operative evaluation. Dr. Thompson documented that plaintiff had no significant past medical history and no known allergies. Dr. Thompson also noted that he advised plaintiff of the risks and benefits of the anesthesia plan, and that plaintiff agreed to proceed with the elective popliteal fossa nerve block followed by general anesthesia. Dr. Thompson further recorded that

plaintiff gave his written consent to proceed with both general anesthesia and regional anesthesia to the operative leg via an elective popliteal fossa nerve block.

That same day, Dr. Thompson performed the popliteal fossa nerve block with plaintiff in the prone position. Dr. Thompson administered mild sedatives to plaintiff, and after disinfecting plaintiff's skin and locating the needle entry point based on plaintiff's particular anatomic landmarks, Dr. Thompson used a nerve stimulator device and a 22-gauge needle to locate the nerves to be anesthetized. The nerve stimulator device was initially set to a current of 2.0 milliamps (mA) when the needle was first inserted into plaintiff's skin. Dr. Thompson then advanced the needle closer to the nerve bundle until he observed the desired muscle twitch response. Thereafter, Dr. Thompson adjusted the position of the needle and the current until the muscle twitch response disappeared just below 0.45 mA. At that point, prior to administering the anesthetic agent, Dr. Thompson aspirated the anesthetic syringe to ensure that the needle did not penetrate a vascular structure, and then incrementally administered the anesthetic agent.

Throughout the nerve stimulation and administration of the nerve block, Dr. Thompson conversed with plaintiff, and plaintiff did not indicate that he experienced any pain during the procedure. After completing the nerve block, Dr. Thompson administered general anesthesia. Dr. Hubbard documented that there were no complications during the surgery or post-operatively, and plaintiff was discharged later that day.

During a post-operative visit on March 21, 2013, Dr. Hubbard noted that plaintiff had no pain, and that he had been non-weight bearing and using post-operative splints. When plaintiff saw Dr. Hubbard again on May 3, 2013, he complained of increased leg arid foot pain. Dr. Hubbard discussed plaintiff's treatment with Dr. Thompson, and referred plaintiff to Dr. Anthony Geraci ("Dr. Geraci"), a neurologist, for an assessment of plaintiff's symptoms. Dr. Geraci ordered

electromyography and nerve conduction studies, which Dr. Geraci believed showed left sciatic nerve injury.

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiff cannot establish that defendants' medical treatment deviated from accepted standards of care or proximately caused plaintiff's alleged injuries.

Defendants argue that Dr. Thompson appropriately administered the popliteal fossa nerve block. In support of their motion, defendants annex the affirmation of Dr. Tiffany Tedore ("Dr. Tedore"), a physician board-certified in anesthesiology. According to Dr. Tedore, Dr. Thompson appropriately administered regional and general anesthesia in conjunction with plaintiff's surgery, and any injury to the nerves in proximity to the nerve block is a recognized risk of the procedure, which may arise in the absence of any negligence.

Specifically, defendants assert that prior to the procedure, Dr. Thompson appropriately placed plaintiff on the operative table in the prone position in preparation for the nerve block, and properly administered plaintiff mild sedatives, which allowed him to communicate with plaintiff throughout the procedure to ensure that plaintiff was not experiencing any pain that could indicate the needle was not in the correct location. Defendants also contend that Dr. Thompson appropriately disinfected plaintiff's skin to prevent infection, properly inserted the needle behind plaintiff's knee based on plaintiff's anatomic landmarks, and properly activated the nerve stimulator device. According to Dr. Tedore, the nerve stimulator stimulates the nerves to be anesthetized within the popliteal fossa to evoke a motor response in the form of muscle twitching. Dr. Tedore explains that the goal is to position the anesthetic needle in a location close enough to the nerve to adequately anesthetize the subject nerve or nerves, but not so close that it makes direct

contact with the nerve, and possibly penetrates or injures the nerve. Dr. Tedore elaborates that the anesthesiologist will monitor a patient's muscle twitching in the lower extremity while adjusting the current of stimulation during the needle advancement, and if the needle were to hit a nerve, the patient would feel a sharp shooting pain, and could thereby advise the anesthesiologist. In that regard, Dr. Tedore emphasizes that this is one of the reasons why a patient is only partially sedated during this portion of the procedure.

Dr. Tedore also opines that Dr. Thompson appropriately set the nerve stimulator to a current of 2 mA when the needle was first inserted into plaintiff's skin, which was within the appropriate range of current since the needle was not yet close to plaintiff's nerves. Dr. Tedore also asserts that Dr. Thompson appropriately advanced the needle closer to the nerve bundle until the appropriate muscle twitch was obtained, and thereafter adjusted both the needle position and the current of the nerve stimulator until the muscle stopped twitching at a current of just less than 0.45 mA, which indicated that the needle was at an optimal distance from the nerve (close enough to produce an effective nerve block, but not so close as to be within the nerve itself). Dr. Tedore concludes that this approach was correct as higher current is needed to stimulate the nerves when the needle is far away, and a lower current is required when the needle is closer to the nerves.

Dr. Tedore further opines that Dr. Thompson appropriately stopped adjusting the needle position when plaintiff's muscle twitching disappeared at a current of less than 0.45 mA. Dr. Tedore avers that amplitudes of 0.40 mA to 0.50 mA are generally accepted as a desirable current range at which the needle is close to the subject nerves, while safely away from the nerves to avoid injury. Dr. Tedore explains that losing a muscle twitch within this range generally means that the needle is as close as possible to the nerves to be anesthetized without penetrating the nerves.

Moreover, Dr. Tedore opines that Dr. Thompson appropriately utilized every known method to prevent nerve injury. According to Dr. Tedore, Dr. Thompson properly aspirated the anesthetic syringe to ensure that the needle did not penetrate a vascular structure, and that Dr. Thompson incrementally administered the regional anesthetic, during which time Dr. Thompson conversed with plaintiff to ensure that plaintiff did not experience any abnormal pain which could indicate an undesirable proximity to, or penetration of a nerve. In that regard, Dr. Tedore points out that plaintiff did not complain of any pain during the administration of the regional nerve block that would suggest that the anesthetic needle was in the wrong location.

Dr. Tedore further opines that Dr. Thompson properly used a nerve stimulator to perform the nerve block as opposed to ultrasound guidance. Dr. Tedore contends that both methods are appropriate, and that the choice of one over the other is not a departure from accepted standards of anesthesiology practice. Dr. Tedore also notes that according to medical literature, neither approach has been shown to be objectively more advantageous to the patient in terms of reducing the incidence of nerve injury.

In addition, defendants argue that plaintiff's claim that Dr. Thompson performed an unnecessary popliteal fossa nerve block must be dismissed. Defendants note that Dr. Thompson discussed with plaintiff the proposed approach to the anesthesia plan, and explained that there were risks associated with the elective nerve block, including infection, bruising, a failed or inadequate nerve block, and potential nerve injury. Defendants also highlight that Dr. Thompson documented that all questions were answered during the anesthesia pre-operative evaluation, and that plaintiff agreed to proceed with procedure after giving his written consent.

Finally, defendants argue that Mount Sinai Beth Israel must be granted summary judgment since plaintiff has not asserted any individual claims against the hospital or its staff. Defendants

maintain that plaintiff only claims that the hospital is vicariously liability for the actions of Dr. Thompson, but since Dr. Thompson did not depart from accepted standards of care, there is no negligence for which the hospital can be held vicariously liable.

