



Editorial

Based upon 7.2% of the Eligible Voting Members, the American Association of Neurological Surgeons (AANS) Suspended Dr. Nancy E. Epstein for Arguing Against Unnecessarily Extensive Spine Surgery

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This is the fourth and final editorial describing my experience with the AANS and the AANS Expert Witness Rules. As explained in my first editorial (“Why I testify for some patients/plaintiffs, and against some doctors/defendants”), I testify in cases in which I believe the plaintiff/patient was a victim of unnecessary, inappropriate, and/or negligent surgery. In my second editorial (“Does the American Association of Neurological Surgeons seek to limit members from testifying for patients/plaintiffs through proceedings resembling a kangaroo court and/or star chamber?”), I supplied evidence for my opinion that the answer to that question is YES! Finally, in the third editorial (“The American Association of Neurological Surgeons (AANS) Suspends Surgeon for Arguing Against Unnecessarily Extensive Spine Surgery; Was this Appropriate?”), I detailed the AANS’ actions up to and including the Nov. 16, 2018 AANS’ Board of Directors’ decision that I be suspended for 6 months. Here is what happened next.

According to the AANS rules, after the Board of Directors recommends a suspension, I can appeal their decision to the membership, which I did. Until recently the members voted on the appeal at the general business meeting. Interestingly, these rules were changed in 2018. According to the new procedures, members are now asked to vote electronically without the benefit of any discussion at the business meeting. In any case, consistent with the new AANS procedures, I wrote a letter stating my case (attachment A) and the President of the AANS wrote a letter to the members (attachment B) in response. Upon viewing the Presidents letter, I sent an email to the President (attachment C) detailing several misleading statements, and in some cases frank misrepresentations of the truth. Both attachments A and B were available on the internet for the voting members of the AANS to see prior to their voting electronically, but attachment C was not.

There are several troubling aspects of what ensued. First, my corrections, attachment C, regarding the inaccuracy in the President’s letter, were never conveyed to the membership. Second, I documented that two members of the AANS Board had clear conflicts of interest (COI). In one case, in April 2018, I had previously alerted the AANS of Dr. Haid’s COI, yet he was at the Nov 16th Board meeting, although he allegedly abstained from the vote (see appendix A). In the second case, I only learned after the Nov. 16th meeting that another member of the Board,

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Dr. Schaffrey, the President-elect of the AANS at that time, had a clear COI, having received substantial money from the manufacturer of the instrumentation involved in the TLIF, according to ProPublica. Yet, he took an active part in the proceedings of Nov 16th, including questioning me, although he did “abstain” for the vote. The AANS lawyer, informed us via letter that “The AANS requires members serving on committees to submit conflict of interest disclosure forms in connection with their service.” However, either this was not true in this case or the AANS allows individuals to take part in discussions when they have a clear COI. As the current President, Dr. Schaffrey signed the letter suspending me based upon “a majority vote of those voting members of the AANS casting ballots”. Finally, we learned from the AANS lawyer that only 500 of the 5400 AANS members eligible

to vote actually voted; 389 voted in favor of the Board’s recommendation, 104 voted against it (in my favor), and 7 ballots were without a vote. Thus, I was suspended based upon the vote of 7.2% of the AANS members!

Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Journal or its management.

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APPENDIX

Appendix A

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February 14, 2019

Re: My appeal of an AANS Suspension

Dear Colleagues and Fellow AANS Members,

As a neurosurgeon of 37 years, and an AANS member of 35 years, I appeal to your collective sense of judgment, fairness, and decency. I have been unfairly targeted by the Professional Conduct Committee (PCC) for expert testimony in which I testified that two fellow neurosurgeons (Dr. McLaughlin and his partner Dr. Joseffer) performed an unnecessary and risky TLIF surgery, causing injury to a patient. The PCC stated that I did not identify opinions that varied significantly from generally accepted neurosurgical practice, and did not correctly represent the full standard of neurosurgical care. Ex. 4: Expert Opinion Rules A(3 & 4).

However,

- After seeing Dr. McLaughlin, the patient saw Dr. David Matusz for a second opinion. Dr Matusz agreed with me: this patient did *not* need a TLIF; and
- I candidly acknowledged at trial that, notwithstanding my professional opinion about TLIF surgery, it is performed “widely throughout the country” (Ex. 2, 14/23); “many doctors disagree” with my opinion (*id.* 15/1); TLIFs “are done all across the country, even for lesser indications” (*id.* 62/13); and “some would consider this [surgery] within the standard of care to proceed” with this patient (*id.* 63/10).

I was candid, forthright, and complied with the Expert Opinion Rules in every respect. Yet based on a complaint

by Dr. McLaughlin, the PCC and then the AANS Board punished me for expressing a thoughtful, evidence-based, expert opinion.

This decision is troubling in multiple respects. First, as the decision admits, it is based on the PCC’s substantive disagreement with my opinion. Based on its own incomplete record, the PCC believed TLIF was appropriate for this patient. But the PCC does not exist to enforce neurosurgical dogma upon thousands of members. It cannot dictate opinions to members. It exists only to enforce the AANS Code of Ethics and Expert Opinion Rules, with which I complied.

Second, the PCC appears to favor defendants in malpractice cases over patients. To my knowledge, the PCC has not punished surgeons who perform unnecessary or risky surgery, but does punish surgeons who testify that other surgeons perform such surgeries. That is not an appropriate role for the AANS, or for any medical organization.

Third, neither the PCC nor the Board disclosed potential conflicts in this case. I do not know how many members of the PCC or the Board perform TLIF; how often they perform them; what their compensation is from performing the surgery; whether and to what extent they are paid by Medtronic (the manufacturer of the procedure); or their relationships, if any, with Drs. McLaughlin and Joseffer. It is a basic rule of due process and fundamental fairness that decisionmakers in a disciplinary proceeding disclose all conflicts and recuse themselves if they are conflicted. Here, no one would disclose whether they had a conflict.

AANS does not exist to enforce a white wall of silence, or to stifle a legitimate debate about patient safety. I urge you to exercise fairness and uphold the integrity of this organization.

