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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: JOAN B. LOBIS *Justice* PART 6

D'ALIASI, PATRICIA DEGRACE

- V -

SHAVELSON, DENNIS, D.P.M.

INDEX NO. 108185/08

MOTION DATE 4-13-12

MOTION SEQ. NO. 006

The following papers, numbered 1 to 40, were read on this motion to/for Summary judgment

Notice of Motion / Order to Show Cause – Affidavits – Exhibits No(s). 1-34

Answering Affidavits – Exhibits No(s). See 3941 on MS#004

Replying Affidavits No(s). 35-40

Motion decided in accordance with the accompanying decision and order.

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

FILED

JUL 02 2012

NEW YORK
COUNTY CLERK'S OFFICE

Dated: 6/28/12

JOAN B. LOBIS, J.S.C.

1. CHECK ONE: ..... ☐ CASE DISPOSED ☒ NON-FINAL DISPOSITION
2. CHECK AS APPROPRIATE: .....MOTION IS ☐ GRANTED ☒ DENIED ☐ GRANTED IN PART ☐ OTHER
3. CHECK IF APPROPRIATE: ..... ☐ SETTLE ORDER ☐ SUBMIT ORDER
☐ DO NOT POST ☐ FIDUCIARY APPOINTMENT ☐ REFERENCE

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

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PATRICIA DeGRACE D'ALIASI & ANTHONY D'ALIASI,

Plaintiffs,

Index No. 108185/08

-against-

Decision and Order

DENNIS SHAVELSON, D.P.M., and LIFESTYLE PODIATRY,

Defendants.

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

Motion Sequence Numbers 004, 006, and 007[1] are hereby consolidated for disposition. In Sequence 004, pro se[2] plaintiffs Patricia DeGrace D'Aliasi[3] and Anthony D'Aliasi move for summary judgment on a number of grounds. In Sequence 006, defendants Dennis Shavelson, D.P.M., and Lifestyle Podiatry also seek summary judgment. In Sequence 007, plaintiffs ask the court to grant them additional time to further oppose defendants' summary judgment motion.

This case sounding in podiatric malpractice arose out of Dr. Shavelson's performance of a procedure to remove a Haglund's deformity on the heel of Ms. D'Aliasi's right foot. Dr. Shavelson's notes reflect that on December 11, 2006, Ms. D'Aliasi first saw him for pain and discomfort related to a right Haglund's deformity. Dr. Shavelson's notes reflect that he discussed

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[1] Motion Sequence Number 005—by which plaintiffs sought to consolidate this case with another pending case—was denied in a decision and order of this court dated November 10, 2011.

[2] When plaintiffs commenced their action, they were represented by counsel. In the spring of 2011, plaintiffs' former attorney moved to withdraw as their counsel, and his motion was granted by this court's decision and order dated June 9, 2011.

[3] Ms. D'Aliasi was admitted to practice law in the State of New York in 2008 but asserts that she has never been employed as an attorney nor practiced law.

surgical options with Ms. D'Aliasi but initially recommended conservative treatment. Ms. D'Aliasi returned on December 28, 2006, reporting that she had not achieved relief through conservative treatment. She wanted to schedule the surgery during the spring of 2006, because she would not be working due to her plan to study for the bar examination. Ms. D'Aliasi returned to Dr. Shavelson on April 3, 2007, with similar complaints as before and a desire to schedule the surgery. Dr. Shavelson's notes reflect that he took x-rays that day and discussed with Ms. D'Aliasi the proposed procedure and anesthesia; the need for a post-operative cast and crutches for three weeks; and the possible complications, including infection, poor healing, tear or injury to the Achilles tendon, residual post-operative swelling, drop foot, and reactions to anesthesia.

The Haglund's deformity removal was scheduled for May 2, 2007. Dr. Shavelson's operative report indicates that on May 2, 2007, he created an incision in Ms. D'Aliasi's heel, exposed the deformity, removed the exostosis, flushed the wound, ensured that the Achilles tendon was intact, and sewed the wound. He then applied Betadine-soaked gauze, sterile dressings, and a fiberglass cast with enough padding to accommodate post-operative swelling. Dr. Shavelson's operative report indicates that he dispensed crutches for non-weight bearing ambulation, and that Ms. D'Aliasi tolerated the procedure well.

