Stolworthy v Lonner
2020 NY Slip Op 34225(U)
December 15, 2020
Supreme Court, New York County
Docket Number: 805423/2017
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

Justice

----------X

KARI STOLWORTHY and MARK STOLWORTHY,

Plaintiffs,

- v -

BARON LONNER, M.D., SCOLIOSIS & SPINE ASSOCIATES, BARON S. LONNER, M.D., P.C., CHANLAND ROONPRAPUNT, M.D., ARKADY DUBOV, KYUSANG S. LEE, M.D., MOUNT SINAI BETH ISRAEL MEDICAL CENTER, THE MOUNT SINAI MEDICAL CENTER, INC., THE MOUNT SINAI HOSPITAL, and BETH ISRAEL MEDICAL CENTER,

Defendants.

----------X

INDEX NO. 805423/2017

MOTION DATE 10/20/2020

MOTION SEQ. NO. 001

DECISION AND ORDER

The following e-filed documents, listed by NYSCEF document number 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 67, 68, 69, 71, 72, 73, 76, 77, 78 ,79, 80, 81, 82, 83, 84, 114, 115, 116, 117, 118, 119, 120, 121, and 122 (Motion 001)

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice, the defendant Chanland Roonprapunt, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiffs oppose the motion. The motion is denied.

In 1977, the plaintiff Kari Stolworthy (the patient) underwent surgery to install Harrington rod instrumentation from the proximal thoracic region down to the L4 vertebra in the course of a procedure to correct her condition of scoliosis.

On September 9, 2013, the patient underwent an L4-L5 hemilaminectomy performed by nonparty orthopedic spine surgeon Dr. John Klekamp, who had diagnosed her with right sided L4-L5 lateral recess stenosis. Dr. Klekamp reported, post-operatively, that the patient had developed L4-L5 facet hypertrophy and arthropathy, while a CT myelogram revealed the presence of right-sided L4-L5 lateral recess stenosis. Nonetheless, the patient testified at her deposition that she tolerated the procedure well and that her symptoms had been alleviated for

approximately one year after Dr. Klekamp's surgery. On February 23, 2015, the patient complained to nonparty neurosurgeon Dr. Allen Sills of numbness in the lateral aspect of her right leg and medial aspect of her right foot, as well as pain, foot drop, and altered gait. An electromyography (EMG) and nerve conduction study revealed acute, chronic L5 and S1 radiculopathy on the patient's right side. Dr. Sills diagnosed the patient with lumbar spondylosis and lumbar scoliosis, but expressed skepticism about the success rate of a nerve decompression surgery, estimating that it would have only a 40-50% chance of benefitting her.

On April 20, 2015, the patient, who was then 51 years old, presented to the defendant Baron Lonner, complaining of continuous, worsening lower back pain that radiated down her right lower extremity to her big toe, with associated weakness and numbness that remained unrelieved by Ibuprofen, physical therapy, and trigger-point injections. Lonner examined the patient and diagnosed her with a forward-pitched sagittal alignment with Flatback Syndrome and lordosis, an excessive inward curvature of the spine, measuring 36 degrees, and pelvic incidence of 57 degrees, although he noted an excellent coronal alignment. A CT myelogram of the patient's lumbar spine revealed moderately severe central and lateral recess stenosis at L4-5, with bilateral L5 nerve root impingement and right L4 foraminal narrowing, as well as a significant disc degeneration at L5-S1. Lonner recommended surgery with both an anterior/posterior approach, in which the distal portion of the Harrington rod would be removed, an osteotomy would be performed at L3-L4 as well as at L4-L5 and L5-S1, in combination with an L4-L5 decompression, laminectomy, and placement of spinal instrumentation from T12 to the sacrum and including the pelvis. Additionally, he recommended that an anterior interbody fusion of L3-L4, L4-L5, and L5-S1 be performed, along with posterior instrumentation of T12 to the sacrum and pelvis.

On June 23, 2015, the patient underwent spinal surgery, including decompression surgery, at the defendant Beth Israel Medical Center, with Lonner as the lead surgeon and the movant, Roonprapunt, assisting him. At Lonner's request, the defendant neurologist Kyusang

Lee and the defendant technician Arkady Dubov performed intra-operative neuromonitoring using somatosensory evoked potential (SEP) devices, a free-running EMG, transcranial motor evoked potential (MEP) devices, and pedicle screw stimulation. Lonner first excavated and removed the distal portion of the patient's Harrington rod and hook at the L2-L3 level, then performed osteotomies at L3-L4. Lonner's operative report reflects that adherent dura were encountered throughout the L3-L4 space and that a large complex dural tear and smaller adjacent dural tear were identified, with the resultant presence of cerebrospinal fluid (CSF).

Roonprapunt explains in his moving papers that he assisted Lonner in the repair of these dural tears and that he reduced a neural hernia that was identified during this portion of the procedure. As described by Roonprapunt in his own post-operative report, he encountered a large, complex dural tear measuring approximately 1 cm in the L3-L4 region, as well as a smaller dural tear immediately rostral thereto, measuring approximately 0.5 cm. Roonprapunt reported that he obtained hemostasis of the area with coagulation and cottonoid patties. Roonprapunt explained that, when he further inspected the dura, he also observed a small neural hernia extending beyond the thecal sac. As recounted by Roonprapunt, he enlarged the right L3-L4 medial facetectomy to perform the repair of the dura, reduced the neural hernia back into the thecal sac, and then repaired the dural tears using suturing techniques and fibrin glue.

After these repairs were completed, Lonner performed laminectomies at L4-L5 and L5-S1, and his operative report reflects that the L5 and S1 nerve roots had been freed. Lonner then performed spinal instrumentation from T12 to the sacrum, and installed screws using fluoroscopy and direct screw stimulation.

During the next phase of the surgery, Lonner, operating from the patient's anterior, removed disks at L4-L5 and L5-S1, prepared endplates for fusion at those levels, and installed and secured cages with pedicle screws and washers. Lonner employed fluoroscopy for this aspect of the procedure, interpreted the images himself, and confirmed the placement of these devices in his report.

Lonner cut and contoured several rods during the final stage of the surgery for the purpose of ensuring satisfactory sagittal plane correction. As described in Roonprapunt's post-operative report, due to the extent of the CSF leaks, Roonprapunt ultimately placed a lumbar drain in the left L5-S1 interspace at the conclusion of the procedure in order to alleviate pressure on the repaired tears. Roonprapunt asserts that, during the June 23, 2015 procedure, he did not perform any portion of the discectomies, measure the disc material related to cage placement, or make any decisions related to the type of equipment used or its placement.

Immediately subsequent to the completion of the surgery, the patient was intubated and transferred to the surgical intensive care unit for resuscitation and ventilator management.

According to Lee's post-operative report, the intraoperative SEPs, free-running EMG, and transcranial MEPs demonstrated no adverse changes throughout the operation. He further indicated that pedicle screw stimulation helped to verify adequate placement of the pedicle screws. Lee also stated that the surgeons and anesthesiologist were kept abreast of the neuromonitoring data during the surgery.

One hour after being extubated on June 25, 2015, the patient complained of numbness in her right foot and leg, and later complained of progressive weakness in her right lower extremity, specifically with respect to dorsiflexion, although plantar flexion of her foot also caused diffuse numbness. A CT scan of the patient's lumbar spine without IV contrast revealed a far lateral L4-L5 disc herniation. She was thus returned to the operating room later that day, where Lonner employed a posterior approach to decompress the L4-L5 nerve roots via an L4-L5 discectomy with revision to the instrumentation. At his deposition, Lonner asserted that he requested Roonprapunt's presence at the follow-up surgery due to the complex dural tear that had occurred during the initial procedure and that Roonprapunt had ostensibly repaired. Lonner's operative report for the second surgery states that, upon "taking down" the pars interarticularis of the L4 vertebra, he encountered abundant disc material that he gradually removed, along with a portion of the pedicle of the L4 vertebra, in order adequately to access

the nerve root and safely decompress the nerve. Lonner also removed the L4 pedicle screw and the pedicle bone in its entirety to allow access to the L4 nerve root and create room to decompress and perform the L4-L5 discectomy. Lonner then palpated the L4 root following decompression, which, according to his report, indicated that the root was free, mobile, and without compression. His report further indicated that palpation in the canal also revealed that the L5 root was mobile as it proceeded caudally. During the procedure, Lonner explored the dural tear at L3-L4, concluding in his report that the tears and CSF leaks remained properly repaired and addressed. Lonner further reported that the repaired tears and the lumbar drain site were augmented with Tisseel, a brand of fibrin glue.

After this second surgery, the patient complained of prominent weakness in her right ankle dorsiflexion, the extensor hallucis longus tendon in her right leg, and, to a lesser extent, in her right ankle plantar flexion. She also suffered sensory deficits, predominantly in L5-S1 dermatomes, walked with an altered gait, and complained of moderate pain that was treated with Gabapentin, a medication that treats pain arising from nerve damage. After the patient was transferred to Beth Israel Medical Center Rehabilitation on July 1, 2015, she was able to walk a distance of five feet with a rolling walker. She was not discharged until July 28, 2015, at which point she was able to walk employing a rolling walker with a right ankle-foot orthosis, and a thoracolumbosacral orthosis.

In their bill of particulars as to Roonprapunt, the plaintiffs alleged that he inflicted injury to the patient's nerves during surgery the June 23, 2015 surgery by causing an L4 nerve root and foraminal disc herniation on the left side. They further alleged that Roonprapunt departed from good and accepted medical practice by failing to use the proper surgical technique to address the L4 disc herniation prior to the insertion of instrumentation and hardware, creating a condition surgically resulting in a L4-L5 disc protrusion that caused compression of the thecal sac and prominent right lateral disc protrusion that projected into the extra foraminal soft tissues, thereupon compressing and exiting right L4 nerve. In addition, the plaintiffs contended that

Roonprapunt negligently caused an L4-L5 disc herniation due to anterior cage placement, negligently inserted a cage at L4 and L5 without complete removal of the L4 disc herniation, negligently exposed the patient to increased risk of nerve damage, drop foot, loss of mobility and further surgery, and negligently failed timely to diagnose the patient's condition of L4 nerve root compression due to L4 disc herniation. The plaintiffs further asserted that Roonprapunt departed from good and accepted practice by failing to heed the significance of the loss of signal during intraoperative neurophysiological monitoring, by continuing with the first surgical procedure despite becoming aware of the loss of signal during intraoperative neurophysiological monitoring despite his failure to undertake any intraoperative or immediate investigation into the reasons for the loss of signal or communicate with the technologist and interpreting physician who assisted in the surgery. They thus contend that Roonprapunt ignored the findings of intraoperative neurophysiologic monitoring, including diminution in SEP and MEP, both of which constituted signs of surgically induced nerve root or spinal cord compression that may have arisen from tears and herniations in vertebral discs and other soft tissue.

In support of his motion, Roonprapunt submits the transcripts of the parties' depositions, medical and hospital records, and reports, and the expert affidavit of Dr. Ron Riesenburger, a physician who is board-certified in neurosurgery. Dr. Riesenburger asserts that Roonprapunt was not responsible for the surgical plan, equipment choice, or performance of the portions of the surgery that he did not personally execute. Specifically, he opined that

> "Dr. Roonprapunt was not responsible or involved in the surgical decisions with regards to the indications for the procedure, how much disc material was removed, or strategy involved in placement of the cage or screws. As an assistant during the decompression, laminectomy, osteotomy, and fusion portions of the surgery, Dr. Roonprapunt's involvement was limited to using vein retractions for exposure, suctioning out fluid, and providing Dr. Lonner with a clear operation field. It is my opinion to a reasonable degree of medical certainty that these tasks performed by Dr. Roonprapunt had no role in the complications or alleged injuries experienced by plaintiff. My opinion is consistent with the deposition of Dr. Lonner, who testified that the surgical decisions regarding the decompression, laminectomy, osteotomy, fusion and hardware placement were made by him."

Dr. Riesenburger goes on to state that, as to those portions for which Roonprapunt was responsible, Roonprapunt properly performed the surgical procedures involving the repair of dural tears, reduction of a neural hernia, and placement of a lumbar drain to alleviate pressure related to the patient's CSF leaks. In this regard, Dr. Riesenburger more particularly opined that:

> "It is my opinion to a reasonable degree of medical certainty that Dr. Roonprapunt appropriately performed his portions of Mrs. Stolworthy's surgery on June 23, 2015. Dr. Roonprapunt properly identified two separate dural tears with attendant CSF leaks as well as a neural hernia. In response, Dr. Roonprapunt used proper surgical technique in cleaning the area, repairing the tears, and reducing the hernia. Moreover, Dr. Roonprapunt demonstrated excellent judgment in placing a lumbar drain at the conclusion of Mrs. Stolworthy's procedure. Due to the fact that Mrs. Stolworthy experienced dural tears, there would have been substantial pressure on both CSF leaks that could have caused an additional tear and leak. By placing a lumbar drain, Dr. Roonprapunt ensured that any substantial pressure would be alleviated and safeguarded against a further leak, which ultimately did not occur. While Dr. Roonprapunt assisted Dr. Lonner in other minor portions of Mrs. Stolworthy's surgery such as using retractors for exposure, the repair of the dural tears, reduction of the neural hernia, and placement of the lumbar drain were the only aspects of the surgery that Dr. Roonprapunt acted as the lead surgeon. Therefore, Dr. Roonprapunt's responsibility extends only to these portions of the surgery."

Dr. Riesenburger rejected the plaintiffs' contention that Roonprapunt failed to heed the relevant intraoperative neurophysiological neuromonitoring. He avers that the intraoperative neurophysiological neuromonitoring reports indicated that there was no loss of signal during the procedure, that there were no adverse changes, and that the pedicle screw stimulation helped to verify the adequate placement of the pedicle screws. Dr. Riesenburger concluded that Lee's report suggested that the neuromonitoring team also kept the surgeons abreast of the neuromonitoring data during the surgery.

Dr. Riesenburger also relied on Lonner's deposition testimony, in which Lonner testified that that the dural tear that was observed was not caused by anything done by Roonprapunt, and that once the dural tears were identified, Lonner simply requested Roonpraprunt to assist him by repairing the tears. Dr. Riesenburger continued:

> "as an assistant Dr. Roonprapunt was not responsible for the laminectomy portion of Mrs. Stolworthy's procedure, the removal of disc material related to that portion, the measurement of the disc space, the safeguarding of the nerves related to the insertion of the cage, the size of the cage used, or determining whether any compression of the nerves existed after cage placement. At his deposition, Dr. Roonprapunt testified that he did not perform the discectomy, assess whether sufficient disc material was removed, measure the disc space for cage placement, palpate the area where the disc material was removed, determine the size of the cages utilized, or safeguard the nerves for cage placement. It is my opinion to a reasonable degree of medical certainty that even if there was remaining disc material in the cage space causing a subsequent protrusion, Dr. Roonprapunt could not have changed this outcome, as he was not involved in the removal of the disc or disc material, determining how much disc material should have been removed, safeguarding of the nerves, or placement of the cage. These decisions were made by Dr. Lonner."

Dr. Riesenburger also stated that Roonprapunt was not responsible for, or involved in, the management of the patient's initial post-operative care and treatment after the June 23, 2015 procedure, but that Roonprapunt nonetheless appropriately assisted Lonner in the June 25, 2015 "exploratory" surgery. As to that later surgery, Dr. Riesenburger opined that Roonprapunt's initial closure of the dural tears and CSF leak areas, while properly undertaken, nonetheless required reopening to allow Lonner to inspect the surgical area for possible causes of the patient's post-operative symptoms. Dr. Riesenburger concluded that the inspection of this area merely confirmed Roonprapunt's appropriate performance during the June 23, 2015 surgery, as the CSF leaks remained closed and the hernia remained reduced.

In opposition to Roonprapunt's motion, the plaintiffs relied on the same transcripts and records, as well as the expert affidavit of their retained physician, who has experience as a general surgeon, orthopedic surgeon, and spinal cord injury surgeon. The plaintiffs' expert explained that

> "It is imperative in performing surgery that involves the placement of a cage that an adequate amount of disc material be removed to allow safe and proper insertion of the cage in order to prevent remaining disc material from compressing nerve roots. The failure to do so is a departure from accepted practice. The reason is that if some disk material is left in the space into which the cage is being placed (pushed into place), the cage can push the remaining disk material into the nerve or the nerve root compressing and injuring same.

> "This is exactly what happened in this case and it is my opinion within a reasonable degree of medical certainty that defendant, Lonner and defendant, Roonprapunt departed from accepted practice during the operation of June 23. 2015, because insufficient disk material was removed prior to the insertion of the interbody fusion cage."

The plaintiffs' expert noted that Lonner himself admitted that there was "abundant" disc material remaining after the initial surgery and that, in an April 20, 2016 letter, Lonner explained that "CT imaging revealed protrusion of disc material on the left side at L4-L5 into the foramen, into which the cage had been placed."

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr*., 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc*., 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc*., 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st

Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

"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]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature (*see Roques v Noble*, 73 AD3d at 206;.*Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must

"explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]).

Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted dental practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, 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" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). 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 an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Consequently, where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24 *Cruz v St. Barnabas Hospital,* 50 AD3d 382 [1st Dept 2008]).

Roonprapunt established his prima facie entitlement to judgment as a matter of law with expert testimony that he properly performed his portion of the initial surgery, and that he was not responsible for the surgical plan itself. As relevant here, Roonprapunt, in his papers, avers that he enlarged the right L3-L4 medial facetectomy to perform a necessary repair of the dura. Roonprapunt argues, in support of his motion, that he had no responsibility for determining how much of disc material should have been removed in connection with that enlargement, as that determination was left to Lonner.

The affidavit of the plaintiffs' expert is, however, sufficient to raise a triable issue of fact as to whether Roonprapunt was not only responsible for removing an insufficient amount of disc material, but also was responsible making an inappropriate determination as to what amount was reasonable, even though Lonner made the initial determination (*see generally Yerich v Bassett Healthcare Network*, 176 AD3d 1359, 1361 [3d Dept 2019]). Roonprapunt conceded that he removed disc material in an area of the patient's spinal column from which disc material had already been removed during the 1977 scoliosis surgery, and that the removal of that material from that area was necessary to permit placement of the cage. As the plaintiffs' expert phrased it:

> "Roonprapunt, as an attending neurosurgeon and spine surgeon, was held to the same standard of surgical practice as defendant, Lonner, who was the lead surgeon. Both of these doctors were attending physicians and both participated in Stage 2 of the surgery and the pertinent decision making and assessments therein.
>
> *****
>
> "Roonprapunt, as a trained and experienced spine surgeon, had a responsibility as in integral part of the team, to make sure that the disk material was fully and appropriately removed and to properly and adequately visualize the area into which the cage was being inserted to make sure it was clear of disk material that could and, in this case, did compress the nerve root at L4-L5."

The expert's affidavit also raises a triable issue of fact as to whether the removal of an insufficient amount of disc material proximately caused injury to the patient. Hence, Roonprapunt's motion for summary judgment must be denied.

The court notes that the plaintiffs' expert did not rebut Roonprapunt's contentions that the signals from the nerve conduction monitoring devices were sufficiently operative during the initial surgery, and that the technician and other physicians properly communicated with Roonprapunt and Lonner during that surgery.

The court further notes that the affidavit of the plaintiffs' expert was executed and notarized in Pennsylvania, but does not include the certificate of conformity required by CPLR 2309, which is a written instrument pursuant to which a person qualified by the laws of the country or state in which an affidavit is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit has indeed been drafted, executed, and notarized in conformity with the laws of that country or state. This defect does not require the court to disregard the affidavit or reject the plaintiffs' opposition, as the defect may be cured by the submission of the proper certificate nunc pro tunc (*see Bank of New York v Singh*, 139 AD3d 486 [1st Dept 2016]; Seiden v Sonstein, 127 AD3d 1158 [2d Dept 2015]).

Accordingly, it is

ORDERED that the motion of the defendant Chanland Roontrapunt for summary judgment dismissing the complaint insofar as asserted against him is denied.

This constitutes the Decision and Order of the court.

12/15/2020
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		**CASE DISPOSED**			[X]	**NON-FINAL DISPOSITION**	
	[ ]	**GRANTED**	[X]	**DENIED**	[ ]	**GRANTED IN PART**	[ ] **OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**			[ ]	**SUBMIT ORDER**	
CHECK IF APPROPRIATE:	[ ]	**INCLUDES TRANSFER/REASSIGN**			[ ]	**FIDUCIARY APPOINTMENT**	[ ] **REFERENCE**