Please vote against this humiliating and unjust membership suspension.

My Background

My father, Joseph A. Epstein was a well-known and talented neurosurgeon, who received a lifetime achievement award from the AANS/CNS Spine Section about 20 years ago. At age 5, I decided I wanted to be, like him, a neurosurgeon. He drilled into me that medicine is always about “what is best for the patient,” and encouraged me to get the best education and training possible. I went to Barnard College/ Columbia College as an undergraduate, and medical school at Columbia University College of Physicians and Surgeons. I did my neurosurgical residency at NYU-Bellevue with Dr. Joe Ransohoff and was the first female neurosurgeon he trained.

In 1984, I became the 12th board certified female neurosurgeon in the United States. I am on the editorial boards of Spine (since 1990), JSDT/CSS, (since 1990), The Spine Journal, (since its inception); Surgical Neurology International SPINE, and am now Editor-in-Chief of Surgical Neurology International. I was Program Chair for the Spine Section AANS/CNS 1993, and the CSRS 1996. Like my father, I was President of the Cervical Spine Research Society (he in 1981, I in 2001). From 1992 to 2001, I was the Chief of Neurosurgery at NSUH, and am presently Chief of Neurosurgical Spine/Research/Education at NYU Winthrop Hospital. I have held the rank of Clinical Professor of Neurological Surgery at The Albert Einstein College of Medicine in New York, and am presently Clinical Professor of Neurological Surgery at the State University of New York at Stony Brook.

I have over 300 peer-reviewed publications, mostly on the spine. The attached letter from Dr. James Ausman describes my background in some more detail. Ex. 8.

Testifying for Patients

I am a surgeon first and foremost. I do not enjoy being in court and much prefer being in the operating room. For many years, I also refused to testify for plaintiffs in medical malpractice cases. But I became sick of seeing how many patients were being damaged by unnecessary, inappropriate, and negligent surgery. The patient comes first, and so on occasion, I will testify for a patient who has been maltreated by one of my colleagues.

This Case

This, unfortunately, was such a case. The patient was a 65+-year old, hypertensive, osteopenic, inactive, obese female with mild radiculopathy attributed to mild/moderate L4-L5

spinal stenosis and grade I degenerative spondylolisthesis (no motion on dynamic X-rays).

According to Dr. McLaughlin, she had “mild to moderate stenosis, that the sagittal T2 does not demonstrate the amount of stenosis that I see on axial T2 images and there was no movement on the flexion extension and her bone scan was negative.”

The patient initially saw Dr. McLaughlin on two occasions, and scheduled surgery with him. She then obtained a second opinion from Dr. David Matusz at the Hospital for Special Surgery. Dr. Matusz graduated from Columbia University College of Physicians and Surgeons, did his residency at Lenox Hill Hospital, received a fellowship at Johns Hopkins University, and is an orthopedic surgeon at Lenox Hill. Ex. 1 at 5-9. I do not know Dr. Matusz. Dr. Matusz recommended lumbar laminectomy, *without* fusion. *Id.* 15/20, 19-20. As Dr. Matusz testified, “I would err on the side of a decompression operation in the vast majority of cases.” *Id.* 19/6-8. The patient then scheduled her surgery with Dr. Matusz.

Due to a blizzard, the patient’s decompression surgery with Dr. Matusz was postponed, and as a result of his busy schedule, and subsequent lack of availability, the patient rescheduled surgery with Dr. McLaughlin instead. A few days before the surgery, Dr. McLaughlin announced that his younger partner, Dr. Joseffer, would perform the surgery. The patient met Dr. Joseffer for the first time shortly before the surgery. Dr. Joseffer had never spoken to, or examined, the patient, and he performed a minimally invasive (MI) TLIF, not a decompression.

As a result of the surgery, the patient woke up with a new, permanent, right-sided foot drop attributed to a stretch injury.

My Testimony at Trial

The patient asked me to review the case. Upon review, I agreed with Dr. Matusz that a fusion (including MI TLIF) was not necessary. At trial, I testified that given the patient’s minimal neurological deficit, “she could have easily been followed on a conservative basis without surgery.” Ex. 2 at 58/12. If surgery were performed, “I would have just done a decompressive laminectomy,” *id.* 63/23, the same surgery Dr. Matusz recommended. I also described how and why a laminectomy was a safer procedure for the patient than a TLIF, *id.* 66- 71, 79-81, and that this unnecessary and more dangerous procedure caused her foot drop, *id.* 82- 88, 97.

I also testified more generally that TLIF is not “a good operation to deal with the majority of pathology that’s out there. I think there are better safer more conservative

alternatives to lumbar spine surgery; particularly discectomy and even degenerative spondylolisthesis.” *Id.* 13/21.¹ However, I also acknowledged that many doctors disagree with this general view. For example:

1 Articles Documenting Risks of TLIF

Chrastil *et al.* Spine 2013: 17 articles about the complications with BMP TLIF/PLIF; these included heterotopic ossification within the epidural space or neuroforamina, postoperative radiculitis, and endplate osteolysis with interbody device subsidence.

Zhang *et al.* Medicine 2016 confirms the comparable efficacy of fusion for PLF vs. TLIF. Bakhsheshian *et al.* J Clin Neurosci 2016 further confirmed 5 MIS TLIF graft/cage extrusions in 513 patients

Joseph *et al.* Neurosurg Focus 2015: 5454 MI TLIF: 1045 complications-rate per patient was 19.2% in the MI-TLIF group ... sensory, temporary neurological deficits, permanent neurological deficits respectively 20.16%, 2.22%, and 1.01% for MI-TLIF ... Rates of intraoperative and wound complications were 3.57% and 1.63% for MI- TLIF

Giorgi *et al.* Orthop Traumatol Surg Res 2015: MI TLIF 182 cases: The rate of postoperative complications was 7.7%.

Liu J, Eur Spine J 2016: In this series, 101 TLIF: 2 cases (1.9 %) root dysfunction, dural tears TLIF 4 cases (3.9 %), re-operation rate TLIF 2 cases (1.9 %), wound infection TLIF 5.0%

Klingler *et al.* Scientific World Journal 2015: more durotomy with MIS TLIF: 372 patients: 32 durotomies (514 levels) (6.2%). Correlated with age over 65 and obesity (Marlowe 66 and obese)

Norton Spine 2015: Degenerative spondylolisthesis: Patients who had TLIF + higher risk of mortality than patients who had PLF

Nixon AT Surgical Neurol Int. 2014 Of 340 TLIF, 4 (1.2%) new lower extremity weakness (with degenerative spondylolisthesis).

Park Y Clin Orthop Surg 2015: Perioperative complications occurred in 9% of TLIF patients (11/124); including three postoperative neuralgia, two deep wound infections, two pedicle screw misplacements, two cage migrations, one dural tear, and one grafted bone extrusion

Hoy K, Eur Spine J 2013: TLIF vs. PLF (instrumented): 51 patients had TLIF, 47 PLF. No statistic difference in outcome between groups could be ... Operation time and blood loss in the TLIF group were significantly higher than in the PLF group.

Wang J, Zhou Y, Spine J. 2014 Sep 1;14(9):2078-84. They noted the reported incidence of perioperative complications associated with MIS-TLIF surgery is highly variable. They found 75 perioperative complications in 204 patients (36.76%); 31.37% (64/204 patients) in the MIS-TLIF operations; seven (9.33%) were classified as persistent and 68 (90.67%) were classified as transient.

Wong AP *et al.* J Neurosurg Spine. 2015 May;22(5):487-95. They analyzed intraoperative and perioperative complications in 513 consecutive MI-TLIF-treated patients with lumbar degenerative disc disease....The perioperative complication rate was 15.6%; durotomy was 5.1%, and the medical and surgical infection rates were 1.4% and 0.2%.

Q: You would agree that the procedure known as a “TLIF” is done widely throughout this country, correct?

A: Yes.

Q: And you have your own particular feelings about it, but there are many, many doctors that disagree with you on that, correct?

A: That’s true.

Id. 14/23-15/5. I also testified that TLIFs “are done all across the country, even for lesser indications,” *id.* 62/13, and “some would consider [the TLIF] within the standard of care” even for this patient, *id.* 63/10. On cross-examination, I testified that “I choose not do to TLIFs because I don’t think that it’s an appropriate operation for almost any surgical procedure,” but again acknowledged that “there are many out there who do TLIFs but I disagree with their choosing that as an operation.” *Id.* 108. And I acknowledged, yet again, that “there are many medical schools that teach their residents to do TLIF procedures” and “some of the leading orthopedic and neurological centers have surgeons there that do TLIF procedures.” *Id.* 111/7- 15.²

The PCC Proceeding

The PCC mischaracterized the “key issues in this case” by asking:

- Is a minimal access transforaminal lumbar interbody fusion with pedicle screw fixation for minimal Grade I L4-5 spondylolisthesis with symptomatic lateral recess stenosis a violation of the standard of care? If so, under what circumstances?

Articles by Dr. Epstein documenting complications from Minimally Invasive Surgery Including MI-TLIF

Epstein, NE, Surg Neurol. 2008 Oct;70(4):386-8. This study demonstrated 4 complications of MIS MetRx and 2 involving X-Stop Devices (all outside cases; 2 MetrRx cases reoperated on by Dr. Epstein showed dissection was not even near the foraminal/far lateral discs.

Epstein NE, Surg Neurol Int. 2011; 2011;2:188.) (Appendix B) she documented that spine surgery in geriatric patients is sometimes unnecessary, too much, or too little (MIS). In one study, she referred to their observed 10% complication rate for decompression alone (average age 76.4), 40% complication rate for decompression/limited fusion (average age 70.4), and 56%... for full curve fusions (average age 62.5).

Epstein NE, Surg Neurol Int. 2016 Jan 25;7(Suppl 3) she documented more nerve root injuries occur with minimally invasive lumbar surgery... Desai *et al.* large Spine Patient Outcomes Research Trial studies showed the frequency for

2 My candor on the stand may well have been the reason Drs. McLaughlin and Joseffer were not found liable at trial.

nerve root injury following an open discectomy ranged from 0.13% to 0.25%, for open laminectomy/stenosis with/without fusion it was 0%, and for open laminectomy/stenosis/degenerative spondylolisthesis with/without fusion it was 2%. Desai A, *et al.*, J Neurosurg Spine. 2011;14:647–53). Alternatively, one study compared the incidence of root injuries utilizing MIS transforaminal lumbar interbody fusion (TLIF) versus posterior lumbar interbody fusion (PLIF) techniques; 7.8% of PLIF versus 2% of TLIF patients sustained root injuries.

- Is a footdrop from L5 nerve root injury after surgery at the L4-5 level, and particularly L4-5 TLIF, evidence of negligent surgery?

Ex. 3 at 3.³ This is wrong. The PCC does not sit as a roving überjury, reviewing medical malpractice cases throughout the country on the merits. The PCC's role is to enforce the AANS Code of Ethics and Expert Opinion Rules, not to impose a single, orthodox medical view on over 4,500 neurosurgeons. Those Rules exist to uphold the ethics and high standards of our sacred profession. The "key issues" are whether I followed the Rules. I plainly did.

Infected by a complete misunderstanding of its role, the PCC claimed I violated Rules A(3 & 4) by failing to identify opinions that varied significantly from generally accepted neurosurgical practice, or to correctly represent the full standard of neurosurgical care. As to both points, the PCC's reasoning was that "TLIF for this condition is widely practiced and unquestionably within the standard of care." *Id.* 13. But this "reasoning" has nothing to do with the Rules; it is an expression of the PCC's own view about TLIF, a view it would impose on me, and now, you.

