Krembs v NYU Langone Hosps.
2021 NY Slip Op 32471(U)
September 9, 2021
Supreme Court, New York County
Docket Number: Index No. 805375/2012
Judge: Eileen A. Rakower
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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon. EILEEN A. RAKOWER PART 6
Justice

SUSAN KREMBS,

Plaintiff,

- against -

NYU LANGONE HOSPITALS; ANDREAS N. NEOPHYTIDES, ANDREAS N. NEOPHYTIDES, M.D., P.C., A FICTITIOUS NAME INTENDED TO REPRESENT THE PROFESSIONAL ENTITY UNDER WHICH ANDREAS N. NEOPHYTIDES PRACTICES MEDICINE; NEUROLOGICAL CONSULTANTS OF NEW YORK, P.C.; MICHAEL L. SMITH; MICHAEL L. SMITH, M.D., P.C., A FICTITIOUS NAME INTENDED TO REPRESENT THE PROFESSIONAL ENTITY UNDER WHICH MICHAEL L.SMITH PRACTICES MEDICINE; ROBERT E. ELLIOTT; ROBERT E. ELLIOTT, M.D., P.C., A FICTITIOUS NAME INTED TO REPRESENT THE PROFESSIONAL ENTITY UNDER WHICH ROBERT E. ELLIOTT PRACTICES MEDICINE; STEPHEN P. KALHORN; BAXTER INTERNATIONAL INC. AND BAXTER HEALTH CARE CORPORATION,

Defendants.

INDEX NO. 805375/2012
MOTION DATE
MOTION SEQ. NO. 6
MOTION CAL. NO.

Amended
Decision and Order

The following papers, numbered 1 to _____ were read on this motion for/to

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answer — Affidavits — Exhibits	
Replying Affidavits	

Cross-Motion: Yes X No

Defendants NYU Langone Hospitals Center ("NYU"), Stephen Paul Kalhorn, M.D. (Dr. Kalhorn"), s/h/a Stephen P. Kalhorn; Andreas N. Neophytides, M.D. ("Dr. Neophytides"), s/h/a Andreas N. Neophytides and Andreas N. Neophytides, M.D., P.C., a fictitious name intended to represent the professional entity under which Andreas Neophytides practices medicine; Michael Louis Smith, M.D. ("Dr. Smith"), s/h/a Michael L. Smith, and Michael L. Smith, M.D., P.C. a fictitious name intended to represent the professional entity under which Michael L. Smith practices medicine; Neurology Consultants of New York, P.C., Robert E. Elliott, M.D. ("Dr. Elliot"), s/h/a Robert E. Elliott, and Robert E. Elliott, M.D., P.C., a fictitious name

intended to represent the professional entity under which Robert E. Elliott practices medicine (collectively, "Defendants") move pursuant to CPLR § 3212 for an Order granting summary judgment dismissing Plaintiff Susan Krembs' ("Plaintiff" or "Ms. Krembs") Summons and Verified Complaint.

Background

This action, sounding in negligence and medical malpractice, arises out Dr. Neophytides, the neurologist, Dr. Smith, the spinal surgeon, and NYU's alleged deviation:

> from accepted medical practice in failing to treat [Plaintiff's] sciatica according to the standard of care; in telling her that she required emergency surgery when she didn't; in failing to inform her of the strong chance of significant remission or cure from conservative (non-surgical) treatment; in failing to read the medical chart which revealed significant improvement during her overnight hospital stay; in depriving her of the substantial possibility of a cure or at least significant abatement via nonsurgical treatment; in failing to obtain her informed consent; in operating on her, and thus in causing her devastating permanent injuries. (Plaintiff's Affirmation in Opposition at 2).

Plaintiff has withdrawn all allegations of negligent surgical techniques and informed consent as asserted against Drs. Kalhorn and Elliot.

Plaintiff first presented to neurologist Dr. Neophytide on June 23, 2010. Plaintiff:

> reported traveling back to NYC from California on the prior Saturday and exercising at the gym on Sunday without any complaints. That evening she developed severe low back pain and had difficulty getting out of bed on Monday. The pain was so severe that she had to call her ex-husband to help get her kids to school. As of Monday she rated her pain 7 or 8 out of 10 and she did not go to work that day. She had a prior history of being in a motor vehicle accident in 1987 and had a C4-10 fusion with the

> placement of instrumentation, including rods. She also had issues with low back pain 10 years earlier and had undergone a radiofrequency neurolysis (also referred to as an ablation) performed by Dr. Emille Hiesiger, a pain management specialist. (Defendants' Affirmation in Support at 6-7).

Plaintiff advised Dr. Neophytides that her pain was persistent and unchanged since the prior Monday despite taking muscle relaxers and pain medications. Plaintiff stated that she could not even straighten-up due to the pain which radiated to her right lower extremity and she had numbness in her right foot. Dr. Neophytides examined Plaintiff and noted that Plaintiff "had extreme lumbar paraspinal spasm and guarding." Dr. Neophytides reviewed the lumbar non-contrast MRI film performed on June 21, 2010, which showed "a right paramedian L4-L5 disc extrusion that protruded into the foramen and compressed the nerve root." Dr. Neophytides' "impression was an extruded right L4-L5 disc, and he believed [Plaintiff] needed to be admitted for an immediate evaluation and a possible emergency discectomy procedure." Dr. Neophytides spoke to Dr. Smith about Plaintiff's possible need for surgery.

Later that day at around 4:00 p.m., Plaintiff was admitted to NYU with complaints of "severe pain in her lower back and right leg." At 5:17 p.m., Dr. Amy Caron, the emergency room physician, ordered "IV morphine 6mg STAT." Shortly before 6:54 p.m., Dr. Smith and Dr. Elliot saw Plaintiff in the emergency room. Plaintiff complained of "severe incapacitating low back and right lower extremity pain" down her right leg. Dr. Elliott noted that Plaintiff could not stand due to pain, that she had a positive straight leg raise on the right side, which was indicative of a herniated disc at L4-5 or L5-S1, and she also had 4+/5 dorsiflexion in her right foot, which represented some weakness. Dr. Elliot further noted that Plaintiff had decreased sensation to touch on her right foot, which was indicative of nerve root dysfunction. Dr. Smith felt there were "some tools still available" to try and treat Plaintiff's symptoms, including IV medications to see if her pain could be controlled, before surgery was an option.

At around 6:55 p.m., Plaintiff was seen by Dr. Malkani, a neurology resident. Dr. Malkani testified that he spoke with Dr. Neophytides regarding his clinical findings and Dr. Neophytides felt that the patient would possibly need surgery the next day. The plan was for Plaintiff to have morphine IV 6mg every four hours as needed for pain, Flexeril as needed, and Solu-Medrol 60 mg IV every six hours. At around 7:00 p.m., Plaintiff arrived on the neurology floor.

At 7:42 p.m., Plaintiff's reported pain was 10/10. At 9:30 p.m., Plaintiff reported her pain was 5/10. At 9:40 p.m., Flexeril 10mg was given to Plaintiff. At 10:30 p.m., Plaintiff's reported pain was 3/10. At 11:00 p.m., Solu-Medrol 60mg IV was given to Plaintiff. Shortly, before 11:00 p.m., Plaintiff's reported pain was 6/10. At 11:30 p.m., Plaintiff was given morphine 6mg. At 12:30 a.m., Plaintiff's reported pain was 2/10 and she fell asleep by 1:15 a.m. At 6:00 a.m. Plaintiff complained of right leg/back pain that was 4/10. At 7:00 a.m., Morphine 6mg IV was given to Plaintiff and she reported pain that was 3/10. Flexeril 10mg was later given.

On June 24, 2010 at 7:50 a.m., Dr. Neophytides saw Plaintiff. Dr. Neophytides noted that Plaintiff could not straighten her body and was in "excruciating pain" with only partial relief from morphine. At 8:30 a.m., Plaintiff obtained medical clearance to have surgery should she wish to proceed with a microdiscectomy. Plaintiff was also seen by Dr. Smith, who discussed her subjective complaints including her "severe radicular pain not responding to IV steroids and opiates" and that Plaintiff "remains in debilitating pain". At 9 a.m., Plaintiff's reported pain was 7/10. At 9:50 a.m., 6 mg of morphine was given to Plaintiff. At 10:10 a.m., Plaintiff continued to report her pain as 7/10. At 10:50 a.m., Plaintiff complained that the pain was noted to be "not resolving" and at 11:30 a.m. two Percocet were also given to help control her pain.

At 2:12 p.m., Plaintiff was examined by a NYU neurosurgical resident, Dr. Kalhorn. The medical records note that Dr. Kalhorn discussed the risk of bleeding, infection, spinal fluid leak, need for reoperation, need for a fusion, chance of disc re-herniation, chance of partial improvement or even failure to completely improve. Dr. Kalhorn also discussed the alternatives of steroid injections, oral or IV pain medications and doing nothing. Dr. Kalhorn testified his practice was to confirm the patient understands and to offer the opportunity for the patient to ask any questions, then the patient makes the decision. Following the discussion, Plaintiff and Dr. Kalhorn signed the informed consent form at approximately 2:15pm.

On June 24, 2010, Dr. Smith performed a right L4-L5 discectomy based on a right L4-L5 herniation with radiculopathy. Dr. Smith was assisted by Dr. Kalhorn. Dr. Smith's pre-operative and post-operative diagnoses were the same: right L4- L5 herniated nucleus pulposus with radiculopathy. Dr. Smith performed a right L4-L5 hemilaminotomy, medial facetectomy and microscopic microsurgical discectomy. In the operative report, Dr. Smith noted that Plaintiff "was admitted to the hospital for acute medical management; however she failed to have symptomatic improvement with IV narcotics and IV steroids. She was functionally incapacitated and thus he recommended early microsurgical excision." Dr. Smith wrote that he "discussed the risks including infection, hemorrhaging, CSF leak, paralysis, failure

to cure, failure to improve, 10% rate of re-herniation, and need for further surgery. The patient understood the risks and rationale, and wished to proceed with the surgery."

Dr. Smith wrote in the operative report that during the surgery he removed a "very large fragment" of disc material impinging on the L5 nerve root, and sent it to Pathology for analysis. Dr. Smith noted that upon removal of the ligamentum flavum he saw "an abnormal very thin walled outpouching" of the dura. According to Dr. Smith's report "[i]t was unclear whether this was a spinal cyst such as an arachnoid cyst or a patulous area of dura. This was not easily resected free and there was some evidence of a minute amount of fluid leak ... Tisseel was placed over the dura and the abnormal patulous segment or section."

Dr. Kalhorn testified that he recalled the abnormal appearance to the dura and that there was a small outpouching clump of scar tissue or a cyst wall. Dr. Kalhorn recalled Dr. Smith putting fibrin glue on the area to protect the abnormality. Dr. Smith testified that it was the standard fibrin sealant used for reinforcing or closing dura, and there was no testing or stitching due to there being no active leak. Dr. Kalhorn testified that following the procedure, he had a conversation with Plaintiff in the recovery room wherein she advised she had undergone spinal injections in the past, which may have caused the abnormally thin dura.

After Plaintiff's procedure, Plaintiff had some incisional and right foot pain that was 5/10. On June 25, 2010, Plaintiff reported pain that was 5/10 and incisional. On June 26, 2010, Plaintiff reported that her incisional pain was 5/10 in the morning and 6/10 in the evening. On June 27, 2010, Plaintiff reported that her incisional pain was 4/10. The medical record states that Plaintiff was ready for discharge and was prescribed pain medications to manage her incisional pain at home. On July 2, 2010, Dr. Smith ordered an MRI of the lumbosacral spine which showed a small fluid collection adjacent to the laminotomy and extending through the laminotomy "defect" into the dorsal epidural space from L3-L4 to L4-L5.