In opposition, plaintiff annexes the affirmation of Dr. Roberto Rappa ("Dr. Rappa"), a physician board-certified in anesthesiology. Dr. Rappa opines that Dr. Thompson deviated from the standard of care by not demonstrating confirmatory extinguishment of muscle twitch responses below a stimulating threshold of 0.2 mA prior to the administration of local anesthetic solution. Dr. Rappa notes that a nerve stimulator was used to stimulate the nerves that needed to be anesthetized, however, there was no documentation of diminished and/or extinguished muscle twitch responses below a certain threshold, and therefore, there was no reasonable confirmatory way to ascertain whether there was an inadvertent intraneural injection of local anesthetic solution. Rather, Dr. Rappa highlights that Dr. Thompson administered plaintiff a sedative, and expected that plaintiff would feel a sharp pain if the needle was placed too close to the nerve. According to Dr. Rappa, Dr. Thompson's exclusive reliance on plaintiff's response to determine if the needle was placed correctly is misplaced, as a careful evaluation of the needle placement was necessary. As such, plaintiff maintains that absent a sonography to guide the needle to the correct spot, if electrical stimulation is used to approximate the location of the nerve, the standard of care required Dr. Thompson to carefully record the levels at which the muscle twitch diminished until it was "so low as not to matter."

Dr. Rappa also opines that Dr. Thompson departed from accepted medical practice by administering anesthesia before ensuring that the needle was properly placed, thereby causing injury to plaintiff's left sciatic nerve. According to Dr. Rappa, Dr. Thompson placed the needle too close to the nerve when using the nerve stimulator, and failed to wait for the muscle to stop

twitching, which would have indicated that the needle was in the correct place to administer anesthesia. Additionally, Dr. Rappa submits that Dr. Thompson's administration of 40 ml of local anesthetic solution, together with his failure to demonstrate the confirmatory extinguishment of muscle twitching below a stimulating threshold of 0.2 mA, contributed to plaintiff's left sciatic nerve injury. Dr. Rappa explains that the literature supports the administration of approximately 15-25 ml of local anesthetic solution for a sciatic nerve block, and that "overzealous" administration of local anesthetic solutions can contribute to dose-related neurotoxicity. Ultimately, plaintiff avers that by injecting local anesthetic solution while plaintiff's muscle was still twitching, plaintiff's nerve injury went unnoticed, as it did not allow Dr. Thompson to be sure that the needle was in the correct location.

In reply, defendants argue that plaintiff conclusory states that Dr. Thompson's alleged negligent administration of a nerve block caused plaintiff's injuries, and that Dr. Thompson's alleged failure to document the current at which he stopped advancing the needle prior to the administration of anesthesia suggests that the anesthesia was administered at an inappropriate position, thereby causing nerve injury. However, defendants reiterate that Dr. Thompson properly administered the popliteal fossa nerve block by placing plaintiff in the prone position, and by giving plaintiff mild sedatives, which allowed plaintiff to converse with Dr. Thompson throughout the procedure.

Defendants also argue that while plaintiff in a conclusory fashion states that Dr. Thompson's only way of assessing the needle placement was by monitoring plaintiff's pain response, plaintiff ignores Dr. Thompson's testimony that monitoring plaintiff's pain response was but one method he used to ensure that the needle was not placed too close to a nerve. Defendants also assert that Dr. Thompson used the nerve stimulator device to adjust the current to achieve the

desired muscle twitch response, and that as Dr. Thompson advanced the needle and simultaneously adjusted the current to stimulate the nerves, a motor response was elicited in the form of a muscle twitch. According to Dr. Thompson, as he advanced the needle toward the nerve bundle to be anesthetized, less current was needed to stimulate the nerve. Defendants also note that Dr. Thompson continued to finetune the placement of the needle until plaintiff's muscle twitch disappeared within the desirable current range, indicating a safe proximity from plaintiff's nerve.

Defendants further argue that plaintiff states in a conclusory manner that Dr. Thompson administered local anesthetic before plaintiff's muscle twitch response disappeared. By contrast, defendants assert that Dr. Thompson carefully placed the needle within a safe distance from plaintiff's nerve bundle based on plaintiff's muscle twitch response, and that plaintiff's muscle twitch response disappeared. Defendants also highlight Dr. Thompson's testimony that, "Studies have shown if you go below 0.4 [mA] then you're too close to the nerve and you might cause damage. I lost the twitch at just less than 0.45 [mA], meaning that I was okay. I couldn't have gone lower because I was going to be too close." Similarly, defendants posit that plaintiff has abandoned his claim that the popliteal fossa nerve block was unnecessary as plaintiff concedes that the use of nerve stimulation was not a departure from the standard of care.

Finally, defendants argue that plaintiff's claim that the dose of local anesthetic administered was too high must be dismissed as this constitutes a new claim. Nonetheless, Dr. Tedore's further affirmation in support of defendants' reply refutes plaintiff's claim. Specifically, Dr. Tedore opines that the medical literature does not support plaintiff's contention, and that there is no established link between the dose of local anesthetic and nerve injury. Rather, Dr. Tedore avers that Dr. Thompson's administration of 40 ml of 0.5% ropivacaine was appropriate since the maximum recommended dose is 3 mg/kg, which is 45 ml for plaintiff who weighed 75 kg. Dr.

Tedore explains that maximum recommended doses are based upon the risk of local anesthetic systemic toxicity, which is a complication separate and apart from nerve injury. In that regard, Dr. Tedore notes that doses larger than 45 ml may carry a risk of local anesthetic system toxicity, but that the administration of 40 ml was appropriate based on plaintiff's size to ensure an effective nerve block for the surgery. Dr. Tedore further highlights that the dosing of ropivacaine in a popliteal fossa nerve block has no known impact on a patient's susceptibility to nerve damage. Ultimately, defendants proffer that plaintiff has failed to demonstrate any causal link between the administration of ropivacaine and plaintiff's alleged injury.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, 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 the patient's injury (*Roques v. Noble*, 73 A.D.3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 A.D.3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 A.D.2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to 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 Hosp.*, 68 NY2d 320, 324 [1986]). To

meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendants set forth separate *prima facie* showings in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendants' expert affidavit, all of which attest to the fact that defendants' treatment of plaintiff was in accordance with accepted standards of care and did not proximately cause plaintiff's alleged injuries. To be sure, defendants' expert affirmation is detailed and predicated upon ample evidence within the record. As defendants have made their respective *prima facie* showings, the burden shifts to plaintiff.

Plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For example, the parties disagree as to whether Dr. Thompson appropriately administered the popliteal fossa nerve block. Specifically, while defendants assert that Dr. Thompson properly administered mild sedatives, which allowed him to communicate with plaintiff during the procedure to ensure that plaintiff did not experience any abnormal pain indicative of an incorrect placement of the needle, plaintiff avers that Dr. Thompson's exclusive reliance on plaintiff's response to determine proper needle placement was misplaced, as Dr. Thompson should have used ultrasound guidance to place the needle. Defendants, on the other hand, maintain that both methods are appropriate, and that the choice of one over the other does not constitute a departure from accepted standards of anesthesiology practice. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Similarly, while plaintiff argues that Dr. Thompson deviated from the standard of care by not demonstrating confirmatory extinguishment of muscle twitch responses below a stimulating threshold of 0.2 mA prior to administering local anesthetic solution, defendants assert that Dr. Thompson appropriately set the nerve stimulator within the appropriate range of current of 2 mA, and continued to finetune the placement of the needle until plaintiff's muscle twitch disappeared within the desirable current range. In that regard, defendants dispute plaintiff's contention that Dr. Thompson placed the needle too close to the nerve when using the nerve stimulator, and failed to wait for the muscle to stop twitching, which would have indicated that the needle was in the correct place. By contrast, defendants submit that Dr. Thompson carefully placed the needle within a safe distance from plaintiff's nerve bundle based on plaintiff's muscle twitch response, and that Dr. Thompson appropriately adjusted both the needle position and the current on the nerve stimulator until the muscle stopped twitching, indicating that the needle was at an optimal distance from the nerve. Because these issues cannot be resolved by the court as a matter of law, summary judgment must be denied.

Moreover, plaintiff raises an issue of fact with respect to Dr. Thompson's administration of 40 ml of local anesthetic solution.[1] Specifically, plaintiff posits that Dr. Thompson's "overzealous" administration of 40 ml local anesthetic solution contributed to plaintiff's left sciatic

[1] While defendants argue that plaintiff's claim regarding the dosage of local anesthetic constitutes an impermissible new claim, plaintiff's bill of particulars asserts a general allegation that defendants were negligent "in improperly administering the popliteal nerve block." As plaintiff's opposition argues that the administration of 40 ml of local anesthetic, coupled with Dr. Thompson's failure to demonstrate the confirmatory extinguishment of muscle twitching below a stimulating threshold of 0.2 mA, contributed to plaintiff's left sciatic nerve injury, plaintiff's argument in his opposition papers relates to the claim asserted in his bill of particulars. Therefore, defendants have sufficient notice of plaintiff's allegation that Dr. Thompson improperly administered plaintiff 40 ml of local anesthetic solution (*see e.g., Anthony v. Smina*, 159 A.D.3d 604, 604 [1st Dept. 2018] [plaintiffs did not attempt to assert a new theory of liability in opposition to defendant's motion for summary judgment by submitting evidence of the acts and omissions of two nonparty physicians, whom they identified by name for the first time in their opposition papers where "defendant not only attended [the physician's] deposition, but also knew of her involvement in the decedent's treatment before it moved for summary judgment"]).

nerve injury, as the administration of more than 15-25 ml of local anesthetic solution can contribute to dose-related neurotoxicity. Defendants, however, maintain that the medical literature does not support plaintiff's contention, and that the administration of 40 ml of ropivacaine was appropriate based on plaintiff's size to ensure an effective nerve block for the surgery. Moreover, contrary to plaintiff's assertion, defendants argue that there is no established link between the dose of local anesthetic and nerve injury, and that the dosing of ropivacaine in a popliteal fossa nerve block has no known impact on a patient's susceptibility to nerve damage. Because these issues similarly cannot be resolved by the court as a matter of law, summary judgment must be denied.

Furthermore, as Dr. Thompson has been denied summary judgment with respect to these claims, defendants' application to dismiss plaintiff's claim for vicarious liability against Mount Sinai Beth Israel must be denied.

However, to the extent that plaintiff asserts a claim for lack of informed consent, such claim must be dismissed as plaintiff failed to address or rebut defendants' *prima facie* showing that Dr. Thompson discussed with plaintiff the proposed approach to the anesthesia plan, explained the risks associated with the nerve block procedure, and answered all questions during the anesthesia pre-operative evaluation. Significantly, defendants submit undisputed evidence that plaintiff executed an informed consent form on March 11, 2013 at 12:40 [p.m.]. for general anesthesia, regional anesthesia, and the nerve block procedure (*see, Orphan v. Pilnik*, 66 A.D.3d 543, 544 [1st Dept. 2010]; *DeCintio v. Lawrence Hosp.*, 55 A.D.3d 407, 407 [1st Dept. 2008] [granting defendants summary judgment where "plaintiffs' expert's conclusory affidavit . . . failed to raise a triable issue of fact as to whether decedent was treated by defendants without informed consent"]; *Aharonowicz v. Huntington Hosp.*, 22 A.D.3d 615, 615 [2d. Dept. 2005] [granting defendant summary judgment regarding lack of informed consent claim where plaintiff's expert affidavit

"contained only conclusory allegations"]). Because plaintiff failed to address or rebut defendants' assertion that plaintiff agreed to proceed with the elective popliteal fossa nerve block followed by general anesthesia, any claims for lack of informed consent must be dismissed.

Accordingly, based on the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is granted only to the extent that plaintiff's claims premised on a lack of informed consent are dismissed; and it is further

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

ORDERED that the parties are directed to appear for a pre-trial conference on 2/4/2020 at 9:30 a.m. at 111 Centre Street (Part 10, Room 1227), New York, New York.

This constitutes the decision and order of the court.

Date: 1/7/2020

George J. Silver
HON. GEORGE J. SILVER