Dr. Shavelson's notes reflect that on May 3, 2007 (the day after the procedure), plaintiffs were seen in his office for an emergency visit. Ms. D'Aliasi was complaining of pain in the area of the cast at her ankle joint. Dr. Shavelson's notes indicate that Ms. D'Aliasi's right foot was cold and her capillary return was reduced. His impression was that her cast was too tight; his

notes reflect that he removed the cast[4] and converted it to a posterior splint, and that Ms. D'Aliasi had immediate pain relief and capillary return improvement after dangling the leg. Dr. Shavelson's notes reflect that he saw Ms. D'Aliasi for weekly appointments through June 21, 2007. His impression over the weeks was that her wound was healing, her cast tightness neuropathy was resolving, and the area of numbness and pain at the right medial forefoot was reversing. His notes also reflect that Ms. D'Aliasi was complaining of pain not relieved by pain medication, although she was taking narcotic pain medications throughout this period of time. Dr. Shavelson's notes reflect that on May 17, 2007, he administered a nerve block; dispensed a compression dressing (referred to as an "Unna boot") and a walking boot (referred to as a "CAM Walker"); and instructed Ms. D'Aliasi to use the walking boot for one to two hours per day, depending on whether she had pain, swelling, or heat at the area of the surgery. Dr. Shavelson's notes reflect that he discontinued the nerve block the next week because Ms. D'Aliasi was doing much better. Dr. Shavelson's notes from June 7, 2007, reflect that Ms. D'Aliasi reported a new complaint of numbness, tingling, and pain at her right dorsum, in an area involving the first, second, third, and fourth digits and the distal one-third of the right forefoot; she reported intense pain and requested more pain medication. On June 7, Dr. Shavelson took x-rays and noted that Ms. D'Aliasi had slight pain on deep palpation of the post-operative Haglund's area, continued swelling at the site, and "a residual Hadlund bump at the surgical site, especially when compared to the left foot." Dr. Shavelson's notes reflect that on June 14, 2007, Ms. D'Aliasi reported a widening area of numbness and severe pain, now involving the

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[4] Whether Dr. Shavelson removed the cast and converted it to a posterior splint is disputed, as Ms. D'Aliasi maintains that Dr. Shavelson re-cast her foot on May 3 and continued her in the cast; that she returned to Dr. Shavelson's office six times to have the cast removed, but that he continued to re-cast her foot; and that six pages of Dr. Shavelson's treatment notes are missing, which correspond to the six instances that the cast was removed and reapplied.

forefoot medially and below the talus and down to the first and second toes, and that she requested additional pain medication. Dr. Shavelson's notes state: "[c]linically, this is not following dermatome patterns." He also noted, in viewing the prior week's x-rays, that there still seemed to be a bony bump in the area of the original Haglund's deformity. He suggested that Ms. D'Aliasi seek a second opinion for the nerve injury and the Haglund's deformity. On June 21, 2007, Dr. Shavelson noted: "[t]he nerve compression continues to involve the right dorsum below the talus and at this time, continues to not follow a dermatome pattern as it extends quite laterally for the anterior tibial nerve previously involved." His notes reflect that Ms. D'Aliasi had consulted another podiatrist and would be scheduled for an elecromyogram ("EMG") test. He refilled Ms. D'Aliasi's pain medication (Percocet). Ms. D'Aliasi did not return to Dr. Shavelson after June 21, 2007.

After Ms. D'Aliasi stopped treating with Dr. Shavelson, she treated with Elizabeth Youngewirth, D.P.M., who diagnosed Ms. D'Aliasi with reflex sympathetic dystrophy ("RSD"), also known as complex regional pain syndrome.[5] In July 2007, Ms. D'Aliasi had an EMG by Earl Smith, M.D., whose impression was that Ms. D'Aliasi had an injury to the right deep peroneal nerve at or below the level of the ankle. In August 2007, Ms. D'Aliasi began receiving treatment from Charles Kim, M.D., a pain management specialist. Dr. Kim's treatment records reflect that over the next sixteen months, Ms. D'Aliasi presented to Dr. Kim approximately thirty-eight (38) times until Dr. Kim discharged her as his patient on December 11, 2008. Over his course of treating Ms. D'Aliasi, Dr. Kim prescribed varying combinations of Neurontin, methodone, clonidine, Dilaudid, and morphine. He also performed twelve (12) sympathetic nerve blocks and administered acupuncture.

[5] The parties, their attorneys, and their experts use the terms RSD and CRPS interchangeably, but for the purposes of this motion, the court will use the term RSD.