On July 3, 2010, Plaintiff presented to the NYU emergency department for "non-positional headaches, nausea, and [right] hip pain and tenderness." The medical report notes that Plaintiff's right hip pain and headache were resolved after taking Percocet and she had some right foot numbness, which was stable. Plaintiff was admitted overnight for pain control, IV fluids, and to determine if a wound exploration was needed. There was no evidence of "leakage from wound." On July 4, 2010, Plaintiff was discharged home and recommended to follow up with Dr. Smith as an outpatient. Defendants allege that Plaintiff did not follow up with Dr. Smith or Dr. Neophytides as an outpatient.

On July 8, 2010, Plaintiff presented to Dr. Snow, a neurosurgeon, for a postoperative consultation to address her complaints of headaches. Dr. Snow noted that Plaintiff had no weakness or pain post-operatively, however she did complain of new numbness in the right leg. On July 21, 2010, Dr. Snow ordered an MRI of the lumbar spine which revealed an "improvement of small residual disc herniation" with enhancing scar tissue. On July 22, 2010, Dr. Snow diagnosed Plaintiff with a "partial right foot drop following her discectomy."

On September 24, 2010, Plaintiff saw neurologist Dr. Hiesiger[1], who diagnosed her with post-operative neuropathic pain.

On October 15, 2010, Plaintiff presented to Dr. McCance, a neurosurgeon, for a second opinion. Dr. McCance noted that Plaintiff's "preoperative leg pain was gone" but Plaintiff had "increasing lower back pain in the central lumbosacral region, as well as a sense of numbness and weakness down the right leg, which is also increasing over time." It was also noted that Plaintiff has intermittent foot drop and that "[s]he feels that her gait is 'not right' but she can walk about a mile. Sitting is the worst position, causing increased lower back pain."

On December 29, 2010, Plaintiff returned NYU's ER. Plaintiff reported chronic pain that impaired her ability to engage in physical activity and upon examination, she was able to move all extremities with a full range of motion and steady gait when ambulating. Plaintiff complained of a worsening headache and neck pain. Following an infectious disease consultation, Plaintiff was diagnosed with probable aseptic meningitis, probably from herpes simplex virus, but given her history of a CSF leak, he also felt she was an elevated risk for bacterial meningitis as well. Plaintiff refused a lumbar puncture, and as a result, an empiric course of treatment was undertaken. The medical records note that over the next several days, Plaintiff's headaches improved with medication and she remained afebrile.

On January 3, 2011, Dr. Smith examined Plaintiff. Dr. Smith noted the surgery and her readmission one week later. Dr. Smith noted that the headaches had resolved and Plaintiff was discharged, but she did not follow up with him for their scheduled appointments as instructed. Dr. Smith wrote that Plaintiff treated with another spinal surgeon who managed her conservatively for CSF leak. Dr. Smith noted that Plaintiff was currently admitted and being treated empirically for meningitis, and wrote that: "incision healed. Right leg has 4/5 strength DF/PF but limited by her desire to not give full effort for fear of exacerbating her meningitis symptoms. Denies current or ongoing leg pain. Notes that she has right leg numbness and LBP as her primary

[1] Plaintiff commenced a medical malpractice action against Dr. Hiesiger on November 8, 2019 under Index No. 805372/2019.

complaints. I asked her to obtain copies of her non-NYU MRIs and come to see me in my office. She agrees to call for an appt."

Later that day, Plaintiff was examined by Dr. Neophytides. Dr. Neophytides performed a series of tests, and stated that his final impression was possible meningismus, and he did not believe she had meningitis and suspected her symptoms were due to muscle spasms that were part of her chronic pain. On January 4, 2011, Dr. Neophytides wrote that he discussed the case with Dr. Smith, "Dr. J. Brody, her psychiatrist; Dr. E. Kolodny, her internist; and with Dr. Rahimian from [infectious disease]," that [t]he neck stiffness continued unabated. [T]he headache was better, [and] [t]he neurological examination was normal." On January 5, 2011, Dr. Neophytides reviewed an MRI of her cervical spine which demonstrated a ridge/disc complex at C5-6 with minimal impingement on the cord, no cord distortion or abnormal cord signal, and with some straightening of the normal lordosis. Dr. Neophytides noted that the MRI result, while not usually significant, may be in this case because it was the only abnormality observed so far and he suspected it was causing her neck spasms. Dr. Neophytides ordered Plaintiff a soft cervical collar and prescribed her Valium. The medical records note that the plan was for Plaintiff to see him after discharge and to continue her physical therapy as an outpatient.

On January 7, 2011, Dr. Rahimian noted that Plaintiff was feeling well and improving. The medical record notes that Plaintiff was on Ceftriaxone and her "white blood cells stable." Dr. Rahimian's diagnosis remained neck pain and question of meningitis. Dr. Neophytides also wrote in the medical records that Plaintiff's primary complaint remained neck stiffness although her neck range of motion improved, and she was out of bed and ambulating. Dr. Neophytides' diagnosis remained neck pain and question of meningitis. Plaintiff was discharged home with instructions to follow up.

After Plaintiff's discharge on January 7, 2011, Plaintiff did not continue to treat with Defendants.

In July 2011, Dr. Hiesiger referred Plaintiff for physical therapy with a differential diagnosis that included Complex Regional Pain Syndrome.

Summary Judgment Standard

CPLR § 3212 provides in relevant part, that a motion for summary judgment,

> shall show that there is no defense to the cause of action or that the cause of action or defense has no merit. The motion shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party… [t]he motion shall be denied if any party shall show facts sufficient to require a trial of any issue of fact.

A defendant moving for summary judgment in a medical malpractice case has the burden of making a *prima facie* showing of entitlement to judgment as a matter of law by showing that "there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged" by introducing expert testimony that is supported by the facts in the record. *Rogues v. Nobel*, 73 A.D.3d 204, 206 [1st Dept. 2010]. Once the defendant has made this showing, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." *Alvarez v. Prospect Hospital,* 68 N.Y.2d 320, 324 [1986]. Specifically, a plaintiff "must submit an affidavit from a physician attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." *Rogues*, 73 A.D.3d at 207.

"As a general rule, employers are held vicariously liable for their employee' torts only to the extent that the underlying acts were within the scope of the employment." *Adams v. New York City Transit Auth.*, 88 N.Y.2d 116, 119 [1996]. The rule extends to medical facilities, who can be vicariously liable for the negligence or malpractice of their employees including their physicians. *Hill v. St. Clare's Hosp.*, 67 NY2d 72 [1986].

"[V]icarious liability for the medical malpractice of an independent physician may be imposed under a theory of apparent or ostensible agency." *Keesler v. Small*, 140 AD3d 1021, 1022 [2d Dept 2016] (citation omitted). "In order to create such apparent agency, there must be words or conduct of the principal, communicated to a third party, which give rise to the appearance and belief that the agent possesses the authority to act on behalf of the principal." *Id.* "The third party must reasonably rely on the appearance of authority, based on some misleading words or conduct by the principal, not the agent." *Id.* "Moreover, the third party must accept the services of the agent in reliance upon the perceived relationship between the agent and the principal, and not in reliance on the agent's skill." *Id.* (citation omitted).

"There are two elements to such a claim of apparent or ostensible agency." *Id.* "To establish the 'holding out' element, the misleading words or conduct must be attributable to the principal." *Id.* "To establish the 'reliance' element, the third party must accept the agent's services and submit to the agent's care in reliance on the belief that the agent was an employee of the principal." *Id.* "In the context of a medical malpractice action against a hospital, the patient must have reasonably believed that the physicians treating him or her were provided by the hospital or acted on the hospital's behalf." *Id.* (citation omitted).

A defendant moving for summary judgment on a lack of informed consent claim must show that there is no factual dispute as to whether the plaintiff was informed "of any foreseeable risks, benefits or alternatives" of the treatment rendered. *Balzola v. Giese*, 107 A.D.3d 587, 588 [1st Dept. 2013].

Parties' Experts

In support of Defendants' motion for summary judgment, Defendants submit the Affirmation of George DiGiacinto, M.D., ("Dr. DiGiacinto"), a physician, Board Certified in Neurological Surgery. According to DiGiacinto's Affirmation, he reviewed the pleadings, including the Verified Bills of Particulars, the Amended Bill of Particulars, medical records and radiology films and deposition transcripts. Dr. DiGiacinto opines with a reasonable degree of medical certainty "that the care rendered to plaintiff by NYU and the individually named physicians, was at all times appropriate and well within the standard of care and did not proximately cause plaintiff's alleged injuries." Dr. DiGiacinto opines that "plaintiff has essentially two claims in this case, the first is that the surgery was not indicated and more conservative treatment options should have been attempted; and the second claim is that the surgery was negligently performed. Both of these claims are without merit."

Dr. DiGiacinto opines that Plaintiff's complete and accurate history "was properly considered by the defendants and there was no additional history that was overlooked by the defendants." DiGiacinto states that:

> the defendants were aware that [Plaintiff] complained of pain from Sunday to Thursday and that she considered it to be debilitating. The defendants were aware of her prior surgical history including back surgery, following a car accident a number of years prior and an ablation procedure in her spine years earlier. They were also aware that she was an active young woman who was complaining of

> sustained debilitating pain interfering with her work and family obligations, despite the use of pain medication and muscle relaxers.

Dr. DiGiacinto opines that it was "not a departure to proceed with surgery after a period of a few days of pain and an overnight of IV pain medications and steroids" and that "[s] urgical intervention was indicated for Ms. Krembs based upon her presentation, history and radiological studies and there was no requirement to continue with conservative treatment for any additional period of time." Dr. DiGiacinto opines that Defendants "provided adequate evaluations and examinations." Specifically, Dr. DiGiacinto opines that on June 23, 2010, Plaintiff was examined by Dr. Neophytides "who felt her severe pain in combination with the MRI findings warranted further evaluation and possible surgery by a neurosurgeon and "[t]herefore properly sent plaintiff to Dr. Smith for further evaluation for potential surgery." Dr. DiGiacinto opines that Dr. Neophytides did not order or direct the surgery and it was properly the decision of Dr. Smith to direct the surgery. Dr. DiGiacinto states that Drs. Smith and Elliot's examination of Plaintiff on June 23, 2010, showed "severe debilitating pain, with some weakness and numbness in her right leg/foot." Dr. DiGiacinto opines that on June 24, 2010, Plaintiff was also examined by Dr. Smith, Dr. Neophytides, a Hospitalist and Dr. Kalhorn who found "no evidence that any further examinations were required and that all of plaintiff's physical symptoms and/or neurological deficits were appropriately understood, recognized and considered."

Dr. DiGiacinto opines that "plaintiff's complaints of pain were appropriately monitored and treated/managed from June 23rd to her surgery on June 24th." Dr. DiGiacinto opines that Plaintiff was properly given "morphine 6mg every four hours, Percocet, and steroids every six hours" based on plaintiff's complaints of debilitating pain and "that the appropriate amounts of each medication were timely given to this patient." Dr. DiGiacinto opines "that it became obvious by the morning of June 24th that pain medications were not a durable solution to her complaints because despite her receiving powerful pain medications, including morphine, steroids and opiates she still have severe debilitating pain."

As to other potential treatments, Dr. DiGiacinto opines that "there were no conservative treatment options, including physical therapy, that could have corrected the disc herniation and relieved her pain in a reasonable period of time, given the severity of her symptoms." Dr. DiGiacinto opines that "there is no requirement to attempt any certain period of conservative treatment before performing back surgery and it is not a deviation from the standard of care to performed back surgery after a few days of symptoms and/or during an initial hospital presentation." Dr. DiGiacinto

states that he agrees "with Dr. Smith that overnight was a sufficient period to observe Ms. Krembs in light of her lack of durable pain relief from her pain medications." Dr. DiGiacinto further opines "that the longer her nerve root was compressed, while she was observed or provided conservative care, the higher her risk would be of a lasting nerve injury."

Dr. DiGiacinto opines that "the neurologic deficits and the patient's subjective complaints of severe pain correlated with MRI findings and provided a proper basis to recommend surgery." Dr. DiGiacinto opines that "the fact that neurologic deficits were already present when Ms. Krembs presented, which had the potential to become permanent or worse, were a further indicator for surgical intervention." Dr. Dr. DiGiacinto opines that "Dr. Smith and Dr. Neophytides were attendings and were not required to seek out other opinions on their treatment options." Dr. DiGiacinto opines "that Dr. Smith, in consideration of her history, complaints, and physical exam, made the decision to recommend surgical treatment with the plaintiff's informed consent on June 24th" and Dr. Neophytides was not responsible for obtaining informed consent for the surgery. Dr. DiGiacinto opines that "Dr. Neophytides did not participate in the subject surgery and all the surgical claims must be dismissed against him."

As to the claim of lack of informed consent, Dr. DiGiacinto opines that "all relevant risks, benefits and alternatives were properly discussed with plaintiff by Dr. Smith then confirmed by Dr. Kalhorn." Dr. DiGiacinto opines that "any reasonable person would have consented to the Tisseel placement to prevent potential CSF leaks." DiGiacinto opines that "Dr. Smith discussed the risks of surgery, including infection, hemorrhage, CSF leak, nerve injury with numbness weakness, paralysis, reherniation, and failure to cure/improve." Dr. DiGiacinto opines that "Dr. Kalhorn also advised plaintiff of the risks of the procedure including the risk of bleeding, infection, spinal fluid leak, need for reoperation, need for a fusion, chance of disc reherniation, chance of partial improvement or even failure to completely improve."

Dr. DiGiacinto opines that Defendants did not negligently cause nerve and dural damage as a result of the June 24, 2010 surgery. Dr. DiGiacinto opines "that any CSF oozing through the thinned dura was properly treated" by Dr. Smith. Dr. DiGiacinto opines "that Plaintiff had an abnormally thin dura and during the surgery she had some oozing which was noticed immediately during the June 24, 2010 procedure" and that "[c]onsiderations for possible etiology would be an unknown anatomical anomaly, her prior ablation procedure and/or her prior epidural injections." Dr. DiGiacinto opines that a dural tear occurring during surgery "is a known complication that is not a deviation from the standard of care." Dr. DiGiacinto opines "there is no evidence that Dr. Smith or the defendants negligently

caused the dural leak, it is also my opinion it was recognized and appropriately treated immediately thereafter and that the use of Tisseel was proper in this case." Dr. DiGiacinto opines that "there is no radiographic evidence of plaintiff acquiring a lasting nerve injury from the procedure performed by Dr. Smith on June 24, 2010 and it is notable that she has a separate action against a pain management physician claiming the same injuries." Dr. DiGiacinto opines that within "a reasonable degree of neurosurgical certainty that plaintiff's claims of any nerve damage following this procedure are baseless, however, any claimed damage in this case would have been the result of her compressed nerve root in the days leading up to surgery and not related to the performance of the surgery, which was properly and skillfully performed."

Dr. DiGiacinto opines that Plaintiff "was properly managed in the post-operative period." Dr. DiGiacinto opines "that the surgery did not proximately cause plaintiff's alleged injuries. Instead, the surgery gave her the best possible outcome because all alternatives would have only treated her symptoms and not her underlying disc herniation." Dr. DiGiacinto opines "that plaintiff's alleged injury of complex regional pain syndrome is meritless." Dr. DiGiacinto opines that "Ms. Krembs post-operative symptoms are inconsistent with this disease as she did not complain of back pain until late July 2010 (nearly a month after surgery) and she did not have any complaints in the post-operative period from June 24th to September 2010 of swelling, redness, change in the temperature, persistent unchanging pain in her right limb or hypersensitivity." Dr. DiGiacinto opines that "plaintiff's own post-operative pain management treating physician and paid expert, Dr. Emile Hiesiger, testified that even after years of treating Ms. Krembs that it is his opinion to a reasonable degree of medical certainty that she never met the criteria for a diagnosis of complex regional pain syndrome as she had a period without complaints of pain, no integument changes (changes to the hair and nails) and a lack of edema." Dr. DiGiacinto further opines that "defendants were not in charge of her long term medications and did not cause any alleged injuries from her medications." Dr. DiGiacinto opines that Plaintiff's claims nerve/tissue injuries, scarring and/or CSF leak headaches "are known potential complications of spinal surgery that can, and do, exist in the total absence of negligence." Dr. DiGiacinto opines "that there is no evidence whatsoever that any nerve/tissue injuries, scarring and/or CSF leak headaches were caused by any negligence, wrongdoing or departures from the standard of care by the defendants."

In opposition, Plaintiff submits the Affirmation of Mehrdad Golzad, M.D., ("Dr. Golzad"), a Board Certified physician in Neurology, Electrodiagnostic Medicine and Brain injury Medicine. According to Dr. Golzad's Affirmation, he reviewed the pleadings, including the medical records and deposition transcripts. Dr.

Golzad opines that that Drs. Neophytides and Smith deviated from good and accepted practice by performing the surgery "on a virtually emergency basis, bypassing the standard of care pain control for patients in Ms. Krembs' nonemergency condition, depriving her the opportunity for treatment without surgery." Dr. Golzad opines that:

> In evaluating and treating patients with low back pain, experienced physicians follow a three-pronged strategy in order to minimize risk, maximize pain relief and achieve a satisfactory functional outcome: 1) exclude an emergency surgical situation; 2) provide adequate pain relief as part of a conservative (non-surgical) treatment regimen; and 3) only with persistence of intractable pain after several weeks of adequate conservative management, consider discectomy to alleviate disc compression of the adjacent nerve root. Thus, the criteria for emergency surgery is where there is no alternative therapy, and any delay could result in death, disfigurement or permanent neurological deficits.

