SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11

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STACIE S. ORELL, as Executrix of the Estate of SANDIN ORELL, Deceased Plaintiff,

INDEX NO. 451043/13

Plaintiff,

-against-

NEW YORK UNIVERSITY LANGONE MEDICAL CENTER, PATRICK J. LAMPARELLO, M.D., and JENNIFER A. STABLEFORD, M.D.,

Defendants.

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JOAN A. MADDEN, J.:

In this action for medical malpractice and lack of informed consent, defendants New York University Langone Medical Center, Dr. Patrick J. Lamparello and Dr. Jennifer A. Stableford move for summary judgment and plaintiff opposes.

On March 14, 2011, defendant Dr. Lamparello performed surgery to repair an aneurysm in decedent Sandin Orell's left leg (a left popliteal artery endovascular repair).[1] Based on the affirmation of plaintiff's expert vascular surgeon, plaintiff alleges defendants departed from the standard of care during surgery by negligently placing self-retaining retractors in decedent's groin, and as a result decedent sustained a permanent and disabling injury to his left femoral and sciatic nerves.[2] Plaintiff further alleges that defendants failed to disclose the risk of nerve injury

[1]According to plaintiff's expert, a left popliteal artery aneurysm is a "dilation or a widening of the popliteal artery" (located in the knee and back of the leg), and is dangerous, since if it thromboses or embolizes distally, it can compromise the circulation of the leg leading to amputation.

[2]To the extent the bills of particulars allege other departures that are not addressed by plaintiff's experts, those departures are deemed withdrawn and the Court will not address them.

or the alternative of performing the surgery percutaneously, i.e. without the need for a femoral surgical incision.

At the outset, the Court determines that Dr. Stableford and New York University Langone Medical Center are entitled to summary judgment. The undisputed sworn testimony of Dr. Stableford and Dr. Lamparello establish that Dr. Stableford was Dr. Lamparello's fellow acting under his direct supervision during decedent's surgery. Plaintiff fails to produce admissible evidence demonstrating that an independent act of negligence by Dr. Stableford was a proximate cause of injury to decedent. See Filippone v. St. Vincent's Hospital & Medical Ctr, 253 AD2d 616 (1st Dept 1998). Thus, as a physician acting in the role of an assistant, Dr. Stableford cannot be held liable for any medical malpractice in connection with decedent's surgery. See Mezzone v. Goetz, 145 AD3d 573 (1st Dept 2016),lv app dism 29 NY3d 1074 (2017); Boston v. Weissbart, 62 AD3d 517 (1st Dept 2009); Filippone v. St. Vincent's Hospital & Medical Ctr, supra.

The undisputed record likewise establishes that Dr. Lamparello was not employed by defendant New York University Langone Medical Center. Defendants submit an affidavit of Michael Browdy, Director of Insurance for Langone, stating he is familiar with the employment status of hospital employees and non-employee attending physicians in connection with NYU Langone. Mr. Browdy states that contrary to plaintiff's contention and Dr. Lamparello's testimony that he believed he was both a Hospital Center and School of Medicine employee in 2011, his review of the applicable personnel materials shows that Dr. Lamparello was an NYU School of Medicine employee only when he treated decedent in 2011 and was paid exclusively by NYU School of Medicine. Plaintiff has not come forward with any competent evidence controverting Mr. Browdy's sworn statements. Thus, since New York University Langone

Medical Center has established that it did not employ Dr. Lamparello at the time of decedent's surgery, it is entitled summary judgment. See Hill v. St. Clare's Hospital, 67 NY2d 72 (1986); Nahigian v. Kaplitt, 165 AD3d 418 (1st Dept 2018); Pratt v. Haber, 105 AD3d 429 (1st Dept 2013).

