| **Kenny v Mount Sinai Hosp.** |
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| 2017 NY Slip Op 30206(U) |
| January 27, 2017 |
| Supreme Court, New York County |
| Docket Number: 805124/14 |
| Judge: Martin Shulman |
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 1

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REGINA KENNY, Index No. 805124/14

Plaintiff, **DECISION**

-against-

THE MOUNT SINAI HOSPITAL, SAMUEL CHO, M.D., and JOHN M. CARIDI, M.D.,

Defendants.

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In this medical malpractice action, defendants The Mount Sinai Hospital (MSH), Samuel Cho, M.D. (Cho) and John M. Caridi, M.D. (Caridi) (collectively defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint. Plaintiff Regina Kenny (Kenny or plaintiff) opposes the motion.

**BACKGROUND**

This action arises from plaintiff's spinal fusion surgery[1] and laminectomy[2] which defendants Cho and Caridi performed at MSH on April 18, 2012. Plaintiff alleges the surgery caused a compression or impingement of the left fifth lumbar (L5) nerve root, resulting in a left drop foot.

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[1] "Spinal fusion is surgery to join two or more vertebrae into one single structure. The goal is to stop movement between the two bones and prevent back pain. Once they're fused, they no longer move like they used to. This keeps [a patient] from stretching nearby nerves, ligaments, and muscles that may have caused discomfort." The surgery can entail the implantation of rods, screws and bone grafts to connect the vertebrae and keep them from moving. See http://www.webmd.com/back-pain/spinal-fusion-facts (bracketed matter added).

[2] A laminectomy entails "a surgeon remov[ing] parts of the bone, bone spurs, or ligaments in [the patient's] back. This relieves pressure on spinal nerves and can ease pain or weakness." See http://www.webmd.com/back-pain/back-surgery-types (bracketed matter added).

Kenny first presented to Cho on September 20, 2011 with complaints of chronic lower back and leg pain (Motion at Exh. I). Cho's notes describe plaintiff as being obese, noting that she was 5'1" tall and weighed 175 pounds (*id.*). Cho performed a physical examination and reviewed and discussed an X-ray of plaintiff's lumbar spine and a prior MRI taken in May 2011 with plaintiff (*id.*). The X-ray revealed spondylotic changes and grade 1 spondylolisthesis (forward shifting of a spinal disk) at L4-L5 (*id.*). The MRI evidenced disk degeneration with bulging at L4-5 and L5 to the first sacral vertebra (S1) and spinal stenosis (narrowing of the spinal canal) from L3 to the sacrum (*id.*). Cho noted that Kenny appeared to appreciate the details he explained to her and concluded that she would likely need a one or two level fusion from L4 to the sacrum, with possible decompression extending to L3 (*id.*).

On January 10, 2012 plaintiff returned to Cho for further discussion of her surgical options, at which time Cho again reviewed the X-ray and MRI with her and explained the surgery, along with its benefits and risks, which he specifically noted as including death, paralysis, nerve root damage, unresolved pain, infection, bleeding and peri-operative medical complications (*id.*). Kenny then signed a surgical consent form acknowledging that Cho had fully explained the risks and benefits of the procedure and that all her questions were fully and satisfactorily answered (*id.*).

Plaintiff was admitted to MSH for surgery on April 18, 2012. Cho's operative report identifies the procedures performed as "posterior spinal fusion from L4 to S1, posterior segmental instrumentation from L4 to S1, transforaminal lumbar interbody fusion [TLIF] at L4-5 and L5-S1, the use of local autograft and allograft, laminectomy at L4-5 and L5-S1 with medial facetectomy and foraminotomy" (*id.*) (bracketed matter

added). Cho performed the procedure with Caridi's assistance. Prior to surgery, Kenny signed another surgical consent form (*id.*).

Summarizing the April 18, 2012 surgery in simplistic terms based upon Cho and Caridi's respective operative reports (*id.*), the procedure entailed the initial removal of tissue and parts of the L4 through S1 vertebrae to increase the disk space for insertion of rods, screws and a "cage" apparatus. The TLIF procedure was performed first at the L5-S1 disk space, the disk was removed and a crescent shaped cage was placed in the disk space along with bone graft material. Caridi's operative report notes that the L5 nerve root was identified and protected during this phase of the surgery. The same TLIF procedure was then performed at the L4-L5 disk space using the same type of cage and a laminectomy was performed at L4-5 and L5-S1. Ultimately, it was necessary to remove both crescent shaped cages and replace them with bullet shaped cages.[3]

During the surgery, plaintiff was under continuous intra-operative neuro-monitoring, which is used to detect any insult or injury to the nerves in and around the operative site and to contemporaneously alert the surgeon to the occurrence. As noted in the medical records, at no time did the intra-operative neuro-monitoring device indicate any injury to Kenny's nerves (*id.*).

Plaintiff's left foot drop was evident as early as the day after the surgery and defendants performed an urgent CT scan which "revealed good placement of all instrumentation without any evidence of L5 nerve root compression" (*id.*). Upon

[3] Caridi's operative report notes that the cage originally placed at L5-S1 had shifted and was recovered in the psoas muscle.

examining the CT scan, Cho determined to continue with steroids, Neurontin and physical therapy (*id.*).

After plaintiff was discharged to Mount Sinai Rehabilitation to begin physical and occupational therapy she "continued to experience significant pain going down the left leg with weakness in her foot" and decreased sensation in her left foot (*id.*). Dr. Cho consulted with and re-evaluated Kenny on April 24, 2012 and ordered a lumbar MRI which revealed an intra-dural hematoma at L1-L2 and poor delineation of the nerve roots with nerve root compression from L1-L2 through the thecal sac (*id.*). Upon this finding, Cho discussed the risks of undergoing a further spinal procedure which might address and relieve Kenny's symptoms (*id.*). Plaintiff then signed a surgical consent form for an exploratory surgery of the lumbar spine (*id.*).

On April 25, 2012, plaintiff was transferred back to MSH for surgical removal of the hematoma at L1-L2, a T12 though L4 laminectomy and assessment and exploration of the L5 nerve root (*id.*). Caridi again assisted Cho in this procedure. The operative report noted a thorough decompression from T12 to L2, removal of a hematoma at the prior surgical site and ready identification of the L5 nerve root, which was under no compression (*id.*). Cho further noted that the TLIF cage was visible just below the L5 nerve root and pushed it more anteriorly to ensure it did not cause nerve root compression (*id.*). Intra-operative neuro-monitoring was again used and was stable and unremarkable throughout this second surgery (*id.*).

Five days later, Kenny was transferred back to Mount Sinai Rehabilitation for approximately two weeks of physical and occupational therapy (Exh. J). She was then discharged and instructed to continue outpatient physical therapy.

Plaintiff commenced this action on April 11, 2014. Her bills of particulars and amended bills of particulars allege that the April 18, 2012 procedure was both negligently undertaken and performed (see Motion at Exhs. D, E).[4] Kenny further alleges that she was not apprised of the risks (to wit, the risk of damage or injury to nerves in the operative site), nor did defendants apprise her of more conservative treatment options (*id.*). Accordingly, plaintiff claims defendants failed to obtain informed consent in advance of the surgery and on the day of surgery. Finally, plaintiff alleges that defendants negligently responded to her post-operative complaints and symptomology and should have undertaken a second reparative surgery more promptly (*id.*).[5]

**EXPERTS' CONTENTIONS**

In support of their motion for summary judgment dismissing the complaint, defendants argue that they did not depart from accepted medical standards in treating Kenny. They submit an expert affirmation from David H. Clements, III, M.D. (Dr. Clements), a surgeon with over 30 years of experience in orthopedic and spinal surgery (Motion at Exh. A), who sets forth, within a reasonable degree of medical certainty, that

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[4] Specifically, plaintiff claims defendants negligently performed (1) the posterior spinal fusion from L4 to S1; (2) the posterior segmental instrumentation from L4 to S1; and (3) the TLIF and laminectomy with medial facetectomy and foraminotomy at L4-L5 and L5-S1.

[5] Plaintiff's second cause of action alleges malpractice with respect to defendants' performance of the second surgery on April 25, 2012 (Motion at Exh. B). However, she appears to abandon this claim in her bills of particulars, indicating that malpractice occurred during the April 18, 2012 surgery and the week thereafter, up to the April 25, 2012 surgery (*id.* at Exh. D, ¶12). The motion papers similarly do not address this cause of action.

defendants followed accepted standards in treating plaintiff. He states in relevant part that:

- plaintiff was an appropriate candidate for the procedure at issue, which was clearly indicated by her symptoms;
- defendants fully apprised Kenny of the risks, benefits and alternatives to the procedure;
- nerve root injury is a known and accepted risk of the subject procedure which was communicated to plaintiff;
- there were no intra-operative deviations from the applicable medical and surgical standards of care; and
- the post-operative care defendants rendered to plaintiff was timely and appropriate under the circumstances.

In opposition, Kenny submits an affidavit from Donald H. Frank, M.D. (Dr. Frank),[6] a physician having over 45 years of experience in the field of neurological surgery who has been board certified by the American Board of Neurological Surgeons since 1972. Dr. Frank avers, within a reasonable degree of medical certainty, that the care defendants rendered to Kenny pre-operatively, peri-operatively and post-operatively significantly deviated from the applicable standards of good and accepted medical and surgical care. He concludes the following:

- plaintiff was not an appropriate candidate for spinal fusion and laminectomy as there were no clinical indications for the procedure;
- obtaining Kenny's signature on an informed consent form does not demonstrate adequate understanding on her part;

[6] Plaintiff designated Dr. Frank as the expert witness expected to be called at trial. See Response to Defendants' CPLR § 3101(d) Demands for Expert Information (Motion at Exh. L).

- if the first surgery had been performed within the applicable standards of care there would have been no injury to the L5 nerve root and no resulting foot drop;
- Dr. Clements ignores intra-operative findings in MSH's chart;
- Dr. Clements' affidavit contains "ill-supported and general conclusory statements with no citation or support . . ."; and
- the post-operative care rendered to plaintiff was deficient in that the second surgery should have been performed sooner.

(see Frank Aff., at Exh. 1 to Lisabeth Aff. in Opp., ¶4). In reply, defendants argue that Dr. Frank's affidavit contains only feigned issues of fact, is based upon speculation and supposition and fails to overcome their entitlement to summary judgment.

**DISCUSSION**

An award of summary judgment is appropriate when no issues of fact exist. *See* CPLR 3212(b); *Sun Yau Ko v Lincoln Sav. Bank*, 99 AD2d 943 (1st Dept), *aff'd* 62 NY2d 938 (1984); *Andrea v Pomeroy*, 35 NY2d 361 (1974). In order to prevail on a motion for summary judgment, the proponent must make a prima facie showing of entitlement to judgment as a matter of law by providing sufficient evidence to eliminate any material issues of fact. *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). Indeed, the moving party has the burden to present evidentiary facts to establish his cause sufficiently to entitle him to judgment as a matter of law. *Friends of Animals, Inc. v Associated Fur Mfrs., Inc.*, 46 NY2d 1065 (1979).

In deciding the motion, the court views the evidence in the light most favorable to the nonmoving party and gives him the benefit of all reasonable inferences that can be drawn from the evidence. *See Negri v Stop & Shop, Inc.*, 65 NY2d 625, 626 (1985).

