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SHORT FORM ORDER

INDEX No. 08-3446
CAL. No. 13-01752MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 10 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JOSEPH A. SANTORELLI
Justice of the Supreme Court

MOTION DATE 3-4-14 (#001)
MOTION DATE 3-12-14 (#002)
MOTION DATE 6-24-14 (#003)
ADJ. DATE 6-24-14
Mot. Seq. # 001 - MotD
002 - MotD
003 - MG

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SALVATORE ECHEL and RENEE ECHEL,

Plaintiffs,

- against -

NORTH SHORE UNIVERSITY HOSPITAL at MANHASSET, CHRISTOPHER RAIO, M.D., SALVATORE PARDO, M.D., "JOHN/JANE DOE, M.D." (first and last name being fictitious to represent the neurologist who evaluated the plaintiff in the emergency department during the evening hours on July 26, 2005), DENNIS GIORDANO, M.D., DAWN BEHR-VENTURA, M.D., JANET ZOLLI, M.D., KUN CHEN, M.D., SAIMA CHAUDHRY, M.D., KYLE KATONA, M.D., VIKAS VARMA, M.D., MARK EISENBERG, M.D., MITCHELL E. LEVINE, M.D., and "JOHN DOE, M.D., P.C." (name being fictitious to represent the professional service corporation of MARK EISENBERG, M.D. and/or MITCHELL E. LEVINE, M.D.),

Defendants.

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Upon the following papers numbered 1 to 59 read on this motions for summary judgment and cross motion to preclude; Notice of Motion/ Order to Show Cause and supporting papers (001) 1-22; 23-25; (002) 26-43; Notice of Cross Motion and supporting papers (003) 44-52 and in opposition; Answering Affidavits and supporting papers_; Replying Affidavits and supporting papers 53-56; 57-59; Other_; (~~and after hearing counsel in support and opposed to the motion~~)

it is,

ORDERED that motion (001) by defendants, North Shore University Hospital, Christopher Raio, M.D.,
Salvatore Pardo, M.D., Dennis Giordano, M.D., Dawn Behr-Ventura, M.D., Janet Zolli, M.D., Kun Chen, M.D., Saima Chaudhry, M.D., and Kyle Katona, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted as to defendants Christopher Raio, M.D., Kun Chen, M.D., Saima Chaudhry, M.D., Dennis Giordano, M.D., Janet Zolli, M.D., and Kyle Katona, M.D., and is denied as to defendants Salvatore Pardo, M.D., Dawn Behr-Ventura, M.D., and North Shore University Hospital; and it is further

ORDERED that motion (002) by defendants, Vikas Varma, M.D., Mark Eisenberg, M.D., Mitchell Levine, M.D., Levine, Overby, Hollis, M.D.s, P.C. s/h/a John Doe, M.D., P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted as to Mark Eisenberg, M.D. and is denied as to defendant Vikas Varma, M.D., Mitchell Levine, M.D., Levine, Overby, Hollis, M.D.s, P.C. s/h/a John Doe, M.D., P.C.; and it is further

ORDERED that cross motion (003) by plaintiffs, Salvatore Echel and Rene Echel, in opposition to motions (001) and (002), and for an order precluding any remaining defendants from seeking Article 16 apportionment and contribution as against any co-defendant to whom summary judgment has been granted, is granted.

In this medical malpractice action, it is asserted that the defendants negligently departed from good and accepted standards of care and practice when the plaintiff, Salvatore Echel, came under their care and treatment on or about July 26, 2005 and thereafter. It is asserted that the defendants failed to recognize his neurological symptoms, and failed to timely diagnose and treat him for cauda equina syndrome, which occurs when a disc herniation below the termination of the spinal cord compresses the nerve roots. The plaintiff alleges these departures from the standard of care caused him to suffer serious, permanent injuries, including bowel and bladder dysfunction, sexual dysfunction, urinary retention, sensory deficits, and numbness and weakness in the lower extremities and in the feet and ankles, requiring the use of assistive devices for walking, among other things. Causes of action for negligence, lack of informed consent, and a derivative claim have been pleaded.

The plaintiff, Salvatore Echel, a 41 year old police officer, was seen in the emergency department at North Shore University Hospital (NSUH) on two separate occasions on July 26, 2005, by defendant Dr. Raio, then by defendant Dr. Pardo, for severe back pain after he twisted his back. On July 26, 2005, on the second emergency room visit, the plaintiff was admitted by Dr. Pardo to NSUH medicine service to Dr. Zolli, an internal medicine resident. The plaintiff remained hospitalized from July 26, 2005 through August 4, 2005. An MRI of the spine was performed on July 26, 2005, read that evening by a radiology resident, and officially read the following morning, July 27, 2005, by Dr. Behr-Ventura and radiology fellow Dr. Giordano. On July 28, 2005, an addendum report revealing compression of the cauda equina was prepared by Dr. Ventura, who realized there was an error in the numbering of the levels on the imaging on the films of the first

MRI of July 26, 2005. Another MRI was then performed on July 28, 2005 and read by Dr. Black. During this admission, the plaintiff was followed by internal medicine physicians, Dr. Chen (a second year resident), and Dr. Zolli, Dr. Katona, and Dr. Chaudhry (internal medicine attendings). On July 27, 2005, the plaintiff was seen by a second year resident, Dr. Grellman, and by Dr. Varna, a neurologist, who recommended another MRI and neurosurgical consultation. On July 28, 2005, the plaintiff was seen by neurosurgeon Mitchell Levine, M.D. who determined immediate surgical intervention was not necessary at that time. On July 29, 2005, Dr. Levine performed a decompressive laminectomy at L4, facetectomy and foraminotomy at L4-5, and bilateral radical discectomy at L4-5.

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 N.Y.U. 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 N.Y.U. 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"(CPLR3212[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 motion (001), movants submitted, inter alia, an attorney's affirmation; affirmation of Gregory Mazarin, M.D., Dina Chenouda, M.D., and Gordon Sze, M.D. dated January 21, 2014; copies of the summons and complaint, answers served by defendants North Shore University Hospital, Pardo, Giordano, Behr-Ventura, Zolli, Chen, Chaudhry, Katona, Varma, Eisenberg, and plaintiffs' verified bills of particulars; supplemental verified bill of particulars asserting lien /claim for medical benefits paid by GHI; transcripts of the examination before trial, and continued, of Salvatore Echel with proof of service; unsigned and uncertified transcript of the examinations before trial of defendants Christopher Raio, M.D. which is not in admissible form; signed and certified transcripts of Salvatore Raio, M.D., Janet Zolli, M.D. which are in admissible form; unsigned but certified transcript of Dawn Behr-Ventura; and certified copy of plaintiff's hospital record. It is noted that the moving defendants served an amended notice of motion on February 19, 2014 with the affidavit of defendants' expert, Gordon Sze, M.D. to correct his original affirmation wherein he averred he was licensed to practice medicine in New York State. Dr. Sze's later affidavit, notarized in the State of Florida, indicates he is licensed to practice medicine in the State of Connecticut, however, he does not indicate when he became so licensed. The remainder of his affidavit appears to be identical to his affirmation. It is further noted that the affidavit is not correctly notarized but is considered as the plaintiff has not objected to the use thereof, and the affidavit is treated herein as having a technical defect in form (*see* CPLR §§ 2001, 2106; ***Sam v Town of Rotterdam***, 248 AD2d 850; ***Uscudera v Mahbubur***, 299 AD2d 535 [2d Dept 2002]).

In motion (002), movants submitted, inter alia, an attorney's affirmation; affirmations of Arthur Rosiello, M.D., copies of the summons and complaint, answers served by defendants Varma, Eisenberg, Levine, plaintiff's verified bills of particulars as to defendants Varma, Eisenberg, Levine; uncertified and unsigned copies of the transcripts of the examinations before trial of Janet Rossi Zolli, M.D., Salvatore Pardo, M.D., Dawn Behr-Ventura, M.D.; affidavits of Vika Varma, M.D. dated January 24, 2014, Mitchell Levine, M.D. dated January 23, 2014, Mark Eisenberg, M.D.; an uncertified copy of plaintiff's medical record; unsigned and uncertified transcripts of the examinations before trial of Renee Echel and Salvatore Echel which are not in admissible form and fail to comport with 22 NYCRR 202.5.

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]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

MOTION (001)

In motion (001), defendants NSUH, Raio, Pardo, Giordano, Behr-Ventura, Zolli, Chen, Chaudhry, and Katona seek summary judgment dismissing the complaint as asserted against them. They have submitted the affirmation of Gregory Mazarin, M.D. who affirms that he is licensed to practice medicine in New York State, and is board certified in emergency medicine. He set forth his education and training, and indicated that he reviewed pertinent medical records and depositions, but did not identify what records and depositions he reviewed. Mazarin stated that it is alleged that the defendants failed to timely diagnose and treat cauda equina syndrome. They have also submitted the affidavit of Gordon Sze, M.D. who avers that he is a physician licensed to practice medicine in the State of Connecticut and is board certified in radiology, with an added qualification in neuroradiology. He set forth his education and training, and the records and materials reviewed, but did not specify which records, films and deposition transcripts he reviewed in rendering his opinion.

These moving defendants have additionally submitted the affirmation of Dina Chenouda, M.D., a physician licensed to practice medicine in New York State who is board certified in internal medicine. He set forth his education and training, his work experience, and indicated he reviewed pertinent medical records, but did not identify those records. Defendants' experts have each set forth their opinions within a reasonable degree of medical certainty.

Both Doctors Mazarin and Chenouda stated that cauda equina syndrome occurs when a disc herniation below the termination of the spinal cord compresses the nerve roots. Clinical symptoms include numbness and/or weakness of the legs, sensory and/or motor deficits, urinary or fecal incontinence, and numbness around the pelvic area. Clinical presentation governs the diagnosis, but an MRI can be helpful in making the diagnosis. Treatment for cauda equina syndrome is by surgical decompression.

CHRISTOPHER RAIO, M.D., SALVATORE PARDO, M.D., AND NSUH STAFF

Dr. Mazarin stated that specific to Dr. Raio, it is claimed that he failed to obtain a proper history from the plaintiff and failed to perform an appropriate physical exam, catheterize him, obtain appropriate consultations, failed to diagnose cauda equina, and discharged him from the emergency room without obtaining proper studies, allowing his condition to worsen. Dr. Mazarin continued that the plaintiff presented to the emergency room on July 26, 2005 at 12:55 a.m. where he was seen by Dr. Raio for complaints of severe back pain after twisting his back. He had seen a chiropractor that day without relief. Dr. Raio's exam revealed back pain, normal tone in the right and left lower extremities, and normal reflexes. Upon neurological evaluation, Dr. Raio found the plaintiff had normal sensation and coordination. Dr. Raio ordered medication for pain, a muscle relaxant, and a nonsteroidal, which decreased the pain from 10/10 to 6/10. However, additional pain medication was given at 2:00 a.m. further diminishing the pain to 2/10. Dr. Raio discharged the plaintiff at 5:15 a.m. and instructed him to return for increased pain, fever, vomiting, numbness, tingling, weakness or other complaints, and follow-up with internist Dr. Price, or the medicine clinic. His impression was musculo-skeletal back pain. Dr. Mazarin opined that Dr. Raio properly evaluated the plaintiff within the standard of care, and found he had no complaints of numbness, weakness, tingling, or urinary symptoms. He continued that the plaintiff ambulated, indicating no neurological impairment; no neurological deficiencies were noted; and therefore, there was no indication for diagnostic testing, consultation with a neurologist, neurosurgeon, or other specialist, or for admission to the hospital.

Dr. Mazarin stated that specific to Dr. Pardo, it is alleged that he failed to obtain a proper history from the plaintiff and failed to perform an appropriate physical exam, catheterize him, obtain appropriate consultations, and failed to timely diagnose and treat cauda equina, delayed his diagnosis and allowed the neurological sequela of cauda equina syndrome to worsen and caused a delay in surgery. Dr. Mazarin continued that on July 26, 2005, the plaintiff returned to the emergency room later that day at 5:32 p.m., after having been discharged that morning. He presented with back pain, experienced no improvement with the medication, and advised that he had urinary incontinence, sensory and motor deficits, and was developing numbness in his legs. He was examined by Dr. Pardo, who, stated Dr. Mazarin, appropriately suspected the plaintiff had some type of spinal cord involvement due to his findings of urinary incontinence and sensory deficits. A foley

catheter was placed at 7:55 p.m. He appropriately ordered blood work and an MRI of the lumbosacral spine, which was completed by 7:45 p.m.

Dr. Mazarin stated that Dr. Pardo is an emergency medicine specialist, and emergency medicine specialists are not trained to read MRI films. He continued that Dr. Pardo properly relied upon the reading of the MRI study by the radiologist. Dr. Mazarin stated that the plaintiff's medical chart indicated that the MRI films showed mild disc herniation at L5-S1 with no compression, that there was no indication for Dr. Pardo to order a repeat MRI or further diagnostic testing, and that he appropriately admitted the plaintiff to the hospital for further workup. Dr. Mazarin added that, based upon the initial MRI findings, there was no indication for Dr. Pardo to order a neurosurgical consultation. A catheter was placed while the plaintiff was still in the emergency room. He was admitted to the medical floor at 12:40 a.m. on July 27, 2005. Dr. Mazarin opined that the plaintiff exhibited no neurological symptoms indicative of cauda equina syndrome and/or compression of the spinal cord, and when he returned to the emergency room, Dr. Pardo admitted him. Thus, he continued, there was no departure on the part of Dr. Pardo which caused a delay in the diagnosis of cauda equina syndrome.

It is also Dr. Mazarin's opinion within a reasonable degree of medical certainty that the staff at NSUH, Dr. Raio and Dr. Pardo, did not depart from accepted standards of medical care and practice by failing to appropriately treat the plaintiff during two emergency room visits to NSUH on July 26, 2005, and during his admission to NSUH from July 26, 2005 through August 4, 2005. Dr. Mazarin also opined in a conclusory and unsupported opinion that the emergency room staff, Dr. Raio and Dr. Pardo did not depart from the standard of care by failing to provide the plaintiff with informed consent, however, he does not indicate what informed consent was provided, and what information comported with the standard of care.

Dina M. Chenouda, M.D. submitted an affirmation on behalf of Dr. Behr-Ventura, Dr. Zolli, Dr. Katona, Dr. Chen, Dr. Giordano, Dr. Raio, Dr. Pardo, Dr. Chaudhry, and North Shore University Hospital. It is Dr. Chenouda's opinion that Dr. Zolli, Dr. Katona, Dr. Chaudhry, Dr. Chen, and the staff at NSUH did not depart from the standard of care and provided informed consent. Dr. Chenouda stated that Dr. Zolli, Dr. Katona, Dr. Chen, and Dr. Chaudhry did not commit any act or omission that was a substantial factor in causing the plaintiff's injuries, including permanent neurological injury, bowel and bladder dysfunction, urinary retention, numbness and weakness in the lower extremities, sensory deficits in the lower extremities, lack of sensation in the feet and ankles, or the need to use assistive devices with walking, among other things.

Dr. Chenouda continued that when the plaintiff presented to the emergency room on July 26, 2005, he was seen by Dr. Christopher Raio, and discharged at 5:15 a.m. When the plaintiff returned to the emergency room later that day at 5:32 p.m., he was seen by Dr. Salvatore Pardo, who ordered an MRI of the lumbar spine, which was completed by 7:45 p.m., and admitted him to the hospital with a mild herniated disc at L5-S1, with no compression. Dr. Chenouda stated that there was no indication at the time to order a repeat MRI or neurosurgical consult, as the plaintiff was evaluated by a neurologist in the emergency room at 10:30 p.m. and a foley catheter was inserted.

It is determined that, based upon Dr. Mazarin's and Dr. Chenouda's opinions, Christopher

Raio, M.D., Salvatore Pardo, M.D. and the emergency room staff at NSUH have established prima facie entitlement to summary judgment dismissing the complaint.

JANET ZOLLI, M.D.

Dr. Chenouda continued that at about 10:00 p.m., Dr. Janet Zolli, the on call physician for NSUH medicine service, was called from the emergency department about the plaintiff, and she agreed to admit him, with the plan that the medical resident would see the plaintiff in the morning. Dr. Chenouda stated that this one telephone call was Dr. Zolli's only contact concerning the plaintiff. There was no reason for her to come to the hospital to see the plaintiff, and there was no further treatment she could have provided as the plaintiff was to be seen by a neurologist, and by a medicine attending in the morning, and she had the right to rely upon the preliminary interpretation of the MRI of plaintiff's lumbar spine. Dr. Chenouda opined that Dr. Zolli did not depart from the standard of care in her limited role, and that her plan was appropriate. Dr. Chenouda opined that Dr. Zolli was not involved in the performance or interpretation of the MRI and was not trained to interpret MRI films and must rely upon the expertise of the radiologist with regard to the initial report and the official report. It is determined that based upon the foregoing, Janet Zolli, M.D. has established prima facie entitlement to summary judgment.

RESIDENT

Dr. Chenouda stated that at 10:30 p.m. on July 26, 2005, the plaintiff was seen by a second year resident whose plan was to admit the plaintiff to the medicine service, continue pain medication, follow-up for the official MRI report, and urinalysis and culture. Dr. Chenouda opined that this resident comported with the standard of care, that his examination, findings, and recommendations were appropriate, and he properly discussed his plan with an attending. However, Dr. Chenouda does not identify the resident. Despite the same, it is determined that the second year resident from medical service, under the supervision of the attending physician, Dr. Zolli, has demonstrated prima facie entitlement to summary judgment.

DAWN BEHR-VENTURA, M.D. AND DENNIS GIORDANO, M.D.

Dr. Sze stated that Dr. Dawn Behr-Ventura, Dr. Dennis Giordano, and the staff at NSUH did not depart from the standard of medical or radiologic care, did not fail to provide informed consent to the plaintiff, and did not cause him to suffer any injury. Dr. Sze stated that the standard of practice for procedures performed after hours in a hospital is that a preliminary interpretation is performed by the radiology resident, and the official reading and interpretation is done the following morning. Dr. Sze stated that Dr. Giordano appropriately read the MRI on the preliminary reading, and that Dr. Behr-Ventura, the neuroradiology attending, appropriately performed the official reading the following morning, with no delay in interpretation of the MRI. Dr. Behr-Ventura appropriately supervised Dr. Giordano when they reviewed the films together the following day, and none of the orders given by Dr. Behr-Ventura were so clearly contraindicated that ordinary prudence required inquiry into the correctness of the orders. Dr. Sze stated that Dr. Behr-Ventura testified that Dr. Giordano did not commit any independent act which constituted a departure from accepted medical practice.

Dr. Sze set forth the findings with regard to the official reading of the MRI by Dr. Behr-Ventura and Dr. Giordano between 8:00 a.m. and 1:30 p.m. on July 27, 2005, however, due to limitations in the study, re-imaging with alternative coils was recommended as clinically warranted. Dr. Sze stated that he reviewed the MRI images and that the film is difficult to interpret and is technically limited at the L4 and L5-S1 levels. Dr. Sze continued that given the limitations in the film, that Dr. Behr-Ventura's interpretation was appropriate, she recognized the limitations, and recommended repeat imaging at 1:30 p.m. on July 27, 2005. However, on July 28, 2005, Dr. Behr-Ventura issued an addendum to the initial report, noting that in her second review of the images, it became apparent to her that there was an error in numbering of the levels as the plaintiff moved between the acquisition of sagittal and axial images, causing inaccuracies in alignment of the numbering of these images. Dr. Sze stated that the correct interpretation of the MRI study revealed a central herniation of the nucleus pulposus at L4-5 which appears to impress the thecal sac. On the sagittal images, there appears to be compression of the cauda equina. At L3-4 there was desiccation of the intervertebral disc space without significant stenosis of the spinal canal; at L5-S1 there was desiccation of the intervertebral disc space and a disc bulge, but the L5-S1 level was not imaged on the axial plane.

Dr. Sze stated that when a radiologist determines that there may have been some inaccuracies with his/her reported interpretation of a study, it is the radiologist's responsibility to report those inaccuracies so that the patient's clinical providers can utilize the information to evaluate the patient's clinical status and determine if repeat imaging is warranted. Dr. Behr-Ventura recommended re-imaging for clarification and notified the neurosurgical P.A. Hilda Lliguin at about 1:35 p.m. on July 27, 2005, of her findings upon again viewing the study. Dr. Sze opined that although Dr. Behr-Ventura did not issue her addendum until July 28, 2005, she notified the clinical providers about the issue, as is the standard of care. Dr. Sze added that there was such a short period of time between Dr. Behr-Ventura's initial interpretation and her conveyance of her revised MRI findings to the neurosurgical P.A., that the delay was not unreasonable, it did not constitute a departure, and it did not proximately cause the plaintiff's condition, change the treatment plan, or play a role in exacerbating his condition, and that it was of no consequence. It is noted that Dr. Rosiello, defendants' expert in motion (002), stated that P.A. Lliguin's note of July 28, 2005 documents that Dr. Levine is aware of the case and that he will see the plaintiff for surgery tomorrow, however, her note does not indicate a discussion with Dr. Behr-Ventura.

It is also Dr. Sze's opinion that given the limitations of the first MRI, it was not a departure for Dr. Behr-Ventura or Dr. Giordano to have not initially identified the compression at L4-5 and L5-S1, as she appropriately documented the limitations of the study and recommended a repeat study. When Dr. Behr-Ventura recognized the inaccuracies in the alignment of the images, she appropriately corrected her interpretation and recommended a repeat MRI. Dr. Sze continued that the decision to perform surgery on the spine is based upon the patient's symptoms and not the MRI. He then stated that the location of the herniation also plays a significant role in determining as to whether conduct emergent surgery. The decision whether to perform surgery, he stated, is best made by the neurosurgeon, in this instance, Dr. Mitchell Levine, who saw the plaintiff on July 28, 2005, and performed surgery on July 29, 2005. Thus, stated Dr. Sze, because Dr. Levine did not determine that immediate surgical intervention was necessary on June 28, 2005, any delay in the detection of compression on the MRI did not alter the treatment or outcome. It is noted, however, that Dr. Sze

did not address the failure of Dr. Behr-Ventura not to recognize the inaccuracies in the numbering of the levels or alignment of the images, and what the standard of care is for reading the MRI study, and ascertaining whether or note the images are accurately aligned, to obtain a correct reading of the study.

Dr. Chenouda stated that on July 28, 2005, Dr. Behr-Ventura issued an addendum to the initial MRI report after reviewing the images again, and realized that an error had been made in numbering the levels on the study due to the plaintiff having moved between the acquisition of sagittal and axial images. Her addendum included central herniation of the nucleus pulposus at L4-5 which appeared to impress the thecal sac. The sagittal image there appeared to be compression of the cauda equina. At L3-4, there was desiccation of the intervertebral disc space without significant stenosis of the spinal canal, and at L5-S1 there was desiccation to the intervertebral disc space and suggestion of a disc bulge. The L5-S1 level was not imaged on the axial plane. Dr. Behr-Ventura, indicated Dr. Chenouda, communicated these new findings to neurosurgical P.A. Hilda Lliguin at 1:35 p.m. on July 27, 2005. Dr. Chenouda did not opine as to the standard of care and the interpretations by Dr. Behr-Ventura initially and in her addendum. It is noted that in motion (002), Dr. Rosiello stated that P.A. Lliguin's note of July 28, 2005, also documents that Dr. Levine is aware of the case and that he will see the plaintiff for surgery tomorrow, however, her note does not indicate a discussion with Dr. Behr-Ventura.

Based upon the foregoing, it is determined that Dr. Dennis Giordano, a resident who was supervised by Dr. Behr-Ventura, established prima facie entitlement to summary judgment dismissing the complaint as asserted against him; however, due to factual issues concerning the misreading or misinterpretation of the July 26, 2005 MRI, Dr. Behr-Ventura has not demonstrated prima facie entitlement to summary dismissal of the complaint as asserted against her.

Dr. Chenouda opined that Dr. Katona and the internal medical team, Dr. Zolli, Dr. Chen, and Dr. Chaudhry, properly relied upon the specialists to determined whether the plaintiff needed surgery. They did not delay surgery and timely ordered and obtained neurology and neurosurgery consultations carried out by Dr. Varma and Dr. Levine, respectively, and then carried out the recommendations of the consultants and appropriately deferred the decision to perform surgery to those consultants. He further opined that these physicians provided informed consent to the plaintiff, including admitting the plaintiff and in performing clinical treatment.

MARK GRELLMAN, M.D.

Dr. Chenouda continued that on the morning of July 27, 2005, the plaintiff was seen by second year internal medicine resident, non-party Mark Grellman, M.D. who ascertained that the plaintiff was having urinary problems prior to his admission, that he had saddle anesthesia and bilateral leg numbness. Dr. Grellman noted that the MRI was negative for nerve root compression or spinal stenosis, although it showed a herniated disc at L5-S1. He ordered laboratory work and physical therapy. That morning, stated Dr. Chenouda, Dr. Dawn Behr-Ventura, and radiology fellow Dr. Dennis Giordano, reviewed the MRI study and issued an official report which indicated limited visualization at L4 and the L5-S1 segments, secondary to the plaintiff's body habitus. The central herniation of the nucleus pulposus at L3-4 and L4-5 indented the ventral aspect of the thecal sac and

was observed to not cause significant canal stenosis. It was noted that the plaintiff could return for re-imaging with alternative coils, as clinically warranted.

Dr. Chenouda continued that later that morning, Dr. Grellman noted that the MRI study did not visualize the L5 and sacral region, and at 1:30 p.m., he ordered a repeat MRI and called for neurological and neurosurgical consults for possible cauda equina syndrome. Internal medicine attending, Milo Queri, M.D. evaluated the plaintiff. Dr. Chenouda opined that Dr. Grellman and Dr. Queri provided appropriate treatment, and when it was realized that the MRI did not visualize L5 and the sacral region, properly ordered a repeat MRI on July 27, 2005. When Dr. Grellman realized the possibility of cauda equina syndrome, he appropirately called for neurological and surgical consults. Thus, opined Dr. Chenouda, there is no merit that the internal medicine team failed to order the necessary consultations in a timely manner.

Dr. Chenouda stated that on July 27, 2005, neurologist Vikas Varma, M.D. saw the plaintiff on neurological consultation and noted that he complained of numbness in his buttocks and legs, and urinary retention, and found decreased light sensation to the plantar surfaces, left greater than right. Because Dr. Varma suspected L5-S1 disc herniation with mass effect, the ordered a repeat MRI, which had also been ordered by Dr. Grellman. On July 28, 2005 at 1:30 a.m. and 3:55 a.m., the plaintiff was sent for the repeat MRI, but due to excruciating pain, the MRI could not be repeated. Because the internal medical team did not want to give the plaintiff more pain medication, Dr. Chenouda opined that it was acceptable to delay the MRI until the following day.

KYLE KATONA, M.D.

Turning to Dr. Kyle Katona, an internal medicine attending, Dr. Chenouda stated that Dr. Katona saw the plaintiff for the first time on July 28, 2005 at about 2:00 p.m. with Dr. Christina Conciatori, a first year resident, who noted the plaintiff had saddle anesthesia bilateral numbness in his lower legs, and urinary retention, but was able to move his legs and had full strength. Dr. Katona ordered that the Decadron recommended by Dr. Varma the day before, be continued. At 2:53 p.m. that day, the second MRI was conducted and interpreted by radiologist Karen Black, M.D. who noted a large central disc herniation at L4-5 with marked thecal sac compression, small central disc herniation at L5-S1 with mild thecal sac compression, with degenerative disc disease at L3-4 through L5-S1, and congenital spinal stenosis. Dr. Mitchell Levine, a neurosurgeon then saw the plaintiff between 2:00 p.m. and 6:00 p.m., and noted the plaintiff's MRI revealed an L4-5 herniated nucleus pulposus, and that he had a normal neurological exam with spotty sensory deficits. He further noted the plaintiff was to be taken to the operating room the following day, and that he was stable on Decadron. Dr. Chenoudra continued that P.A. Lliguin also saw the plaintiff, and noted that Dr. Levine had been made aware of the MRI findings, and that the plaintiff required medical clearance, so Dr. Katona saw the plaintiff at 6:00 p.m. on July 28, 2005 and found no medical contraindications for the procedure.

Based upon the foregoing, Kyle Katona, M.D. has established prima facie entitlement to summary dismissal of the complaint as asserted against him.

SAIMA CHAUDHRY, M.D.

Dr. Chenoudra continued that on July 29, 2005, Dr. Levine performed a complete bilateral decompressive laminectormy at L4, a facetectomy and foraminotomy at L4-5 bilaterally, and bilateral radical discectomy at L4-5. For the first time on August 1, 2005, the plaintiff was seen by Dr. Saima Chaudhry, an internal medicine attending. He noted that the plaintiff was doing better and was able to walk with a rolling walker. Dr. Chaudhry saw the plaintiff again on August 3, 2005, at which time he agreed to rehabilitation after his discharge from NSUH, with a foley catheter in place, and use of the rolling walker. Dr. Chaudhry did not see the plaintiff until after surgery, stated Dr. Chenoudra, and appropriately evaluated the plaintiff and discharged him after urology consults, and further neurology and neurosurgery consults.

Based upon the foregoing, it is determined that Dr. Saima Chaudhry has demonstrated prima facie entitlement to summary dismissal of the complaint as asserted against him.

KUN CHEN, M.D.

Dr. Chenouda opined that Dr. Chen, a second year resident in internal medicine, was not involved in the performance or interpretation of the MRI and was not trained to interpret MRI films. Chen must rely upon the expertise of the radiologist with regard to the initial report and the official report. On August 1, 2005, the plaintiff was seen by Dr. Chen for the first time. Along with Dr. Chaudhry, they noted that the plaintiff was doing better and was able to walk with a rolling walker. When Dr. Chen saw the plaintiff on August 2, 2005, he determined that the plaintiff could be discharged when he was able to urinate and move his bowels. Dr. Chen did not see the plaintiff until after surgery, stated Dr. Chenoudra, and appropriately evaluated the plaintiff and discharged him after urology consults, and further neurology and neurosurgery consults. Dr. Chen worked under the direction of his supervising attending physicians, and those physicians gave orders which were not contraindicated and ordinary prudence did not require inquiry into the correctness of the orders.

Based upon the foregoing, it is determined that Kun Chen, M.D. has demonstrated prima facie entitlement to summary dismissal of the complaint as asserted against him.

MOTION (002)

Turning to motion (002), defendants Vikas Varma, M.D., Mark Eisenberg, M.D., Mitchell Levine, M.D., and Levine, Overby, Hollis, M.D.s, P.C., each submitted their own affidavit as well as the affirmation of Arthur Rosiello, M.D.

The affirmation of Dr. Arthur Rosiello sets forth that he is licensed to practice medicine in New York State and is board certified in neurological surgery. He set forth his education and training. He bases his opinions on his education and training, and work experience, as well as the records and materials which he reviewed. Dr. Rosiello set forth the care and treatment provided by the various health care providers from July 26, 2005 during both of plaintiff's presentations to the emergency department, and during his admission to NSUH to the service of Dr. Zolli, who

subsequently transferred care of the plaintiff to Dr. Milo Queri, also of the medical service.

Dr. Rosiello stated that the emergency room record for the second presentation documented a lumbo-sacral MRI showed mild disc herniation with no compression, and based upon that interpretation, Dr. Pardo ruled out spinal cord involvement while the plaintiff was a patient in the emergency room. Dr. Dawn Behr-Ventura, he indicated, reviewed the July 26, 2005 MRI on July 27, 2005 with Dr. Giordano. Dr. Rosiello does not state her interpretation of the study, but noted that she made a subsequent addendum to the report. He stated that the addendum was dictated on July 28, 2005, and that Dr. Ventura testified that she discussed the results with P.A. Hilda Lliguin, a hospital employee, at 1:35 p.m. on July 27, 2005. Dr. Rosiello stated that the report of the July 26, 2005 MRI, including the addendum, documents that at the L3-4 level, there was desiccation of the intervertebral disc space without significant stenosis of the spinal canal, however, the addendum documents that at L4-5, there was a central herniation of the nucleus pulposus which appeared to impress upon the thecal sac, compressing the cauda equina; and at the L5-S1 level, there was desiccation of the intervertebral disc space and suggestion of a bulge.

VIKAS VARMA, M.D.

Vikas Varma, M.D. submitted an affidavit wherein he avers to being licensed to practice medicine in New York State and board certified in neurology. Dr. Varma averred that at the time he rendered care and treatment to the plaintiff, he was not an employee of NSUH, but was an on call consulting physician with an affiliation with NSUH. Dr. Varma requests dismissal of the complaint as asserted against him on the basis he conformed with the standard of care, and contends there is no proximate cause between the care he provided and the injuries alleged by the plaintiff.

Dr. Varna stated that he was asked by medicine service to evaluate the plaintiff on July 27, 2005, at which time he examined the plaintiff. His impression was that of possible L5-S1 disc herniation with mass effect. He recommended to the requesting service that a neurosurgical consult be requested, and that a new lumbar MRI be obtained to include the sacral area. Dr. Varma continued that in reading the note of Dr. Christina Conciatori, it is documented that on July 28, 2005, the MRI was read, and that the impression was of possible cauda equina syndrome. When Dr. Varma saw the plaintiff on July 28, 2005, he was stable and unchanged neurologically. He indicated that the repeat MRI on July 28, 2005 confirmed the diagnosis of cauda equina syndrome. He stated that a neurosurgery consult had been performed by Dr. Levine, and decompressive surgery was scheduled for, and performed by Dr. Levine, on July 29, 2005.

Dr. Varma continued that he discussed the plaintiff's spine condition with him. He next saw the plaintiff on July 31, 2005, and noted he was doing better, had good motor strength, and was improving. He recommended physical therapy. On August 2, 2005, the plaintiff was much improved, could walk with a walker, but complained of occasional incontinence. He did not see the plaintiff thereafter. Dr. Varma concluded that any claims by the plaintiff, including that he failed to diagnose cauda equina syndrome and or failed to provide informed consent, are baseless as he did consider the diagnosis of cauda equina syndrome and did not perform surgery which required informed consent.

Dr. Rosiello opined with a reasonable degree of medical certainty that the care and treatment

provided by Dr. Varma was in accordance with accepted medical practice and was not the proximate cause of the plaintiff's alleged injuries. Dr. Rosiello continued that Dr. Varma was asked to evaluate the plaintiff on July 27, 2005, and that he requested medicine service to obtain a new lumbar MRI, because his impression was possible L5-S1 disc herniation with mass effect. The repeat lumbar MRI of July 28, 2005 revealed a large central disc herniation at L4-5 with marked thecal sac compression; small central disc herniation at the L5-S1 level with mild thecal sac compression; degenerative disc disease L3-4 through L5-S1, and congenital spinal stenosis. Dr. Rosiello stated that Dr. Varma requested a neurosurgical consult. Dr. Christina Conciatori documented that the July 28, 2005 MRI was read, and that Dr. Varma's impression was possible cauda equina syndrome, and that he discussed the condition with the plaintiff. Dr. Rosiello opined that Dr. Varma appropriately performed a neurology consult on the plaintiff on July 27, 2005, the NSUH records establish that there was no delay by Dr. Varma in diagnosing cauda equina syndrome, the plaintiff was thereafter seen by Dr. Levine on July 28, 2005, who performed surgery on July 29, 2005. Thus, stated Dr. Rosiello, Dr. Varma did not delay in diagnosing the plaintiff's condition and in making the appropriate request for a neurosurgical consult.

Dr. Rosiello continued that Dr. Varma saw the plaintiff on July 28, 2005, and was aware of the finding of the large L4-5 disc herniation, found the plaintiff was neurologically unchanged and stable, and discussed the plaintiff's condition with him. He stated that Dr. Varma was not involved with the plaintiff's surgical intervention. He had several discussions with the plaintiff during his involvement in his care, and advised him of his impression and plan of treatment based on clinical findings reflective of his involvement with his patient care. Dr. Rosiello stated that Dr. Varma saw the plaintiff again postoperatively, and that the medical records reveal that the plaintiff had marked improvement in his neurologic condition. It is Dr. Rosiello's opinion that Dr. Varma rendered care and treatment to the plaintiff in accordance with accepted medical practice, and that his care and treatment was in no way the proximate cause of the plaintiff's alleged injuries.

Based upon the foregoing, Dr. Varma has not demonstrated prima facie entitlement to summary judgment dismissing the complaint. Dr. Rosiello has not set forth the standard of care for a neurologist in treating cauda equina syndrome and possible compression of the cauda equina.

MITCHELL LEVINE, M.D.

Mitchell Levine, M.D. submitted an affidavit wherein he avers that he is licensed to practice medicine in New York State and is board certified in neurosurgery. He continued that when he rendered care and treatment to the plaintiff, he was not an employee of NSUH, but was an on call physician with an affiliation with NSUH. He stated that on July 28, 2005, he performed a neurosurgical consultation on the plaintiff. His note indicated that there were MRI findings of the L4-5 herniated nucleus pulposus, and the plaintiff had an essentially normal neurological examination, with normal strength and spotty sensory deficits. Dr. Levine stated that he planned surgery for July 29, 2005, at which time he performed a complete bilateral decompressive laminectomy at L4, facetectomy and foraminotomy at L4-5, and a bilateral radical discectomy at L4-5. He noted in his operative report that the pre-operative diagnosis was herniated disc at L4-5, central and right sided, with cauda equina compression. He indicated that the plaintiff was morbidly

obese which contributed to his condition. Dr. Levine continued that postoperatively, the plaintiff complained of left foot numbness and numbness over the entire sacral area. He continued to improve and was discharged on August 4, 2005 with improved saddle anesthesia.

Dr. Levine indicated that when he saw the plaintiff in his office on August 9, 2005, he was walking without difficulty, had normal strength, but complained of some peroneal numbness, which was improving. He was continent and was being followed by his urologist for this issue, and for his Foley catheter. On September 13, 2005, the plaintiff was continent of both bowel and bladder function, and had no pain. Sexual function had not yet returned and he had continued numbness in the peroneal area. On November 1, 2005, Dr. Levine stated that he assured the patient that given the injuries he suffered, more time was needed to heal. He stated that the plaintiff had not experienced an erection since his injury, continued to complain of marked anesthesia in the peroneal region, and had some sensory abnormalities across both feet. The plaintiff was seen on January 3, 2006, March 7, 2006, and on September 5, 2006, his erectile dysfunction was noted as improving. He reported sexual function on December 12, 2006. He was on restricted duty at work. Dr. Levine determined on June 12, 2007, that the plaintiff was disabled from his cauda equina syndrome, he had decreased sexual function, and could not feel himself when he urinated. He was unable to walk on his toes, and had diffuse numbness of the lower extremities, and sacral anesthesia. Dr. Levine last saw the plaintiff on November 27, 2007, at which time his condition was essentially unchanged, in that the plaintiff presented with pain in both lower extremities, and had difficulty controlling bowel and bladder functions. Dr. Levine's assessment was that the plaintiff was primarily disabled from his injury. He had also fallen at work and herniated a disc and required surgery due to the fall.

Dr. Levine set forth the various MRI reports, and stated he would not venture to speculate on these seeming inconsistent internal reports, and that he was not made aware of the plaintiff's cauda equina syndrome until July 28, 2005, when he was requested to perform the neurosurgical consult. Upon examination of the plaintiff, he determined that the neurological examination was normal with only spotty sensory deficits. His plan included starting him on Decadron, an anti-inflammatory steroid used preoperatively to reduced swelling and to facilitate surgical decompression, which generally takes 12 to 24 hours to become effective in the reduction of swelling. Based upon his neurological findings, assessment and plan, Dr. Levine stated that it was his best judgment to perform decompressive surgery the next morning. Thereafter, contrary to plaintiff's claims, Dr. Levine stated that his office notes from July 29, 2005 through December 2006 demonstrated continued neurologic improvement, demonstrating that he timely performed the decompressive surgery and halted any further neurologic damage. He indicated that the plaintiff consented to the surgery.

Dr. Rosiello stated that P.A. Lliguin's note of July 28, 2005, documents that Dr. Levine was made aware of the case and that he will see the plaintiff for surgery tomorrow, however, her note does not indicate a discussion with Dr. Behr-Ventura about the MRI addendum. He stated that Dr. Levine also authored a note wherein he indicated on July 28, 2005, that he saw the plaintiff on neurosurgical consult, the MRI documented findings of the L4-5 herniated nucleus pulposus, and his examination was normal with normal strength and spotty sensory deficits. He continued that it was Dr. Levine's medical judgment to perform surgery the following day.

Dr. Rosiello stated that there is no evidence that Dr. Levine saw the plaintiff or became involved in the plaintiff's care and treatment on consultation until July 28, 2005, after the diagnosis of cauda equina had already been made. Dr. Levine properly confirmed the plaintiff's diagnosis of cauda equina and acted in accordance with the standard of care, using his best medical judgment that decompressive surgery could be performed the following morning, based upon the normal neurologic examination of the plaintiff, normal strength, and spotty sensory deficits. Based upon these findings, Decadron was started as a steroidal anti-inflammatory agent to reduce swelling and facilitate surgical decompression, but that it would take 12 to 24 hours to become effective. Based upon the foregoing, it is Dr. Rosiello's opinion that Dr. Levine acted in accordance with the standard of care and did not cause plaintiff's injuries. He further opined that the surgical procedure performed by Dr. Levine was timely and appropriate. Thereafter, as supported by the medical records, the plaintiff made continued progress in his neurologic and urologic functions, further demonstrating that Dr. Levine performed a timely and appropriate surgical procedure. Through December 12, 2006, the plaintiff continued to progress, his motor function improved, he was continent in bowel and bladder function, and erectile dysfunction was improving, although the plaintiff reported some sensory abnormalities across both feet.

Dr. Rosiello also opined that the plaintiff was provided informed consent by Dr. Levine who spoke with the plaintiff to make him aware of the diagnosis and the recommendation for surgical intervention to decompress the spine as a result of the cauda equina syndrome to halt further neurologic damage, to which the plaintiff consented.

Based upon the foregoing, it is determined that Dr. Mitchell Levine has not demonstrated prima facie entitlement to summary judgment. The standard of care for treatment of cauda equina has not been set forth by Dr. Rosiello. There are factual issues concerning Dr. Levine's statement that he wanted to start Decadron, however, Dr. Katona, on July 28, 2005, ordered that the Decadron, recommended by Dr. Varma the day before, be continued. Thus, there is factual issue with Dr. Rosiello's opinion that the Decadron needed 12 to 24 hours to become effective, when it was already being continued. There is a further factual issue concerning whether or not the surgery by Dr. Levine was timely as Dr. Rosiello merely stated that it was timely, however, he did not set forth the standard of care once cauda equina compression has been diagnosed. It is additionally noted that Dr. Rosiello's affirmation, submitted in the defendants' reply, raises further factual issues in that he disagrees with plaintiff's neurosurgical expert on anatomy terms and opinions. It has been demonstrated that the cauda equina is the involved structure, also referred to by Dr. Mazarin, who stated that cauda equina syndrome occurs when a disc herniation below the termination of the spinal cord compresses the nerve roots, and plaintiff's neurosurgical expert specifically and repeatedly referenced compression of the cauda equina.

MARK EISENBERG, M.D.

Mark Eisenberg, M.D. set forth in his affidavit that he is a physician licensed to practice medicine in New York State. He did not set forth his education, training, and whether he is board certified in any area of medicine, where he was practicing at the time this claim arose, and whether he was an employee of NSUH or any other entity. He indicated that at no time did he provide any care or treatment to the plaintiff either in his office or at NSUH.

Based upon the foregoing, Mark Eisenberg, M.D. has demonstrated prima facie entitlement to summary judgment dismissing the complaint.

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]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang***, 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

The plaintiff submitted unredacted copies of his expert affirmations[1] in opposition to the motions on behalf of defendants North Shore University Hospital, Salvatore Pardo, M.D., Dawn Behr-Ventura, M.D., Vilas Varma, M.D., Mitchell E. Levine, M.D., and Levine, Overby, and Hollis, M.D.s, P.C. s/h/a John Doe, M.D., P.C.

Plaintiffs' radiology expert avers that he is licensed to practice medicine in New York State and is board certified in radiology. He set forth his education and training, and that he is engaged in active practice. As a result of his education, training, and practice, he is aware of the standards of accepted medical and radiology practice pertaining to patients exhibiting symptoms of cauda equina syndrome, as those standards existed in 2005, and is also familiar with, and experienced in, the evaluation, diagnosis and treatment of patients with cauda equina syndrome. He set forth the materials and records which he reviewed. He opined within a reasonable degree of medical certainty that defendants NSUH, Christopher Raio, M.D., Salvatore Pardo, M.D., Dennis Giordano, M.D., Dawn Behr-Ventura, M.D., Janet Zolli, M.D., Kun Chen, M.D., Saima Chaudhry, M.D., Kyle Katona, M.D., Vikas Varma, M.D., Mark Eisenberg, M.D., Mitchell E. Levine, M.D. and Levine, Overby, Hollis, M.D.s. P.C., departed from accepted standards of care and treatment in failing to timely and properly appreciate the significance of the plaintiff's presenting symptoms of cauda equina syndrome; in failing to timely and properly interpret a lumbosacral MRI performed during the plaintiff's emergency admission on July 26, 2005, in failing to have protocols in place for proper interpretation and communication of urgent radiology findings to the appropriate treating physicians-all of which caused delay in diagnosing and treating the plaintiff for cauda equina syndrome. He continued that these departures were the substantial contributing factors in causing the plaintiff to sustain permanent neurological injury.

Plaintiff's radiology expert stated that the 41 year old plaintiff, Salvatore Echel, presented to

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[1]The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to plaintiff's attorney.

NSUH on the evening of July 26, 2005 with neurological symptoms consistent with cauda equina syndrome, and that it was imperative to timely diagnose and treat the cause of these neurological symptoms as quickly as possible to limit and/or reverse those symptoms of nerve dysfunction before they became permanent. He continued that as a result of multiple missed interpretations of the lumbosacral MRI performed while the plaintiff was in the emergency room on July 26, 2005, and further failure to timely perform surgery to relieve spinal cord compression, his cauda equina syndrome went undiagnosed and untreated until there was permanent injury to the plaintiff's spinal cord.

The plaintiff's radiology expert continued that approximately 12 hours after the plaintiff was seen for his first visit in the emergency room at NSUH on July 26, 2005 by Dr. Raio, and was treated with pain medication and muscle relaxants, the plaintiff returned at 5:30 p.m. and was seen by Dr. Salvatore Pardo. The plaintiff presented with complaints of back pain, sudden onset of numbness in his lower extremities, as well as the onset of both sensory and motor deficits in his lower extremities, numbness in his right buttock, and bowel and bladder incontinence. Dr. Pardo examined the plaintiff and recorded this onset of neurological symptoms since he had been seen earlier in the day in the emergency room. Dr. Pardo ordered an MRI, which was interpreted by an unknown radiology resident who reported to the emergency personnel that there was only mild disc herniation at L5-S1 with no spinal cord compression. Dr. Pardo did not document a differential diagnosis, and recommended that the plaintiff be admitted for back pain. While still in the emergency room, the plaintiff was seen by someone from neurology at approximately 10 p.m., however, the record does not indicate whether that person was a neurologist, neurology physicians assistant, or neurology nurse, and there is no documentation of any neurologic findings. At 10:30 p.m., the plaintiff was evaluated by a second year resident who documented that the plaintiff had increasing pain and difficulty walking, bilateral lower extremity numbness, decreased sensation, as well as numbness or saddle parasthesia in his buttocks, and that he had not urinated in 12 hours, but had no sense of urgency. This resident indicated on the record that the MRI was negative for nerve root compression or spinal stenosis.

The plaintiff's radiology expert continued that at some time during the day on July 27, 2005, the plaintiff was evaluated by second year resident Dr. Grellman, who documented there was continuing bilateral leg weakness and saddles anesthesia. Dr. Grellman attributed the urinary retention to the possible effect of pain medications rather than as part of the plaintiff's neurological profile. He documented that the MRI which had been performed the evening before showed no nerve root compression of spinal stenosis, but he further indicated that the MRI did not visualize the L5 and sacral region, so he requested an MRI be repeated, as well as a neurology and neurosurgical consult for possible cauda equina syndrome.

On July 27, 2005, the plaintiff was also seen by Dr. Vikas Varma, a neurologist who noted that the plaintiff had been admitted with back pain, difficulty walking, and numbness in the lower extremities and buttocks. He documented that the plaintiff was experiencing urinary retention, but the MRI of July 26, 2005 did not show any spinal cord compression, so he ordered a repeat MRI on the suspicion of L5-S1 disc dessication with mass effect (cauda equina syndrome).

The plaintiff's expert continued that at an unknown time on July 27, 2005, an official

radiology report, prepared by Dr. Behr-Ventura regarding the July 26, 2005 MRI study without contrast, was a limited examination with a small central herniated disc at L3-4 and L4-5 which did not cause any significant spinal canal stenosis. However, stated plaintiff's radiology expert, Dr Behr-Ventura issued an addendum on July 28, 2005 which stated that there had been "an error in the numbering of the [spinal] levels" and there were, therefore, inaccuracies in the interpretation and official report of the July 26, 2005 MRI report. The revised impression based on the correct numbering of the spinal levels showed a herniated disc at L4-5 level which was pressing on the thecal sac, compressing the cauda equina nerve bundle. Dr. Behr-Ventura also noted in that addendum that she had discussed these findings with a neurosurgical physician's assistant, Hilda Lliguin at approximately 1:35 p.m. on July 27, 2005. The plaintiff's radiology expert stated that the hospital record does not contain any documentation of a conversation with Dr. Behr-Ventura on July 27, 2008 regarding her inaccurate interpretation of the spinal MRI of July 26, 2005. The plaintiff's radiology expert continued that on July 27, 2005, a second year resident ordered a lumbar-sacral MRI with contrast, but it was not ordered stat, and it is not indicated whether it was ordered at the behest of Dr. Varma or Dr. Behr-Ventura.

On July 28, 2005, at approximately 2 p.m., attending physician Dr. Katona, and a first year resident saw the plaintiff and documented bilateral lower extremity numbness with inability to walk, saddle anesthesia, and urinary retention. Again, the note documented in two separate places that the MRI of July 26, 2005 was negative for nerve root compression or spinal stenosis and that a repeat MRI would be scheduled for Sunday. The plaintiff's expert continued that in an obvious, untimed, and undated "fill in" addendum, the resident wrote that Dr. Varma, a neurologist, reread the MRI of July 26, 2005 and corrected the findings to indicate that there was an L5-S1 disc herniation with mass effect which was indicative of possible cauda equina syndrome. The note further indicated that a neurology consult with Dr. Eisenberg had been requested at this time-July 28, 2005.

The plaintiff's radiology expert stated that in another untimed note on July 28, 2005, Dr. Varma saw the plaintiff and wrote that there was no change in neurological status from the previous day, but the
MRI now showed a large L4-5 HNP.

The plaintiff's radiology expert noted that there is an untimed consultation note from July 28, 2005, by neurosurgical physicians assistant Lliguin who stated that the MRI of July 28, 2005 shows a huge HNP at L4-5 and small HNP at L5-S1. She further noted his history of back pain from June 25, 2005, lower extremity numbness with urinary retention since July 26, 2005, that he had a herniated disc at L4-5 with cauda equina nerve compression, and that he would be seen by a neurosurgeon, with spinal surgery scheduled for July 29, 2005.

Between 2 p.m. and 6 p.m. on July 28, 2005, stated plaintiff's radiology expert, the plaintiff was seen by Dr. Levine, a neurosurgeon, whose note indicated that his neurological exam of the plaintiff was normal with normal strength and spotty sensory deficits. His plan was for surgery the following morning for spinal decompression surgery. The plaintiff's radiology expert continued to describe the surgery and the plaintiff's postoperative course.

Plaintiff's radiology expert continued that the NSUH records show that the MRI of July 26,

2005 at 6:00 p.m. was not only read incorrectly once, but was actually misread on two separate occasions: the first by a radiology resident, and the second by Dr. Dawn Behr-Ventura. He continued that the radiology resident did not issue a report but simply informed the emergency room physician that there was mild disc herniation at L5-S1 and no spinal cord compression. Based upon that report, and despite plaintiff's clear clinical symptoms of evolving cauda equina syndrome, including severe low back pain and the onset of bilateral lower extremity numbness and urinary retention, the plaintiff was discharged from the emergency room. He was later admitted to NSUH for "low back pain.

Plaintiff's radiology expert continued that, contrary to the assertions by Dr. Sze that when an MRI is performed "after hours" in a hospital, it is standard practice for the "preliminary interpretation" to be performed by a radiology resident, whom, Dr. Sze stated, appropriately performed the preliminary reading. However, stated plaintiff's expert, the radiology resident completely missed an obvious compression of the spinal cord at L4-5. This first incorrect interpretation of that MRI actually revealed a compression of the cauda equina nerves, a medical emergency which requires surgical intervention to relieve the spinal cord compression. He continued that the failure of NSUH to provide proper supervision, by an experienced radiologist, of the radiology resident who is performing preliminary interpretations of imaging studies, particularly MRIs performed after hours on patients presenting to the emergency room, more particularly in the month of July when new resident rotations begin, is a departure from good and accepted standards of medical and radiology practice. This, he stated, was a substantial contributing factor in allowing the plaintiff's cauda equina syndrome to go undiagnosed and untreated.

The plaintiff's radiology expert continued that Dr. Behr-Ventura departed from good and accepted standards of medical and radiology practice in failing to properly interpret the MRI of the evening of July 26, 2005, and failed to see obvious herniation of the nucleus pulposus at the level of L4-5 which, in turn, was compressing the bundle of nerves at the base of the spinal cord known as the cauda equina. This failure to timely and properly interpret the plaintiff's MRI significantly contributed to the delay in diagnosing an insult to the cord. As a result, prompt surgical intervention to address an evolving cauda equina was allowed to progress and become permanent. Dr. Behr-Ventura and radiology fellow Dr. Giordano, whom she was supervising, failed to properly interpret the MRI, issued a formal radiology report dated July 27, 2005, signed by Dr. Giordano, and failed to document the large disc herniation at the L4-5 level, and misnumbered the spinal cord levels during their interpretation. It is plaintiff's radiology expert's opinion that Dr. Behr-Ventura's failure to properly interpret said MRI caused a delay in definitively diagnosing the plaintiff's condition as cauda equina syndrome and was a substantial contributing factor in the failure to provide proper and timely surgical intervention to limit and/or reverse the neurological damage to the nerves which comprise the cauda equina, and caused permanent neurological deficits and injuries. He continued that the MRI is the gold standard for diagnosing an evolving cauda equina syndrome as it allows direct visualization of the spinal cord, nerve roots, and discs. Recovery is dependent upon the severity and duration of compression upon the damaged cauda equina nerve, so time is of the essence in diagnosing and treating the evolving condition. Relieving spinal cord compression quickly can determine whether one resumes a normal life or lives with urine and /or bowel incontinence, and leg numbness, or even paralysis.

The plaintiff's expert stated that while Dr. Behr-Ventura issued an addendum, dictated on June 28, 2005, she stated that she actually reread the July 26, 2005 MRI films on July 27, 2005, and spoke to PA Lliguin at 1:35 p.m. on July 27, 2005. However, if this is believed, and no neurosurgical consultation or surgical intervention was undertaken by PA Lliguin or the neurosurgeons at NSUH following this conversation, then there was an additional delay on the part of hospital personnel and neurosurgeons in providing urgent surgical relief for the plaintiff's cauda equina compression. He continued, in disagreement with Dr. Sze, that Dr. Behr-Ventura's failure to timely prepare the addendum until July 28, 2005 was of "no significance." The plaintiff's radiology expert stated that the American College of Radiology Guidelines for Communication for Diagnostic Imaging Findings requires expedited delivery of a report by an interpreting physician in a manner that reasonably ensures timely receipt of the findings by the treating physician, and that there is no indication that Dr. Behr-Ventura communicated her differing findings to plaintiff's treating physicians, as required, but instead to a physician's assistant, causing the radiology finding of ongoing spinal cord compression to be unavailable during the critical time when the damage could be reversed and/or limited with appropriate and urgent intervention.

Plaintiff's radiology expert disagrees with Dr. Sze's statement that the MRI of July 26, 2005 was very difficult to interpret and was therefore "properly interpreted" by Dr. Behr-Ventura, and stated that it is clear that the spinal levels were incorrectly numbered by the radiologist and this was the cause of her failure to properly interpret the MRI. It is further clear that once Dr. Behr-Ventura corrected the mis-numbering of the spinal levels, she was able to identify the compression of the cauda equina at L4-5 on the July 26, 2005 MRI. The plaintiff's radiology expert opined that it was due to Dr. Behr-Ventura's own negligence in numbering the spinal levels that she was not able to properly interpret the spinal pathology which was there to be seen from the time the MRI was performed. This was a substantial contributing factor to the delay in properly diagnosing the plaintiff's cauda equina syndrome, causing the plaintiff not to receive urgent surgical intervention to limit and/or reverse his neurological symptoms.

Based upon the foregoing, it is determined that plaintiff has raised factual issues to preclude summary judgment from being granted to defendant Dr. Dawn Behr-Ventura.

Plaintiff has also submitted the expert affidavit of a physician licensed to practice medicine in New Mexico and Florida who is board certified in neurological surgery. He/she set forth his education and training and the medical records and materials he reviewed. He opined within a reasonable degree of medical certainty that defendants Salvatore Pardo, M.D., Dawn Behr-Ventura, M.D., Vikas Varma, M.D., Mitchell Levine, M.D., and North Shore University Hospital departed from accepted standards of medical, surgical and hospital care. He stated that the defendants did so in failing to timely and properly appreciate the significance of the plaintiff's presenting symptoms of cauda equina syndrome, and in failing to have hospital protocols in place for the proper communication of urgent radiology findings to the appropriate physicians and surgeons, which caused a delay in diagnosing the plaintiff's cauda equina syndrome, and further delay in performing neurosurgery to correct the cause of the cauda equina syndrome. It is plaintiff's neurosurgical expert's opinion that these departures by the defendants were substantial contributing factors in causing the plaintiff to sustain permanent neurological injuries.

Plaintiff's neurosurgical expert explained that the cauda equina is a collection of nerves at the base of the spinal cord, and that cauda equina syndrome occurs when these nerves are compressed. He continued that this bundle of nerves is responsible for sensation to the bladder, bowel, legs, and for sexual function. When there is disruption or compression of this group of nerves, it can cause severe pain, bladder dysfunction, bowel dysfunction, sexual dysfunction, and leg numbness or weakness. It most often occurs when a massive herniated disc in the lumbar or low back regions causes compression of the cauda equina nerve bundle. Classic symptoms of cauda equina syndrome include sudden onset of severe low back pain, motor weakness, sensory loss and/or pain in one, or more commonly, both legs, recent onset of urinary retention or incontinence, recent onset of bowel incontinence, sensory abnormalities in the bladder or rectum (saddle anesthesia), recent onset of sexual dysfunction, and loss of reflexes in the extremities. These dysfunctions can become permanent, and therefore, a patient presenting with cauda equina syndrome should be treated as a medical emergency, with urgent MRI to definitively confirm or diagnose the cause of the cauda equina syndrome. Upon MRI confirmation, urgent surgery is needed to relieve the spinal cord compression causing the neurological symptoms. He continued that it was imperative to timely diagnose and treat these neurological symptoms as quickly as possible to limit and/or reverse those symptoms of nerve injury before they became permanent.

The plaintiff's neurosurgical expert stated that the plaintiff had neurological symptoms consistent with cauda equina syndrome at the time of his presentation to the emergency room at NSUH on the evening of July 26, 2005. The plaintiff, upon presentation to the emergency room, complained of sudden back pain following an episode of twisting his back at work, onset of numbness in both lower extremities, onset of both sensory and motor deficits in his lower extremities, numbness in his right buttock (saddle anesthesia), and an onset of bowel and bladder incontinence. Dr. Pardo examined the plaintiff, noting his symptoms, and ordered an MRI of the plaintiff's lumbosacral spine, which was completed by 7:00 p.m., and interpreted by an unknown radiology resident who reported to the emergency room personnel that there was "mild disc herniation at L5-S1 with no spinal cord compression." At 10:30 p.m. on July 26, 2005, a second year resident evaluated the plaintiff, and documented that the plaintiff had increasing back pain and difficulty walking, bilateral numbness and decreased sensation in his lower extremities, as well as saddle anesthesia in his buttocks, with no urination in 12 hours but no sense of urgency. He indicted that the MRI showed no nerve root compression or spinal stenosis. Plaintiff's neurosurgical expert opined that Dr. Pardo, although ordering an MRI on July 26, 2005, while the plaintiff was in the emergency room, he did not appreciate the serious implications of the plaintiff's neurological symptoms, and failed to act with a sense of urgency to diagnose and obtain treatment for the cause of the symptoms presented, and failed to obtain a neurological consultation. He continued that Dr. Pardo simply diagnosed the plaintiff with low back pain, and admitted him to the hospital as a back pain patient, without entertaining a differential diagnosis of an evolving cauda equina syndrome. This, he stated, was a departure from the standard of care and caused a delay in diagnosis and prompt surgical treatment of the plaintiff's evolving cauda equina syndrome, which was a substantial contributing factor to the development of his permanent injuries.

The plaintiff's neurosurgical expert opined that a review of the hospital chart indicates that the nursing staff was not monitoring the plaintiff's neurological status or performing any neuro checks at regular intervals on July 27, 2005, and that despite the documentation of continuing

symptoms of cauda equina syndrome, no surgical evaluation was performed, nor was any surgical intervention taken. On July 27, 2005, Dr. Giordano failed to properly interpret the July 26, 2005, MRI study, and Dr. Behr-Ventura issued an unofficial radiology report which stated that there was no spinal cord compression, although the plaintiff was continuing to exhibit symptoms of an evolving cauda equina syndrome.

The plaintiff's neurosurgical expert continued that on the following day, July 27, 2005, Dr. Grellman, a second year resident, examined the plaintiff and found back pain, bilateral leg weakness, urinary retention, and saddle anesthesia. He noted that the MRI did not visualize the L5 and sacral region of the plaintiff's spinal vertebrae and recommended a repeat MRI without contrast for possible cauda equina syndrome. The MRI was not ordered on an urgent basis.

The plaintiff's neurosurgical expert indicated that Dr. Varma, a neurologist, also saw the plaintiff on July 27, 2005, noting the plaintiff had been admitted for severe back pain, difficulty walking, numbness in both lower extremities and buttocks, and urinary retention. He noted that the July 26, 2005 MRI revealed no spinal cord compression, but recommended that the MRI be repeated as he suspected the plaintiff sustained an L5-S1 disc herniation with mass effect. On July 28, 2005, Dr. Varma again saw the plaintiff, indicating no change in his neurological symptoms, but the repeat MRI of July 28, 2005, showed a large L4-5 HNP. Also, on July 28, 2005, PA Lliguin wrote that the plaintiff had been complaining of back pain since July 25, 2005; lower extremity numbness with urinary retention since July 26, 2005, the day he presented to the emergency room. She noted that the plaintiff had an L4-5 HNP with cauda equina compression and would be seen by a neurosurgeon in preparation for surgery on July 29, 2005. The plaintiff's neurosurgical expert stated that at some time on July 28, 2005, the plaintiff was seen by Dr. Mitchell Levine, a neurosurgeon, who wrote that the neurological exam was "normal" with normal strength and spotty sensory deficits, and that the MRI showed a herniated nucleus pulposa at L4-5, for which he would be taken to the operating room on July 29, 2005. At 6:00 p.m on July 28, 2005, Kyle Katona, M.D., an internist, saw the plaintiff and found no contraindications for the planned spinal cord decompression surgery for the confirmed cauda equina syndrome.

On July 27, 2005, an official radiology report was prepared for the spinal MRI done without contrast on July 26, 2005, however, the report incorrectly indicated that it was done with contrast. The plaintiff's neurosurgical expert stated that the official report indicated there was a limited examination with a small central herniated disc at L3-4 and L4-5 which "did not cause any significant spinal canal stenosis." The addendum to that report was dictated by Dr. Behr-Ventura on July 28, 2005 at 3:08 p.m. noting that there "had been an error in numbering of the levels" which caused "inaccuracies in the alignment in the numbering" of the spinal levels in the MRI images. The plaintiff's neurosurgical expert stated that the addendum attributes the error in numbering the spinal levels on the MRI films as the reason why there had been a mis-interpretation of the correct findings in the MRI performed in the emergency room on July 26, 2005. He continued that Dr. Behr-Ventura wrote that the corrected impression, based on the correct numbering of the spinal levels, revealed a "herniated disc at the L4-L5 level which was compressing Mr. Ethel's cauda equina," and that she discussed this new corrected interpretation with a neurosurgical PA named Hilda Lliguin at 1:35 p.m. on July 27, 2005. The plaintiff's expert continued that this was some 24 hours before she actually dictated the addendum. He stated that there was an apparent lapse in

communicating the "corrected" MRI findings by either Dr. Behr-Ventura or PA Lliguin and the physicians who were treating the plaintiff since no surgical consultations were obtained and no surgical intervention undertaken to decompress the spinal cord on July 27, 2005. This failure to communicate the corrected findings as the definitive cause for the plaintiff's cauda equina syndrome symptoms, and the further failure to perform decompressive spinal surgery within the first 24 hours after the onset of the acute symptoms precluded the plaintiff from achieving maximal reversal of his neurological symptoms, and led to progression into permanent neurological injuries.

The plaintiff's neurosurgical expert stated that had the July 26, 2005 MRI of plaintiff's lumbar spine been properly read by the radiology resident on July 26, 2005, and by Dr. Behr-Ventura on July 27, 2005, the compression of the cauda equina would have been diagnosed. Had surgery been performed at this point, the plaintiff's prognosis for a complete recovery would have been markedly increased. This is so, he stated, because the prognosis for reversing the symptoms of cauda equina syndrome depends in large measure upon how soon a definitive cause for the presenting neurological symptoms is identified and how quickly treatment is undertaken. When surgical decompression is performed within 24 hours of the onset of symptoms, the prognosis for a complete resolution of those symptoms is significantly improved. The longer the spinal cord compression is allowed to continue, the less favorable the prognosis for preventing permanent neurological injuries.

The plaintiff's neurosurgical expert continued that when the plaintiff was seen by Dr. Mitchell Levine on July 28, 2005, he placed a note in the hospital chart which stated that the neurosurgical examination was "normal" with "spotty sensory deficits." Dr. Levine's findings are contrary to the findings documented by all of the physician notes and the neurosurgical consult by PA Lliguin preceding his examination, and were made after the July 28, 2005 MRI revealed the spinal cord compression as the cause of the cauda equina. Dr. Levine's note, he continued, contained no explanation as to why he did not immediately take the plaintiff to the operating room for decompression surgery. He continued that it was a departure from the standard of care not to undertake immediate surgical decompression of the spinal cord, and was a substantial contributing factor to the permanent injuries sustained by the plaintiff.

Based upon the foregoing, it is determined that factual issues have been raised to preclude summary judgment from being granted to Dr. Salvatore Pardo, North Shore University Hospital, Dr. Dawn Behr-Ventura, Dr. Vikas Varma, Dr. Mitchell Levine, and Levine, Overby, Hollis, M.D.s, P.C. s/h/a John Doe, M.D., P.C. It is further determined that factual issues have not been raised to preclude summary judgment from being granted to Dr. Christopher Raio, Dr. Dennis Giordano, Dr. Kun Chen, Dr. Saima Chaudhry, Dr. Janet Zolli, Dr. Mark Eisenberg and Dr. Kyle Katona.

MOTION (003)

In motion (003), the plaintiff's seek an order precluding any remaining defendants from seeking contribution and Article 16 apportionment against any defendant to whom summary judgment has been granted. It is noted that none of the remaining defendants have submitted expert affirmations demonstrating liability as to those co-defendants to whom summary judgment has been granted, and they are precluded from seeking contribution or asserting the limited liability protection

afforded by Article 16 at the time of trial as to any co-defendant to whom summary judgment has been granted (*see* ***Dembitzer v Broadwall Management Corp***, 2005 NY Slip Op 50303U, 6 Misc 3d 1035A, 800 NYS2d 345, 2005NY Misc LEXIS 420; citing ***Hanna v Ford Motor Co.***, 252 AD2d 478, 479, 675 NYS2d 125 [2d Dept [1998]). Here, it would be cold comfort to the defendants against whom summary judgment has been granted, and to the plaintiff, if the remaining defendants were permitted to assert the limited liability protection afforded by Article 16.

Accordingly, motion (003) is granted.

Dated: AUG 25 2014

HON. JOSEPH A. SANTORELLI
J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION