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SHORT FORM ORDER

INDEX No. 10-19870
CAL. No. 13-02003MM

COPY

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 3-18-14
ADJ. DATE 6-13-14
Mot. Seq. # 004 - MotD

WILLIAM JORDAN and CHRISTINE JORDAN, Plaintiffs, - against - ANDREA K. VOUTSAS, M.D., DEBROAH C. RICHMAN, M.D., JOHN DOE, M.D., MARTIN J. REDMOND, M.D. and F. BARRY FLORENCE, M.D., Defendants.	BRIAN P. NEARY, PC Attorney for Plaintiffs 50 Elm Street Huntington, New York 11743 GORDON & SILBER, P.C. Attorney for Defendants 355 Lexington Avenue New York, New York 10017

Upon the following papers numbered 1 to 31 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (004) 1 - 20; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 21-28; Replying Affidavits and supporting papers 29-31; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (004) by defendants, Andrea K. Voutsas, M.D., Martin Redmond, M.D., and Barry Florence, M.D., seeking an order granting them summary judgment pursuant to CPLR 3212 and dismissing the complaint as asserted against them is denied as to defendants Martin Redmond, M.D. and Andrea K. Voutsas, and is granted as to defendant Barry Florence, M.D.

William Jordan sustained an injury to his right knee consisting of a small fracture of the right knee patella in 2007. He was treated non-operatively initially, however, subsequent x-rays revealed a patella osteophyte, and a loose bone fragment. On July 29, 2009, Nicholas Divaris, M.D. performed an excision of the right knee patella osteophyte under general anesthesia with a local block and tourniquet placement on his right thigh. The bone fragment was also removed. In this medical malpractice action, William Jordan now seeks damages for personal injuries he allegedly sustained during that surgical procedure at Stony Brook Ambulatory Surgery Center. It is alleged that the defendants negligently departed from good and accepted standards of medical care and treatment relating to administration of a femoral nerve block into plaintiff's right groin area prior to the knee surgery, causing the plaintiff to

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sustain damage to his femoral/saphenous nerve from direct trauma and/or intraneural injection to the nerve. The plaintiff alleges he now experiences numbness in the right anterior tibia; weakness of the right leg; and instability of the right leg due to injury to the femoral nerve/saphenous nerve distribution. Causes of action for negligence, lack of informed consent, and a derivative claim have been pleaded.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v New York Univ. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v New York Univ. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this motion, the moving defendants submitted, inter alia, copies of the summons and complaints for the consolidated actions, defendants' answers, plaintiff's bill of particulars; copies of the curriculum vitae of Drs. Reiser and Gadsden without their sworn affidavits attesting to the truth of the contents of each curriculum vitae; the transcripts of the examination before trial of William Jordan; Frank Florence, Andrea Voutsas, and Redmond; omitted Exhibit I which is referenced to Exhibit Q; an improperly certified copy of the medical record Stony Brook University Medical Center, and operative report from July 29, 2009, record of a neurology outpatient visit of Dr. Gursoy dated January 7, 2010, Dr. Gursoy's diagnostic neurophysiology report dated March 8, 2010, all of which are not in admissible form pursuant to CPLR 3212 and 4518 (*see* ***Friends of Animals v Associated Fur Mfrs.***, *supra*); and a stipulation of discontinuance as to Deborah C. Richman, M.D., dated February 12, 2014, which is not signed by all defendants.

Expert testimony is limited to facts in evidence (*see* ***Allen v Uh***, 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom***, 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts, Inc.***, 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]). Uncertified medical records and inadmissible evidentiary submissions are not in evidence.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see*

Derdiarian v Felix Contracting Corp., 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

Jeffrey Gadsden, M.D. averred that he is licensed to practice medicine in New York State and is board certified in anesthesia. He stated that he formed his opinions upon his knowledge and experience in the field of anesthesia, his review of the pleadings, deposition transcripts, and appropriate medical/anesthesia records, however, he has not identified what medical records and whose deposition transcripts he reviewed. Dr. Gadsden does not state what the plaintiff's condition and complaints were prior to surgery based upon the plaintiff's treating orthopedist's records. He opined to a degree of medical certainty that Drs. Richman, Florence and Voutsas did not perform any activity or treatment with respect to Mr. Jordan that could have possibly caused the alleged injury to the femoral/saphenous nerve and resultant numbness to the inner aspect of his right leg. He continued that it is his opinion that Dr. Redmond performed the femoral nerve block (FN) in a fashion consistent with good and accepted medical practice. It is his further opinion that informed consent was given to the plaintiff consistent with good and accepted medical practice.