The remaining issue for determination is whether Dr. Lamparello is entitled to summary judgment. It is undisputed that Mr. Orell, based upon a February 1, 2011 angiogram, suffered from a popliteal artery aneurysm in his left leg which was partially thrombosed, and which presented a significant risk of severe left leg arterial ischemia that could be limb threatening. It is also undisputed that on March 14, 2011, Dr. Lamparello performed an endovascular surgical repair which involved an incision in Mr. Orell's left leg and the insertion of a graft across the popliteal arterial aneurysm. Nor is it disputed that the surgery repaired the aneurysm and five months after the surgery, Mr. Orell had a neurologic deficit in his left leg. What is disputed, is whether Dr. Lamparello, during the surgery, caused injury to Mr. Orell's femoral and sciatic nerves which caused the neurologic deficit or whether it was caused by neurodegenerative disease and/or radiculopathy. Plaintiff alleges that Dr. Lamparello departed from the standard of care by placing self-retaining retractors in an area which caused a pressure/stretch injury to Mr. Orell's femoral nerve; that negligence in dissection affected the blood supply to his sciatic nerve; and that the departures caused permanent injury to Mr. Orell's left leg, such that after the surgery he needed a cane and braces for walking.

Plaintiff also alleges that Dr. Lamparello did not obtain Mr. Orell's informed consent, as he did not inform him of the risk of nerve injury, nor did he inform him of an alternative procedure, specifically, a percutaneous stenting procedure.

Dr. Lamparello alleges that the surgery, and in particular, the incisional site, was in Mr. Orell's thigh, and as the femoral and sciatic nerves are in the groin, neither the femoral nor sciatic nerve were in the field of operation and were not damaged. Regarding plaintiff's claim of lack of informed consent, Dr. Lamparello alleges that nerve injury is not a risk of this surgery, and therefore, the standard of care did not require that Mr. Orell be informed of such alleged risk, and that the percutaneous stenting procedure does involve a risk of damage to nerves.

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 this burden, defendant 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; see Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on facts in the record or those personally known to the expert, and the opinion of defendant's expert should specify "in what way" the 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]).

"[T]o 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. If the parties' 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). "Where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. New York Downtown Hospital, 99 NY2d 542, 544 (2002); accord Rivera v. New York Pain Care Center, 154 AD3d 421 (1st Dept 2017).

Applying the foregoing standards, the Court finds, for the reasons discussed below, that in the absence of clear evidence as to area of the incision and the location of the femoral and sciatic nerves, and the area in the operative field where the retractors were placed, and the anatomical relation between these areas and the nerves, issues of fact exist as to whether Dr. Lamparello departed from the standard of care, and whether such departure was a substantial factor in causing injury to Mr. Orell.

Dr. Lamparello, in support of his motion, submits the expert affirmations of Dr. Alan Ira Benvenisty, a board certified surgeon with special qualifications in vascular surgery, and Dr. Stephen N. Scelsa, a board certified neurologist and psychiatrist with added qualifications in clinical neurophysiology. Both experts reviewed the pleadings, the bills of particulars, the parties' depositions, and the medical and hospital records.

Dr. Lamparello's operative report states in pertinent part, as follows:

> The entire left leg was prepped and draped in the usual sterile fashion. Longitudinal incision was made in the area of the thigh after ultrasound evaluation of the femoral arteries were performed. It was brought down through the

> subcutaneous tissue. The sartorius muscle retracted. Hemostasis secured in the usual manner. Self-retaining retractors were placed. Superficial femoral artery was dissected free and encircled with vessel loops. Longitudinal arteriotomy was made. X-ray equipment was brought into the room. Using a stiff wire and needle, access was gained and then the catheter and sheath placed. This was placed in an antegrade fashion. A 9-French sheath was placed. Angiograms of the leg performed. The popliteal artery aneurysm identified behind the knee. The patient was systemically heparinized. Measurements were taken with a measuring catheter. Over the stiff wire, a 7 x 10 Viabahn graft was placed. Balloon angioplasty of the graft was performed using a 7 x 10 balloon in order to iron-out. The superficial femoral artery was repaired using 6-0 Prolene sutures. Wounds were closed in layers with Vicryl. The skin closed with subcuticular sutures. The patient tolerated the procedure and left the operating room in good condition.

At his deposition, Dr. Lamparello described the procedure as follows: an incision was made through the fatty tissue to the fascia; the superficial femoral artery, which lies directly beneath the sartorious muscle, was dissected out; a large needle was then used to puncture the femoral artery; and, under x-ray guidance, a wire was placed extending into the area of the popliteal artery aneurysm, and the graft was placed.

Dr. Benvenisty opines that based upon the lack of evidence of any trauma to the nerves nor evidence of an "ischemic injury to the nerve roots," the surgery did not result in any nerve injury, femoral neuropathy, peripheral ischemia or spinal neurological deficit; and decedent experienced typical post-surgical pain that was appropriately evaluated and addressed.

In support of this opinion, Dr. Benvenisty points to the operative report, and opines that Dr. Lamparello appropriately utilized a preoperative CT scan to mark the location of the femoral artery; the only incision involved in the surgery was in the thigh; and Dr. Lamparello's use of ultrasonic guidance was appropriate to reach the superficial femoral artery and avoid any nerves. Based upon his review of the fluoroscopy scan, he opines that Dr. Lamparello's incision avoided

any nerves; and based on the CT scan, the ultrasound and the fluoroscopy, he opines there was no nerve injury.

In further support of his opinion, Dr. Benvenisty points to the absence of any indication of neurological complaints with respect to Mr. Orell's left lower extremity in the PACU and discharge records. He opines that if Mr. Orell experienced femoral neuropathy as a result of the surgery, he would have experienced weakness in his left leg immediately after surgery; that such weakness would have been readily evident on discharge; and that he would not have been able to climb stairs which he asserts was documented by the discharge nurse.

With respect to post-operative visits to Dr. Lamparello's office on March 24, May 24 and June 14, 2011, Dr. Benvenisty, in support of his opinion, relies on the lack of documentation in office records of any complaints by Mr. Orell of weakness in his left leg. He points out that the first documentation of complaints of weakness was five months after surgery, at the August 2, 2011 visit, when he states that Dr. Lamparello appropriately recommended that Mr. Orell see a neurologist for an urgent evaluation.

Dr. Benvenisty opines that Mr. Orell's complaints of injuries and nerve dysfunction stems from radiculopathy and Amyotrophic Lateral Sclerosis (ALS), a neurodegenerative disease. In support of this opinion, Dr. Benvenisty points to the preoperative report of an MRI performed on December 16, 2010 , at the direction of Dr. Keith Siller, Mr. Orell's treating neurologist, which found thoracic kyphosis and mild degenerative changes in the cervical and thoracic regions, and states that Mr. Orell had a history of left leg weakness prior to surgery.

As to the lack of informed consent claim, Dr. Benvenisty opines that Dr. Lamparello obtained a full informed consent from Mr. Orell prior to surgery, as Dr. Lamparello's sworn

statements indicate that on February 1, 2011, he explained that imaging revealed a popliteal artery aneurysm in his left leg that was partially thrombosed and posed a significant risk of severe arterial ischemia that could be limb threatening; he advised that surgery was the only option or decedent risked losing his limb; he advised that the risks of the surgery are bleeding, infection and stent graft thrombosis; and he had a second discussion with decedent regarding the risks, benefits and alternatives to the surgery, and based on those discussions, Mr. Orell signed a written consent form. With respect to the absence of information regarding nerve injury, Dr. Benvenisty opines that since this type of surgery is performed under ultrasonic guidance, nerve injury is not a risk of the procedure.

Defendants' second expert, Dr. Scelsa, a neurologist, opines that Mr. Orell did not suffer a femoral nerve or any nerve injury during surgery, since, if he had such an injury, he would immediately have had neurological symptoms of numbness and weakness while still in the hospital and during his post-operative period. Dr. Scelsa points to the December 16, 2010 MRI which revealed thoracic kyphosis and mild degenerative change in the cervical and thoracic regions, and to Mr. Orell's history of lumbar stenosis and radiculopathy. He opines that with this type of history, a recurrence of radiculopathy would be expected. He also points in support to Mr. Orell's reported pain in the early post-operative period, and opines that this pain was more likely than not attributable to his pre-existing radiculopathy from lumbar stenosis, and it is not uncommon for such pain to flair up after surgery.

Dr. Scelsa also discusses an EMG conducted by Dr. Ma in August 2011. At his deposition, Dr. Lamparello testified that when he saw Mr. Orell in August 2011, he had a "significant" neurologic deficit in his left leg, "could no longer walk" and "was having

significant discomfort in that leg." Dr. Lamparello testified that he referred Mr. Orell for an emergency neurological evaluation, which included Dr. Ma's EMG. According to Dr. Scelsa, Dr. Ma's EMG showed deficiencies in the nerves to the left lower extremity, which was the general area of the March 2011 surgery. He opines that the EMG does not support a nerve injury from the surgery, as a "proper" EMG would have studied other limbs or trunk muscles and would have revealed early stages of ALS. He supports this opinion based on the nature of the disease, since ALS is a neurodegenerative disease typically manifesting as weakness of a limb, speech or swallowing, which spreads to other areas of the body.

Dr. Scelsa further opines that a review of Dr. Bhatt's neurological exam and EMG in January 2012 shows that Mr. Orell was suffering from early stage of ALS, rather than femoral neuropathy from surgery, as the hallmark symptoms of ALS are pathologically brisk reflexes with weakness and atrophy. According to Dr. Scelsa, these symptoms are reflected in Dr. Bhatt's records that indicated a 3+ measurement of Mr. Orell's left knee reflexes, and atrophy of his left thigh, which he opines, in conjunction with the EMG results, show that the upper thigh weakness was caused by an upper motor neuron problem, rather than a local problem such as femoral neuropathy.

In addition to the two expert affirmations, Dr. Lamparello submits his own affirmation that prior to surgery, a preoperative CT scan was performed, and then the initial incision was made "under ultrasonic guidance" to ensure he reached the superficial femoral artery and avoided any nerves. As to the informed consent claim, Dr. Lamparello states that at the February 12, 2011 office visit, he "advised Mr. Orell that surgery was the only option or he risked losing his limb," and surgery "carries the risks of bleeding, infection and stent graft thrombosis"; and on the

day of surgery, he again explained the risks, benefits and alternatives, and based on their discussion, Mr. Orell signed a written consent form. Acknowledging he did not discuss the a risk of a femoral nerve injury, Dr. Lamparello states that injury to the femoral nerve is not a risk of the procedure and is "not the sort of injury doctors in my position discuss with patients in Mr. Orell's position."

In opposition, plaintiff submits expert affirmations from a surgeon and a neurologist which are redacted as to the names of the affirmants. Plaintiff's surgical expert opines that Dr. Lamparello departed from the standard of care by negligently causing retractor injury to Mr. Orell's left femoral nerve and injury to the blood supply to his sciatic nerve, and that such departures caused permanent injury. In support of this opinion, the expert states that ultrasound was used to examine the femoral arteries and the surgeons made an incision "over the artery in Mr. Orell's left groin and placed self-retaining retractors to aid in dissection of the superficial femoral artery." With respect to the self-retaining retractors, the expert opines that they must be carefully placed when dissecting the femoral artery, as the "femoral nerve lies immediately adjacent and lateral to the artery," and if the self-retaining retractor blades are placed "in a manner creating inordinate lateral pressure on the surrounding nerve for a prolonged period of time, as occurred here, injury to the femoral nerve by pressure/stretch can occur."

The expert disputes Dr. Benvenisty's opinion that the fluoroscopy scan from the surgery shows that Dr. Lamparello completely avoided all nerves. Plaintiff's expert opines that the fluoroscopy shows only the bony structure and the columns of injected dye outlining the arteries; it does not visualize nerves or provide information as to nerve location; and it is used during surgery solely to locate and aid surgeons to cut down over the artery, and is not used in the

placement of self-retaining retractors.

The expert notes that while the NYU hospital records show that Mr. Orell complained of post-procedural pain in his left thigh following surgery, and while Mr. Orell did not evidence weakness in his left leg at that time and was able to ambulate, approximately a week later, he developed clinical evidence of iatrogenic injury to his left femoral nerve. Addressing Dr. Scelsa's opinion that Mr. Orell would have felt the effects of an injury during surgery while in the hospital, the expert opines that "post-operative pain in Mr. Orell's left groin masked the nerve pain caused by defendants' iatrogenic injury," and only when the incision pain abated about a week after surgery, did Mr. Orell notice "pain and weakness" from the femoral nerve injury, and that the timing of decedent's pain is consistent with retractor pressure/stretch trauma. According to the expert, injury from this type of trauma takes time to manifest, as compared to a nerve transaction or laceration where neurological dysfunction is generally immediately apparent.

With respect to the lack of documentation of complaints of weakness in Dr. Lamparello's office records until August 2, 2011, the expert relies on Mr. Orell's testimony that he started getting "horrible pains" in his left leg as soon as a week after the surgery, his left lower extremity "did not work" after surgery, and he could not walk and had to use a cane and multiple sets of braces.

The expert also relies on the post-surgical examinations by vascular surgeon Dr. Carrocio, neurologist Dr. Bhatt, and Dr. Cohen of the Rusk Institute, who performed a physical medicine and rehabilitation evaluation. As to Dr. Carrocio's October 11, 2011 report, the expert notes his records indicate "that following endovascular repair, Mr. Orell reported experiencing severe pain in the anterior thigh as well as the distal medial aspect of his leg. In addition he has

also experienced inability to dorsiflex his ankle and inability to flex his hip. . . The timing is consistent with his surgery." The expert points out that Dr. Carroccio further stated that the neuropathic pain was not from arterial insufficiency or venous obstruction.

As to Dr. Bhatt, the expert points to Dr. Bhatt's January 27, 2012 neurological examination when he indicated that Mr. Orell reported that he was in good neuromuscular health until about a week after the surgery when the pain resolved and he experienced weakness of the left leg proximally, so that he needed a cane; also about a week after surgery, his ankle extension became weak and he developed a left foot drop. The expert points to the results of Dr. Bhatt's electrodiagnostic testing which showed "clear evidence of active chronic peripheral nerve injury in the left femoral nerve."

In connection with Dr. Cohen's April 18, 2012 examination that indicated the same history regarding the complaints from Mr. Orell as reported by Drs. Carrocio and Bhatt, the expert points to Dr. Cohen's reference to Dr. Bhatt's evaluation and electrodiagnostic testing in January 2012, and Dr. Bhatt's impression that Mr. Orell was "71-year old male with evidence of both active and chronic peripheral nerve injury in the left femoral nerve." The expert opines that the use of term "peripheral nerve injury" refers to direct nerve trauma, which in this case was surgical, and that this type of nerve injury is distinct from radiculopathy, i.e. a pinched nerve in the back, or some systemic body-wide process such as a neurodegenerative disease. The expert opines that Mr. Orell did not have ALS in 2011, and that Dr. Scelsa's opinion that a proper EMG in August 2011 would have included his right side and would have revealed Mr. Orell was suffering from ALS, is pure speculation. The expert further opines that Dr. Scelsa's reliance on the December 2010 MRI as evidence of radiculopathy is also speculative, since that MRI had

"unimpressive findings" of thoracic kyphosis with mild degenerative changes in the cervical and thoracic regions, and did not examine the lumbar spine.

As to the sciatic nerve, the expert notes that while the sciatic nerve was not directly involved in the surgery, the medial circumflex femoral artery was, and that this artery, "a branch of the profunda (deep) femoral artery, runs directly under the proximal superficial femoral artery, which defendants dissected and opened during the stenting procedure." Based in part on the foregoing, the expert opines that it is more likely than not defendants' "carelessness during their groin dissection injured the arterial vessel (the medial circumflex femoral artery), which adversely affected the circulation to Mr. Orell's sciatic nerve, resulting in secondary ischemic injury to said nerve."

With respect to the informed consent issue, the expert opines that defendants had a "clear duty" to disclose the risk of nerve injury, and it is more likely than not that Mr. Orell would not have proceeded with surgery, had he known about such risk. The expert further opines that Mr. Orell was not informed of the alternative of a percutaneous stenting procedure, which would have eliminated the need for a femoral surgical incision and the placement of self-retaining retractors, and avoided the risk of nerve injury.

Plaintiff's second expert, a neurologist, opines that Mr. Orell suffered severe permanent iatrogenic injury to the left femoral nerve during surgery, and that the records provided by Dr. Lamparello, NYU Langone and other providers do not support the contention of defendants' experts that Mr. Orell was suffering from ALS on or before the day of surgery.[3] To support this

[3]The expert notes that iatrogenic is defined as "any adverse condition in a patient resulting from treatment by a physician, nurse, or allied health professional."

conclusion, the expert opines that in December 2010, Mr. Orell's treating neurologist, Dr. Siller, suspected his left calf pain was vascular in nature, and referred him to Dr. Lamparello who diagnosed a popliteal artery aneurysm; Mr. Orell's complaints of thigh atrophy and thigh pain, arose only after surgery; and despite Mr. Orell's complaints of pain for four months after surgery, Dr. Lamparello did not refer him for testing until August 2011. The expert relies on post-operative examinations by Dr. Bhatt and Dr. Carrocio, and his/her opinions as to the findings of those physicians mirror those of plaintiff's expert surgeon.

The expert disagrees with Dr. Scelsa's opinion that Mr. Orell should have felt the effects of any nerve damage immediately after surgery while still in the hospital. The expert points out that Dr. Scelsa ignores Mr. Orell's post-operative pain from the incision and consequent masking. The expert asserts that about a week after surgery, Mr. Orell noticed "pain and weakness" in the distribution of the left femoral nerve.[4] The expert opines that given the "lack of pre-operative semiology to the left femoral nerve, but said semiology emerging post-operatively, it is medically reasonable, in fact far more probable than not, that Mr. Orell's femoral nerve injury was a result of that surgery," and the cause of such nerve injury was "iatrogenic, occurring during surgery."

The expert opines that contrary to Dr. Scelsa's opinion, ALS is not related to Mr. Orell's femoral nerve injury, as neither the record nor testimony suggests that at the time of surgery or before, he was suffering from any clinical manifestations of ALS; and Mr. Orell and his daughter

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[4]This assertion by plaintiff's expert regarding "weakness" is without attribution in the record. However, it is apparently based on Mr. Orell's deposition testimony and his statements to Dr. Carrocio, Dr. Bhatt and Dr. Cohen, who examined him respectively in October 2011, January 2012 and April 2012.

testified that the first symptoms of ALS did not manifest until 41 months after surgery. The expert opines that ALS can be ruled out as the "cause of pain in the distribution of the femoral nerve post-operatively, because it is primarily a motor condition, does not produce pain in a distinct neural distribution and there is another far more medically probable explanation for Mr. Orell's post-operative thigh pain, namely iatrogenic femoral nerve injury."

The expert also disagrees with Dr. Scelsa's opinion that Mr. Orell's femoral nerve injury is a result of severe degenerative disease of the spine, and points to the December 2010 MRI report which indicates a history of left leg weakness, but does not contain any lumbosacral spine findings. Pointing to a subsequent MRI performed in August 2011, indicating chronic degenerative changes consistent with Mr. Orell's age, the expert opines that this MRI did not demonstrate a lumbosacral spondylitic cause of radiculopathy resulting in left femoral nerve pathology. The expert asserts that prior to surgery, had Mr. Orell complained of significant low back pain or pattern suggestive of sciatic nerve involvement to his left leg, his treating doctors would have noted this fact and ordered an MRI of the lumbosacral region and appropriate electrophysiologic studies. The expert further asserts that Dr. Scelsa's opinion that Mr. Orell's left leg nerve damage and pain were the result of sciatic radiculopathy is pure speculation, as the sciatic nerve has a different nerve pathway and location from the femoral nerve.

In reply to plaintiff's opposition, defendants submit an additional affirmation from Dr. Benvenisty, who addresses the opinions of plaintiff's surgical expert.[5] Dr. Benvenistly opines that since plaintiff claims an injury to the femoral and sciatic nerves, which nerves are located in the groin, and since the surgery was in the thigh, the surgery could not have caused any

[5]The Court did not receive any request from plaintiff to submit a sur-reply.

degeneration of these nerves as seen in later EMGs. He maintains that since it is undisputable that the surgery was in the thigh, plaintiff's expert makes the "false representation" that Dr. Lamparello operated in the groin.

Dr. Benvenisty asserts that this mischaracterization as to the location of the surgery is a fatal flaw in plaintiff's theory regarding the departure. Dr. Benvenisty further asserts that the basis of plaintiff's expert opinion is that the femoral and sciatic nerve injury was caused by "carelessness during their groin dissection" and the placement of retractors in the groin, when Dr. Lamparello "cut down (made a surgical incision) over the artery in Mr. Orell's left groin and placed self-retaining retractors to aid in dissection." Dr. Benvenisty points to the operative report which states that a "[l]ongitudinal incision was made in the area of the thigh after ultrasound." He also points to the statement in the operative report that the sartorious muscle was retracted, and asserts that since the sartorious muscle is located in the thigh, this shows that the surgery was in the thigh.

Dr. Benvenisty asserts that plaintiff's surgical expert also attempts to mischaracterize the statements in his original affirmation that Dr. Lamparello properly used ultrasonic and fluoroscopic guidance to create the incision and guide the catheter. Dr. Benvenisty contends that plaintiff's expert suggests he indicated that he could see the nerves on the fluoroscopy; this is "not what I said," but rather, "I was highlighting that the fluoroscopy, in conjunction with the ultrasound and the operative report, proves that the incision was made in the thigh and the catheter was properly guided the entire procedure with nothing untoward occurring."

Dr. Benvenistry additionally responds to the opinion of plaintiff's expert that Dr. Lamparello failed to obtain an informed consent by not disclosing the alternative of a performing

a percutaneous stenting procedure without a surgical incision. Dr. Benvenisty opines that the percutaneous approach is "known to be associated with a risk of nerve injuries and an additional risk of not being able to obtain proper hemostasis," and for that reason such approach would not have decreased Mr. Orell's risk of suffering the claimed nerve injury. He also opines that the "surgical access approach to the artery is a technical issue" and a matter for the surgeon's judgment, and it is not the standard of care to discuss these "technical intricacies as part of the informed consent conversation."

Based on the foregoing, summary judgment is not warranted as to Dr. Lamparello. The undisputed medical evidence establishes that on March 14, 2011, Dr. Lamparello performed surgery on Mr. Orell's left leg which successfully repaired in aneurysm in his popliteal artery; and ten months later, on January 26, 2012, Dr. Bhatt's neurological examination showed "severe weakness in left femoral and sciatic myotomes," and his EMG testing showed "clear evidence" of a nerve injury in the left femoral nerve and the sciatic nerve. Moreover, at his deposition, Dr. Lamparello acknowledged that in August 2011, five months after the surgery, Mr. Orell had a significant neurologic deficit in his left leg, which he referred for an immediate evaluation. The parties' experts sharply disagree as to nature and cause of Mr. Orell's nerve injury, specifically whether during surgery, Dr. Lamparello injured Mr. Orell's left femoral and sciatic nerves, or whether the nerve injury was the result of a pre-existing radiculopathy condition or an early symptom of later diagnosed ALS.

Plaintiff's surgical expert opines that Dr. Lamparello negligently and carelessly placed self-retaining retractors in Mr. Orell's groin which caused a pressure or stretch injury to his femoral nerve, and that negligence in dissection affected the blood supply to the sciatic nerve.

Defendants' expert, Dr. Benvenisty, does not address this theory directly, but asserts that the incision was in the thigh and not the groin, and therefore the femoral nerve could not have been injured since it is located in the groin. Although Dr. Lamparello's operative report states that a "longitudinal incision was made in the area of the thigh," it provides no details as to the precise location on the thigh. Notably, the thigh encompasses the entire area of the leg, starting from the hip or pelvis and ending at the knee. While Dr. Lamparello was questioned at his deposition about the size of the incision (3 - 4 inches), he was not asked to identify the precise the location of the incision. Moreover, Dr. Benvenisty's emphasis on the distinction between the thigh and the groin, is undermined by the NYU hospital records which contain numerous references to the groin and left groin as the surgical site, wound site, incision site and dressing site.

The parties' experts also sharply disagree as to whether and when Mr. Orell began to exhibit the signs and symptoms of a femoral nerve injury. Defendants' experts opine that if Mr. Orell's femoral nerve had been injured during surgery, he immediately would have had weakness in his leg while still in the hospital and would not have been able to climb stairs as indicated in the hospital discharge notes; and Dr. Lamparello's office notes show that Mr. Orell did not complain of weakness in his leg until the August 2011 follow-up visit. Plaintiff's experts opine that Mr. Orell's post-operative pain from the incision and consequent masking must be considered; about a week after surgery, Mr. Orell noticed pain and weakness in his left leg; and nerve injury from this type of trauma takes time to manifest, as compared to a nerve transaction or laceration where neurological dysfunction is generally immediately apparent.

The Court notes that at his deposition, Mr. Orell testified that he began falling down two to three weeks after surgery, which arguably suggests he was suffering from weakness in his leg.

Also, the records of Mr. Orell's treating neurologist, Dr. Siller, state that at the visit on August 3, 2011, Mr. Orell indicated he had intense pain in the middle left thigh, often very intense, and increased difficulty walking due to the buckling of his left lower extremity, which again arguably suggests weakness in his left leg; and on December 5, 2011, Dr. Siller noted that Mr. Orell's "main complaint continues to be numbness and weakness in the L thigh which appear to match a femoral nerve distribution." The reports of Drs. Bhatt and Cohen, who examined Mr. Orell, respectively, in January and April 2012, likewise include statements by Mr. Orell that over the following week after the surgery when the pain from the surgery resolved, he had continued weakness of the left leg and left lower extremity to the point where he needed a cane to ambulate.

Also, to the extent defendants' experts rely on Mr. Orell's ability to climb stairs when he was discharged, the NYU hospital records indicate that on March 15, 2011, the day after surgery and the day he was discharged, Mr. Orell had a session with a physical therapist focusing on "gait training and stair negotiation with standard cane," and he was able to ascend/descend "2 steps x8, step to step pattern with unilateral hand hold on banister and opposite hand on standard cane." The record indicates that Mr. Orell resided in a walk-up building with four steps outside and 18 steps inside to his apartment.

Under the circumstances presented, the issue of causation cannot be resolved as a matter of law, since causation is inextricably linked to the disputed issues of fact relating to the alleged departure. The experts offer diverging opinions as to whether Mr. Orell suffered from radiculopathy prior to Dr. Lamparello's surgery, and whether he suffered from the early signs of ALS in 2011, and even if he did suffer from either or both those conditions, the extent to which they could have caused or contributed to his femoral nerve injury.

Finally, given experts' conflicting opinions as to whether Dr. Lamparello should have advised Mr. Orell of the risk of nerve injury and the existence of a viable alternative, the informed consent claim stands.

Thus, since the conflicting expert opinions are adequately supported by the record, summary judgment must be denied as to Dr. Lamparello. See Frye v. Montefiore Medical Center, supra; Cruz v. St Barnabas Hospital, supra.

Accordingly, it is

ORDERED that defendants' motion for summary judgment is granted to the extent the complaint is dismissed as against defendants New York University Langone Medical Center and Jennifer A. Stableford, M.D., and the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the motion is denied as to defendant Patrick J. Lamparello, M.D.; and it is further

ORDERED that the pre-trial conference previously scheduled for April 30, 2020 is re-scheduled for June 11, 2020 at 10:00 a.m., and shall take place remotely, and the remaining parties shall contact the Court at SFC-Part11@nycourts.gov to set up the conference call with the Court; and it is further

ORDERED that pursuant to CPLR 213(e), a copy of this decision and order may be filed and served.

DATE: May 20, 2020

ENTER:

Joan Madden

Digitally signed by Joan Madden
DN: C=US, OU=NY County Supreme Court, O=NYS Courts, CN=Joan Madden, E=jmadden@nycourts.gov
Reason: I am the author of this document
Location: New York, NY
Date: 2020-05-20 17:00:07
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J.S.C.