Short Form Order



**SUPREME COURT - STATE OF NEW YORK**

**I.A.S. PART 7 SUFFOLK COUNTY**

PRESENT:
**HON. WILLIAM B. REBOLINI**
**Justice**

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Azmat Zahir, as Administrator of the Estate of Kiran Fatima Zahir, Azmat Zahir and Nuzhat Zahir,

Plaintiffs,

-against-

Good Samaritan Hospital, Mary Gidget Vilela, M.D., Delia Rogu, M.D., Mark Schwartz, M.D., Elizabeth Pleickhardt, M.D., Marion Rose, M.D., Catherine Caronia, M.D., Donald Moyer, M.D., Cynthia Rosenthal, M.D., Michael Bianco, M.D. & Hafiz Rehman, M.D.,

Defendants.

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Motion Sequence No.: 008; MG
Motion Date: 4/24/12
Submitted: 6/5/12

Index No.: 33245/2006

Attorneys/Parties [See Annexed Rider]

Upon the following papers numbered 1 to 24 read upon this motion for summary judgment: Notice of Motion and supporting papers (008), 1 -19; Answering Affidavits and supporting papers, 20 - 22; Replying Affidavits and supporting papers, 23 - 24; it is,

***ORDERED*** that this motion (008) by the defendant, Elizabeth Pleickhardt, M.D., pursuant to CPLR 3212 for an order granting summary judgment dismissing the complaint is granted and the complaint as asserted against her is dismissed with prejudice.

In this action, the plaintiffs, Azmat Zahir and Nuzhat Zahir, assert causes of action for medical malpractice premised upon the alleged negligent departures from good and accepted standards of care and treatment provided to their seven year old infant daughter, Kiran Fatima Zahir, and for her wrongful death. At the direction of her pediatrician, Dr. Hafiz Rehman, the infant had

been admitted to the emergency room at Good Samaritan Hospital for evaluation of right lower quadrant abdominal pain on December 14, 2004. In the emergency room, she was seen by the emergency department attending physicians, Dr. Mary Vilela and Dr. Delia Rogu. She was thereafter admitted from the emergency room to the pediatric intensive care unit (PICU) for observation on December 15, 2004, with a diagnosis of possible appendicitis. Dr. Catherine Caronia was the attending pediatric intensivist. Defendant Dr. Elizabeth Pleickhardt was the resident physician who administered care and treatment to the infant under the supervision of Dr. Caronia. Dr. Mark Schwartz was the attending surgeon. Dr. Michael Bianco was the attending anesthesiologist. The infant died December 15, 2004.

The moving defendant, Elizabeth Pleickhardt, M.D., seeks summary judgment dismissing the complaint as asserted against her on the bases that, as a pediatric resident physician, she did not depart from good and accepted standards of medical care and treatment; there is no proximate cause between the care and treatment rendered by her and the injuries suffered by the deceased infant; she followed the directions of the attending physicians; she did not exercise any independent medical judgment; and the direction of the supervising physician did not deviate so greatly from normal medical practice that she should be held liable.

The proponent of a summary judgment motion must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this application, the moving defendant has submitted, inter alia, an attorney's affirmation; a copy of the summons and complaint, the moving defendant's answer, and the amended verified bill of particulars; a certified copy of the Good Samaritan Hospital record; the unsigned but certified copies of the transcripts of the examinations before trial of Mary Gidget Vilela, M.D. dated April 16, 2008, Mark A. Schwartz, M.D. dated June 12, 2009, Elizabeth Pleickhardt, M.D. dated June 9, 2009, Michael Bianco, M.D. dated June 28, 2010, Azmat Zahir dated January 28, 2008, and Nuzhat J. Zahir dated January 28, 2008; the signed transcripts of the examinations before trial of

Delia Rogu, M.D. dated June 24, 2008, and Catherine Caronia, M.D. dated October 29, 2009; and the affirmation of the moving defendant's expert, Bruce Michael Greenwald, M.D.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420 [1999]). To prove a *prima facie* case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see*, ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 224 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see*, ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

A resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene (***Bellafiore v Roccotta***, 83 AD3d 632, 920 NYS2d 373 [2d Dept 2011]; ***Muniz et al v Katiowitz, et al***, 49 AD3d 511, 856 NYS2d 120 [2d Dept 2008]; ***Brinkley v Nassau Health Care Corporation***, 2012 NY Slip Op 30961U [Sup. Ct., Nassau County]). A private physician may be held vicariously liable for conduct of a resident physician where the resident is under the direct supervision and control of the private physician at the time of the conduct; the key is whether the resident exercises independent medical judgment (see ***Hill v St. Clare's Hospital***, 67 NY2d 72, 499 NYS2d 904 [1986]; ***Freeman et al v Mercy Medical Center et al***, 2008 NY Slip Op 31337U [Sup. Ct., Nassau County]).

Azmat Zahir testified to the extent that on Monday, December 13, 2004, Kiran complained she was not feeling well. That evening she began to run a fever. Dr. Rehman's office was called, and Motrin was advised. The following day, she did not attend school. She was not active and rested on the couch. She wore a jacket as she was cold. She could not walk on her own and complained of pain in her stomach. Upon seeing Dr. Rehman, her pediatrician, on December 14, 2004, she was sent to Good Samaritan emergency room, where an intravenous was started, blood and urine tests and x-rays were taken. She then waited to be seen by the surgeon, Dr. Schwartz. About midnight, Kiran complained of having a hard time breathing, had pain in her belly, and was feeling hot but stated that her feet were cold. She was given oxygen. Her eyes had become swollen.