In October 2007, Ms. D'Aliasi underwent a revision surgery at the site of the right Haglund's deformity by Steven Weinfeld, M.D., to repair her right Achilles tendon. Afterwards, she complained of right lower extremity pain, spasm, and cast tightness, though she was taking pain medication and her x-rays showed good connectivity. Ms. D'Aliasi has presented to numerous physicians over the years since Dr. Shavelson's surgery. She has had a number of diagnoses, including RSD; carpal tunnel syndrome and/or tenosynovitis; tarsal tunnel syndrome; chronic pain syndrome; depression and/or depressive disorder; fibromyalgia; neuropathy; and narcotics addiction. Reportedly, Ms. D'Aliasi obtains little relief from pain medication, so she has undergone an extreme treatment regimen of ketamine infusions, which are thought to bring temporary relief to her pain.

Plaintiffs commenced this action by the filing of a summons and complaint on or about June 11, 2008. The complaint raises claims sounding in podiatric malpractice, lack of informed consent, and loss of services on behalf of Mr. D'Aliasi. Their essential allegation is that Dr. Shavelson's malpractice in treating Ms. D'Aliasi's Haglund's deformity caused her to become afflicted with RSD. In their bills of particulars, plaintiffs allege that defendants ignored Ms. D'Aliasi's complaints of pain after the May 2, 2007 surgery; failed to consider RSD as the cause of Ms. D'Aliasi's pain; failed to make the appropriate and timely referrals for pain syndrome management; improperly performed the surgery on May 2, 2007, such that inadequate bone was resected, the deformity persisted, and further surgery was required; improperly placed the cast by failing to safeguard the right lower extremity from vascular/neurological compromise; caused vascular/neurological compromise; failed to timely diagnose RSD and allodynia; failed to attribute significance to Ms. D'Aliasi's intransigent pain; and failed to promptly initiate treatment for the pain syndrome. Plaintiffs allege that the above alleged malpractice caused Ms. D'Aliasi's alleged

injuries, including RSD; damage to the tissues, muscles, and bones around the surgical site; pain and suffering; mental anguish; and the sequella of RSD.

On August 11, 2010, Ms. D'Aliasi was examined by Samuel Rapoport, M.D., a neurologist hired by defendants to perform an independent medical evaluation ("IME"). After his examination, Dr. Rapoport reported that Ms. D'Aliasi has no neurologic deficit in either foot, her feet were normal and symmetrical, and she had no sign of RSD in either foot. She had normal capillary refill time; normal skin turgor, thickness, quality, and color; and normal hair growth, sweating, nail growth, and toenail cuticles. Dr. Rapoport reported that Ms. D'Aliasi had equal and symmetrical skin temperature in both feet and legs. She had normal strength, range of movement, and sensation. Dr. Rapoport reported that a person with RSD in her foot would have a cold, atrophied foot with very thin, shiny skin; no demarcation between skin and toenail at the cuticle; very little nail growth and no hair growth on the foot; a very prolonged capillary refill time; and tapering of the ends of the toes caused by resorption of the bone and contractures of the joints. Dr. Rapoport reported that Ms. D'Aliasi had none of these abnormalities. Thus, he concluded that Ms. D'Aliasi did not presently have RSD.

Plaintiffs and defendants now, separately, move for summary judgment. As established by the Court of Appeals in Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) and Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 (1985), and as has recently been reiterated by the First Department, it is "a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that [he or she] is entitled to judgment as a matter of law." Ostrov v. Rozbruch, 91

A.D.3d 147, 152 (1st Dep't 2012), citing Winegrad, 64 N.Y.2d at 853. In moving for summary judgment in a podiatric malpractice action, a plaintiff must demonstrate that the defendant's negligence (i.e., departure from the standard of care) proximately caused his or her alleged injury, and a podiatrist must demonstrate that he or she did not depart from accepted standards of podiatric practice or that, even if he or she did depart from the standard of care, the departure did not proximately cause plaintiff's injuries. See Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010) (citations omitted). Once the movant meets this burden, it is incumbent upon the opposing party to proffer evidence sufficient to establish the existence of a material issue of fact requiring a trial. Ostrov, 91 A.D.3d at 152, citing Alvarez, 68 N.Y.2d at 324. In medical malpractice actions, expert medical opinion testimony is the sine qua non for demonstrating either the absence or the existence of material issues of fact pertaining to an alleged departure from accepted medical practice or proximate cause.

In support of their summary judgment motion, plaintiffs argue that the evidence overwhelmingly favors them. However, they fail to submit an expert's opinion establishing departure and proximate cause, a requirement in this podiatric malpractice case. To the extent that plaintiffs argue that their claims do not require expert opinion testimony, they are mistaken. This malpractice claim is for negligence in performing an excision of a Haglund's deformity and in failing to recognize and treat RSD, which are not matters within the ordinary experience of laypersons. Accordingly, plaintiffs' motion for summary judgment must be denied, for failure to meet their prima facie burden to demonstrate the absence of material issues of fact.