Moreover, the court should not pass on issues of credibility. *Assaf v Ropog Cab Corp.*, 153 AD2d 520, 521 (1st Dept 1989). While the moving party has the initial burden of proving entitlement to summary judgment (*Winegrad*, *supra*), once such proof has been offered, in order to defend the summary judgment motion, the opposing party must "show facts sufficient to require a trial of any issue of fact." CPLR 3212(b); *Zuckerman v City of New York*, 49 NY2d 557, 562 (1980); *Freedman v Chemical Constr. Corp.*, 43 NY2d 260 (1977); see also, *Friends of Animals, Inc.*, *supra*.

Here, Kenny denies that defendants met their burden of proof, citing Dr. Clements' affidavit as conclusory and unsupported by the record. While plaintiff claims defendants' showing is insufficient to shift the burden of proof to her and warrants denial of their summary judgment motion, nonetheless, in the event this court determines otherwise, Kenny argues that her expert's affidavit raises issues of fact warranting a trial.

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury." *Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 (1st Dept 2009) (citation omitted). A defendant physician seeking summary judgment must make a prima facie showing establishing the absence of a triable issue of fact as to the alleged departure from accepted standards of medical practice (*id*).

In opposition, "a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to

establish the essential elements of medical malpractice'." *Id.*, citing *Alvarez v Prospect Hosp.*, 68 NY2d at 325. "In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude a grant of summary judgment in a defendant's favor (citation omitted)." *Id.* However, where an expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, the opinion should be given no probative force and is insufficient to withstand summary judgment. *Id.*, citing *Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 (2002).

"To establish the reliability of an expert's opinion, the party offering that opinion must demonstrate that the expert possesses the requisite skill, training, education, knowledge, or experience to render the opinion [citations omitted]" (*Hofmann v Toys "R" Us-NY Ltd. Partnership,* 272 AD2d 296, 296 [2d Dept 2000]). An expert "need not be a specialist in a particular field" in order to render an expert opinion "if he [or she] nevertheless possesses the requisite knowledge necessary to make a determination on the issues presented" (*see Joswick v Lenox Hill Hosp.,* 161 AD2d 352, 355 [1st Dept 1990]).

In this case, the record reveals plaintiff's expert is a neurosurgeon and defendants' expert is an orthopedic surgeon. Both experts based their opinions on their review of Kenny's medical records, as well as the pleadings and deposition transcripts herein. Therefore, it appears that both experts are qualified to provide expert opinions. *See Frye v Montefiore Med. Ctr.,* 70 AD3d at 24-25; *Guzman v 4030 Bronx Blvd. Assoc. L.L.C.*, 54 AD3d 42, 49 (1st Dept 2008) ("whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court . . .").

Defendants question Dr. Frank's qualifications as compared to those of Dr. Clements due to his failure to allege any expertise in spinal fusion surgery and his completion of surgical training in 1969, "roughly 43 years before the instant surgery... which itself has only been performed within the last ten-to-fifteen years" (Smith Reply Aff. at ¶10). However, having reviewed Dr. Frank's affidavit, this court finds that he has sufficient professional experience to provide an expert opinion on the facts underlying this action. His affirmation refers to his many years as a neurosurgeon and it is apparent that his expertise in this subject matter is adequate.

**A. Indications for the Surgery**

On defendants' behalf, Dr. Clements concludes that Kenny was a perfect candidate for spinal fusion and laminectomy based upon her presenting complaints and symptomology. Specifically, she presented to Cho "with a significant history of degenerative disk disease, disk bulging, spondylolisthesis, spinal stenosis, as well as back pain substantial enough to limit her ability to walk and necessitate the use of a cane and walker . . ." See Motion at Exh. A, ¶21. Moreover, the surgery was "clearly indicated" because Kenny's "presenting symptomology was progressive in nature, and would only get worse as time passed" (*id.*).

By contrast, Dr. Frank disputes that plaintiff was a candidate for the procedure at issue, stating "[t]here was a total absence of objective indications for surgery at L4-L5 let alone a two-level fusion including L5-S1, and that such "aggressive surgical treatment" would be indicated in the case of "radiculopathy, sensory loss, reflex diminution and pre-operative motor loss on examination, none of which were present here preoperatively" (Exh. A to Lisabeth Aff. in Opp., ¶10). He also disputes that the

pre-operative MRI and X-ray indicated abnormalities or instability warranting surgical intervention (*id.*).[7]

Defendants respond by pointing to Dr. Frank's further conclusion that lumbar fusion is the preferred treatment "for low back pain associated with stenosis and spondylosis", which Dr. Frank claims was not the case for plaintiff (*id.*).[8] Notably, Dr. Frank overlooks that the medical records and pre-operative imaging studies indicate spondylotic changes and grade 1 spondylolisthesis at L4-L5, disk degeneration with bulging at L4-5 and L5-S1 and spinal stenosis from L3 to the sacrum. Defendants further cite Kenny's extensive pre-operative work-up and evaluation and the fact that she elected to undergo the surgery after extensive discussions with Cho concerning the risks and benefits associated therewith.

On this point, Dr. Frank's conclusory affidavit fails to rebut that of Dr. Clements. Dr. Frank broadly states that the pre-operative imaging tests indicated no abnormalities, without citing any record proof to counter the diagnosis set forth in the medical records. He also concedes that spinal fusion surgery is indicated for stenosis and spondylosis, both of which are included in Cho's diagnosis. Finally, Dr. Frank fails to address

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[7] Dr. Frank contends the MRI "disclosed no abnormalities, not even significant degenerative disease that indicated surgery" and the CT scan similarly showed no abnormalities, "only trace anterolisthesis of L4 on L5 . . ." See Lisabeth Aff. in Opp. at Exh. A, ¶10.

[8] Dr. Frank cites a July 2014 article discussing guidelines for performing fusion procedures in cases of degenerative lumbar spine disease which *inter alia* questions the performance of fusion surgery **in the absence of stenosis or spondylolisthesis** (J. Neurosurgery Spine 21: 2014) (emphasis added).

Kenny's presenting symptoms as well as Dr. Clements' conclusion that Kenny's condition would progressively worsen.

Under these circumstances, Kenny fails to rebut defendants' prima facie showing that the surgery Cho suggested and which plaintiff chose to proceed with deviated from accepted medical and surgical standards. Accordingly, summary judgment is granted in defendants' favor dismissing all negligence and medical malpractice claims pertaining to Kenny's pre-operative treatment.

**B. Lack of Informed Consent**

As stated in *Colarusso v Lo*, 42 Misc3d 1210(A), 2013 WL 6985388, [*5] (Sup Ct, NY County, Schlesinger, J.S.C.):

> Claims of lack of informed consent are statutorily defined. Pub. Health § 2805–d. The law requires persons providing professional treatment or diagnosis to disclose alternatives and reasonably foreseeable risks and benefits involved to the patient to permit the patient to make a knowing evaluation. *Id.* § 2805–d(1). Causes of action for lack of informed consent are limited to non-emergency procedures or other treatment and include diagnostic procedures that involve invasion or disruption to bodily integrity. *Id.* § 2805–d(2). To ultimately prevail on a lack of informed consent claim, a claimant must prove that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis had the patient been fully informed, and the claimant must prove that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought. *Id.* § 2805–d(3).

On this record, defendants successfully demonstrated their prima facie entitlement to summary judgment dismissing the fourth cause of action alleging lack of informed consent. This court notes the extensive and detailed nature of the consent forms Kenny signed on January 10, 2012 and on the date of the first surgery, as well as the medical records specifically detailing that risks including but not limited to death,

paralysis, permanent nerve root damage and infection were specifically discussed with plaintiff on both dates (Motion at Exh. I).[9]

For his part, Dr. Frank only summarily states that Kenny's signature on the consent forms does not demonstrate that she adequately understood the risks and benefits of the surgery. He fails to cite any record evidence to support his conclusion. Further, Dr. Frank does not address Dr. Clements' statement that the applicable standard of care did not require Cho to disclose each and every type of nerve injury that could result from the procedure, or his conclusion that Cho would have satisfied the standard of care even if he only used broad terms such as "nerve injury" or "nerve damage" when discussing the surgery's risks and benefits with Kenny. For these reasons, plaintiff's showing is insufficient to rebut defendants' prima facie entitlement to summary judgment dismissing the fourth cause of action for lack of informed consent. Accordingly, this cause of action is dismissed.

**C. The April 18, 2012 Surgery and Post-Operative Care**

In determining that the April 18, 2012 surgery was completed well within the pertinent standard of care, Dr. Clements emphasizes that the nerve at issue here is the

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[9] Parenthetically, Dr. Clements states that nerve damage is a known and accepted risk of the procedure at issue herein. Defendants cite *Brinkley v Nassau Health Care Corp.*, 120 AD3d 1287 (2d Dept 2014), for the proposition that "it is well-settled in New York jurisprudence that a plaintiff who suffers a widely-known or medically-accepted 'risk of the procedure' has no cognizable claim against a medical provider" (Smith Aff. in Supp. of Motion, ¶40). However, *Brinkley*'s holding does not stand for such a proposition and this court was unable to find any case law supporting defendants' claim.

L5 nerve root (Exh. A to Motion, ¶24) and notes that due to Kenny's obesity,[10] Cho employed a "back approach" technique in placing the instrumentation and bone graft material (*id.* at ¶25). This surgical technique "is associated with a risk of damage or insult to the nerve root as the nerves within the operative site must be moved 'out of the way' to allow placement of implants and fixtures." Further, once the nerves are released they may come to rest over the fixtures and bone graft materials, another potential source of nerve root irritation.

Dr. Clements concludes that "irritation or insult to the L5 nerve root unequivocally did not occur in this case" (*id.*). He emphasizes that intra-operative neuro-monitoring did not register injury to any of the nerves along Kenny's spinal column (*id.* at ¶28). Dr. Clements further observes that post-operative diagnostic imaging studies and the April 25, 2012 exploratory surgery confirmed that the L5 nerve root was not compressed or impinged (*id.* at ¶29). While acknowledging that the April 19, 2012 CT scan indicated the presence of bone graft material at the S1 vertebra and L5-S1 disk space, Dr. Clements explains that the L5 nerve root exits the spine above the L5-S1 disk space. Thus, bone graft material evidenced in the CT scan at S1 could not cause compression or impingement to the L5 nerve root (*id.* at ¶30).

In light of the foregoing, Dr. Clements finds that Cho's conservative approach to treatment, including steroids, medication and physical therapy, was appropriate. Dr.

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[10] Both Drs. Clements and Frank concur that obesity is not a contraindication for spinal fusion surgery and laminectomy, but merely a complicating factor. Dr. Clements elaborates that access to and visualization of the spine is more difficult in such patients as there is less space in which to maneuver and insert fixtures and grafts (*id.*).

Clements finally opines that Kenny's post operative symptoms were "likely the result of irritation to the nerves manipulated during the subject surgery" (*id.*).

By contrast, Dr. Frank opines that "Defendants failed to use reasonable care under the circumstances and departed from the accepted spinal surgical and neurosurgical practice and techniques in that excess traction and/or pressure was placed on the left L5 nerve root during the surgery of April 18, 2012; the L5-S1 cage was not firmly and properly placed initially in the prepared disc space which caused the cage to completely leave the disk space during all the time it took for the L4-L5 disc removal, cage placement and initial cage removal as well as the subsequent cage replacement" (*id.* at ¶5).[11] He avers that it is "*vitally significant*" (emphasis in original) that the L5-S1 cage device was "lost" in the psoas muscle, evidencing a lack of surgical technique (*id.* at ¶6) and negligent failure to monitor the L5-S1 cage position while performing the TLIF procedure at L4-L5 (*id.* at ¶9).

Dr. Frank states that "*further manipulation of the psoas muscle, through which the L5 nerve root passes was another potential source of the insult to Plaintiff's L5 nerve root and the resulting foot drop*" (*id.* at ¶6) (emphasis in original). He explains that defendants' search for the "lost" L5-S1 cage took pace in a "deep blind location in which the nerve roots and sacral plexus cannot be clearly visualized and can easily be grasped by a clamp and severely damaged" (*id.*). Finally, he concludes that Kenny's "left foot drop could not have occurred unless the left L5 nerve root was exposed to

[11] Dr. Frank states that "excessive force typically during hammering with the impactor had to be applied" in order for the cage at L5-S1 to loosen while the L4-5 disk was removed.

excessive mobilization and traction during the surgery or while manipulating within the psoas muscle . . . and could not have happened absent negligence and malpractice of the surgeon" (*id.* at ¶8).[12]

As to intra-operative neuro-monitoring, Dr. Frank disputes defendants' position that an alert would have sounded if nerve root injury occurred. He states that "the absence of any demonstrated abnormalities does not preclude damage to a neural structure as was clearly the case here" (*id.* at ¶11).

As to Kenny's post-operative care, Dr. Frank disagrees with defendants' reading of the CT scan taken one day after plaintiff's surgery. As opposed to Dr. Clements' unequivocal finding that the April 19, 2012 CT scan indicated no impingement or compression of the L5 nerve root, Dr. Frank states that the CT scan "showed severe artifact, interfering with complete analysis of relevant portions of the spine, from the surgery and hardware" as well as the L5-S1 cage being "far to the left" (*id.* at ¶9). According to Dr. Frank, this, together with the left foot drop and Kenny's other post-surgery complaints, indicated continued pressure on the L5 nerve root and required immediate surgery.

Dr. Frank's affidavit raises issues of fact precluding summary judgment as to whether proper surgical techniques were employed and whether the second surgery should have been performed earlier. At the outset, both experts' conflicting opinions regarding neuro-monitoring are unavailing as they are both unsupported. As to surgical

[12] Dr. Frank contends Caridi conceded as much in his operative report of the April 25, 2012 surgery by stating that plaintiff's post operative weakness in her lower left extremity following the first surgery "was felt to be due to traction on the L5 nerve root."

skill, although Dr. Frank does not criticize defendants' "back approach" technique, he raises issues as to whether the initial L5-S1 cage was properly placed and whether defendants were negligent in failing to notice its movement. Prior to submitting his affidavit, Dr. Clements had the benefit of reviewing plaintiff's expert witness disclosure pursuant to CPLR §3101(d) (Motion at Exh. L), which is virtually identical to Dr. Frank's opposing affidavit. Dr. Clements does not address whether the cage movement and replacement could compress or impinge the L5 nerve root, instead relying on the post-surgery CT scan and MRI. However, Dr. Frank contends that the April 19, 2012 CT scan is obscured. This raises a further issue of fact as to whether defendants deviated from the applicable standard of care in delaying the second exploratory surgery until April 25, 2012. Finally, Dr. Clements offers no opinion as to what may have caused Kenny's left foot drop. Accordingly, defendants' motion for summary judgment is denied with respect to claims based upon the April 18, 2012 procedure itself (first cause of action) and the timeliness of plaintiff's second surgery (third cause of action). For all of the foregoing reasons, it is

ORDERED that Defendants' motion for summary judgment dismissing the complaint is granted with respect to plaintiff's claims of medical malpractice and negligence premised upon alleged lack of indication for the initial surgery and as to fourth cause of action alleging lack of informed consent, and is denied with respect to the first and third causes of action alleging negligence and medical malpractice premised upon the performance of plaintiff's initial surgery and the timing of the second surgery.

Counsel for the parties shall appear in Part 40 on February 27, 2017 as previously scheduled.

The foregoing is this court's decision and order.

Dated: New York, New York
January 27, 2017

Hon. Martin Shulman, J.S.C.