Dr. Gadsden stated that the plaintiff fractured his right patella (knee) in a work-related incident that occurred in 2007. He continued that due to increased pain and the development of osteophytes in that area, his orthopedic surgeon, Dr. Divaris, performed surgical excision of the right knee patella osteophyte on July 29, 2009 at Stony Brook University Hospital. He stated that the plaintiff underwent a FN in which an anesthetic is injected in the area, and in proximity of the femoral nerve. The goal of the anesthesiologist is to avoid going inside and hitting the femoral nerve, but instead to spread the anesthesia around the femoral nerve. He indicated the benefits of the FN is as an adjunct to general anesthesia so that less anesthesia is needed during the actual surgery, often providing an easier postoperative recovery, and reducing the potential use of opioids, thus minimizing potential respiratory complications. He opined that the fact that the plaintiff may have suffered the alleged injury is in no way indicative of the fact that the FN procedure was performed in a negligent fashion. Injury to the femoral/saphenous nerve is a known, albeit rare complication of a FN, and occurs in approximately .02% - .04% of cases.

Dr. Gadsden stated that Dr. Redmond performed the January 29, 2009 FN after the plaintiff was already sedated. He located the appropriate position for administration of the block on only one attempt, utilizing both a nerve simulator (stim) which involves the use of an electrical current to determine activity near the nerve area, and an ultrasound, which is considered the most sophisticated method which allows the anesthesiologist to observe precisely where the stim needle is located in relation to the nerve. After exceeding the standard of care and determining the appropriate location, an appropriate dosage of 30 ccs of Ropivacaine anesthetic was administered without indication of a complication reflected in the anesthesia records.

Dr. Gadsden stated that, for the purpose of the opinions set forth in his affidavit only, he assumed that the numbness was caused by the FN, and continued that the only aspect of the FN that could conceivably have caused the injury was the insertion of the stimulation needle in such a fashion that it impacted on the femoral/saphenous nerve. Dr. Gadsden stated that neither Drs. Richman, Florence, or Voutsas could have even conceivably caused the injury. Dr. Richman's involvement, he stated, was limited to the pre-operative anesthesia clearance which was done several weeks before administration of the FN. Dr. Florence 's involvement, he stated, was limited to clearing the plaintiff for discharge after Dr. Redmond had administered the FN, and in ordering the appropriately prescribed Fentanyl on an as needed basis for the plaintiff's pain. Dr. Voutsas' involvement, he stated, was only to provide informed consent to the plaintiff and possibly to hold the syringe and inject the medication under the supervision of Dr. Redmond, after the site of administration was located. He stated that Dr. Voutsas had the plaintiff sign the consent form after informing him of the risks, benefits, and alternatives of an FN, and how the procedure would be done as an adjunct to anesthesia. Dr. Voutsas advised of the risks of infection, bleeding, and nerve damage, which he noted was very rare.

The affidavit of Howard Reiser, M.D. has also been submitted by the moving defendants. Dr. Reiser averred that he is a physician licensed to practice medicine in New York and is board certified in neurology. He indicated his opinions are based upon his knowledge and experience in the field of neurology, and his review of the pleadings, deposition transcripts, and appropriate medical/anesthesia records. However, he does not state which medical records were reviewed, and the records concerning the plaintiff's care and treatment prior to surgery have not been provided to this court. Dr. Reiser does not state what the plaintiff's condition and complaints were, based upon the plaintiff's treating orthopedist's records prior to surgery of July 29, 2009. It is Dr. Reiser's opinion that the plaintiff cannot establish that the performance of the FN was more probable than not a proximate cause or substantial factor in causing the plaintiff's claimed injury because the injury could have been caused when the plaintiff fell and fractured his knee, or by the right knee surgery performed on July 29, 2009.

Dr. Reiser stated that the plaintiff fractured his right patella in a work-related incident/fall in 2007, and due to increased pain and development of osteophytes in that area, Dr. Divaris performed an excision of the right knee patella osteophytes at Stony Brook University Hospital on July 29, 2009. After the surgery, which included anesthesia with a FN, the plaintiff experienced numbness to the inner aspect of his right leg from the bottom of his knee to the top of his ankle. Dr. Reiser stated that the relevant nerve distribution that impacts that area includes the femoral nerve and the SN (saphenous nerve) which branches off the femoral nerve and is the sensory nerve for the area of the plaintiff's leg where he claims to be numb. He indicated that the femoral nerve is a large nerve and only a small number of its fibers will form the saphenous nerve. To cause a saphenous nerve disorder, the FN would have had to precisely impact only this tiny bundle of nerves and not the rest of the femoral nerve. Dr. Reiser stated that the FN did not impact the rest of the femoral nerve because other femoral nerve functions were not affected.

Dr. Reiser opined that the saphenous nerve is in close proximity to the knee, and when the plaintiff fell in 2007, there was a real potential of impacting the saphenous nerve and causing saphenous nerve dysfunction. He does not indicate, however, whether the plaintiff experience the claimed numbness from 2007 following the accident up to the time of surgery on July 29, 2009. Dr. Reiser also

stated that the surgery performed by Dr. Divaris on July 29, 2009, involved the use of bandages and tourniquets at high pressure to exsanguinate the right leg. He continued that the saphenous nerve is located within the neuro-vascular bundle, and exsanguination compresses the blood vessels, compresses the nerve, and had the real potential of damaging the saphenous nerve causing the saphenous nerve dysfunction, which the plaintiff claims he is experiencing. Dr. Reiser continued that Dr. Divaris advised the plaintiff after surgery, when he complained of numbness in his leg, that it could have been caused by the FN or from the operation and recommended that the plaintiff follow-up with a neurologist.

Dr. Reiser indicated that the plaintiff followed-up with Nurcan Gersoy, M.D. PhD, whose office note reveals the impression, "I am not sure etiology of this. It can be related to surgery, femoral nerve block, or his initial injury." Therefore, stated Dr. Reiser, even Dr. Gersoy could not determine the cause of the claimed injury. Dr. Gersoy ordered EMG nerve conduction studies which Dr. Reiser stated he reviewed himself. He stated that the EMG/NCV findings were inconclusive as to whether Mr. Jordan sustained a saphenous nerve injury. In reviewing Dr. Gersoy's report, it is determined that Dr. Gersoy reported in his interpretation and conclusion that, "[a]s extensive electrodiganostic examination of the right lower extremity with limited comparative studies of the left lower extremity is normal except absent bilateral saphenous sensory nerve responses. This finding is of unclear clinical significance and may be due to technical factors or the patient's physiognomy."

Dr. Reiser stated that neither Drs. Richman, Florence, or Voutsas could have even conceivably caused the injury. Dr. Richman's involvement, he stated, was limited to the pre-operative anesthesia clearance which was done several weeks before administration of the FN. Dr. Florence 's involvement, he stated, was limited to clearing the plaintiff for discharge after Dr. Redmond had administered the FN, and in ordering the appropriately prescribed Fentanyl on an as needed basis for the plaintiff's pain. Dr. Voutsas' involvement, stated Dr. Reiser, was only to provide informed consent to the plaintiff and possibly to hold the syringe and inject the medication under the supervision of Dr. Redmond after the site of administration was located.