Plaintiffs also offer a number of ancillary arguments about their case. To the extent that plaintiffs argue that Dr. Rapoport (defendants' IME physician) falsified certain data in his report or was otherwise unqualified to provide a report, these complaints touch on issues of credibility, which are best left for the trier of fact. To the extent that plaintiffs argue that defendants' expert witness disclosure was untimely, the court notes that the parties' pre-trial order requires defendants to make their C.P.L.R. § 3101(d) disclosures no later than thirty (30) days prior to trial. In this matter, the trial date has not yet been set down, so defendants' expert witness disclosure is not yet due; regardless, it appears that defendants did serve expert witness disclosures on plaintiffs' former attorney when he still represented them. To the extent that plaintiffs ask this court to re-evaluate their former attorney's prior motion to withdraw as their attorney (which was granted), they have presented no valid grounds for reargument or renewal of that motion, and their remedy was an appeal.

Defendants, in support of their motion for summary judgment, submit a podiatric expert affidavit from Paul M. Greenberg, D.P.M. Dr. Greenberg recounts Dr. Shavelson's treatment and opines, based on Dr. Shavelson's records and the deposition testimony, that Ms. D'Aliasi's alleged RSD did not occur as a result of any deviation from the standard of podiatric care by Dr. Shavelson. With regard to plaintiffs' claim that Dr. Shavelson failed to remove a sufficient amount of bone during the excision of the Haglund's deformity, Dr. Greenberg opines that there are no specific medical parameters as to how much bone should be removed during this procedure; rather, the physician must use his or her clinical judgment. Dr. Greenberg sets forth that it is preferable to remove slightly less bone than necessary than to remove too much. He opines that there is no indication that Dr. Shavelson failed to exercise proper clinical judgment in deciding how much of

Ms. D'Aliasi's bone to remove, despite the fact that a residual bump remained after the surgery. Dr. Greenberg also opines that nerve injuries can result even when casts and padding are properly applied, and that such injuries are a known risk and do not signal a departure from the standard of care. Dr. Greenberg maintains that Dr. Shavelson applied an appropriate amount of undercast padding, with extra padding to the long arch, ankle, and lower leg, and that Dr. Shavelson did not depart from the podiatric standard of care in applying the undercast padding or the cast itself. Dr. Greenberg opines that when Ms. D'Aliasi presented with pain, delayed capillary refill, and a cold foot on May 3, 2007, Dr. Shavelson properly converted the cast to a posterior splint, which relieved the pressure caused by the cast. Dr. Greenberg states that Dr. Shavelson converted the cast in a timely manner. Defendants' expert further opines that Dr. Shavelson did not negligently fail to timely diagnose RSD because Ms. D'Aliasi's complaints—numbness and pain that improved after the cast was cut open—were inconsistent with RSD. Dr. Greenberg opines that Ms. D'Aliasi's symptoms were consistent with cast tightness neuropathy, which Dr. Shavelson appropriately treated with a nerve block and Percocet. Further, Dr. Greenberg states, Dr. Shavelson's diagnosis of nerve compression was confirmed by Dr. Smith's EMG, which revealed a right deep peroneal nerve entrapment. Dr. Greenberg opines that normal post-operative swelling within a properly applied cast can cause nerve entrapment, but that Dr. Shavelson appropriately and timely converted Ms. D'Aliasi's cast into a splint to relieve any such pressure. Dr. Greenberg also sets forth that Dr. Shavelson properly referred Ms. D'Aliasi for a second opinion when he recognized that her post-operative recovery was not progressing as expected. Dr. Greenberg opines that Ms. D'Aliasi's alleged RSD was not proximately caused by Dr. Shavelson's treatment because Dr. Shavelson's treatment was within the standard of care and because it is not possible to definitively or accurately state that RSD is caused by any single event. However, Dr. Greenberg notes that Dr. Rapoport did

not find that Ms. D'Aliasi suffers from RSD and that he agrees with this conclusion based on Ms. D'Aliasi's clinical presentation and the usual symptoms of RSD.

