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SHORT FORM ORDER

INDEX No. 10-1735
CAL No. 12-00664MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 21 - SUFFOLK COUNTY

PRESENT:

Hon. JEFFREY ARLEN SPINNER
Justice of the Supreme Court

MOTION DATE 9-5-12
ADJ. DATE 5-8-13
Mot. Seq. # 002 - MD

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MARIA KOLAHIFAR and JAFAR KOLAHIFAR,

Plaintiffs,

- against -

STEVEN P. SAMPSON, M.D., STEVEN P. SAMPSON, M.D., P.C. and STONY BROOK ORTHOPAEDIC ASSOCIATES, P.C. UNIVERSITY FACULTY PRACTICE CORPORATION,

Defendants.

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Upon the following papers numbered 1 to 39 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 31; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 32-35; Replying Affidavits and supporting papers 36-39; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by defendants, Steven P. Sampson, M.D., Steven P. Sampson, M.D., P.C., and Stony Brook Orthopaedic Associates, P.C., University Faculty Practice Corporation, for summary judgment dismissing the complaint is denied.

In this action for medical malpractice, the plaintiff, Maria Kolahifar, asserts that defendants Steven P. Sampson, M.D., Steven P. Sampson, M.D., P.C., and Stony Brook Orthopaedic Associates, P.C. University Faculty Practice Corporation, negligently departed from good and accepted standards of medical care and practice in treating a distal radius comminuted intra-articular fracture of the plaintiff's right wrist with volar displacement of several fragments, and avulsion of the ulnar styloid process, which injury she sustained as a result of a fall on December 8, 2007. It is further alleged that the defendants negligently failed to diagnose a right shoulder injury. Damages are sought personally on behalf of Maria Kolahifar on the basis of negligence, and lack of informed consent, and derivatively on behalf of her spouse, Jafar Kolahifar. As a result of the alleged malpractice, it is claimed that the plaintiff's fracture

failed to heal, and that she had to undergo surgical repair and tenosynovectomies, and endure pain and suffering, scarring, and limitation of motion.

The defendants seek summary judgment dismissing the complaint on the basis that they did not depart from good and accepted standards of medical care and treatment; that proper informed consent was provided; and that the derivative claim must fail.

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. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***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" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this application, the moving defendants have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendant's answers and demands, plaintiffs' verified bill of particulars; copies of the examinations before trial of Steven Sampson, M.D. dated October 15, 2010 and continued July 1, 2011 and October 28, 2011, some of which are unsigned and uncertified but considered adopted as accurate by the moving defendant (*see* ***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); unsigned and uncertified copies of the transcripts of the examinations before trial of Jafar Kolahifar dated October 15, 2010 and Maria Kolahifar dated September 3, 2010 which are not in admissible form (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]), are not accompanied by an affidavit or proof of service pursuant to CPLR 3116, and are not considered; uncertified copies of the plaintiff's medical records and incomplete excerpts of records from St. Catherine of Sienna Hospital, Stony Brook University Hospital, Hospital for Special Surgery, and other unidentified and uncertified medical records; uncertified medical records of Robert N. Hotchkiss, M.D. and Ather Mirza, M.D., and the affirmation of defendants' expert physician, Neal Hockwald, M.D. Medical records must be certified on a motion for summary judgment, CPLR 3212 (***Friends of Animals v Associated Fur Mfrs.***, *supra*). Expert opinions are limited to facts in evidence, and the uncertified medical records which are not in admissible form are not considered (*see also* ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002];).

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 [1999]). 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***, 224 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], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

It is determined that even if the defendants' moving papers were in admissible form to be considered on a motion for summary judgment, the defendants have not established prima facie entitlement to summary judgment dismissing the complaint as the moving papers raise factual issues. Further, plaintiffs' expert has raised factual issues which preclude summary judgment from being granted.

Jafar Kolahifar testified to the extent that he is a board certified psychiatrist. He testified that two years after the surgery by Dr. Hotchkiss in July 2008, his wife still has some pain and limitation in lifting things, taking care of their grandchildren, and doing housework, and in writing and doing things which require fine movements.

Maria Kolahifar testified to the extent that prior to her injury, she worked in her husband's office doing billing, but since her fall, she cannot work as much as she is right handed and the injury was to her right hand and wrist. She has difficulty writing or entering information into the computer. She cannot write phone messages. Depending on how she feels, she now works three hours, three days a week. She takes out charts, but she does not answer the phones. She does billing unless her arm is in severe pain or her billing is not neat. She can only write about seven or eight words before her hand starts hurting, and then she has to stop.

Steven Sampson, M.D. testified that he is licensed to practice medicine in New York, and is board certified in orthopedic surgery. He stated that Maria Kolahifar became his patient on December 11, 2007, through a referral by Dr. Glass, for complaints of pain in her right wrist and right shoulder after falling down stairs on December 8, 2007. He diagnosed her with a very comminuted, exploded right distal radius, with intrarticular involvement, a metaphyseal and metadiaphyseal involvement, with multiple fragments and shortening involving the radial carpal joint and the radial ulnar joints, as well as an avulsed ulnar styloid. He stated that there were too many fractures to state specifically how many there were. He also stated that alignment was not terrible. It was his plan to use an external fixator to reduce the fracture, and if that was not successful, to insert a plate and screws. No alternative plans were considered. At surgery on December 13, 2007, however, he could not reduce the apical fragments on the volar surface, the bottom surface of the radius with muscle interposed between the bone, so he had to inset the internal plate and screws. He used the external fixator above and below the fracture to obtain length to manipulate the fracture fragments. Two screws or pins were placed in the metaphyseal articular portion of the fracture, along the volar or bottom part of the palm side of the forearm, and one above the metadiaphysis. Dr. Sampson continued that the screws each have a purpose to maintain the fracture, and

he described the same. Dr. Sampson described the screws he used and why he used them. He stated that screw length does not determine the healing. He did not know what screw sizes he used on the plaintiff, but used the depth gauge for each screw to determine how long each screw should be. Afterwards, he took an x-ray and stated he was pleased with the reduction. In his continued deposition, Dr. Sampson identified the size screws he used and where they were placed. He used an x-ray machine for placing the external screws.

Dr. Sampson continued that although there was a gap between the bone and the distal plate, he decided to accept the reduction rather than risk the loss of a corrected position. He thought alignment was excellent given the fracture the plaintiff had. The dorsal fragments of bone that were not accessed from the volar side of the bone were not affixed to the plate physically, but he decided to use only one plate rather than two as two plates create a "dead bone sandwich." He continued that a delayed union is a fracture that fails to unite in a reasonable amount of time, and the time period for this complex fracture to heal was difficult to say. Fractured bones heal at different rates based on the location of the fracture and the blood flow to the fracture. The piece of bone that was apex to the volar side of the wrist was a dead bone fragment which he did not remove, but used it as a bone graft with the intention that bone growth would diffuse the bone. He believed the avulsed bone was dead as there was no soft tissue attached to it. The causes of delayed union relate to the soft tissue disruption around the bone that is causing a loss of blood flow. Improper placement or displacement can cause a delayed healing of the bone. He testified that it is a judgment when to determine when the delayed union isn't going to advance to nonunion. He continued that there were multiple small portions of the dorsal metaphyseal surface of the distal radius that extended along the dorsal diaphyseal portion of the radius that had no screws and that did not have fixation, however, he hoped mother nature would help heal this if the soft tissues healed. On January 13, 2008, the external fixator with four pins were removed.

He stated that there was tendon damage at the time of the injury as a spike of bone was sticking into it, but the tendon itself was not compromised. He determined this at the time of surgery. The bone fragment hit the tendons without cutting them. He did not know it the tendons went back to full function after the bone was removed from contact with the tendon as the plaintiff could not move her fingers fully because of the severity of her pain. There was also tremendous soft tissue swelling in the area of the tendons. Under anesthesia, the tendons worked fine. He continued that the pronator muscle was damaged from the injury and could not act as a buffer between the tendons and the plate anymore. He secured the muscle to the bone to prevent the plate from coming into contact with the tendon. He did not believe there was any injury caused to the tendons from the screws. He believed the ligaments were intact as well. Thereafter, he discussed the postoperative care and treatment as well as his findings. On February 8, 2008, the ulnar styloid was still avulsed with no fixation, but he had no intention of doing surgery to reattach it, as he did not think it was necessary. On March 14, 2008, there was a continued lack of healing at the metadiaphyseal segment of the radius as per x-rays. The ulnar styloid was still avulsed, but Dr. Sampson testified that such nonunion had no bearing on the intra-articular nature of her injury. He continued that it did not contribute to lack of supination and pronation which was due to the fracture being transverse, from one side of the radius into the distal ulnar radial joint. Thus, he felt a bone stimulator was necessary.

Dr. Sampson stated that he had no contact with the plaintiff between February 8, 2008 and April 25, 2008, at which time she was unable to make a fist, or close her fingers to her palm, and had limited supination and flexion of the wrist, as indicated in the record by the physician's assistant who did see the plaintiff. He stated that the fact that she was receiving continuous hand therapy from the time of her

injury to the present time was an indication of the need to move her fingers better, otherwise, hand therapy would have been discontinued. She had MP contractur as the joint only moved from 0 to 50 degrees, and not through its full range of motion of 80 to 90 degrees. He considered this to be intrinsic tightness not involving the tendon. Such range of motion recordings were not made at his office prior to this date as the range of motion findings do not have to be written. On June 10, 2008, the plaintiff was unable to bring her fingers to her palm, which he felt was due to a long trigger finger, creating pain and having a negative effect on flexion of the fingers. There was swelling over the middle of the palm in the region of the metacarpal phalangeal joint. X-rays were taken on this visit, and Dr. Sampson testified that there was no lucency around the screws, or no delayed healing or nonunion shown of the fracture sites. He did note that there were portions of the fracture site that were incompletely healed along the radial aspect of the distal radius at the metadyaphysis due to the explosion fracture that blew into her muscles. He continued that she had a segmental fracture including a metaphysis fracturing and a metadyaphysis fracturing, and, in between the two sites, was the volar cortical fragment. The metaphyseal portion of that fragment healed completely, the avascular bone was used as a bone graft, and there was continued healing of the metadiaphyseal fragment at the apex with some bone callus on the ulnar side. He was not aware of her care and treatment after June 10, 2008.

Defendants' expert, Neal Hockwald, M.D., has not set forth his qualifications to render his opinions as an expert, as he has not provided information concerning his education, training and experience, to establish the basis for his expertise. It is determined that even if his affirmation established the same, or a curriculum vitae were submitted with the moving papers, that his affirmation raises factual issues which preclude summary judgment. Additionally, he has stated that he reviewed relevant medical records and radiological studies and deposition testimonies, but does not identify those materials for the record. Dr. Hockwald affirms that he is licensed to practice medicine in New York and is board certified in orthopedic surgery with an added qualification for hand surgery. It is his opinion within a reasonable degree of medical certainty that Steven P. Sampson, M.D. did not depart from the accepted standards of medical practice in his care and treatment of Maria Kolahifar, and that he did not proximately cause the injuries claimed by the plaintiff.

Dr. Hockwald set forth that on December 8, 2007, the plaintiff fell and was treated at St. Catherine of Sienna Medical Center emergency room for injuries to her right wrist, right shoulder, right lateral neck, left knee, and right clavicle. She was seen by Dr. Veliath, and a reduction to her right hand was performed. She was then seen by the orthopedist, Dr. Kenneth Glass, for a comminuted intra-articular fracture of the distal radius with volar displacement of several fragments and avulsion of the styloid process of the ulnar. A soft splint was placed, and she was to be scheduled for an open reduction and internal fixation. Dr. Glass recommended that a further opinion be obtained from Steven Sampson, M.D. at Stony Brook University Hospital, department of hand surgery, secondary to the severe nature of the injury. Upon consultation and examination, Dr. Sampson admitted the plaintiff to Stony Brook Hospital on December 13, 2007, and performed an open reduction, internal fixation and external fixation of the right distal radius fracture, due to failed non-surgical treatment. Dr. Hockwald noted that an anatomic reduction of the fracture was achieved, the plate was applied internally and secured into place with threaded locking cortical screws. Alignment appeared to be adequate under fluoroscopy. A volar splint was placed immobilizing the right upper extremity with an external fixator in place. The plaintiff was discharged home on about December 15, 2007.

Dr. Hockwald continued that Dr. Sampson saw the plaintiff in his office on December 24, 2007, at which time sutures were removed. She was noted to have decreased thumb sensitivity. Hand therapy

was prescribed. Right wrist x-rays on that date revealed that alignment was near anatomic with several distal bone fragments remaining displaced. Dr. Sampson's impression was internal and external fixation of the comminuted radial fracture. On January 11, 2008, Dr. Sampson discussed the new x-ray findings, advising plaintiff that the pins were in good position and alignment of the fracture was maintained. The external fixator and screws were thereafter removed on January 23, 2008, and a soft-arm cast was applied. When Dr. Sampson saw the plaintiff on February 8, 2008, the right wrist x-rays were unchanged. There was some fracture healing of the most distal segment of the distal radius as there appeared to be bridging of bone from one side of the bone to the other. However, he stated, there was incomplete healing of the distal radius at the metadiaphyseal junction due to the original severe trauma. Splint immobilization was continued. Dr. Sampson also noted decreased numbness and stiffness of her fingers, and the plaintiff complained of tenderness over the AC joint of the right shoulder. The cast was removed and she was referred to Dr. Glass.

Dr. Hockwald stated that the plaintiff followed up on March 14, 2008 with Dr. Sampson, at which time she complained of sensitivity to touch and pain on the dorsum of her forearm. It was Dr. Sampson's impression that the distal radius fracture was healing and that she should continue occupational therapy and use the removable splint. Bone simulator therapy was considered at this time. When the plaintiff was seen by Dr. Sampson on April 25, 2008, he noted she was using the bone simulator, and that she had MP contracture of the fourth finger "+ intrinsic tightness." He reviewed intrinsic tightness stretching exercises with her. Right wrist x-rays revealed no interval change in appearance or alignment of the distal radial fracture with the volar plate and screw fixation. PT and bone simulator were to be continued. Dr. Hockwald continued that when Dr. Sampson saw the plaintiff on June 10, 2008, she had intrinsic tightness, + long trigger finger, and incomplete fist, indicating an inability to bring fingers to her palm, which he attributed to her long trigger finger. His plan was to continue PT and follow up in six weeks. There was no change upon x-ray of the right wrist, but there was some interval healing. Avulsion of the ulnar styloid was again noted without evidence of dislocation or radial carpal joint space narrowing. Thereafter, the plaintiff did not return for follow up care with Dr. Sampson. Dr. Hockwald indicated that the plaintiff was next seen by Dr. Scott Rodeo who found the plaintiff had a grade III AC joint separation of her right shoulder, subacromial pathology, and AC joint separation for which he recommended subacromial injection which was done that day. She was advised to continue PT. He also recommended the plaintiff to Dr. Robert Hotchkiss, a hand surgeon, for evaluation at Hospital for Special Surgery.

Upon seeing the plaintiff, Dr. Hotchkiss noted that in February and March 2008, the plaintiff had full digital motion, but now, over the weeks, has decreased ability to flex the ring, middle, and small fingers. There was increased numbness in her thumb and index finger, and pain and swelling over the volar compartment of the right wrist at the carpal tunnel level. Dr Hotchkiss' impression was that of reactive flexor tenosynovitis in the volar compartment, evidence of tendon erosion secondary to either the plate or some other inflammatory source, inability to flex the digits consistent with impending rupture or perhaps existent tendon rupture in the ring finger. Upon review of x-rays, Dr. Hockwald stated that Dr. Hotchkiss noted delayed healing, or non-union, approximately 3 to 4 cm from the distal radial ulnar joint approximately. His impression was that of complex fracture of the distal radius with some intra-articular displacement that is healed but also with a metaphyseal nonunion; and prominence of the plate relative to the bone in its proximity to the flexor tendons which has resulted in erosive flexor tendinitis with probable near rupture or impending rupture of the flexor tendons. An MRI was recommended to assess the contents of the carpal canal and to plan for flexor tenosynovectomy, possible tendon transfers with carpal tunnel release, and repair of the nonunion by plating and bone grafting. The

plaintiff was admitted to Hospital for Special Surgery on July 7, 2008, and underwent an open reduction and internal fixation of the right distal radius nonunion with iliac crest bone graft; tenolysis with left flexor tendons on the right side, and right carpal tunnel release. No frank rupture of the flexor tendons was noted. The plate and screws placed by Dr. Sampson were removed, and a distal radius plate and screws were placed. Thereafter, stated Dr. Hockwald, when Dr. Hotchkiss saw the plaintiff on August 14, 2008 and September 11, 2008, the bone graft was healed. She was undergoing PT. She was placed on Medrol (a steroid) therapy associated with the inflammatory response.

Dr. Hockwald continued that on October 20, 2008, the plaintiff saw Dr. Ather Mirza, an orthopedic hand surgeon, for complaints of stiffness in her right wrist and fingers, pain in the wrist, difficulty moving her thumb, and weakness of grip and pinch. After examining the plaintiff and taking x-rays, Dr. Mirza referred the plaintiff back to Dr. Hotchkiss with a recommendation to have the plate and screws removed, as any impingement on the extensor pollicis longus and the flexor pollicis longus could pose a fracture problem or rupture of the tendons. When the plaintiff saw Dr. Hotchkiss next on November 20, 2008, there was a lump which had developed over the base of her thumb. On December 5, 2008, the plaintiff was admitted to the Hospital for Special Surgery by Dr. Hotchkiss who performed a transfer of the right extensor indicis proprius tendon to the right extensor pollicis longus tendon due to rupture of the right extensor pollicis longus tendon. During the procedure, it was apparent to Dr. Hotchkiss, stated Dr. Hockwald, that there was a complete rupture of the extensor pollicis longus tendon when he entered the tendon sheath. The sutures were removed and the wound was healing well on December 16, 2008. On May 14, 2009 when the plaintiff was seen by Dr. Hotchkiss, she complained of pain and intermittent swelling of the area of the scar from the tendon transfer, but she was still making progress in therapy. Dr. Hotchkiss advised her that the hardware might be causing irritation and her symptoms might improve with its removal. On May 29, 2009, Dr. Hotchkiss removed the deep implant to the right of the distal radius consisting of a plate and 9 screws. On June 9, 2009, when she saw Dr. Hotchkiss, she had improved range of motion in the wrist and digits, could make a complete fist, and on August 6, 2009, had regained the ability to perform activities of daily living. Swelling and tenderness improved dramatically, and x-rays showed a healed fracture.

Dr. Hockwald opined that Dr. Sampson properly diagnosed, evaluated, and treated the plaintiff's fracture and performed a proper surgical procedure on December 13, 2007 for a very severe fracture of the right distal radius, a fracture common in woman with osteopenia or osteoporosis, such as Ms. Kolahafar had. He continued that Dr. Sampson provided proper informed consent prior to performing the open reduction internal fixation procedure on December 13, 2007 by explaining that this was a very complex fracture with many pieces, and that he would do the best he could to initially place an external fixator to help put the fracture fragments in place, as well as a plate and screws to hold the fracture fragments in alignment if alignment could not be obtained with the external fixator. He explained that not having surgery was not a good choice. The risks of the procedure, Dr. Hockwald stated, were delineated on the operative consent form. Dr, Hockwald opined that the plan by Dr. Sampson was an appropriate therapeutic plan to correct the fracture by utilizing a well-recognized combination approach with open reduction and internal fixation. He continued that Dr. Sampson achieved stable reduction and alignment of the bone fragments in a way to avoid injury to the tendons, which Dr. Sampson determined were intact. A volar splint immobilized the right upper extremity. Dr. Hockwald continued by setting forth Dr. Sampson's testimony, and opined that Dr. Sampson appropriately informed the plaintiff regarding the removal of the external fixator, and set forth the risks, benefits, and potential side effects of removal. He continued with stating the plaintiff's condition thereafter, and noted that it was appropriate to send the plaintiff to an orthopedist for evaluation of the pain in her right shoulder. Thereafter, PT,

bone simulator, and a removable splint were appropriately prescribed for the pain in the dorsum of her forearm. When, on June 20, 2008, the plaintiff was unable to complete a fist with her right hand, Dr. Sampson correctly attributed that finding to the long trigger finger and continued PT with followup in six weeks.

Dr. Hockwald opined that the plaintiff had delayed healing and nonunion at the distal radius fracture site, which means that there was a fracture that failed to unite in a reasonable time. He stated that it is a judgment when to determine when the delayed union is not going to advance to nonunion, and that Dr. Sampson discussed this with the plaintiffs. Dr. Hockwald continued that the plaintiff's complex distal radius and radial shaft fractures were so smashed that the fracture sites would have trouble healing due to the severity of the fracture alone, and therefore, Dr. Sampson's decision to graft, or not to bone graft, the fracture site is not clear cut. He continued that the plaintiff's complaints set forth in the bill of particulars are secondary to the fracture and are not the result of anything which Dr. Sampson did or did not do. Dr. Hockwald opined that the plaintiff will not get back normal function of the right wrist and hand due to the severity of the fracture, and that she has attained reasonable function after sustaining such a severe comminuted fracture. He continued that Dr. Hotchkiss, on August 6, 2009, noted that the plaintiff had regained the ability to perform activities of daily living and was advised to continue all activities as tolerated, including swimming. He further noted that her swelling and tenderness had dramatically improved, and x-rays showed the fracture was healed. Dr. Hockwald concluded that there is nothing which Dr. Sampson did nor did not do which proximately caused, or was a contributing factor to, any of the injuries alleged sustained by the plaintiffs.

It is determined that while Dr. Hockwald has reiterated much of Dr. Sampson's testimony and findings included in the plaintiff's medical record, he has not set forth his readings of the various diagnostic serial x-rays and has not opined as to his interpretation of the same, and whether or not he agreed with the defendant's findings and interpretations of those radiographic studies. Additionally, he has not set forth the standard of care during the plaintiff's care and treatment to demonstrate how the defendant comported with the same. Dr. Hockwald has not opined that the plate and screws were properly placed, achieving the desired effect. He has not set forth his opinion concerning Dr. Hotchkiss' impression that the plaintiff had reactive flexor tenosynovitis in the volar compartment, or the evidence of tendon erosion secondary to either the plate or some other inflammatory source, considering the plaintiff's inability to flex the digits consistent with impending rupture or perhaps existent tendon rupture in the ring finger. He does not comment on the finding by Dr. Hotchkiss of the plaintiff's intra-articular displacement that was healed but also with a metaphyseal nonunion, which nonunion Dr. Sampson testified that the plaintiff did not have. While Dr. Hotchkiss noted intra-articular displacement that is healed but also with a metaphyseal nonunion, and that prominence of the plate relative to the bone in its proximity to the flexor tendons which resulted in erosive flexor tendinitis with probable near rupture or impending rupture of the flexor tendons, Dr. Hockwald disagrees with the plaintiff's subsequent treating physician from Hospital for Special Surgery, by stating that there was delayed healing and not a nonunion. The foregoing raise factual issues concerning whether or not Dr. Sampson departed from the standard of care, whether the internal plate was properly placed by Dr. Sampson, whether appropriate screw sizes were used and properly placed, whether or not bone grafting should have been done, and whether there was delayed healing or nonunion, which could have been prevented and the additional surgeries avoided.

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]).

In opposing this motion, it is noted that the plaintiff has not submitted an unredacted copy of the plaintiffs' expert affirmation. The plaintiffs' expert has also failed to set forth his education, training, and work experience to qualify as an expert in this matter, but is licensed to practice medicine in New York State and is board certified in orthopedic surgery. He set forth the history of the injury and treatment of that injury provided to the plaintiff by the defendants. It is the plaintiffs' expert's opinion that Dr. Sampson deviated from good and accepted medical practice during his care and treatment of the plaintiff in that Dr. Sampson used inappropriate surgical technique in performing surgery on the plaintiff's right wrist, including, failing to properly stabilize the fracture resulting in improper dorsal angulation; and because he improperly placed and secured the volar plate with the wrong screws. He continued that the x-rays taken on December 13, 2007 clearly show that the position of the plate and screw placement is not properly supporting the bone and is inadequate to stabilize the fracture. Due to the improper placement of the plate, the median nerve was compressed and increased the pressure on the thumb, and the flexor tendon was put under distress. He stated that Dr. Sampson failed to recognize that the fracture was not properly healing in that the plate was pulling away from the bone, and that he failed to follow up with a CT scan or MRI . The plaintiffs' expert continued that Dr. Sampson failed to recognize the progressive change in position of the distal fragment angling dorsally, and failed to see the nonunion. He further added that Dr. Sampson failed to consider any other treatment, including bone grafting, and failed to permit the plaintiff to make an informed decision by failing to explain to her that there was nonunion and the necessity for a bone graft. He stated that Dr. Sampson failed to appreciate the biology of the plaintiff's wrist injury and the mechanical imperative to support and provide stabilization with the plate. He failed to recognize the deficit of healthy bone, and failed to provide proper follow up care.

The plaintiff's expert opined that upon a review of the x-ray films, it is clear that the internal fixation was inadequate and led to a painful nonunion, the need for additional surgical intervention, and associated post-surgical care. As a result of the stated departures, opines plaintiff's expert, her chances for a successful result were clearly diminished. He continued that for a fracture to heal, there needs to be: (1) adequate bone to bone contact; (2) adequate blood supply; (3) adequate molecular (cellular) signaling to stimulate new bone formation; and finally, (4) stability of bone fragments to prevent gross motion. The plaintiff's expert opined that all four of these requirements were not met in Dr. Sampson's treatment of the plaintiff's fractured wrist. Because of the high energy of the injury, healing of the fracture was made more difficult, and therefore, Dr. Sampson should have been more diligent in his approach in adhering to the aforementioned principles, which was not done. The plaintiff's expert stated that Dr. Sampson testified that he determined that there was no blood flow in the fragment or segment that was displaced above the level of the bone, causing bone death to the piece of bone that was apex to the volar side of the wrist, which bone he did not remove, but used it as a bone graft. The plaintiff's expert opined that replacing a piece of devascularized (dead) bone fragment as a bone graft is totally inadequate, and that Dr. Sampson should have used a cortico-cancellous bond graft and not a piece of devascularized cortical bone fragment which constituted a deviation from good and accepted medical practice.

The plaintiff's expert continued that, as seen on the intraoperative x-rays, the position and angle of the plate was improper for this fracture, and that Dr. Sampson failed to appreciate this. By moving the plate proximally, the joint space is avoided, and he could have, and should have, used longer screws to capture some of the dorsal aspect, as well as using wires to assist in the immobilization. He continued that Dr. Sampson testified that in viewing the x-rays under fluoroscopy, had he decided that the screws were not the proper length, he could have been able to change them intraoperatively. In x-ray (Exhibit 3d), he stated, it shows that the distal screws were inserted at the wrong angle to obtain proper fixation, and that Dr. Sampson should have bent the plate or moved it proximally so he could have used longer screws to obtain more fixation of the bone. In comparing the screws placed by Dr. Hotchkiss, the "hold" power of the screw and limited movement of the distal radius fragment was dramatically increased. The plaintiff's expert stated that the bone must be secure and not moving, and that stability is necessary to promote bone healing as opposed to fibrous union and nonunion. These deviations by Dr. Sampson, opined the plaintiff's expert, led to malunion, nonunion, excess inflammation, and the need for further intervention by Dr. Hotchkiss. All subsequent treatment would have been unnecessary if Dr. Sampson had followed good and accepted orthopedic management practice at the time of his initial treatment of the plaintiff.

The plaintiff's expert further opined that the defendant ignored the signs and symptoms of progressing failure of the treatment and the complaints by the plaintiff, such as: (1) backing away of the plate from the bone; (2) failure of progression of healing at the distal site of the comminuted fracture; and (3) increasing functional complaints (use of hand) that should have been improving with time, which are also deviations from the standard of care. The plaintiff's expert continued that at that point, Dr. Sampson should have immobilized the wrist and re-operated with a graft and changed the position of the internal fixation to obtain adequate fracture fixation and immobilization. The plaintiff's expert opined that Dr. Sampson's follow up care after the surgeries was a deviation from good and accepted medical practice, decreasing the plaintiff's chance for a better outcome by diminishing recovery of the soft tissue functions. The plaintiff saw Dr. Sampson on February 8, 2008. On March 14, 2008, the plaintiff was seen by a physician's assistant, and Dr. Sampson did not see the plaintiff thereafter for another ten weeks until April 25, 2008, at which time the plaintiff was unable to close her fingers to her palm and make a fist.

The plaintiff's expert opined that the defendant misinterpreted the x-rays of June 10, 2008 as there was lucency by the screw in the middle of the plate and the fracture could still be seen, but Dr. Sampson denied that there was nonunion of the fracture or that the plate was pulling away from the bone. These findings required that a CT scan or MRI be conducted which would have shown what a proper reading of the x-rays showed: that the plate was displaced and that there was a failure to unite the distal radius fracture. Thus, stated plaintiff's expert, the plaintiff was left with a metaphyseal nonunion which resulted in erosive flexor tendinitis with probable near rupture or impending rupture of the flexor tendons, as noted by Dr. Hotchkiss on July 2, 2008, during her first examination by him. Based upon Dr. Hotchkiss' findings, he performed tenolysis with left flexor tendons on the right side, right carpal tunnel release, open reduction and internal fixation of the right distal radius nonunion with iliac crest bone graft, and which necessitated removing the negligently applied plate and screws. The nonunion site was identified and bone graft was placed on this site. Distal radius plate and screws were placed, and a volar splint applied to the right upper extremity on July 7, 2008. Thereafter, on December 5, 2008, Dr. Hotchkiss performed a transfer of the right extensor indicis propius tendon to the right extensor pollicis longus tendon due to complete rupture of the of the right extensor pollicis longus tendon. By May 14, 2009, the plaintiff was still having pain and intermittent swelling of the area of the scar from the tendon

transfer, possibly from irritation from the hardware, which was subsequently removed on May 29, 2009. Thereafter, she gained range of motion and was able to make a composite fist. By August 6, 2009, x-rays showed that the fracture was healed. She was advised to continue all activities as tolerated, including swimming.

The plaintiff's expert concluded that the nonunion and incomplete healing of the fracture site was caused by the failure of the defendants to properly immobilize the fracture by internal fixation and bone graft, resulting in nonunion and inflammatory response in the adjacent structure and erosive flexor tendinitis, as identified by Dr. Hotchkiss. The defendants departures from good and accepted medical care and treatment caused the nonunion of the distal radial fracture which necessitated the treatment and additional surgeries rendered by Dr. Hotchkiss. The plaintiff's ultimate outcome in function has been significantly diminished by the need to undergo all of the subsequent procedures.

Based upon the foregoing, the factual issues and conflicting expert opinions set forth by the defendants' and plaintiffs' experts, summary judgment is precluded, even if the defendants' moving papers were in admissible form, and both the plaintiffs and defendants' experts affirmations set forth the additional information to qualify each as an expert, and the plaintiff provided an unredacted copy of her expert's affirmation to this court, as required.

Accordingly, motion (002) by the defendants for summary judgment dismissing the complaint is denied.

Dated: July 9, 2017

J.S.C.
JEFFREY ARLEN SPINNER

____ FINAL DISPOSITION ___X___ NON-FINAL DISPOSITION