First, as to this particular patient, with her particular condition and history, only two medical teams reviewed the full record: Dr. Matusz and the team of Drs. McLaughlin/Joseffer. Of those two, the only independent, disinterested party (Dr. Matusz) agreed that a decompression, *not* a TLIF, was the appropriate procedure. For *this* patient, on *this* record, my opinion did not "vary significantly from generally accepted neurosurgical practice" at all. Ex. 4 (Expert Rule A(3)). To the contrary, mine was the view of the only independent, treating doctor in the case.

3 As recently as February 14, 2019, counsel for AANS misstated the issue and the role of the disciplinary process, stating: "[T]he underlying issue to be decided by the general membership with respect to Dr. Epstein's testimony is whether TLIF's fall within generally accepted neurosurgical practice, along with other approaches, or whether the procedure constitutes a violation of the standard of care for lumbar stenosis with spondylolisthesis." Ex. 9 (last par.). But this was an issue in the malpractice case. It is *not* the issue in this disciplinary proceeding. The only question is whether I violated the Expert Rules. Ex. 4.

Second, the issue is not whether "TLIF for this condition is widely practiced and unquestionably within the standard of care." *Id.* 13. The issue is whether, in discussing TLIF, I identified "any personal opinions that vary significantly from generally accepted neurosurgical practice." Ex. 4. To the extent I expressed any minority medical view, I made that repeatedly apparent to the jury. Ex. 2 at 14/23-15/5 ("many, many doctors... disagree with [me]"); 62/13 (TLIFs "are done all across the country, even for lesser indications"); 63/10; 108; 111/7-15. The PCC ignored all of this inconvenient testimony as if it didn't exist.

As to Rule A(4), it requires an expert to "recognize and correctly represent the full standard of neurosurgical care" and state "whether a particular action was clearly within, clearly outside of, or close to the margins of the standard of neurological care." Ex. 4. The PCC stated (again) that TLIF "is a widely accepted, taught and practiced surgical technique for this condition," and though I "acknowledged that others do TLIF procedures and that residents are taught how to do them," I "did not acknowledge that such procedures are generally accepted practice" and therefore did not "correctly represent[] the full standard of neurosurgical care." Ex. 3 at 13-14.

This is again wrong. First, I told the jury, almost *ad nauseum*, how common, how often TLIF is used, even for lesser indications than this patient's condition. *See above*. Second, as to this patient with this condition and history, the only doctors in a position to evaluate the case are those who either evaluated the patient or reviewed the entire record. The PCC is in no position to determine what procedure should have been performed on this patient, nor is that the PCC's role, nor do the Expert Rules give the PCC any power to make such judgments. Again, the PCC is not an überjury; it is a conduct committee.

The Board Appeal

Without explanation, the AANS Board decided 11-1, with two abstentions, to uphold the PCC decision. Ex. 5. It gave no reasoning. I have no idea why the Board did what it did, and no one will tell me.

The Integrity of the PCC, the Board, and the AANS

The membership must now decide whether I followed the Rules, and whether my expert opinion was honest, transparent, and supported by documentation, *not* whether a TLIF was the standard of care in this case. Even if TLIFs were indisputably the leading neurosurgical procedure for this patient in this condition, which it is not, this does not mean that other options favored by experienced and caring physicians are invalid or unworthy of expression in a legal dispute. I can be accused only of telling the truth

about what I have seen, and continue to see, in my practice of neurosurgery and what is supported currently in the literature. *See* n.1.

The PCC grievance process appears designed to deter neurosurgeons from testifying against other neurosurgeons. That is an abdication of AANS' role. We should support patients, not protect ourselves. We should encourage debate, not stifle it. We should support members who express contrary views, not target them. The AANS is a membership organization of dedicated, caring professionals. We are not, and should not be, a white wall of silence.

Issues of Bias, Conflict, and Money

It is no secret that TLIF procedures are far more lucrative than decompressions. The reimbursement rates for TLIF are considerably higher. Surgeons have a substantial financial interest in performing TLIFs.

What is secret, though, is whether and to what extent members of the PCC and the Board who heard my disciplinary case have financial conflicts. I requested this information and have been told nothing. To this day, for both PCC and Board members, AANS has refused to disclose:

- Whether, and how often, they have performed TLIF surgery;
- The income they have received from performing TLIF surgery;
- Any other financial interest they have in performing TLIF surgery;
- Whether, and to what extent, they have received any money from, or have any financial interest in, Medtronic, the manufacturer of TLIF;
- Whether they have been sued for performing TLIF surgery, and the results of those cases; or
- Any professional or other relationships they have with Drs. McLaughlin or Joseffer.

One Board member, Dr. Haid, (i) trained Dr. McLaughlin, and (ii) received \$25.5 million from Medtronic, the manufacturer of TLIF. The AANS did not disclose this information. As to the financial conflict, I learned it from the *Wall Street Journal*. Ex. 6. Notwithstanding these conflicts, Dr. Haid appeared at my Board hearing. When I asked him

whether he intended to recuse himself in light of the obvious conflicts, he remained for the duration of the hearing, something that would never happen in any court. Only after the hearing did Dr. Haid allegedly abstain, but I do not know if he participated in the deliberations or Board discussion before or after the hearing. Nor do I know how many other PCC or Board members have financial or other interests in disciplining me for questioning this lucrative surgery. Ex. 7 (letter from my counsel requesting disclosure of conflicts); Ex. 9 (AANS counsel's response, refusing to disclose).

This is absurdly unfair. At best, it raises serious questions about the integrity of the proceeding. At worst, it explains why the PCC and the Board abandoned their duty to enforce the Expert Rules, punished me for criticizing TLIF, and would now impose their own personal views about TLIF upon the entire membership on pain of disciplinary suspension.

Finally, at the PCC hearing I was repeatedly questioned about my "feelings" about this procedure. The case is not about "feelings," it is about medicine. As one of the first board-certified female neurosurgeons in the United States, I wonder whether a man in my position would ever have been subject to the same questions.

Conclusion

After a long, dedicated, unblemished career, serving thousands of patients, it is humiliating for me to have to defend myself, my reputation, and my AANS membership before over 4,500 of my colleagues. I also know how busy you are, and how easy it would be simply to accept the determination of the Board. But what happened here is unjust. It is wrong. It should never happen in our organization.

To suspend an AANS member, a majority of the voting membership must vote to uphold the suspension. I urge you to vote against this manifest injustice. Please vote for the integrity of this organization, and against the suspension.

Respectfully,


Dr. Nancy Epstein

Appendix B



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Dr. Nancy Epstein Appeal of AANS Decision to Temporarily Suspend Membership for Violation of the AANS Rules for Neurosurgical Medical/Legal Expert Opinion Services

AANS President Response Statement

On November 16, 2018, the Board of Directors of the American Association of Neurological Surgeons (AANS) found that Nancy Epstein, MD violated Rules A.3 and A.4 of the AANS Rules for Neurosurgical Medical/Legal Expert Opinions Services (Rules for Expert Testimony). These violations occurred during expert witness testimony she provided in a medical malpractice case against Michael McLaughlin, MD. The Board voted to suspend Dr. Epstein's AANS membership for six months. This action was taken pursuant to Article II, Section 4 of the AANS Bylaws, which allows an AANS member to bring a complaint against another AANS member for unprofessional conduct, including alleged violation of the Rules for Expert Testimony.

To provide context, a complaint is first referred to the AANS Professional Conduct Committee (PCC), which reviews and considers the information submitted by both the complainant and respondent (the AANS member against whom the complaint is made), including transcripts of testimony, medical records, professional literature, and other materials submitted by the parties. If the complaint passes preliminary review, the PCC conducts a hearing during which both parties present their side of the case. A court reporter is present at the hearing and prepares a transcript of the proceeding.

Following the hearing, the PCC submits a detailed written report to the Board of Directors for action on the complaint. According to the Bylaws, a complaint can be dismissed if no violations are found. In the event the allegations in a complaint are sustained, the respondent can be disciplined by censure, suspension from membership for a defined period, or expulsion from the AANS. In addition to the PCC report, the Board receives a copy of the hearing transcript, all party submissions, and any additional written statement submitted by a respondent. The parties also receive a copy of the PCC report and the hearing transcript.

After the PCC has issued its report and recommendation, a respondent has the right to appear before the Board of Directors to make a presentation in his or her defense and to dispute the findings contained in the report. The Board then votes to either accept the PCC recommendation or take different action. The Board generally does not issue a separate decision when, as here, it adopts the PCC recommendation.

The respondent may appeal an adverse Board decision to the voting AANS membership for ratification or reversal. In this case, Dr. Epstein has exercised her right to appeal the Board decision. The vote by the AANS members responding to the appeal is either to accept or reject the Board decision. A majority vote to accept the Board decision will sustain the decision to suspend Dr. Epstein's AANS membership for six months. A majority vote to reject the Board decision will result in dismissal of the complaint.

Complaint Background

Dr. McLaughlin alleged in his complaint that Dr. Epstein violated six separate provisions of the Rules for Expert Testimony. The PCC found two clear violations relating to impartial testimony and recommended dismissal of the remaining four complaints. The provisions violated are Rule A.3 ("*[t]he neurosurgical expert witness shall identify as such any personal opinions that vary significantly from generally accepted neurosurgical practice*") and Rule

A.4 (“[t]he neurosurgical expert witness shall recognize and correctly represent the full standard of neurosurgical care and shall with reasonable accuracy state whether a particular action was clearly within, clearly outside of, or close to the margins of the standard of neurosurgical care”).¹

The underlying case in question involved a foot drop after a minimal access L4-5 transforaminal posterior lumbar interbody fusion (TLIF) with percutaneous pedicle screw fixation. The plaintiff in the case (the patient) was a 66-year-old woman with a history of progressive right hip and leg pain for months in 2009-10. She had physical therapy and lumbar epidural injections without relief. A lumbar MRI on 8/12/09 showed “L4-5 spondylolisthesis with some mild stenosis” according to Dr. McLaughlin’s history and physical from an initial office consultation on 12/10/09, or “mild-to-moderate stenosis” during the office follow-up visit on 1/07/10. During the follow-up office consultation on 1/7/10, Dr. McLaughlin found mild right foot dorsiflexion weakness (4+/5) and positive straight leg raising on the right at 70 degrees, “very small anterolisthesis of L4 on L5” and “severe lateral recess stenosis at L4-5 consistent with her symptoms.” Dr. McLaughlin recommended “lumbar laminectomy at L4-5 without fusion.” An EMG study on 1/25/10 showed “acute and chronic denervation in a right L5 distribution.” The patient saw an orthopedic surgeon on 1/28/10 and scheduled an L4-5 lumbar laminectomy without fusion, to be done in February, which the patient subsequently cancelled because of a blizzard on the scheduled date.

The patient returned to Dr. McLaughlin for an office visit on 2/23/10, when Dr. McLaughlin changed his surgical recommendation from decompression alone to decompression and fusion. He wrote in his office note that the lumbar MRI “demonstrates an L4-5 spondylolisthesis with mild to moderate stenosis ... Flexion-extension studies suggest a possibility of 1 mm of movement and her EMG confirms [an L5] radiculopathy” and that the patient “will be scheduled for a minimally invasive L4-5 decompression by TLIF, transforaminal interbody fusion technique.” As Dr. McLaughlin was planning to leave town for vacation soon after the scheduled surgery date, he recommended that his younger associate, Dr. Joseffer, serve as the primary surgeon, while Dr. McLaughlin serve as assistant during the surgery.

The surgery on 3/1/10 was an “L4-L5 transforaminal lumbar interbody fusion with local and iliac crest autograft, interbody cage, and pedicle screw fixation” according to the operative report. The operative technique utilized fluoroscopic guidance, electro-physiological monitoring, paramedian incisions, tubular access, operating microscope, right facetectomy and

interbody cage placement with “protection of the traversing and exiting nerve roots” and bilateral pedicle screw placement using the Medtronic Sextant system. The anesthesia record began at 7:30 a.m. and ended at 1:30 p.m. The intraoperative monitoring report recorded no abnormalities in the L4, L5, and S1 running EMG monitored electrodes. Postoperative lumbar CT scan at 4:40 p.m. on the day of surgery was performed to confirm correct pedicle screw placement.

On the night of surgery, Dr. Joseffer noted 2/5 motor weakness in right ankle dorsiflexion and extensor hallucis longus function, and on the second postoperative day found 3/5 right dorsiflexion and plantar flexion. The patient was discharged to rehabilitation. Later examinations differ on the degree of residual foot drop, ranging from 4/5 by a neurologist to 0/5 by Dr. Epstein in 2011.

The patient filed a medical malpractice lawsuit against Dr. McLaughlin, Dr. Joseffer, the Princeton Brain and Spine Care practice, and the University Medical Center at Princeton. Dr. Epstein served as the expert witness for the patient. Dr. Epstein examined the patient on 10/7/11, and thereafter signed an affidavit of merit supporting the lawsuit on 10/31/11, testified in a discovery deposition on 4/11/14, and testified at trial on 1/12/17. The jury subsequently found in favor of Drs. Joseffer and McLaughlin on both counts – negligence and lack of informed consent – and the court entered judgment in favor of the defendants.

Pertinent Testimony

The following portions of Dr. Epstein’s expert testimony were pertinent to the findings of the Professional Conduct Committee and the Board of Directors. First, Dr. Epstein was asked in discovery deposition, “You believe that the defendant physicians, Dr. Joseffer and Dr. McLaughlin, deviated [from the standard of care] by performing a TLIF procedure. Is that correct?” Dr. Epstein responded, “Yes.” She was then asked, “You believe that surgery would have been a reasonable option, just not the type that they chose, correct?” Dr. Epstein responded, “Correct.” (Epstein Deposition p. 43.)

Second, Dr. Epstein stated in discovery deposition, “I think the deficit in question would and should have been avoided although I believe the surgery performed to be unnecessary, if any surgery were to be done, it should have been recommended that an open procedure, consisting of laminectomy L3,4,5, to decompress the stenosis with an in situ/non- instrumented posterolateral fusion at the L4-5 level to address the grade one slip should have been performed.” (Epstein Deposition p. 46.)

Third, Dr. Epstein was asked during discovery deposition, “So are there any circumstances where you believe a TLIF procedure is appropriate?” She answered simply, “No.” (Epstein Deposition p. 47.)

1 <https://zneurosurgery.com/wp-content/uploads/2014/05/AANS-Rules-for-Neurosurgical-Medical-Legal-Expert-Opinion-Services-2006.pdf>

Fourth, during the trial, Dr. Epstein was asked during direct examination, “Is it within the standard of care to do a TLIF in these circumstances?” She responded, “The answer is yes,” followed by “These are done all across the country, even for lesser indications ... I would not have personally done this ...” (Epstein Trial Testimony p. 62.) However, during cross examination, Dr. Epstein reversed her position on the standard of care, stating she was “confused.” Specifically, Dr. Epstein was asked the following question, “Doctor, you say that, in this case, where Drs. McLaughlin and Joseffer performed the TLIF operation, you testified on direct examination that that was not a breach of the standard of care to do that, correct?” She responded, “Well, let me just reassess ... well, but when I was saying that I was confused because my opinion is that I think that is below the standard of care. Are there others out there who think that is consistent with the standard of care? So my answer is no, I don’t think it is consistent with the standard of care. Others will tell you otherwise.” (Epstein Trial Testimony pp. 109-10.)

Fifth, Dr. Epstein further testified at trial that the occurrence of a foot drop during surgery at the L4-5 level was below the standard of care. She stated that a minimal access approach posed a higher risk of nerve injury because it provided “less room to work in... a greater risk of inadequate exposure of the nerve root.” (Epstein Trial Testimony p. 78.) At that point in the trial, Dr. Epstein was asked, “Do you have an opinion as to whether Drs. Joseffer and McLaughlin conducted the actual procedure on March 1, 2010 in accordance with the standard of care?” She responded, “Yes ... I think it was below the standard of care.” (Epstein Trial Testimony p. 79.) Dr. Epstein was asked, “You would agree, would you not, that a nerve root injury can occur during an operation, even when the surgeon is doing everything properly?” She answered, “The answer is no.” Dr. Epstein was further asked, “In other words, the very outcome of it means that somebody was negligent?” She responded, “Yes.” (Epstein Trial Testimony pp. 112-13.)

With respect to this last line of questioning, Dr. Epstein explained during the PCC hearing that she does not perform posterior interbody fusions herself, in part because she believes the risk of nerve root injury is higher than occurs with more traditional decompression and posterolateral fusion. She further explained in her written response to the complaint that, “In every evolution in science and medicine there are ‘canaries in the coal mine’ where those who speak up and warn of the dangers at hand need to be encouraged to do so and not silenced. For the committee to silence opinions such as Dr. Epstein’s would be to intervene and suppress intellectually honest opinions where it is in the best interest of organized neurosurgery to encourage such expressions of opinion ... Based on her experience, her

research, and the literature, Dr. Epstein concluded that the MIS TLIF was not the right procedure for this patient or a good approach to spinal disease when dealing with a mild grade I spondylolisthesis with moderate foraminal stenosis in a 66 year old woman ... Dr. Epstein was trying to educate the jury as to what she considered the best practice to avoid incurring the type of deficit that occurred in this case.” (Epstein Response pp. 7-8.)

PCC and Board Findings

Based on the foregoing testimony, the Professional Conduct Committee concluded unanimously that Dr. Epstein violated the AANS Rules for Expert Testimony by testifying that a TLIF procedure was below the standard of care, and that the occurrence of a nerve root injury during the surgery was evidence of a violation of the standard of care. The Board of Directors agreed with the PCC by a vote of 11 to 1 with two Board members abstaining.

The performance of TLIF with pedicle screws for lumbar stenosis with spondylolisthesis is widely accepted and practiced by neurosurgeons. The procedure unquestionably falls within the standard of care. In this case, either decompression alone or decompression with fusion would fall within the standard of care, and either could be chosen by reasonably prudent neurosurgeons. If fusion is chosen, either posterolateral fusion or interbody fusion with pedicle screws would fall within the standard of care, as both are widely utilized in actual practice. This is not a subjective disagreement, and the PCC and Board of Directors are not imposing their view on Dr. Epstein (or anyone else) as she contends. A surgeon’s personal preference or belief does not constitute standard of care. The definition of standard of care for legal purposes is that which a reasonably prudent surgeon with similar training and experience would do in similar circumstances. It reflects what is actually done in clinical practice, not necessarily what the expert witness would do personally. The standard of care includes a range of options, and it is the obligation of the expert witness to inform the court and jury of the full range of alternative treatment options.

Dr. Epstein violated the Rules for Expert Testimony because she dogmatically refused to acknowledge that TLIF falls within the standard of care. While she expressed her view that a TLIF procedure was inappropriate for this patient’s condition, Dr. Epstein did not identify or otherwise qualify her testimony as a personal opinion in accordance with Rule A.3. Nor did her testimony correctly represent the full standard of neurosurgical care as required by Rule A.4. Dr. Epstein merely stated that others will tell you differently and residents are taught how to do them. This is insufficient because, throughout her testimony, Dr. Epstein resisted any acknowledgement that there are several surgical approaches

for the treatment of spinal stenosis with spondylolisthesis *that fall within the standard of care*. As noted above, these options include her preference for laminectomy with or without posterolateral fusion. However, they also do not exclude TLIF as a widely used option that could be and often is chosen by reasonably prudent neurosurgeons under like circumstances.²

The occurrence of a nerve injury during neurological surgery is also a recognized complication and does not per se indicate a violation of the standard of care. Dr. Epstein, accordingly, did not state within reasonable certainty whether a particular action was clearly within, outside of, or close to the margins of the standard of neurosurgical care in violation of Rule A.4. The choice of operation such as TLIF cannot be considered within the standard of care contingent upon the absence of a subsequent known complication, such as nerve root injury, and it cannot become a violation of the standard of care if such a complication does occur. While careless surgery can result in nerve injury, the mere occurrence of nerve injury during a properly conducted surgical procedure does not constitute negligence, or indicate a violation of the standard of care, absent evidence of improper surgical technique.

Moreover, the occurrence of post-operative nerve dysfunction does not imply *de facto* negligence, and prior case law supports this position. With respect to nerve injury, Judge Richard Posner wrote the Seventh U.S. Circuit Court opinion in the *Austin vs. AANS* case in 2001 involving similar testimony about a recurrent laryngeal nerve injury after ACDF. In this opinion, Judge Posner averred that no scientific article “states that permanent injury to the recurrent laryngeal nerve of a patient with a normal neck occurs without negligence on the part of the surgeon, and since his [Dr. Austin’s] position if accepted would, by making the surgeon an insurer against any serious mishaps in an anterior cervical fusion, make the operation exceptionally risky in a financial or liability sense for the surgeon, and since Austin plainly had not attempted to sound the opinion of his profession to determine whether a majority of the nation’s several thousand neurosurgeons agree with his unorthodox view, there is little doubt that his testimony was irresponsible and that it violated a number of sensible-seeming provisions of the Association’s ethical code.” This same reasoning applies equally to nerve root injury during lumbar spine surgery.

Both the Professional Conduct Committee and the Board of Directors found that Dr. Epstein was well qualified to serve as an expert witness in the underlying case. That is not at issue here. However, designation as an expert does not ensure

2 Dr. Epstein’s argument that her research found higher reported rates of surgical complications in TLIF surgery than for posterolateral fusion surgery similarly does not change that fact that TLIF is widely practiced and within the standard of care.

accurate or proper testimony in accordance with the AANS Rules for Expert Testimony. Indeed, expert testimony in a medical malpractice case is not the time or place to argue the merits of competing scientific theories or preferences; it is the time to describe objectively and impartially the range of options actually offered and performed by reasonably prudent neurosurgeons in practice. Professional scientific meetings, publications, and discussions are the proper venue for debating the relative value of differing methods or novel innovations. The expert witness, by contrast, has an obligation to educate the court and jury on what is actually done throughout the neurosurgical community, and what alternatives are accepted in practice, as well as to identify personal preferences that vary from, or are part of but do not fully represent, generally accepted practice. The expert witness should not characterize widely practiced alternatives as being outside the standard of care, as this incorrectly implies negligence, malpractice, and tort liability.

It is disingenuous for Dr. Epstein to claim she has no idea why the Board of Directors did what it did. As she was informed, the Board adopted the 17-page report and recommendation issued by the Professional Conduct Committee. Moreover, in reaching its decision, the Board has given thorough and thoughtful consideration to this matter, including the substantial party submissions, the transcript of the PCC hearing, and Dr. Epstein’s written statement and presentation to the Board (in addition to the PCC Report).

Nor has Dr. Epstein been unfairly targeted through the complaint submitted by Dr. McLaughlin. To the contrary, the complaint has been handled by a fair, unbiased and impartial process in accordance with the AANS Bylaws³ and the Procedural Guidelines of the Professional Conduct Committee⁴. The intent of these procedures and the Rules for Expert Testimony is not to favor defendants in medical malpractice cases over patients, nor to deter neurosurgeons from testifying against other neurosurgeons, nor to promote a so-called “white wall of silence.” These same arguments that Dr. Epstein now raises were rejected by the Seventh Circuit Court of Appeals in the *Austin* case where the Court ruled in favor of the AANS. As Judge Posner recognized in that decision, the aim of the AANS Professional Conduct Program and the Rules for Expert Testimony is to encourage and ensure that all expert witness testimony – equally for the

3 https://www.aans.org/-/media/Images/AANS/Header/Governance/AANS_Bylaws_7-2018.ashx?la=en&hash=2281D87914B1C4527A046AAE78105D2673612D49

4 https://www.aans.org/-/media/Images/AANS/Header/Governance/AANS_Professional_Conduct_Committee_Procedural_Guidelines.ashx?la=en&hash=00FB3C791B079051D02FD1DD70F95FDD275C0749

plaintiff and the defense – is correct, informative, balanced, complete, and impartial.

One final matter should be addressed. Dr. Epstein attempts to raise purported issues of alleged bias, conflicts, and financial interest with respect to TLIF procedures. The AANS conducts a conflicts-of-interest review for each complaint. This review includes personal and professional relationships with the parties and any other basis requiring recusal in a given matter. In addition, the AANS requires members serving on committees to submit conflict of interest disclosure forms in connection with their service. In accordance with this review, two Board members, including Dr. Haid, abstained from voting on this matter. All other members of the Professional Conduct Committee and Board of Directors properly participated and voted in this matter. Dr. Epstein suggests that the mere *performance of* TLIF procedures by PCC and Board members implies bias and conflict of interest, which somehow supports the notion that this procedure is not standard of care and that was the basis for the expert opinion she rendered.

Appendix C

Email from Dr. Epstein to Dr. Timmons.

From: Nancy Epstein <nancy.epsteinmd@gmail.com>
Subject: RE: Timmons' Letter
Date: March 24, 2019 at 8:02:38 AM EDT
To: stimmons@mac.com
Cc: Jennifer Sweet <jenniferswee@gmail.com>, Nancy Epstein <nancy.epsteinmd@gmail.com>

Dear Shelly,

I know you did not have time to read all the relevant material and that your letter had to be largely written by lawyers. In any case, they have done you and the AANS a disservice as indicated by the 5 examples below.

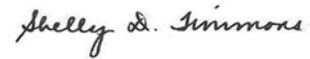
In short, your letter contains many misleading statements, and in some cases misrepresentations of the truth. Here are 5 examples.

1. *Timmons Letter States (Pg. 7, paragraph 2): "the AANS requires members serving on committees to submit conflict of interest disclosure forms in connection with their service. In accordance with this review, two Board members, including Dr. Haid, abstained from voting on this matter."*

RESPONSE: What were they doing in the room in the first place? The conflicts involved were not minor and were not dealt with appropriately by the AANS. Dr. Regis Haid, not only trained Dr. McLaughlin, but also had received millions of dollars from Medtronic. He said he would abstain only after I confronted him at the end of my presentation to the

The AANS Board of Directors is intended to represent the full AANS membership. This vote will clarify membership concurrence with the Board decision. The Board has determined that Dr. Epstein violated Rules A.3 and A.4 of the AANS Rules for Neurosurgical Medical/Legal Expert Opinion Services, and has found the violations serious enough to warrant a temporary six-month suspension of Dr. Epstein's AANS membership. In an appeal of the Board decision to the full membership, a majority "yes" vote sustains the decision of the Board; a majority "no" vote reverses the Board decision and results in dismissal of the complaint. The AANS Board of Directors asks the membership to respond with an electronic vote of "yes" to sustain the decision of the Board for the reasons set forth above.

Shelly D. Timmons, MD, PhD, FAANS AANS President



Shelly D. Timmons, MD, PhD, FAANS
AANS President

Board. Furthermore, Dr. Shaffrey, the next President of the AANS, never acknowledged that he too has received substantial money from Medtronic for TLIF-related products. Although he recused himself for the vote, he was still there in the room and took an active part in my interrogation. Again, why was he even in the room, and why did he take part?

2. *Timmons Letter States (Pg. 3 paragraph 3 last line): "Later examinations differ on the degree of residual foot drop ranging from 4/5 by a neurologist to 0/5 by Dr. Epstein in 2011."*

RESPONSE: This statement is not only misleading, but frankly a misrepresentation of the truth. Multiple other examining physicians documented a significant foot drop, except for Dr. Vester. He was the EXTREME, not me, as Dr. Timmons' letter clearly insinuates.

Dr. Scott stated in his deposition, "Question: Now throughout the course of time after her surgery in March 2010, it appears that EVERY DOCTOR apart from Dr. Vester finds the motor strength in the right ankle dorsiflexion to be two out of five or less. Correct? Answer: Correct. How could that be? Answer: Those were his findings. I can't explain that, so he had his findings, and there were findings by Dr. Hughes as well in 2011. Question: Dr Hughes sees Ms. X in June 2011. Correct? Answer: Correct. Question: he finds right ankle dorsiflexion motor strength 1/5. Correct? Answer: Correct. Question: Dr. Vester two months before that says the right ankle dorsiflexion motor strength was five out of five? Answer: Correct.

3. *Timmons Letter States (Pg. 3 last paragraph): “Third, Dr. Epstein was asked during discovery deposition, “So are there any circumstances where you believe a TLIF procedure is appropriate?” She answered simply, “No.”*

RESPONSE: VERY misleading. In short, at both the deposition and as an expert witness, I recognized and correctly represented the full standard of neurosurgical care with reasonable accuracy. If you read my entire testimony, too much to detail here, you will see that I was clear that the TLIF was NOT the correct operation for THIS patient.

4. *Timmons Letter States (Pg.2 last paragraph/last sentence and Pg. 3 paragraph 1): “As Dr. McLaughlin was planning to leave town for vacation soon after the scheduled surgery date, he recommended that his younger associated, Dr. Joseffer, serve as the primary surgeon, while Dr. McLaughlin serve as the assistant during the surgery.”*

RESPONSE: The letter fails to mention that his partner, Dr. Joseffer, showed up the morning of surgery, having NEVER met the patient prior to the morning of surgery, having never spoke to her, or examined her. Nevertheless, he performed the surgery that resulted in a new and permanent foot drop.

5. *Timmons Letter States (Pg. 3 full paragraph 1 last line):“Postoperative lumbar CT at 4:40 pm on the day of surgery was performed to confirm correct pedicle screw placement” (underlining added).*

RESPONSE: Again, misleading. The CT scan was ordered BECAUSE she had an immediate postoperative foot drop and not just performed as a ROUTINE to “confirm correct pedicle screw placement”

Regards,
Nancy