Mr. Zahir continued that about 1:00 a.m., Dr. Schwartz saw the child and ordered a CT scan, which was performed at about 3:00 a.m. He was advised that nothing showed on the scan, and that

Kiran was being admitted to the hospital. About 8:00 a.m., Dr. Schwartz saw the child and advised him that they couldn't find anything, but needed to operate on her appendix. Mrs. Zahir arrived at the hospital, and Dr. Caronia spoke with him and his wife. Kiran went to the operating room waiting area, then to the operating room. Thereafter, Dr. Schwartz told him that Kiran had a heart attack and passed away. An autopsy was done by Dr. Wilson. He did not know the results of the autopsy, but remembered hearing something about a viral infection.

Dr. Elia Rogu testified to the extent that she is licensed to practice medicine in New York and was employed at Good Samaritan Hospital in December 2004. She stated that Kiran Zahir was admitted to the pediatric emergency room at Good Samaritan Hospital on December 14, 2004. She was seen in triage after she passed out in the triage area bathroom. She saw the infant about 10:00 p.m. while making rounds with Dr. Vilela, another emergency room physician who had seen and examined the child. She was advised by Dr. Vilela that the infant presented with abdominal pain, fever, and some urinary complaints, and that the working diagnosis was a urinary tract infection or appendicitis. Dr. Rogu testified that she examined the child but did not write a note as it was a very busy night in the emergency room. She stated that Kiran was medicated for pain with Morphine at 1:00 a.m. on December 15, 2004, and with Toradol at 4:05 a.m. At 4:00 a.m., the infant was noted to be lethargic, she had swelling of her eyelids, her respirations were shallow, and her hands and extremities were cool and clammy. She developed nasal flaring, was given oxygen, and arterial blood gases were drawn. The CT scan of the abdomen was completed at about 3:00 a.m. on December 15th and was read as negative for appendicitis. Her diagnosis was that of intra-abdominal infection. She described the care and treatment which she ordered for the child. She could not remember if she contacted the infant's pediatrician. She could not remember whether she considered that the infant might be in septic shock. Dr. Rogu stated that the child's temperature was low, her respirations were labored, her extremities cool, and her eyelids swollen, but she did not have fluid overload at this time.

Dr. Rogu continued that she thought she started to entertain the diagnosis of sepsis and contacted Dr. Schwartz, the surgeon, advising him that the child was having severe abdominal pain. Dr. Schwartz saw Kiran at about 12:40 a.m. on December 15, 2004. She could not recall if she advised him that the child had a rapid heart and respiratory rates, low temperature, difficulty breathing, cool and clammy extremities, elevated glucose, acidosis, lethargy, thready pulse, and that she was dehydrated. She testified that these were early signs that the infant was decompensating or had sepsis. It was decided to admit Kiran to the pediatric intensive care unit (PICU). At about 5:30 a.m., Kiran was seen by a resident from PICU, Dr. Pleickhardt. At 5:40 a.m., a report was given to the PICU nurses, and the child was transferred to PICU to the service of Dr. Caronia. Dr. Rogu testified that she reported to Dr. Caronia about the infant at about 4:00 a.m., then left the emergency room at 7:00 a.m. at the end of her shift. At about 1:00 p.m. later that day, she learned Kiran had died. Dr. Rogu opined that it was not a departure from the standard of care not to administer pressors for Kiran's blood pressure while she was still in the emergency room prior to

her transfer to PICU as she had been administered a fluid bolus. She had considered her vital signs and determined that the child appeared stable.

Mark A. Schwartz, M.D. testified that he is licensed to practice medicine in New York and is board certified in general surgery, with added qualifications in vascular surgery. He first saw Kiran Zahir at 1:00 a.m. on December 15, 2004. He obtained the history that the child had lower abdominal pain for two to three days prior to coming to the hospital. Upon examination, he found that she had mild right lower abdominal pain, no peritonitis, nausea, or vomiting. He spoke to Dr. Caronia and advised her that he felt the child was very sick and that she should come in to see her as he did not think Kiran was suffering from a surgically correctable cause for her illness. Dr. Schwartz stated that the CAT of the child's abdomen had been read as negative with no acute signs of appendicitis, however, he noted her pain to be in the right lower quadrant of the abdomen, consistent with appendicitis. He felt there was a questionable appendicitis, although he thought it was highly unlikely. Therefore, he wanted to discuss her CAT scan with radiology and see the child again in one to two hours. Dr. Caronia asked him to speak to the resident. At the time of this examination, he felt the child had septic shock and advised the pediatricians, but he did not write it in the note.

Dr. Schwartz testified that he then saw the infant again at 5:00 a.m. before she was transferred to PICU. He wanted her admitted to PICU for resuscitation (aggressive fluid therapy, treatment for acidosis and her respiratory condition, with the possibility of antibiotics) and reevaluation thereafter. He did not have a working cause for the acidosis and stated that it was important to determine the cause. He stated that he felt the infant was in shock when she was transferred to PICU. He testified that shock is the inadequate perfusion of bodily organs, characterized by cool and clammy skin, dry mucous membranes, cyanosis or discoloration of the extremities, low blood pressure, elevated heart rate, low urine output, and lethargy. He believed that Kiran was suffering from septic shock and stated that he advised the pediatricians, but did not write it in the note. He continued that the child was getting sicker and thought Kiran possibly had appendicitis.