Dr. Golzad opines that "Defendants provided a substandard and relatively minimal pain regimen for acute sciatica in terms of doses and medications, not to mention a lack of other treatments as required under the standard of care." Dr. Golzad opines that "the fact that [Plaintiff] responded so favorably to very low doses of pain medications, demonstrated the adequacy of a non-invasive treatment approach, thereby strengthening the disproportionate and superfluous nature of immediate surgery." Dr. Golzad opines that Drs. Neophytides and Smith "did not provide appropriate treatments and medications for her pain, improperly dosed medications that they did provide, did not evaluate Ms. Krembs' response to their treatments, did not take Ms. Krembs' actual clinical course and response into consideration when making treatment choices, did not get appropriate consultations and make necessary referrals including to pain management, and did not provide or refer her to other treatment modalities consistent with the standard of care such as physical therapy." Dr. Golzad opines that "under the standard of care, if either of Drs. Neophytides and Smith opined that Ms. Krembs' pain was not stabilizing adequately, not only should the morphine dose have been increased, but more potent analgesics, such as Percocet (50% stronger than morphine) or Dilaudid (2-8 times stronger than morphine) should have been given." Dr. Golzad opines that "it was a departure from good and accepted practice for Drs. Neophytides and Smith to not provide and not refer Ms. Krembs initially to a pain management physician who

could evaluate her for [injections of steroids directly into the epidural space] as part of a comprehensive conservative care program."

Dr. Golzad opines that Defendants improperly recommended surgery. Dr. Golzad opines that "Defendants improperly based their recommendation to Ms. Krembs that surgery was in her best interest, upon her purportedly inadequate response to their pain control." Dr. Golzad states that Dr. Smith wrote in his June 24, 2010, operative report:

> She was admitted to the hospital for acute medical management; however, she failed to have symptomatic improvement with IV narcotics and IV steroids. She was functionally incapacitated; therefore I recommend early microsurgical excision.

Dr. Golzad opines that Dr. Neophytides departed from good and accepted medical practice when "he did not correct his initial emergency and/or imminent surgery assessment, and neither informed Dr. Smith that she did not clinically qualify for imminent surgery, nor did he inform Ms. Krembs that she did not have an emergency and surgery was not emergently and/or imminently required" prior to the surgery. Dr. Golzad opines that after the surgery, Plaintiff had a "new spectrum of problems she ultimately developed were the result of Dr. Smith's surgery: right leg weakness and numbness, dropped right foot, neuropathic pain, Complex Regional Pain Syndrome, opioid dependence and addiction, and severe spinal headaches as a result of a surgical dural tear causing a cerebrospinal fluid (CSF) leak."

Dr. Golzad opines that Defendants failed to obtain informed consent for surgery. Dr. Golzad opines that "Dr. Smith did not tell Ms. Krembs that her condition was not an emergency and did not require emergency and/or imminent surgery even though he knew or should have known she was under that impression and minimized the actual expected effectiveness of conservative care treatment, which resulted in Ms. Krembs not having all information a reasonable patient would want prior to deciding to have surgery." Dr. Golzad opines that Dr. Smith "also failed to offer the alternative of comprehensive conservative care, including referral to a pain management physician, as part of a non-surgical approach and delay consideration of surgery for at least six to twelve weeks to assess her response to that program."

Additionally, Plaintiff submits the Affirmation of Michael Flomenhaft, Esq. ("Mr. Flomenhaft"). Mr. Flomenhaft asserts that "Defendants fail to submit any documentary evidence establishing, *prima facie*, that Dr. Smith was not under the Hospital's control and was not its agent when he rendered care to Susan Krembs."

Mr. Flomenhaft argues that Defense "Counsel asserts only that 'Dr. Smith was employed by NYU School of Medicine' (Def. Atty. Barresi Aff. at ¶78) and leaves it at that. There is not one piece of documentary evidence offered to demonstrate that Dr. Smith was not an agent in fact of Langone." Mr. Flomenhaft asserts that "Susan Krembs entered the emergency room seeking treatment from Langone, a hospital she had gone to many times in the past... She was to be evaluated there by a physician that Dr. Neophytides thought that he may have been on call [Def. Ex. H, pp. 125-126]. She signed what was at the time a blank consent form signature page (Def. Ex. G, pp. 308-309, 336, Ex. 2, pp. 30, 31) that bore the logo of Langone."

In Reply, Defendants assert that Dr. Golzad's Affirmation fails to set forth a sufficient foundation to issue an opinion as to the care and treatment by Dr. Smith. Defendants argue that Dr. Golzad is a neurologist and not a neurosurgeon, and "cannot affirm that he has knowledge regarding the applicable standard of care for neurosurgeons." Defendants assert that therefore, Dr. Golzad's Affirmation must not be considered as to Dr. Smith and NYU. Furthermore, Defendants argue that Dr. Golzad "does not perform microdiscectomy procedures there is no basis to believe that he is knowledgeable of the risks, alternatives, and/or benefits of the procedure" and therefore, Plaintiff's informed consent claim should be dismissed.

Defendants argue that even if Dr. Golzad's Affirmation is considered as to the care and treatment rendered, Plaintiff still fails to establish a genuine issue of fact as it is conclusory, overly speculative and is based on incorrect and/or misleading evidence. Defendants assert that Plaintiff's surgery was not performed on a "virtually emergency basis" and an attempt at conservative treatment was made by Defendants. Defendants further assert that Plaintiff's claim that she should have been referred to a pain management physician should be disregarded because it is not in the Bill of Particulars.

Defendants assert that "plaintiff has not opposed NYU Langone's request that any direct claims against the Hospital be dismissed." Defendants argue that "any vicarious liability claims premised on the employment of Dr. Elliott and Dr. Kalhorn must be dismissed as their motion for summary judgment is unopposed. Defendants further argue that "Plaintiff acknowledge that NYU Langone was not vicariously liable for any care by Dr. Neophytides." Defendants argue that Dr. Smith was employed by NYU School of Medicine and not NYU Langone. Defendants assert that Dr. Smith testified on March 10, 2017:

Q: Are you an employee of that practice?

> A: Technically, I am an employee of the School of Medicine, that is what the paychecks say.

Dr. Smith further testified:

> Q: How long have you been an employee of the School of Medicine?
>
> A: Since-initially employment was in October 2009.

Defendants argue that "Plaintiff's counsel even filed a motion to seek to Amend their Complaint to add claims against NYU School of Medicine based upon the doctrine of vicarious liability, which pursuant to the December 6, 2017 Order was granted, but plaintiff ultimately abandoned the claims by failing to serve the School of Medicine." Defendants further argue that Plaintiff's agency arguments are misplaced. Defendants assert that

> Plaintiff went to Dr. Neophytides' office (not at the Hospital) upon a recommendation from her primary care physician, Dr. Kolodny. Dr. Neophytides then referred Ms. Krembs directly to Dr. Smith who happened to have privileges at NYU Langone. Therefore, the Hospital never assigned plaintiff to Dr. Smith, but rather Ms. Krembs was referred to Dr. Smith by her private treating neurologist Dr. Neophytides.

Discussion

Preliminarily, Plaintiff has withdrawn all claims asserted against Drs. Kalhorn and Elliot. Thus, Defendants' motion for summary judgment on the negligent surgical techniques and informed consent causes of action as to Drs. Kalhorn and Elliot is granted.

Turning to the portion of the summary judgment motion seeking to dismiss all claims as to NYU, Plaintiff has acknowledged that NYU was not vicariously liable for the care by Drs. Kalhorn, Elliot, and Neophytides. Plaintiff has failed to show there exists "material issues of fact which require a trial of the action" on

whether NYU is vicariously liable for the care rendered by Dr. Smith. *Alvarez*, 68 N.Y.2d at 324. Plaintiff filed a motion to Amend her Complaint and add claims against NYU School of Medicine based upon the doctrine of vicarious liability, which was granted on December 6, 2017. Plaintiff failed to serve NYU School of Medicine. On February 3, 2021, Plaintiff brought a new motion under Motion Sequence 7, to extend the time to serve NYU School of Medicine with the Supplemental Summons, Amended Verified Complaint and Certificate of Merit. On March 24, 2021, the Court denied Plaintiff's motion, finding Plaintiff failed to show that she established good cause for the requested extension or that the extension was warranted in the interest of justice. Plaintiff concedes that she failed to serve NYU School of Medicine within the statute of limitations. Therefore, Defendants' summary judgment motion as to NYU is granted.

Defendants make a *prima facie* showing of entitlement to summary judgment as to the care rendered by Drs. Neophytides and Smith. *Alvarez,* 68 N.Y.2d at 324. Defendants, through Dr. DiGiacinto's Affirmation, demonstrate "that the care rendered to plaintiff by NYU and the individually named physicians, was at all times appropriate and well within the standard of care and did not proximately cause plaintiff's alleged injuries."

Dr. DiGiacinto opines that it was "not a departure to proceed with surgery after a period of a few days of pain and an overnight of IV pain medications and steroids." Dr. DiGiacinto opines that "[s]urgical intervention was indicated for Ms. Krembs based upon her presentation, history and radiological studies and there was no requirement to continue with conservative treatment for any additional period of time." Dr. DiGiacinto opines that "Dr. Neophytides did not participate in the subject surgery and all the surgical claims and informed consent claim must be dismissed against him." Dr. DiGiacinto opines that Dr. Neophytides did not order or direct the surgery and it was properly the decision of Dr. Smith to direct the surgery. Dr. DiGiacinto opines that "plaintiff's complaints of pain were appropriately monitored and treated/managed from June 23rd to her surgery on June 24th." Dr. DiGiacinto opines that Plaintiff was properly given "morphine 6mg every four hours, Percocet, and steroids every six hours" based on plaintiff's complaints of debilitating pain. Dr. DiGiacinto opines that "the fact that neurologic deficits were already present when Ms. Krembs presented, which had the potential to become permanent or worse, were a further indicator for surgical intervention." Dr. DiGiacinto opines that "Dr. Smith and Dr. Neophytides were attendings and were not required to seek out other opinions on their treatment options." Dr. DiGiacinto opines that "there were no conservative treatment options, including physical therapy, that could have corrected the disc herniation and relieved her pain in a reasonable period of time, given the severity of her symptoms." Dr. DiGiacinto further opines "that the longer her nerve

root was compressed, while she was observed or provided conservative care, the higher her risk would be of a lasting nerve injury."

Dr. DiGiacinto opines that Defendants did not negligently cause nerve and dural damage as a result of the June 24, 2010 surgery. Dr. DiGiacinto opines "that any CSF oozing through the thinned dura was properly treated" by Dr. Smith. Dr. DiGiacinto opines "that Plaintiff had an abnormally thin dura and during the surgery she had some oozing which was noticed immediately during the June 24, 2010 procedure" and that "[c]onsiderations for possible etiology would be an unknown anatomical anomaly, her prior ablation procedure and/or her prior epidural injections." Dr. DiGiacinto opines that a dural tear occurring during surgery "is a known complication that is not a deviation from the standard of care." Dr. DiGiacinto opines "there is no evidence that Dr. Smith or the defendants negligently caused the dural leak, it is also my opinion it was recognized and appropriately treated immediately thereafter and that the use of Tisseel was proper in this case." Dr. DiGiacinto opines that "there is no radiographic evidence of plaintiff acquiring a lasting nerve injury from the procedure performed by Dr. Smith on June 24, 2010 and it is notable that she has a separate action against a pain management physician claiming the same injuries." Dr. DiGiacinto opines that within "a reasonable degree of neurosurgical certainty that plaintiff's claims of any nerve damage following this procedure are baseless, however, any claimed damage in this case would have been the result of her compressed nerve root in the days leading up to surgery and not related to the performance of the surgery, which was properly and skillfully performed."

Dr. DiGiacinto opines that Plaintiff "was properly managed in the post-operative period." Dr. DiGiacinto opines "that plaintiff's alleged injury of complex regional pain syndrome is meritless." Dr. DiGiacinto opines that:

> Ms. Krembs post-operative symptoms are inconsistent with this disease as she did not complain of back pain until late July 2010 (nearly a month after surgery) and she did not have any complaints in the post-operative period from June 24th to September 2010 of swelling, redness, change in the temperature, persistent unchanging pain in her right limb or hypersensitivity.

Dr. DiGiacinto further opines that "defendants were not in charge of her long term medications and did not cause any alleged injuries from her medications." Dr. DiGiacinto opines that Plaintiff's claims nerve/tissue injuries, scarring and/or CSF

leak headaches "are known potential complications of spinal surgery that can, and do, exist in the total absence of negligence."

Since Defendants have made a *prima facie* showing of entitlement to summary judgment, the burden now shifts to Plaintiff to demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action. *Lindsay-Thompson*, 147 A.D.3d at 639. Plaintiff submits the Affidavit of Dr. Golzad, which show "material issues of fact which require a trial of the action." *Alvarez,* 68 N.Y.2d at 324. Dr. Golzad sets forth a sufficient foundation to issue an opinion as to the care and treatment by Drs. Smith and Neophytides and will be considered by the Court. Dr. Golzad opines that that Drs. Neophytides and Smith deviated from good and accepted practice by performing the surgery "on a virtually emergency basis, bypassing the standard of care pain control for patients in Ms. Krembs' nonemergency condition, depriving her the opportunity for treatment without surgery." Dr. Golzad opines that "Defendants provided a substandard and relatively minimal pain regimen for acute sciatica in terms of doses and medications, not to mention a lack of other treatments as required under the standard of care." Dr. Golzad opines that "the fact that [Plaintiff] responded so favorably to very low doses of pain medications, demonstrated the adequacy of a non-invasive treatment approach, thereby strengthening the disproportionate and superfluous nature of immediate surgery." Dr. Golzad opines that "it was a departure from good and accepted practice for Drs. Neophytides and Smith to not provide and not refer Ms. Krembs initially to a pain management physician who could evaluate her for [injections of steroids directly into the epidural space] as part of a comprehensive conservative care program."

Dr. Golzad opines that Dr. Smith departed "from good and accepted practice, [when] Dr. Smith performed surgery despite: i) only observing her response to treatment for less than 24 hours (actually only overnight for approximately 6-8 hours), a far-too short period of time under the standard of care; ii) providing an inadequate pain-control regimen; and iii) disregarding Ms. Krembs' actually good clinical response to their insufficient pain-control regimen." Dr. Golzad opines that Dr. Neophytides departed from good and accepted medical practice when "he did not correct his initial emergency and/or imminent surgery assessment, and neither informed Dr. Smith that she did not clinically qualify for imminent surgery, nor did he inform Ms. Krembs that she did not have an emergency and surgery was not emergently and/or imminently required" prior to the surgery. Dr. Golzad opines that after the surgery, Plaintiff had a "new spectrum of problems she ultimately developed were the result of Dr. Smith's surgery: right leg weakness and numbness, dropped right foot, neuropathic pain, Complex Regional Pain Syndrome, opioid dependence and addiction, and severe spinal headaches as a result of a surgical dural

tear causing a cerebrospinal fluid (CSF) leak." Plaintiff has satisfied her burden of showing an issue of fact as to whether the assessment that Plaintiff presented as an emergency or required imminent surgery deviated from the standard of care, and Defendants' motion for summary judgment on the medical malpractice cause of action as to Drs. Neophytides and Smith is denied.

Defendants' expert claims Plaintiff does not suffer from CRPS as a result of the 2010 surgery. Defendants' expert argues that Plaintiff does not present with swelling, redness, change in the temperature, persistent unchanging pain in her right limb or hypersensitivity. Plaintiff's expert does not address the absence of such symptoms. Instead, Plaintiff's expert relies on the diagnosis of CRPS being "confirmed by the physical therapist." This is insufficient to rebut Defendant's showing that Plaintiff does not suffer from CRPS as a result of the 2010 surgery. Defendants' motion is granted to the extent that the claim that Defendants' negligence resulted in Plaintiff suffering from CRPS should be dismissed.

Lastly, Defendants are entitled to summary judgment for Plaintiff's lack of informed consent claim. Plaintiff signed the "Consent for Surgery and/or Interventional Procedures and Medical Treatment" on June 24, 2010. (Exhibit E at 30-31). Dr. DiGiacinto opines that "all relevant risks, benefits and alternatives were properly discussed with plaintiff by Dr. Smith then confirmed by Dr. Kalhorn." *See* Zelefsky. DiGiacinto opines that "Dr. Smith discussed the risks of surgery, including infection, hemorrhage, CSF leak, nerve injury with numbness weakness, paralysis, reherniation, and failure to cure/improve." Dr. DiGiacinto further opines that "Dr. Kalhorn also advised plaintiff of the risks of the procedure including the risk of bleeding, infection, spinal fluid leak, need for reoperation, need for a fusion, chance of disc reherniation, chance of partial improvement or even failure to completely improve." Plaintiff signed a form which indicated that she was informed "of any foreseeable risks, benefits or alternatives" of the treatment rendered by Dr. Smith. *Balzola*, 107 A.D.3d at 588. Plaintiff in opposition has failed to raise an issue of fact.

Wherefore, it is hereby

ORDERED that Defendants' motion for summary judgment is granted to the extent that Plaintiff Susan Kremb's negligent surgical techniques and informed consent claims are dismissed as to Defendants Stephen Paul Kalhorn, M.D. and Robert E. Elliott, M.D; Plaintiff Susan Kremb's direct and vicariously liability claims are dismissed as to Defendant NYU Langone Hospitals Center; and Plaintiff Susan Kremb's claims for lack of informed consent are dismissed and the Clerk is directed to enter judgment accordingly and dismiss the action as to Defendants

Stephen Paul Kalhorn, M.D., Robert E. Elliott, and NYU Langone Hospitals Center; and it is further

ORDERED that Defendants' motion for summary judgment is denied as to all remaining claims as against Defendants Andreas N. Neophytides, M.D. and Michael Louis Smith, M.D.

This constitutes the Decision and Order of the Court. All other relief requested is denied.

Dated: September 9, 2021

EILEEN A. RAKOWER, J.S.C.

Check one: FINAL DISPOSITION X NON-FINAL DISPOSITION