Eisenstadt v Lallemand
2022 NY Slip Op 33092(U)
September 6, 2022
Supreme Court, Kings County
Docket Number: Index No. 515806/16
Judge: Ellen M. Spodek
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At an IAS Term, Medical Malpractice Trial Readiness Part of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 6th day of September, 2022.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

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DESIREE EISENSTADT,
Plaintiff,

-against-

ROGER LALLEMAND, M.D.,
and THE LENOX HILL HOSPITAL,

Defendants.

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DECISION AND ORDER

Index No. 515806/16

Mot. Seq. Nos. 6-7

The following e-filed papers read herein:	NYSCEF Doc. No.:
Notice of Motion, Affirmations, and Exhibits Annexed	123-126, 137-152
Affirmations (Affidavits) in Opposition and Exhibits Annexed	156-163, 164-171
Reply Affirmations and Exhibits Annexed	174-175, 176-180

In this action to recover damages for medical malpractice and lack of informed consent, defendants Roger Lallemand, M.D. ("Dr. Lallemand"), and The Lenox Hill Hospital ("Lenox") separately move for summary judgment dismissing the complaint of plaintiff Desiree Eisenstadt ("plaintiff") as against them (Seq. Nos. 7 and 6, respectively).

Background

Plaintiff's claims arose as a result of a combined spinal-epidural procedure ("CSE") performed on her by Dr. Lallemand at Lenox on March 19, 2015, for labor and vaginal delivery of her sixth child. Prior to performing CSE on plaintiff, Dr. Lallemand knew, by way of plaintiff's obstetrical history, that: (1) a different on-call anesthesiologist had caused an accidental dural puncture ("ADP"), also known as a "wet tap," in the course of

her CSE during one of her prior childbirths at Lenox; (2) the wet tap, in turn, had caused plaintiff's cerebrospinal fluid ("CSF") to leak through the ADP with the resulting decrease in her CSF pressure; (3) the decrease in the CSF pressure, in turn, caused her to experience a post-dural puncture headache ("PDPH"); and (4) plaintiff, during the prior childbirth, had undergone a separate invasive procedure, known as an epidural blood patch ("EBP"), to seal the ADP, restore the CSF pressure, and relieve PDPH (which, by the time of CSE at issue on March 19, 2015, had ceased).[1]

As a general matter, the epidural space is located, using either the midline or the paramedian approach (*i.e.*, depending on the angle at which the epidural needle is inserted), as the epidural needle pierces the patient's skin and advances into her body. The advancement of the epidural needle from the internal surface of the ligamentum flavum to the external surface of the dural sac before the epidural needle is able to penetrate the dural sheath requires an anesthesiologist to stop the advancement by no more than a few millimeters as soon as he (or she) enters the epidural space. The sooner the anesthesiologist stops the advancement of the epidural needle after it enters the epidural space, the shorter will be the length of the epidural needle protruding from the ligamentum flavum. As the anesthesiologist guides the epidural needle through the ligamentum flavum, he/she uses the loss-of-resistance technique, with either a saline, or an air-filled, syringe, to locate the epidural space (the "LOR-to-saline" and "LOR-to-air" techniques, respectively). In addition (and as noted), plaintiff's documented history of a prior ADP (followed by a prior

[1] *See* Lenox Records at 18/478 (Pre-Anesthesia Assessment); Dr. Lallemand's EBT tr at page 49, lines 11-19.

curative EBP) required a patient-oriented, non-standardized approach for applying clinical judgment in the anesthesiologist's first encounter with his new patient.

Here, viewing the evidence in a light most favorable to plaintiff as the non-movant, it is reasonable to conclude that Dr. Lallemand, instead of proceeding with caution, initiated plaintiff's CSE with what appears to have been his preconceived notions as to where her epidural space should have been located. Dr. Lallemand, over the course of at least 30 consecutive minutes, made a total of ten separate attempts[2] at epidural placement with a large-bore 17-gauge epidural needle, as evidenced by his multiple (and then recently made) puncture wounds in plaintiff's back. In his quest to locate plaintiff's epidural space, Dr. Lallemand initially tried to enter her epidural space at the L3-L4 level, then at a higher L2-L3 level, and then at an even higher L2 level.[3] He tried both the midline and the paramedian approaches. It appears that he used the LOR-to-air technique to locate the epidural space. Dr. Lallemand became flustered at his repeated inability (despite his multiple attempts) to locate plaintiff's epidural space.

In the meantime, plaintiff was experiencing spasms of pain with Dr. Lallemand's every attempt at epidural placement. According to plaintiff, Dr. Lallemand continued with

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[2] An epidural needle, if inserted incorrectly, cannot be repositioned once it is inside the patient's body, but must be taken out and re-inserted.

[3] *See* Dr. Lallemand's EBT tr at page 66, lines 2-3 ("According to my record, it was at the level of L3/4."); page 82, lines 13-14 (same); page 109, lines 21-22 ("Multiple attempts for CSE at L3/4 and L2/3."). *See also* Dr. Strongin's EBT tr at page 34, lines 18-20 (plaintiff's back showed at least ten puncture wounds, the highest of which appeared at L2); page 46, line 18 to page 47, line 4 ("Q. So L2 is higher than expected. A. For an epidural labor. And the higher you go, the greater the chance that anesthesia can drip up and cause some nerve changes which would impair your ability to take deep breaths and breathe."); page 68, line 22 to page 69, line 4 ("Some of the puncture wounds [on plaintiff's back] were rather high so they would [be] consistent with a higher area than we normally would expect the epidural to take place. Epidural is usually taken around L4-L5 and several of those puncture wounds were definitively higher than usual.").

his attempts at epidural placement despite her vocal pleas to him to stop and abandon CSE, particularly after – following one of his failed attempts at epidural placement – she experienced a sudden electric shock when her left leg involuntary "shot up" from the sitting (90 degree to the floor) position to the horizontal (180 degree to the floor) position.[4]

Dr. Strongin, plaintiff's life-long obstetrician (who either on his own or by his practice partners had delivered all of plaintiff's five older children), was present at Lenox for (among other duties) delivery of plaintiff's sixth baby. As it was already late in the day when Dr. Lallemand finished his pre-induction re-evaluation at plaintiff's bedside at 5:00 pm, Dr. Strongin needed him to perform CSE smoothly and promptly so that, while plaintiff was under the CSE sedation, he could augment her labor with Pitocin and then deliver her child. To Dr. Strongin, a highly experienced obstetrician then approximately 1½ years away from retirement, Dr. Lallemand's multiple punctures of the spine of plaintiff and his refusals to stop CSE (despite Dr. Strongin's and plaintiff's separate requests to him to stand down) were unacceptable. By the time a replacement anesthesiologist allegedly arrived at plaintiff's bedside following Dr. Strongin's telephone

[4] *See* Plaintiff's May 23, 2018 EBT tr at page 149, lines 2-20 ("And during one attempt [at epidural placement by Dr. Lallemand], Dr. Strongin had been walking in at that moment . . . , and it was a crazy shock down my [left] leg, and my leg flew in the air like that. And Dr. Strongin started screaming to Dr. Lallemand, saying 'Roger that's enough, enough, stop.' . . . [Dr. Strongin] kept asking Dr. Lallemand, 'What's wrong? Is she crooked? [*i.e.*, is plaintiff's back crooked?]' And [Dr. Lallemand] said, 'No, I keep hitting [the] bone.' And at one point, it was so painful, I remember I was crying . . . *I asked [Dr. Lallemand] to stop. I said, 'I don't want it anymore.'* And he said, 'No, no, it's okay. I almost got it.' *He refused to stop. He kept going.*") (emphasis added). *See also* Plaintiff's March 27, 2019 EBT tr at page 82, line 22 to page 83, line 6 ("[W]hen [Dr. Strongin] went to check on me the following time, it was at that moment when my left leg flew up in the air and I had this crazy electric current going down my leg and Dr. Strongin witnessed that and he yelled at Dr. Lallemand and [Dr. Strongin] said, 'Okay, stop, that's enough. Take it out of her,' and *[Dr. Lallemand] still refused and he just kept going.*") (emphasis added).

call to the anesthesiology department, however, Dr. Lallemand had managed to find the epidural space and to place the epidural catheter, but not without causing an ADP.[5]

As noted, Dr. Lallemand made a total of at least ten separate attempts at identifying plaintiff's epidural space. Seven of Dr. Lallemand's attempts at identifying her epidural space failed when he, seven times in succession, struck her bony spinal process with his epidural needle at the depth of approximately two centimeters from her skin surface. His three additional attempts at identifying her epidural space resulted in him penetrating her ligamentum flavum with his epidural needle. Only one of the latter attempts, however, was precise enough to pass ligamentum flavum and to enter the epidural space. While Dr. Lallemand estimated plaintiff's skin-to-epidural space distance to have been 5-6 centimeters in length, he apparently overestimated her posterior epidural space distance, with the consequence that he accidentally penetrated her dural sheath with his epidural catheter, causing her to suffer an ADP (or a wet tap).

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[5] Pretrial testimony is conflicting as to whether Dr. Lallemand asked for assistance, with him testifying that he *did* ask Dr. Strongin, to call the anesthesia department for help, whereas Dr. Strongin testified that Dr. Lallemand emphatically *refused* any outside help. *Compare* Dr. Lallemand's EBT tr at page 28, line 7 ("as I said, it was a difficult procedure. But at a certain time, *I asked . . . Dr. Strongin . . . to call for help*. And before I got anybody to come to help me, I got it [the epidural needle] in."); page 77, line 11-22 ("I asked [Dr. Strongin] to call the chief of anesthesia to send somebody to help. . . . [B]efore anybody [could] come, right after Dr. Strongin['s] call, I got into the space. So I told Dr. Strongin to call back to tell them I don't need anyone.") *with* Dr. Strongin's EBT tr at page 43, line 17 to page 44, line 2 ("Q. . . . I will represent to you that during Dr. Lallemand's deposition he stated that he asked you to call someone for assistance, is that correct, to your knowledge? . . . A. That is not my recollection at all. *I specifically asked him.*"); page 28, lines 7-14 ("After the second or third time I [Dr. Strongin] went into the [L&D] room, I distinctly remembered asking him [Dr. Lallemand] if he would like to have some assistance with maybe someone else giving a try at getting the epidural space and . . . I called upstairs for another anesthesiologist to come down and give him assistance."); page 29, lines 13-16 ("[B]y the time the other anesthesiologist came down [to the L&D room], [Dr. Lallemand] had already completed the epidural. So [Dr. Lallemand] was in the space.") (emphasis added in each instance).

Shortly after the completion of CSE and with plaintiff having been repositioned in her bed from her original (90 degree) sitting position to the supine (or lying-down) position, she experienced a tingling in her shoulders and a chill in her chest, along with some breathing difficulties. Plaintiff's chest and breathing-related complaints were conservatively addressed (and, by and large, resolved) by the application of an Albuterol inhaler and the administration of supplemental oxygen. Plaintiff's complaint of a tingling in her shoulders was taken more seriously, as it raised the possibility of a high-level spinal anesthesia (*i.e.*, the anesthetic block extending above the brachial plexus level of C6-T1). Dr. Lallemand was summoned to plaintiff's bedside to assess her post-CSE status. Upon arrival to plaintiff's bedside, Dr. Lallemand asked her to squeeze his hand, and when she complied, he ruled out the possibility of a high-level spinal anesthesia. For the remainder of plaintiff's childbirth admission which ended the following Sunday, March 22, 2015, Dr. Lallemand did not attend (nor was he called upon to attend) on her again.

The more severe consequences of the ADP made themselves acutely known within the ensuing 12 hours. According to the Lenox chart plaintiff complained of postural headache (*i.e.*, the PDPH or post-dural puncture headache) at 12:19 am and again at 7:09 am on March 20, 2015. According to plaintiff she experienced "severe headaches" "as soon as [she] sat up after delivery," as well as episodes of vomiting. Because an ADP causes a CSF leak, the latter, in turn, causes intracranial hypotension which is one of the causes of PDPH. Another consequence of a CSF leak (and, by parity of reasoning, another cause of PDPH) is the sagging of intracranial structures and the downward pulling of nerves, veins, and vessels of the brain, in each instance, as the result of intracranial

hypotension. Conservative treatment of plaintiff's headache (by way of hydration and pain medications) failed to alleviate her PDPH overnight.[6]

At 11:00 am on Friday, March 20, 2015, plaintiff underwent an EBP by another anesthesiologist then on-call, nonparty Enzro Greenidge, M.D. ("Dr. Greenidge"). With the patient in a sitting position, Dr. Greenidge used a more accurate LOR-to-saline technique in locating the ADP (in contrast to Dr. Lallemand's use of a less accurate LOR-to-air technique in locating the epidural space). In performing the EBP, Dr. Greenidge drew no CSF. To address the prior day's ADP, Dr. Greenidge injected 25 ml of plaintiff's own, contemporaneously drawn ("autologous") blood until she complained of pressure at the injection site. With the blood patch in place, plaintiff's PDPH gradually reduced in intensity by the time of her discharge from Lenox on Sunday, March 22, 2015, and eventually stopped by the time of her second deposition session approximately four years later in March 2019. Separately, however, plaintiff's back pain persisted (albeit to a lesser degree) following her March 22nd discharge and, according to her, still persists to this day.

Post-discharge, plaintiff developed several neurological problems which were potentially related to the CSF leak caused by the ADP. Those neurological problems centered around plaintiff's allegedly deficient functioning of her vestibulocochlear nerve (known as cranial nerve eight or "Cranial Nerve VIII"), which consists of the vestibular and cochlear nerves. The vestibular nerve is responsible for (among other functions) maintaining body balance, whereas the cochlear nerve is responsible for hearing.

[6] A vasoconstricting medication (a combination of Butalbital, Aspirin, and Caffeine) to alleviate plaintiff's headache was not available at Lenox's pharmacy although it had been ordered from there..

According to plaintiff, she suffered (and still suffers) from once-per-day, one-minute-long episodes of vertigo, as well as from a unilateral hearing loss and tinnitus in her left ear.

Approximately seven months post-discharge, on November 10, 2015, plaintiff was evaluated by a neurology team (consisting of a resident and an attending) at nonparty Columbia-Presbyterian Medical Center ("CPMC") where (among other cranial nerves) her vestibulocochlear (or Cranial Nerve VIII) was tested. The testing neurologist found that:

> "[Plaintiff had a] decreased hearing on [her] left [side]. [The] Weber [*i.e.*, the tuning-fork test] lateralizes right [*i.e.*, that her right ear had a better hearing than her left]. Air > bone conduction on [her] left [side; *i.e.*, that the air conduction was more sensitive than bone conduction in her left ear]. Negative Dix Hallpike [*i.e.*, that she did not suffer from benign positional paroxysmal vertigo]. Negative head impulse test [for a vestibulo-ocular reflex]. No nystagmus [*i.e.*, no involuntary eye movement]."[7]

It appears that the CPMC neurology team's impressions and conclusions (initially drafted by the resident and revised by the attending) related plaintiff's vertigo and unilateral hearing loss/tinnitus to the ADP-related CSF leak. In that regard, the CPMC neurology team's report stated that:

> "On exam [the patient] has hearing loss and tinnitus/hearing changes. . . . *Potentially* both hearing loss/tinnitus [and] vertigo . . . difficulties *could* be related to traction on *8th [cranial] nerve* and pituitary" (emphasis added).[8]

The CPMC neurology team recommended that plaintiff undergo a brain MRI (with and without contrast) and a thoracic/lumbar MRI (without contrast), as well as consider a neuroendocrine evaluation. The CPMC neurology team's report was sent to Dr. Strongin.

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[7] *See* Dr. Strongin's Records, CPMC's Neurology Report, November 10, 2015, page 1 of 2.

[8] *Id.* at page 2 of 2.

On receipt of that report, Dr. Strongin (according to plaintiff) discouraged her from undergoing further imaging or obtaining additional consultations.

According to Dr. Strongin"s pretrial testimony (at page 78, lines 3-8 of Dr. Strongin's EBT transcript):

> "The electronic [*i.e.*, Lenox] records are not always as fruitful but the fact that she had a blood patch was specific for the complication of the wet tap and speaks for itself that there were issues with the epidural."

Notwithstanding the ADP and its sequelae, plaintiff appears to have been living a rather full life by the time her second deposition session was conducted on March 27, 2019, approximately 2½ years after she had commenced the instant action on September 8, 2016.

Discussion

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. *Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v Streiter*, 83 AD3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Brinkley v. Nassau Health Care Corp.*, supra; *Fritz v. Burman*, 107 A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. City of New York*, 99 AD3d 673, 675 (2d Dept. 2012); *Bezerman v. Bailine*, 95 AD3d 1153, 1154 (2d Dept. 2012); *Stukas v. Streiter*, at 24. A plaintiff succeeds in a medical malpractice action by showing that a defendant

deviated from accepted standards of medical practice and that this deviation proximately caused plaintiff's injury. *Contreras v Adeyemi*, 102 AD3d 720, 721 (2d Dept. 2013); *Gillespie v New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Semel v Guzman*, 84 AD3d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas*, at 24.

Plaintiff's Medical Malpractice Claim

In support of their motion, LHH submitted the affidavit of Louis Brusco, M.D., a doctor board certified in Anesthesiology and Critical Care Medicine. In support of his motion, Dr. Lallemand submitted the affirmation of Ethan Bryson, M.D, a board certified doctor in anesthesia. Plaintiff opposed the motions and submitted the affidavit of Ronald E. Burt, M.D., a board certified doctor of Anesthesiology.

The competing expert affirmations (affidavits) raise triable issues of material fact as to whether Dr. Lallemand (and vicariously LHH) met the standard of care in performing CSE on plaintiff and whether his alleged departures from the standard of care proximately caused some of her alleged injuries. The triable issues of fact regarding the *standard of care* include:

(1) whether Dr. Lallemand adequately appreciated and took into account: (a) plaintiff's documented history (in the course of a prior CSE) of an accidental dural puncture with a CSF leak that was of sufficient volume (as judged by the severity of her then-experienced post-dural puncture headache) as to require a curative epidural blood patch; (b) her advanced state of pregnancy with the ongoing early-labor contractions; and (c) the particulars of her spinal anatomy, including her body habitus (weight and height),

before embarking, with a large-bore 17 gauge epidural needle, on performing CSE on plaintiff who (as far he was concerned) was a previously unfamiliar patient;

(2) whether Dr. Lallemand, after his *three* initial (and all unsuccessful) *attempts* at epidural placement (irrespective of the depth of his penetration of plaintiff's skin), should have stopped making any further attempts at epidural placement, as plaintiff and Dr. Strongin each allegedly had urged him to do;

(3) whether Dr. Lallemand's *six additional* (but all equally unsuccessful) *attempts* at epidural placement unreasonably increased the risk of: (a) an accidental dural puncture; (b) the size of the puncture; (c) the amount of the resulting CSF leak; and/or (d) other iatrogenic injuries.

With respect to plaintiff's still extant injuries, the triable issues of fact regarding proximate cause include:

(1) whether the ADP-related CSF leak was a substantial factor in causing (or contributing to) plaintiff's persisting Cranial Nerve VIII palsy in the form of vertigo and unilateral hearing loss/tinnitus; and

(2) whether the ADP-necessitated epidural blood patch (either on its own or in combination with the ADP) was a substantial factor in causing (or contributing to) plaintiff's persisting back pain.

Plaintiff's Informed Consent Claim

After Dr. Lallemand obtained plaintiff's oral consent to CSE and performed it on her, Dr. Strongin at 6:30 pm on March 19, 2015 co-signed a "Consent to Surgical Procedure, Invasive Test, Procedure, Treatment and/or Anesthesia" (the "Lenox form"). The Lenox form, notwithstanding its expansive title, clearly distinguished between the

"surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s)" (the "surgical procedure section") on the one hand, and the anesthesia (the "anesthesia section") on the other hand. The surgical procedure section had a blank line to be filled in with the name of the procedure that, in plaintiff's case, was handwritten as a "Pitocin augmentation of labor." Further, the surgical procedure section reflected plaintiff's *present* consent to the procedure, as follows:

> "The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) *has/have been explained* to me and I *have also been informed* of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no treatment *have also been discussed*. I *have been given* an opportunity to ask questions, and all of my questions *have been answered* fully and satisfactorily" (emphasis added).

In contrast to the foregoing, the anesthesia section of the Lenox form failed to reflect plaintiff's *present* consent (or, for that matter, *any* consent) to anesthesia.[9] Rather, the anesthesia section of the Lenox form merely notified plaintiff about the *prospective or future* anesthesia:

> "I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary *will* be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use *will* also be explained to me" (emphasis added).

On its face, therefore, the Lenox form did not evince plaintiff's consent to CSE or to any other anesthetic procedure. In that regard, Dr. Lallemand conceded at his pretrial deposition that he did not obtain plaintiff's written consent to CSE, and furthermore that

[9] Likewise, the anesthesia section of the Lenox consent form failed to identify the type of the anesthetic procedure and the name of the performing anesthesiologist.

he did not inform her of a potential risk of a nerve injury or a cranial nerve palsy as a consequence of an ADP-related CSF leak.

More fundamentally, plaintiff withdrew her consent to CSE after several of Dr. Lallemand's unsuccessful attempts at epidural placement. As plaintiff's expert opines (in ¶ 88 of Dr. Burt's affidavit), "consenting to an epidural is not akin to consenting to be punctured [ten] times and risk unnecessary nerve damage which transpired." Contrary to the position of Dr. Lallemand's expert (in ¶ 9 of Dr. Bryson's reply affirmation), Dr. Strongin's thoughts and opinions both as a witness to CSE, as plaintiff's long-term obstetrician (including for the childbirth at issue), and as a veteran obstetrician with 30-plus years of experience, *are* relevant to the general understanding of what transpired during CSE and are corroborative of plaintiff's pretrial testimony in that regard. One need not be an anesthesiologist to know that multiple back punctures from Dr. Lallemand's repeatedly unsuccessful attempts at placing a spinal epidural in plaintiff, a patient of normal habitus, were unacceptable. The court has considered the parties' remaining contentions and found them to be unavailing.

Conclusion

It is hereby,

ORDERED that the separate motions of defendants Roger Lallemand, M.D., and The Lenox Hill Hospital in Seq. Nos. 7 and 6, respectively, for summary judgment dismissing the complaint of plaintiff Desiree Eisenstadt as against him or it, as applicable, are *each denied in their entirety*; and

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this decision and order with notice of entry on defendants' respective counsel and to

electronically file an affidavit of service thereof with the Kings County Clerk; and it is further

This constitutes the decision and order of the Court.

ENTER,

J. S. C.
HON. ELLEN M. SPODEK