Dr. Schwartz testified that at 7:00 a.m., the child was still having right lower quadrant pain and tenderness with a negative CT scan, however, he suspected acute appendicitis and planned to proceed with the appendectomy. The pediatricians had exhausted their search, felt nothing else could be done, and the child appeared to be getting worse. Kiran's white blood cell count was 16,900, which he characterized as abnormally high. He consulted with his senior partner, Bob D'Angeles. The child was seen by the anesthesiologist, Michael Bianco. She was taken into the operating room at 8:40 a.m., administered anesthesia by IV induction, and was intubated at 8:55 a.m., when she became bradycardic (her heart rate slowed) and hypotensive (her blood pressure lowered). A code was called at 8:59 a.m. due to sinus bradycardia. Chest compressions were started. CVP and A lines were inserted establishing bilateral femoral lines. Dopamine and Dobutamine were administered for her blood pressure, and her heart rate increased to 130's and her

blood pressure to 115/80. Oxygen saturation levels were at 100 percent. Dr. Schwartz stated that they determined that she was reasonably stable and that surgery could be started, but it just did not turn out to be the case as another code was called at 10:11 a.m. Kiran had developed a quivering heart with little contractility due to pericardial effusion which was tapped to drain the fluid around the heart. She was defibrillated and chest compressions were continued. Kiran was pronounced dead at 10:41 a.m. on December 15, 2004.

Elizabeth Pleickhardt, M.D. testified that she is currently licensed to practice medicine in New Jersey. In December 2004, she was in her third year of residency at Winthrop Hospital. As part of that residency, she was required to do a pediatric rotation from December 1 through December 31, 2004, at Good Samaritan Hospital. She began her 24 hour shift working on December 14, 2004 at 7:00 a.m. and was on duty until 7:00 a.m. on December 15, 2004. She saw patients on the pediatric floor during the day, and at about 5:00 or 6:00 p.m., she then saw PICU patients until the following morning. She stated that the attending physician is always in charge of PICU. Dr. Caronia was the director of PICU, and was the pediatric intensive care attending from 6:00 p.m. on December 14, 2004 through 7:00 a.m. December 15, 2004.

Dr. Pleickhardt stated that she remembered Kiran Zahir because the child expired. Dr. Pleickhardt testified that she saw the child on December 15, 2005 at about 5:30 a.m. in the emergency room because she was the PICU resident on duty and the child was being admitted to PICU. She obtained the history and the test results, which she reviewed with the emergency room attending physician, Dr. Rogu. She also obtained history from the family. She recorded that the child had a three-day history of a fever, that she was drinking and eating less, and that two nights prior, she complained of abdominal pain and the inability to urinate. She noted the results of the blood tests, including venous blood gas test results taken at 4:40 am., which showed she was in metabolic acidosis (a drop in the body PH below normal), unrelated to acidosis associated with respiratory problems. This metabolic acidosis, she stated, possibly indicated dehydration. The bands portion of the white blood cell test, which indicate an active infection, was zero. She felt the test results could indicate very early stages of bacterial infection, or stress on the body if there was a recent surgery. The electrolytes were normal but the sodium bicarbonate was a little low at 17. She continued that the unofficial read of the CT scan of the abdomen/pelvis was that there was no appendicitis, however, it did reveal a positive amount of pericardial fluid (fluid around the heart). Vital signs were normal. Kiran's eyelids were noted to be edematous (swollen). Bowel sounds were positive in all four quadrants, and her abdomen was soft and nondistended. Abdominal pain was difficult to ascertain as the child had been medicated with Morphine. It was her opinion that the child was dehydrated. She did not note the child's extremities as being cold and clammy, her respirations shallow, that she had nasal flaring, or that she was having abdominal or chest pain. Fluid boluses had been ordered and antibiotics administered, which meant that the child could have been improving, and thus, these findings charted by the nurse earlier had improved. Kiran's blood sugar increased from 131 to 239, possibly indicating stress on the body.

It was Dr. Pleickhardt's assessment that the child had an acute febrile illness, moderate dehydration, and metabolic acidosis of unclear etiology. She also assessed that the child was developing shock, but crossed it out in her note. It was her opinion that Kiran was not developing shock when she saw her, as her mental status was not compromised, her blood pressure was not low as it was normal for a seven year old at 105/45. She continued that similarities between moderate dehydration and early shock are developing metabolic acidosis, elevated heart rate, weaker pulse, prolonged capillary refill, possible abnormal temperature, possible difficulty breathing, cool and clammy extremities, and decreased urinary output. The mainstay for both conditions is fluid resuscitation. In the emergency room, the child was receiving D5 ½ normal saline at 80 cc's an hour, and was administered three boluses of normal saline. Her working differential diagnosis was bladder infection that progressed into a kidney infection, a virus, diabetes based upon the elevated blood sugar, and possible appendicitis, though less likely due to the negative CT scan of the abdomen. Dr. Pleickhardt stated the child's condition was guarded as her clinical status was changing or could change. She was evaluated in the emergency room by a cardiologist, Dr. Rose. An EKG was taken. She ordered an endocrinology consult. Dr. Pleickhardt testified that she spoke to Dr. Caronia between 5:30 a.m. and 5:50 a.m., after she examined the child in the emergency room, and reported to her the history, her findings upon physical examination, and the test results. Dr. Pleickhardt stated that Dr. Caronia accepted the child for admission and formulated a therapeutic plan as attending physician. Dr. Moyer, a third year pediatric resident, took over for Dr. Pleickhardt when she signed off at 7:00 a.m. Dr. Pleickhardt testified that the child was not critically ill when her shift ended.

Catherine Caronia, M.D. testified to the extent that she is licensed in New York and is board certified in general pediatrics and pediatric critical care medicine. She stated that she is part of administration and runs the graduate medical education programs. She was the PICU attending for Kiran Zahir. She had been contacted about Kiran Zahir at home by Dr. Rogu at about 5:00 or 5:30 a.m. on December 15, 2004, and was advised that she was waiting to see if the child would be going to the operating room or would be admitted to PICU. She stated that Dr. Rogu was concerned because the child had received Morphine and Toradol and was still having abdominal pain. She arrived at the hospital at about 7:00 to 7:30 a.m. She spoke with Dr. Pleickhardt while she was driving to the hospital, and could recall only that one conversation with her. She stated that once admitted to PICU, a child is on continuous cardiopulmonary monitoring for the heart and respiratory rates, and oxygen saturation. Dr. Pleickhardt, as a third year resident, could write orders, and ordered recorded neuro checks every three hours and continuous cardiorespiratory monitoring. Dr. Caronia testified that Dr. Pleickhardt wrote her orders prior to contacting her.

Dr. Caronia testified that when the child was admitted to PICU, she was a sick young girl who was sleepy but arousable, and appropriate when aroused. She had tachycardia (high heart rate), three second capillary refill (delayed by one second), and her skin was cold and clammy. Her eyelids were edematous, her blood sugar was high, indicating a stressed patient who is very sick or diabetic, but her oxygenation and ventilation were fine. Nasal flaring was noted, but she stated that it had to be put into context with the status of the patient at the time, with considerations such as fever.

Oxygen was started. Blood tests revealed acidosis, not respiratory in origin, but probably secondary to poor perfusion. Dr. Caronia stated that she believed that the child was in compensated shock at 4:00 a.m. based upon the record, considering that her blood pressure was still normal, but her heart rate was high, her extremities cool and clammy, weak radial pulses, central perfusion present, high glucose level, prolonged capillary refill, and the results of the blood gas which revealed acidosis. She could not determine the degree of shock without having examined her to determine if she was arousable and the amount of her urine output. Dr. Caronia then testified that she did not "think it was compensated shock... She's in shock." Then she continued, "It's compensated. She's still compensating."

Dr. Caronia continued that there is compensated shock when the body and its mechanisms are able to maintain perfusion to vital organs, and maintain a cellular perfusion. A child who is in compensated shock is able to maintain blood pressure, may be tachycardic, and maintains blood flow. Uncompensated (decompensated) shock is when those mechanisms, which are able to maintain perfusion, and oxygen and nutritional delivery to vital organs, are no longer able to do so. In a child in decompensated shock, the blood pressure will fall, there will be a decrease in perfusion, or worsening of the perfusion to the extremities, urine output may not be there, and the heart rate itself may fall due to increasing acidosis and electrolyte abnormalities. She described a lethargic patient as a patient who may be easily aroused, and when aroused, typically will be awake and alert and appropriate. If a patient has been up all night, especially a child, or Morphine has been administered, lethargy may be noted. Dr. Caronia stated that a child with an infection who is in a septic state and who receives fluid, especially that of a colloidal factor, can develop capillary leak syndrome. This can cause swelling of the eyelids, or can cause fluid to leak out anywhere there is a space, such as into connective tissue, underneath the skin, genitalia, peritoneal cavity, or the pleural space. This capillary leak is due to not only the organism which causes the infection, but due to the body's own immunological inflammatory response to the organisms.

Dr. Caronia further testified that there are many forms of shock, such as hypovolemic shock, hemorrhagic shock, cardiogenic shock, and septic shock. It was her opinion that the child had septic shock with redistribution, meaning that it is not only the organism which is causing the problem, but the body's own immunologic or inflammatory processes, which continues to worsen the status of the patient. The septic shock causes a redistribution of fluid, whether extracapillary or extravascular. Small clots may form throughout the vascular system. She stated that septic shock should be treated with fluid (usually boluses followed by reevaluation), treating the infection by removing an abscess or administering antibiotics, and giving supportive care. If deterioration continues, chronotropic (heart rate) support such as epinephrine, inotropic (pump) support, and vasopressors can be utilized. She stated that at 5:30 a.m., she would have used fluid first, instead of a vasopressor, as the child's blood pressure was 105/45 and heart rate 146. A third bolus of fluid had been given, and her IV fluid was increased one and a half times to one hundred and five cc's per hour at 7:00 a.m. pursuant to Dr. Pleickhardt's order at 5:50 a.m. However, that order was not picked up by nursing until 6:45 a.m. At 5:30 a.m., the child needed to be in PICU and to be monitored. The 6:00 a.m. blood

pressure in PICU was 80/60. Dr. Caronia testified that upon confirmation of this blood pressure, she should have been notified. She stated that Dr. Pleickhardt, as a third year resident, could evaluate and care for the patient. She continued, though, that if she had known that the child already received multiple boluses of fluid, that a colloid (Albumin) would also have been added.

Dr. Caronia stated that when she arrived at the PICU, she met with Dr. Pleickhardt, examined the child, spoke to the father and the nursing staff, attempted to start a second IV, and gave some verbal orders about fluids. The child then went to the operating room. When she examined the child, she noted that she was sedated, had cool periphery, was acidotic, responded appropriately to questions, complained of being thirsty, had swollen eyelids, clear lungs bilaterally with good aeration, but had positive Kussmaul breathing[1]. She ordered a fluid bolus sometime between 7:00 a.m. and 8:00 a.m. after she examined the child. Albumin was given at 8:00 a.m. Dr. Caronia opined that it was not a departure from the standard of care for her not to order or administer treatment with a vasopressor at 7:00 a.m. Dr. Caronia did not know if she or Dr. Moyer ordered Morphine to be given to the infant at 7:45 a.m., just prior to the child going to surgery, and stated that she did not know if it was appropriate to order the Morphine.

Dr. Caronia stated that when she was in the operating room, she spoke to Dr. Bianco and to Dr. Schwartz, and asked that a central line be placed for postoperative management. She did not believe she spoke to Dr. Schwartz in PICU, although he wrote a note at 7:00 a.m. while the child was still in PICU, which note she stated she did not review. Her note indicated the child was critically ill and needed emergency surgery. After she left the child in the holding area, she returned to PICU when she was summoned to return to the operating room as the child was coding. CPR was initiated by Dr. Rosenthal at 8:59 a.m. After the child died, she wrote a note which indicated the CBC revealed "WBC with left shift" indicting neutrophils or segmented white blood cells, typically more indicative of bacterial infection. It was her opinion that she could not have done anything differently with respect to the care of the child.

Dr. Bianco testified to the extent that he is licensed to practice medicine in New York State and is board certification in anesthesiology. He stated that Kiran Zahir arrived in the holding area of the operating room at about 7:45 a.m. He was in the operating room on another case with Dr. Schwartz and saw the child in the holding room at about 8:30 a.m. He was given a report by Dr. Rosenthal and the other intensivist, and was advised that the child had been admitted the night before due to a three day history of fever of 104, and that appendicitis was to be ruled out. Dr. Rosenthal advised him that she felt the child needed a CVP line inserted because she was behind in fluid and

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[1]Dr. Caronia testified that Kussmal breathing is a type of breathing that a patient has when they are trying to blow off carbon dioxide or acid from the metabolic component. Getting rid of the acidosis would eliminate the Kussmal breathing.

could possibly be going into shock. He reviewed the chart and the labs, assessed the child, and reviewed her vital signs. He found that the child was just barely arousable, had an irregular heartbeat of 150, the respiratory rate was 33, double what it should be, and that she had a low blood pressure of 80/55. He assessed that the child was severely ill, and was either in shock or going into shock. He classified her condition as 4E. The worst condition is a 5, and E is emergent. He testified that the blood gas taken at 4:40 a.m. revealed a PH of 7.12, indicating that she had either metabolic or respiratory acidosis.

Dr. Bianco testified that he depends upon the surgeon to tell him whether the patient is physically or clinically in need of an appendectomy. Dr. Schwartz advised him that the child had appendicitis and needed surgery. Dr. Bianco asked another anesthesiologist, Dr. Richard Moore, to assist him as he thought the child was severely ill and that he might need a hand. He proceeded to induce anesthesia after taking vital signs and placing a laryngoscope to intubate her. He thought her blood pressure would drop after he induced her, and it did drop from 83/41 to 50-60/20. Her heart rate also dropped from about 150 to 70 or 60, so he administered ephedrine about five minutes after inducing her. He testified that he did not think that the blood pressure and heart rate would drop as much as it did. A code was then called at 8:59 a.m. Chest compressions were started by Dr. Rosenthal. He administered emergency medications, including Dopamine and Dobutamine. Dr. Caronia administered epinephrine. CVP and A-lines were established. At 9:30 a.m., the child's heart rate was 130 and blood pressure 115/80, indicating she was stabilized. Hetastarch, a synthetic volume expander was given to replace intravascular fluid which was escaping into the interstitial spaces. Thereafter, the child's vital signs began dropping slowly. At 10:11 a.m., her blood pressure was barely palpable, her oxygen saturation dropped to 80%, and her heart rate became low. An echocardiogram showed little heart contractility due to pericardial effusion which was tapped. Calcium was given. She was thereafter defibrillated without capture. Kiran Zahir was pronounced dead at 10:41 a.m.

It is noted that the cause of death listed on the Autopsy Report of May 9, 2005 by James C. Wilson, M.D. is "Acute viral syndrome affecting heart, liver and lungs."

Bruce Greenwald, M.D., the expert physician for Elizabeth Pleickhardt, M.D., has submitted his affirmation in which he affirms that he is licensed to practice medicine in New York and is board certified in pediatric critical care medicine and pediatrics. He does not indicate with any specificity which materials he reviewed, except to state that he reviewed " the pleadings, Bills of Particulars, pertinent medical records and deposition transcripts of the parties." He does not set forth his training and work experience to qualify as an expert in this matter, however, plaintiffs have not interposed an objection thereto. He set forth his opinion with a reasonable degree of medical certainty that the care and treatment provided to the child by Dr. Pleickhardt was at all times in accordance with good and accepted standards of care for a pediatric resident, and that there were no departures or deviations from the standards of care on her part which caused or contributed to Kiran Zahir's death.

Dr. Greenwald set forth the care and treatment rendered to Kiran Zahir by Dr. Vilela and Dr. Rogu upon her admission to Good Samaritan Hospital emergency department on December 14, 2004 at 1:27 p.m. for complaints of right abdominal pain and fever. He further set forth the testing ordered and the findings upon evaluation, including the working diagnosis of UTI (urinary tract infection) versus appendicitis. At 11:00 p.m., Dr. Schwartz, the attending surgeon, was called in to evaluate the child. Dr. Rogu, the emergency room physician, monitored the child while she was in the emergency room and ordered antibiotics intravenously at 4:00 a.m. December 15, 2004. After receiving the results of the CT scan of the abdomen, Dr. Rogu decided to admit the child to PICU and notified Dr. Caronia, the attending pediatric intensivist for PICU, of the test results. Dr. Schwartz reexamined the child at about 5:00 a.m. on December 15, 2004. Elizabeth Pleickhardt, M.D., the pediatric resident on call for pediatric ICU admissions at 5:30 a.m., spoke to Dr. Rogu, completed an admitting history and physical examination, documented her findings, the available test results, and her assessment and plan. Dr. Pleickhardt discussed the patient with Dr. Caronia and they formulated the plan of treatment together. Dr. Pleickhardt wrote her admission note and admitting orders at 5:30 a.m. The child was transferred to PICU at 5:40 a.m. Dr. Pleickhardt remained in attendance in PICU until 7:00 a.m., December 15, 2004, when her shift ended.

Dr. Greenwald stated that at all times during Kiran Zahir's admission to Good Samaritan Hospital on December 14 and 15, 2004, her care and treatment was under the supervision, direction, and control of the attending physicians in the emergency room, PICU, and operating room. He continued that, as a pediatric resident physician in training in December 2004, Dr. Pleickhardt provided medical care to patients under the supervision and control of attending physicians while the child was in the emergency room on December 15, 2004 between 5:30 a.m. and 7:00 a.m., and in PICU under the supervision and control of the pediatric intensivist, Catherine Caronia, M.D. Dr. Greenwald stated that Dr. Caronia was in charge of patients in the PICU and was responsible for the medical care provided by Dr. Pleickhardt. Additionally, during that time, the child was also seen and evaluated by Dr. Schwartz, the attending surgeon. At 7:45 a.m., the management of care was transferred to Dr. Schwartz and Dr. Bianco. Dr. Pleickhardt did not participate in the child's management and care after 7:00 a.m on December 15, 2004.

Dr. Greenwald opined that Dr. Pleickhardt acted in accordance with the standard of care and her responsibilities as a resident in obtaining a detailed and appropriate history. He continued that she performed a complete and appropriate physical examination, as was reflected by the documentation contained in her 5:30 a.m. note of December 15, 2004. Based upon the history and physical examination findings, and review of test results, including blood gases obtained at 4:42 a.m., CBC with differential and biochemistry panel, urinalysis and abdominal CT Scan, Dr. Pleickhardt's assessment was acute febrile illness, moderate dehydration, and metabolic acidosis of unclear etiology. In accordance with the standard of care and her responsibilities as a pediatric resident, Dr. Pleickhardt communicated with her supervising attending physician, Dr. Caronia, to report the findings, available test results, and assessment of the child's condition and course in the emergency department. She then entered orders for the admission of the child to PICU at 5:50 a.m.

Dr. Greenwald opined that Dr. Pleickhardt's assessment of the child's condition at 5:30 a.m. was reasonable and appropriate based on the information obtained by her and available to her at the time, including consultation with the emergency department attending, Dr. Rogu.

Dr. Greenwald further opined that Dr. Pleickhardt initially considered "developing shock" as part of her assessment, and corrected her note to delete shock from the assessment because it was her opinion that the child was not clearly in shock at the time she saw her, as supported by the available information that the child was alert and oriented, had urinated in the emergency room, and that her blood pressure was within an accepted and normal range for a seven year old child. None of the attending physicians who managed the child's care in the emergency room, PICU, or holding area of the operating room, documented a diagnosis of shock. From 5:30 a.m. through 7:00 a.m. on December 14, 2004, there was no indication to intubate the infant or to initiate vaso-pressor medication as the child was not in respiratory failure, her blood pressures were acceptable, there was urine output at 7:00 a.m., and she was oriented and appropriately responded to questions and made complaints.

Dr. Greenwald stated that Dr. Pleickhardt's initial plan of care and admission orders, made in consultation with, and under the supervision of Dr. Caronia, were appropriate and properly provided for appropriate intravenous fluids, continuous cardio-respiratory monitoring, temperature and neuro checks, strict intake and output, and additional laboratory work. Repeat boluses of intravenous fluid as needed was included in Dr. Pleickhardt's plan of care at 5:30 a.m. At 8:00 a.m., one hour after Dr. Pleickhardt's shift ended, Dr. Caronia made the determination to administer these fluid boluses. Dr. Greenwald stated that the decision of whether to treat the child with sodium bicarbonate, based upon the initial blood gas results at 4:42 a.m. received by the emergency department, was the responsibility of Dr. Rogu, and not Dr. Pleickhardt. When Dr. Pleickhardt appropriately reported the results to Dr. Caronia, the decision to administer treatment with sodium bicarbonate was then the responsibility of Dr. Caronia. Dr. Greenwald concluded that Dr. Pleickhardt did not exercise any medical judgment in connection with the medical services provided by her to the child who was under the supervision and control of the attending physician, Dr. Caronia, between 5:30 a.m. and 7:00 a.m. on December 15, 2004.

Upon review of the evidentiary submissions, it is determined that Dr. Pleickhardt has demonstrated *prima facie* entitlement to summary judgment dismissing the complaint. The admissible evidence demonstrates that Dr. Pleickhardt did not depart from good and accepted pediatric and medical standards of care; that she did not proximately cause or contribute to the infant plaintiff's injuries; that she acted under the direction of the attending physicians; she did not exercise any independent judgment; and that during her care and treatment of the infant, the physicians did not deviate so greatly from normal practice that she was responsible to intervene.

To rebut a *prima facie* showing of entitlement to an order granting summary judgment by defendants, plaintiff must demonstrate the existence of a triable issue of fact by submitting an

expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr.-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). As set forth in ***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 (2d Dept 2005), "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (citations omitted). Such credibility issues can only be resolved by a jury." The plaintiffs have submitted the affidavit of their expert physician, with the physician's name and the notary redacted.[2]

The plaintiffs' expert averred that he is licensed to practice medicine in Massachusetts and is board certified in general pediatrics and pediatric critical care medicine. He set forth his training and experience and the records and reports reviewed, including the autopsy report. He opined with a reasonable degree of medical certainty that Dr. Pleickhardt departed from good and accepted standards of medical practice by failing to promptly and accurately report Kiran's condition and symptoms to Dr. Caronia at 5:30 a.m. and failing to ask Dr. Caronia to come to the hospital immediately as the child was clearly in circulatory shock. He further opined that it was a departure from the standard of care for Dr. Pleickhardt not to diagnose circulatory shock when she examined the child at 5:30 a.m.

The plaintiff's expert opined that circulatory shock is a syndrome in which there is an inadequate delivery of oxygen to the tissues of the body, causing the body to ineffectively metabolize sugar to generate energy, causing a build up in lactic acid resulting in metabolic acidosis. This build-up is best detected by either measuring an elevated level of lactic acid or a decreased level of serum bicarbonate in the blood. Findings consistent with circulatory shock are tachycardia, lethargy, cool and clammy skin, elevated respiratory rate, metabolic acidosis, weak peripheral pulses, delayed capillary refill, and decreased urine output. The plaintiff's expert noted that when Dr. Vilela examined Kiran at 6:50 p.m., she already had symptoms of shock, to wit, cool and clammy skin, rapid heart rate and thready pulses. If this constellation of signs and symptoms, opined plaintiffs' expert, is present, and the blood pressure remains in the normal range, the patient is said to be in compensated shock. He continued that decompensated shock ensues when the blood pressure becomes inadequate. Hypotension is usually a late finding in children because they are able to sustain the tachycardia for much longer than adults because their hearts are so healthy.

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[2]A signed copy of plaintiffs' expert affirmation has been submitted to this court for in camera inspection (***Marano v Mercy Hospital***, 241 A.D.2d 48 [2d Dept 1998]; ***McCarty v. Community Hosp. of Glen Cove***, 203 A.D.2d 432 [2d Dept 1994]).

The plaintiffs' expert also opined that it was a departure from the standard of care when Dr. Pleickhardt examined Kiran at 5:30 a.m. and did not obtain her own vital signs instead of recording signs obtained the day before; failed to order additional boluses of fluid to restore perfusion; failed to order vasopressors at 5:40 a.m.; failed to correct the metabolic acidosis with either sodium bicarbonate or THAM; failed to recognize the need for the child to be intubated to correct the metabolic acidosis; failed to order more frequent vital signs; failed to order more frequent monitoring and documentation of fluid intake and output; failed to adequately assess the child's response to fluid challenges; failed to stabilize the child; failed to adequately assess tissue perfusion; and failed to adequately assess volume status, thus contributing to the demise of the child.

The plaintiff's expert stated that Dr. Pleickhardt crossed out "developing shock" and changed it to moderate dehydration and did not discuss that diagnosis with Dr. Caronia, who denied speaking with Dr. Pleickhardt until sometime between 7:00 and 7:30 a.m. The plaintiffs' expert opined that Kiran should have been admitted to PICU earlier than she was admitted, and that she needed a central venous catheter to accurately monitor the adequacy of fluid resuscitation. He continued that the child's condition deteriorated between 5:30 a.m. and 7:00 a.m., as evidenced by her decreasing blood pressure and persistent metabolic acidosis, evidencing decompensating shock. It is the plaintiffs' expert's conclusion that if Kiran's shock had been timely diagnosed and aggressively treated, perfusion to her vital organs would have been restored and she would have survived.

Based upon the opinions of the defendant's and plaintiff's experts, there are factual issues concerning whether or not Kiran was in circulatory shock at 5:30 a.m. when Dr. Pleickhardt examined the child. However, it is determined that plaintiffs' expert's opinions do not establish that Dr. Pleickhardt's alleged departures were the proximate or substantial cause of the infant's demise. The plaintiffs' expert's opinions with regard to proximate cause are conclusory and unsupported. The plaintiffs' expert does not address the cause of death set forth in the autopsy report: "acute viral syndrome affecting heart, liver and lungs" to proximately relate the child's death to Dr. Pleickhardt.

While plaintiffs' expert stated that the child's condition was deteriorating between 5:30 and 7:00 a.m., as evidenced by her decreased blood pressure and persistent metabolic acidosis, he does not support this opinion with the blood pressure readings, and instead stated that there were no vital signs taken between 6:15 a.m and 8:00 a.m. Thus, his opinion that the blood pressure was decreasing is unsupported by the record.

The plaintiffs' expert stated that Dr. Pleickhardt failed to order additional boluses of fluid to restore perfusion; failed to order vasopressors at 5:40 a.m.; failed to correct the metabolic acidosis with either sodium bicarbonate or THAM; failed to recognize the need for the child to be intubated to correct the metabolic acidosis; failed to order more frequent vital signs; failed to order more frequent monitoring and documentation of fluid intake and output; failed to adequately assess the child's response to fluid challenges; failed to stabilize the child; failed to adequately assess tissue perfusion; and failed to adequately assess volume status, thus contributing to the demise of the child.

However, the plaintiffs' expert does not set forth the standard of care or how the volume status should have been assessed or the child stabilized, and the basis for such opinions. The plaintiff's expert stated that Dr. Pleickhardt crossed out "developing shock" and changed it to moderate dehydration and did not discuss that diagnosis with Dr. Caronia, who denied speaking with Dr. Pleickhardt until sometime between 7:00 and 7:30 a.m. However, Dr. Rogu stated she spoke with Dr. Caronia at 4:00 a.m. and Dr. Pleickhardt stated she spoke with Dr. Caronia at 5:30 a.m. The plaintiffs' expert does not opine that it was Dr. Pleickhardt's responsibility to admit the child to PICU earlier, or that she exercised independent judgment or acted without being under the supervision or direction of the attending physicians.

With regard to the plaintiff's expert's claim that Dr. Pleickhardt should have employed the use of a vasopressor at 5:40 a.m., Dr. Caronia stated that at 5:30 a.m., she would have used fluid first instead of a vasopressor as the child's blood pressure was 105/45 and heart rate 146. A third bolus of fluid had been given, and her IV fluid was increased one and a half times to one hundred and five cc's per hour at 7:00 a.m. pursuant to Dr. Pleickhardt's order of at 5:50 a.m. However, that order was not picked up by nursing until 6:45 a.m. Based upon the foregoing, the plaintiffs' expert does not opine that Dr. Caronia would have permitted Dr. Pleickhardt to administer a vasopressor at that time, nor does he state how Dr. Pleickhardt departed from the standard of care when she ordered additional fluids which were not administered timely by the PICU staff. Additionally, Dr. Pleickhardt stated that she did not note the child's extremities to be cold and clammy, her respirations shallow, that there was nasal flaring, or that she was having abdominal or chest pain at 5:30 a.m. She testified that fluid boluses had been ordered and antibiotics administered, which meant that the child could have been improving when she examined her in the emergency room, and thus, these findings charted earlier by the nurse had improved with the fluid boluses given. Thus, except for a conclusory assertion, the plaintiffs' expert does not support his opinion that a vasopressor should have been employed at 5:40 a.m., or that the child was in decompensating shock.

The plaintiffs' expert opined that the child needed a central venous catheter to accurately monitor the adequacy of fluid resuscitation. However, even after Dr. Caronia arrived in PICU about 7:00 a.m., a central venous catheter and an A-line were not established until approximately 9:00 a.m., two hours after Dr. Pleickhardt completed her shift. The plaintiffs' expert continued that the child's condition deteriorated between 5:30 a.m. and 7:00 a.m., as evidenced by her decreasing blood pressure and persistent metabolic acidosis, evidencing decompensating shock. The plaintiffs' expert does not support this opinion with evidence of decreasing blood pressures between 5:30 a.m. and 7:00 a.m. or additional blood gas studies to demonstrate changes or worsening metabolic acidosis.

Based upon the foregoing, it is determined that plaintiff's expert has not raised any factual issues to preclude summary judgment being granted to Dr. Pleickhardt. He has not raised factual issue as to any alleged departures by defendant Dr. Pleickhardt being the proximate cause of Karin Zahir's death. The plaintiffs' expert has not established that Dr. Pleickhardt exercised independent

judgment. Nor has he established that Dr. Caronia so greatly deviated from normal practice that Dr. Pleickhardt should be held liable for failing to intervene.

Accordingly, summary judgment is granted to defendant Dr. Pleickhardt and the complaint as asserted against her is dismissed.

Dated: 8/14/2012

William B Rebolini

**HON. WILLIAM B. REBOLINI, J.S.C.**

_____ **FINAL DISPOSITION** ___X___ **NON-FINAL DISPOSITION**

# RIDER

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