It is determined that the defendants Andrea Voutsas, M.D. and Martin J. Redmond have not established prima facie entitlement to summary judgment dismissing the complaint as to them. Dr. Gadsden opined that the risk of nerve injury and numbness is so rare that had the plaintiff not been advised of the same, that still would not have been a departure from good and accepted medical practice. Absent in Dr. Gadsden's discussion is any statement that nerve damage to the femoral/saphenous vein cannot occur in the absence of negligence, and he expresses no cause for the alleged injuries claimed by the plaintiff. Dr. Martin Redmond performed the FN and Dr. Voutsas is stated by defendant's experts as having possibly held the syringe and injected the medication under the supervision of Dr. Redmond. The FN has not been ruled out as a possible cause of the alleged femoral/saphenous nerve injury. Dr. Reiser offers three possible causes for the saphenous nerve injury claimed by the plaintiff. While he indicated the injury from 2007 may have been the cause, such opinion is conclusory and unsupported by any evidentiary proof as the prior treating records and plaintiff's complaints from that accident until the surgery of July 29, 2009 have not been provided. Dr. Reiser also opined that the surgery performed by Dr. Divaris on July 29, 2009 involved the use of bandages and tourniquets at high pressure in order to exsanguinate the right leg and that exsanguination compresses the blood vessels, compresses the nerve, and had the real potential of damaging the saphenous nerve causing the saphenous nerve dysfunction.

Neither Dr. Divaris nor Dr. Gursoy determined the cause of the injury, and the EMGs and NCS were inconclusive concerning injury to the saphenous nerve. Therefore, Dr. Voutsas and Dr. Redmond have not established prima facie entitlement to summary judgment.

It has been established that Dr. Florence's involvement was limited to clearing the plaintiff for discharge after Dr. Redmond had administered the FN, and in ordering the appropriately prescribed Fentanyl on an as needed basis for the plaintiff's pain. Based upon the foregoing, Dr. Florence has established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

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

The plaintiffs submitted the affidavit of plaintiff, William Jordan, who stated that he did not have any loss of sensation or tingling or pins and needles in his right leg from the time of his accident in 2007 until the surgery of July 20, 2009. He stated that Dr. Redmond told him that if they did the femoral nerve block, his recovery time would be shorter, less anesthesia would be used, he would need less pain medication after surgery, and that he would probably have numbness running from his right groin to his right knee, but the numbness would go away within a day or two. No risks or complications were discussed with him by Dr. Redmond. In October 2009, after his second knee surgery, Dr. Redmond came to him and told him that there are times when you hit a nerve and it could be six months for the nerves to regenerate, or it may never go away, and that there is a nerve in the area where the nerve block was done which correlated with the area of lack of sensation in his right leg.

Plaintiffs submitted the unredacted affirmation of Alexander Weingarten, who affirms that he is a physician licensed to practice medicine in New York State and is board certified in anesthesiology with a subspecialty in pain management. He set forth his education and training and indicated the materials and records which he reviewed, including the office records of Nicholas Divaris, M.D. and Bruce R. Mayerson, M.D., and the EMG study of May 29, 2013, which records and reports defendants' experts have not indicated they reviewed.

Dr. Weingarten stated that Dr. Redmond testified that his name was on the consent form for the FN which was performed into plaintiff's right femoral nerve prior to the plaintiff being placed under general anesthesia. Dr. Weingarten set forth the benefits of an FN, indicating that the anesthetic is injected around the femoral nerve during the FN, with the objective to avoid penetration of the needle into the femoral nerve itself (intraneural injection), which can result in nerve damage. He stated that electrical stimulation is used by the anesthesiologist to locate the femoral nerve to ensure that the stim needle is outside the nerve. The stim needle is to be placed in close proximity to the femoral nerve to elicit a motor response-a twitch of the thigh (quadriceps muscle) which moves the patella due to the electrical current via the stim needle. Dr. Weingarten stated that motor responses to very low electrical

currents (less than 0.2 mA) correlate to intraneural needle tip placement, and the operator should start at a higher voltage and decrease the voltage gradually. If a twitch is still observed at less than, or equal to 0.2mA, then this means the needle tip has been placed inside the nerve and must be withdrawn immediately or it can result in nerve injury.