In opposition to defendants' motion, plaintiffs submit affidavits from two professionals. Melanie S. Levine, Ph.D., provides an affidavit, but does not provide an opinion as to departure or causation; rather, she details Ms. D'Aliasi's struggles in coping with RSD from the perspective of a mental health professional and a fellow RSD patient. Jack B. Gorman, D.P.M.,[6] opines that, based on an x-ray taken by Dr. Youngewirth, Dr. Shavelson did not remove Ms. D'Aliasi's entire Haglund's deformity, which is below the standard of care and which caused her to undergo a revision surgery on October 3, 2007. Dr. Gorman asserts that the revision surgery caused Ms. D'Aliasi's pain syndrome to flare. Dr. Gorman further opines that once Dr. Shavelson suspected that the walking boot may have been contributing to Ms. D'Aliasi's nerve injury (as he so-testified at his deposition), there was no reason that Dr. Shavelson should have continued to have Ms. D'Aliasi use the boot. Dr. Gorman opines that, based on Dr. Shavelson's testimony that he did not formulate a differential diagnosis by June 14, 2007, Dr. Shavelson has a complete lack of knowledge in the differentiation of RSD. Dr. Gorman opines that Dr. Shavelson applied a fiberglass cast on a patient who had an edematous leg, and that the improper casting created a neurogenic deformity which led to RSD. He maintains that the subsequent bivalving of the cast followed by an application of a Unna boot and a walking boot were contraindicated in a patient with RSD. Dr. Gorman states

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[6] The court notes that in her own affidavit, Ms. D'Aliasi states that Dr. Gorman lied in his affidavit. Since it appears that Dr. Gorman had more than one draft of his expert affidavit, it is unclear whether Ms. D'Aliasi is referring to the affidavit submitted with plaintiffs' opposition papers or to a previous draft of the affidavit. However, because Dr. Gorman's statement indicates that it was sworn to and subscribed before a notary public of the Commonwealth of Pennsylvania, the court will consider his statement for the purposes of deciding this motion.

that RSD should be evaluated by a magnetic resonance imaging examination or bone scan, and should be treated with physical therapy, pain management, spinal blocks, spinal simulators, and medication such as Neurontin, Cymbalta, or Lyrica, none of which Dr. Shavelson did. Dr. Gorman maintains that once Dr. Shavelson noted Ms. D'Aliasi's pathology—cold distal limb and multiple other problems—his failure to refer her for a neurological evaluation, vascular specialist, or pain management specialist fell below the standard of care of a reasonable, prudent podiatrist. He opines that Dr. Shavelson's care caused Ms. D'Aliasi to require additional surgery and additional treatments after she developed RSD, and opines that Ms. D'Aliasi will continue to deteriorate with chronic pain and discomfort for the remainder of her life.

Although Ms. D'Aliasi was diagnosed with RSD by Dr. Youngewirth approximately two months after Dr. Shavelson's surgery, a review of the records submitted by the parties indicates wide discrepancies over whether Ms. D'Aliasi actually has RSD. However, there is no dispute that Ms. D'Aliasi did experience a nerve compression injury from the cast that Dr. Shavelson applied. While defendants' expert opines that Ms. D'Aliasi's post-surgery symptoms indicated cast tightness neuropathy and that Dr. Shavelson appropriately treated the neuropathy, he does not clarify the distinction between diagnosing cast tightness neruopathy and RSD, which seems especially relevant given plaintiffs' allegations that the nerve compression injury was a traumatic precursor to her development of RSD. Further, questions remain as to whether Dr. Shavelson departed from the standard of care in the amount of bone he removed during the May 2, 2007 procedure; although defendants' expert opines that the amount of bone removed is a matter of judgment, he does not address the need for Ms. D'Aliasi's revision surgery. As material issues of fact remain after defendants' motion, the court finds that they did not meet their prima facie burden, and summary

judgment must be denied, regardless of the sufficiency of plaintiffs' opposition papers. Regardless, plaintiffs' expert opines that Ms. D'Aliasi's post-surgery symptoms indicated that she had developed RSD and that she required different, more immediate treatment than Dr. Shavelson offered. Even assuming that defendants had made out a prima facie case for summary judgment, plaintiffs sufficiently demonstrated the existence of material issues of fact in their opposition papers, and summary judgment would have been denied on that basis as well.

Given the disposition of defendants' motion, the court need not consider plaintiffs' request in Sequence 007 for more time to oppose defendants' motion for summary judgment. Accordingly, it is hereby

ORDERED that all three motions (Motion Sequence Numbers 004, 006, and 007) are denied; and it is further

ORDERED that the parties shall appear for a pre-trial conference on July 17, 2012, at 11:00 a.m., prepared to enter into a pre-trial order and to pick a trial date.

Dated: June 28, 2012

ENTER:

JOAN B. LOBIS, J.S.C.