Dr. Weingarten continued that there is no testimony by Dr. Redmond as to what current or voltage he utilized when using the nerve simulator unit, and the record is silent as to what his custom and practice was concerning the amount of current he used for a femoral nerve block. Dr. Voutsas, who assisted Dr. Redmond, could not say what voltage was used, only that it was low voltage, which Dr. Weingarten stated is too vague to be useful information. Thus, stated Dr. Weingarten, there is nothing in the record or in the testimonies evidencing appropriate current/voltage was used, and thus it was impossible for Dr. Gadsden to opine that the electrical stim part of the procedure was performed appropriately. If Dr. Redmond failed to gradually decrease the current to .2 mA, this could have resulted in needle penetration into the nerve because a motor response at too high a current does not tell the operator if the needle is outside or inside the femoral nerve. Utrasound utilized in connection with a nerve simulator is a reliable means to prevent intraneural injection because there is real-time imagining of the needle and nerve, so it is only by operator error that a needle is inserted into the nerve. Dr. Weingarten opined that an anesthesiologist experienced with femoral nerve blocks should not, in the absence of negligence, penetrate the femoral nerve when utilizing both nerve stimulation and ultrasound guidance, and the clinician should not advance the needle until he can visualize the femoral nerve on the ultrasound image.

Dr. Weingarten indicated that the plaintiff was experiencing pain levels of six out of ten to ten out of ten from 4:20 p.m. through 5:45 p.m. despite being medicated pursuant to Dr. Florence's orders of Fentanyl 25 mcg/.5mL intravenous push at 4:16 p.m., 4:22 p.m., 4:27 p.m. and 4:32 p.m. At 4:20 p.m., the plaintiff's pain level was ten out of ten. At 4:45 p.m., his pain level was six out of ten and at 5:00 p.m., five out of ten. When Dr. Florence saw the plaintiff prior to 5:45 p.m., he ordered additional Fentanyl 50 mcg because the nurses told him that the plaintiff was hurting a lot and the customary pain medication was not sufficient to make him comfortable. This, stated Dr. Weingarten, was an indication that the FN was not performed properly as the plaintiff should not have been in such severe pain this long after the procedure, and would not have required the additional pain medication.

Dr. Weingarten stated that when the plaintiff saw Dr. Divaris for a postoperative visit on August 13, 2009, he reported some paraesthesias (numbness) over the anterior aspect of the tibia and over the medial thigh. Dr. Divaris noted that the plaintiff had decreased sensation to touch over the anterior aspect of his right tibia on the September 10, 2009 visit. At the October 29, 2009 office visit, the decreased sensation over the saphenous nerve continued, so the plaintiff was referred for follow-up with a neurologist. On January 7, 2010, the plaintiff saw Dr. Nurcan Gursoy for numbness and tingling below his right knee in his distal leg, especially in the anterior and medial aspect, which continued from the time he woke up from surgery on July 29, 2009. On March 8, 2010, an EMG was conducted and reviewed by Dr. Gursoy, whose impression was that the presence of a right saphenous neuropathy could not be excluded due to the absence of saphenous sensory nerve response on the right or left sides. She explained to the plaintiff that the saphenous nerve can be difficult to pick up. When the plaintiff saw neurologist Bruce Mayerson, M.D. a neurologist, on May 29, 2013, Dr. Mayerson noted the numbness in

the right anterior calf from the knee to the top of the foot without the symptoms in his left leg. Dr. Mayerson's impression, after examining the plaintiff, was that of saphenous neuropathy as a complication of a femoral nerve block. An EMG and nerve conduction study on May 29, 2013 showed a right saphenous neuropathy with no motor nerve involvement to suggest a more proximal femoral neuropathy.

It is Dr. Weingarten's opinion within a reasonable degree of medical certainty that the plaintiff's right saphenous neuropathy is causally related to the femoral nerve block performed on July 29, 2009. He stated that the saphenous nerve is a branch of the femoral nerve that arises from femoral nerve in the femoral triangle and descends through it on the lateral side of the femoral vessels where it enters the adductor canal. The saphenous nerve is in the immediate area where the stim needle is inserted for the femoral nerve block. Dr. Weingarten disagrees with Dr. Reiser's opinion that the femoral nerve block did not impact the rest of the femoral nerve. This is so, stated Dr. Weingarten, because the plaintiff complained of numbness and tingling in his medial thigh on his postoperative visits with Dr. Divaris on August 13, 2009 and August 17, 2009, three weeks after the nerve block, indicating the femoral nerve block not only affected his saphenous nerve, but that he also had transient nerve dysfunction of the femoral nerve, demonstrated by the paresthesia on his right thigh, which fortunately resolved with time.

Dr. Weingarten continued that while Dr. Reiser also opined that the plaintiff's saphenous nerve injury could have been caused by the accident of 2007, such opinion is not supported by the record as the plaintiff had no loss of sensation or tingling in his right lower extremity or right thigh prior to the femoral nerve block on July 29, 2009. He disagrees with Dr. Reiser's opinion that the injury to the saphenous nerve could have occurred during the surgery of July 29, 2009 from the use of bandages and tourniquets at high pressure to exsanguinate the lower right leg, causing compression of the nerve and resulting injury. However, stated Dr. Weingarten, this is not supported by the Stony Brook intra-operative report which indicates a pneumatic tourniquet was used on the right upper leg and was set at 300 mmHg, inflated at 3:14 p.m. and deflated at 3:29 p.m., well within the two hour safety range of pressure. After deflation, the plaintiff's skin condition was noted to be intact. No complication was noted. The pressure and tourniquet time were both well within the safety range and would not have caused the temporary paresthesia in the plaintiff's thigh and permanent saphenous nerve injury. Because the patient experienced both thigh paresthesia and loss of sensation in his saphenous nerve distribution, this clearly points to the femoral nerve block as the competent producing cause of the patient's nerve dysfunction.

Dr. Weingarten stated that when nerve damage occurs with an FN, 99% of the time it resolves within weeks, and at the latest, one year. Permanent nerve injury, stated Dr. Weingarten, is not a risk of FN, thus disagreeing with Dr. Gadsden. Dr. Weingarten stated that penetration of the nerve with the stim needle is substandard care, and if the procedure was done with real-time ultrasound guidance, and with reasonable care, the nerve should not have been penetrated. It is Dr. Weingarten's opinion within a reasonable degree of medical certainty that Dr. Redmond departed from the generally accepted standard of medical practice by penetrating the plaintiff's femoral/saphenous nerve with the stim needle. Because the injury is permanent, this reveals circumstantially, not only that he penetrated the nerve with the needle, but that he probably used excessive injection pressure which is known to cause nerve injury. He continued that Dr. Redmond injected 30 ccs of .5% Ropivacaine, and that 10 to 20 ccs of local anesthetic

is usually sufficient for an adult FN. Excessive local anesthetic can be toxic to the nerve.

With regard to informed consent, Dr. Weingarten stated that it was the responsibility of Dr. Redmond and/or his assistant Dr. Voutsas to inform the plaintiff of the risks, benefits, and alternatives to the femoral nerve block, including the risks of infection, bleeding, reaction to the local anesthetic, and temporary nerve injury. The alternative was not doing the FN or local anesthetic wound infiltration after the surgeon closed the wound prior to the patient leaving the operating room, which was done successfully when the plaintiff had a second surgery in October, 2009. Having the plaintiff sign a consent in the absence of a discussion with the doctor addressing the risks, benefits, and alternatives does not satisfy the doctor's duty to obtain informed consent.

Based upon the foregoing, there are factual issues, as set forth above, concerning the conflicting opinions among Dr. Weingarten, Dr. Reiser and Dr. Gadsden as to alleged departures from the standard of care and proximate cause of the injury of saphenous nerve damage claimed by the plaintiff concerning the care and treatment provided by defendants Dr. Redmond and Dr. Voutsas.

The motion for summary dismissal of the complaint is denied as to Dr. Martin Redmond and Dr. Andrea Voutsas, and the motion is granted as to defendant Dr. Barry Florence, and the complaint as asserted against him is dismissed.

Dated: 8-18-14

Hon. Denise F. Molia
A.J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION