Kontos v Tovar
2017 NY Slip Op 31674(U)
August 9, 2017
Supreme Court, Suffolk County
Docket Number: 11-16828
Judge: W. Gerard Asher
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PUBLISH

SHORT FORM ORDER

INDEX No. 11-16828
CAL. No. 16-00610MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 32 - SUFFOLK COUNTY

PRESENT:

Hon. W. GERARD ASHER
Justice of the Supreme Court

MOTION DATE 7-26-16 (001)
MOTION DATE 9-20-16 (002, 003, 004)
ADJ. DATE 1-10-17
Mot. Seq. # 001 - MG # 003 - MG
002 - MG # 004 - MG

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EVAN KONTOS An Infant by His Parents and Natural Guardians, KIMBERLY SILVERIO and JAMES KONTOS, and KIMBERLY SILVERIO and JAMES KONTOS, Individually,

Plaintiffs,

- against -

WINFRED TOVAR, M.D., LAN NA LEE, M.D., SHELLY-ANN JAMES, M.D., J. GERALD QUIRK, M.D., LEIA CARD, M.D., CECILIA AVILA, M.D., PAUL OGBURN, M.D., RANDI TURKEWITZ, M.D., CHANDA REESE, M.D., KINNARI DESAI, M.D., NOREEN DENNEHY, R.N., BRENDA SHYNGLE, R.N., JOSEPH DE CHRISTOFARO, M.D., EUNICE HAGEN, M.D., and SWATI ALETI-JACOBS, M.D.,

Defendants.

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Upon the following papers numbered 1 to 83 read on these motions for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1-20; 21-43; 44-57; 58-71 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 72-78 ; Replying Affidavits and supporting papers 79-81; 82-83 ; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion (#001) by the defendant Joseph DeCristofaro, M.D., the motion (#002) by the defendants Lan Na Lee, M.D., Shelly-Ann James, M.D., Leia Card, M.D., Randi Turkewitz, M.D., Chanda Reese, M.D., Noreen Dennehy, R.N., Brenda Shyngle, R. N., Eunice Hagen, M.D., and Swati

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Aleti-Jacobs, M.D., the motion (#003) by the defendants J. Gerald Quirk, M.D., and Paul Ogburn, and the motion (#004) by the defendant Cecilia Avila, M.D., hereby are consolidated for the purposes of this determination; and it is

ORDERED that the motion by the defendant Joseph DeCristofaro, M.D., for an order dismissing the complaint against him is granted; and it is

ORDERED that the motion by the defendants Lan Na Lee, M.D., Shelly-AnnJames, M.D., Leia Card, M.D., Randi Turkewitz, M.D., Chanda Reese, M.D., Noreen Dennehy, R.N., Brenda Shyngle, R.N., Eunice Hagen, M.D., and Swati Aleti-Jacobs, M.D., for an order dismissing the complaint against them is granted; and it is

ORDERED that the motion by the defendants J. Gerald Quirk, M.D., and Paul Ogburn, M.D., for an order dismissing the complaint against them is granted; and it is further

ORDERED that the motion by the defendant Cecilia Avila, M.D., for an order dismissing the complaint against her is granted.

In December 2008, the plaintiff Kimberly Silverio learned that she was pregnant with the infant plaintiff Evan Kontos. On March 10, 2009, the plaintiff Silverio presented to the Marilyn Shellabarger South Brookhaven Health Center for her first prenatal visit, and following an examination she was informed that her estimated due date was August 3, 2009. Upon taking Ms. Silverio's medical history, she was noted to be obese, a cigarette smoker, a user of marijuana, and an occasional alcohol user. It also was noted that on August 10, 2007, Ms. Silverio had given birth to a premature female infant, who weighed 5-and-a-half pounds, via a spontaneous vaginal delivery with vacuum assistance delivery at 35 weeks gestation at Brookhaven Memorial Hospital. During the course of her pregnancy, Ms. Silverio was diagnosed with gestational diabetes, and was advised to follow a strict diet and to monitor her blood sugar levels. Ms. Silverio also was provided with a logbook and a glucose monitor to check her blood glucose levels on a daily basis. Ms. Silverio rarely produced her logbook and glucose monitor to her doctors during her pregnancy, and, after losing the logbook in June 2009, she ceased documenting her blood sugar levels. In addition, Ms. Silverio was required to treat with a nutritionist at the Stony Brook University Clinic to discuss her eating habits and to monitor her weight throughout her pregnancy. Moreover, on May 29, 2009, Ms. Silverio was transported to Stony Brook University Hospital's emergency department via ambulance after being involved in a motor vehicle accident where she was admitted and monitored overnight, and released after being diagnosed with a urinary tract infection and obesity.

Due to her gestational diabetes, the size of the baby was monitored, and during her prenatal visit on May 27, 2009, Ms. Silverio, who was approximately 30 weeks gestation, was informed that her unborn child was "measuring large," and that she would have a "big baby" due to her gestational diabetes. At her appointment on June 21, 2009, Ms. Silverio was informed that she had gained approximately 28 pounds since her first prenatal visit and that her blood glucose levels were elevated at 166 milligrams/deciliter ("mg/dl"). Therefore, Ms. Silverio was informed that it was important for her to follow her diet, as well as monitor her blood glucose levels, because it was a danger to her unborn child if she did not control her

blood sugar levels. On June 24, 2009, it was recorded in Ms. Silverio's chart that she was morbidly obese due to her excessive caloric intake, that she failed to follow a healthy diet, and that she continued to disobey doctor's orders. On June 29, 2009, when Ms. Silverio presented for her followup, her blood glucose levels were extremely elevated at 176 mg/dl, and she had excessive white carbohydrate intake. Due to Ms. Silverio's need for oral medication to treat her elevated blood sugar levels and her gestational diabetes diagnosis, her prenatal care was transferred to University Associates Obstetrics & Gynecology, PC., a high risk clinic at Stony Brook University Hospital, when she was approximately 35 weeks gestation.

On July, 2, 2009, Ms. Silverio presented to University Associates Obstetrics & Gynecology high risk clinic for her first appointment. During that appointment she was prescribed Glyburide to be taken twice per day as a way to try to control her gestational diabetes in light of her gestational age and weight gain, and it was recorded in her medical chart that she failed to present her blood glucose logbook at her visit. A sonogram performed by a nurse practitioner that same day revealed an amniotic fluid index ("AFI") of 22.7 cm, which was above the normal limit, and it was noted that the increased amniotic fluid levels were baseline for hydronephrosis of the fetus. On July 6, 2009, Ms. Silverio underwent blood sugar testing, a urinalysis, and a biophysical profile via ultrasound to assess the baby's health. Dr. Cecilia Avila, an obstetrician-gynecologist, interpreted the ultrasound, which showed that the fetus was developing normally for its gestational age, and a plan for weekly antepartum testing was developed for Ms. Silverio.

On July 14, 2009, Ms. Silverio had a followup appointment where her blood sugar was noted to have "fair control," and her biophysical profile, which was interpreted by Dr. Paul Ogburn, an obstetrician-gynecologist, showed a normal biophysical profile and a normal amniotic fluid index. Ms. Silverio also was seen by Dr. J. Gerald Quirk, a maternal-fetal specialist, and a plan was developed for Ms. Silverio to return within one week. On July 21, 2009, Ms. Silverio had a further biophysical profile, which was normal, as was her amniotic fluid index, according to Dr. Avila. Dr. Quirk, who also saw Ms. Silverio, noted that her blood sugars were "mostly controlled," scheduled her for an induction of labor with an anticipated vaginal delivery for the following week.

On July 26, 2009, Ms. Silverio, who was approximately 39 weeks pregnant, was admitted into the antepartum unit at Stony Brook University Hospital for a schedule induction of labor due to her gestational diabetes. Upon admittance, Dr. Randi Turkewitz, a third-year resident, took Ms. Silverio's medical history and performed a physical, which included the taking of her vital signs. Testing showed her blood glucose level was 72, and the fetal heart rate was 130 beats per minutes ("bpm") with moderate variability and the presence of accelerations. In addition, the fetal weight was determined by Leopold maneuver to be approximately seven pounds, five ounces, and an ultrasound demonstrated a live fetus in a cephalic lie, i.e., a head-first presentation. A plan to initiate the medication Cervidil for "cervical ripening" purposes was formulated by Dr. Kinnari Desi, the attending physician, and Dr. Turkewitz. At approximately 7:00 p.m., Dr. Chanda Reese, a second-year resident, placed the Cervidil insertion, which was removed at approximately 9:30 p.m. After removal of the Cervidial vaginal insert, Ms. Silverio was transported to the labor and delivery unit, and Pitocin augmentation was initiated at two milliunits per minute at 10:26 p.m.

per protocol. At approximately 12:00 a.m., artificial rupture of the membranes was performed after an unchanged vaginal examination, and the Pitocin was continued.

On July 27, 2009, by 1:00 a.m., Ms. Silverio began having contractions every five minutes. She declined an epidural anesthetic; instead, Stadol and Phenergan were administered at approximately 1:45 a.m. for pain relief. An internal uterine pressure catheter was inserted to measure the strength of Ms. Silverio's contractions, and the observed elevated blood pressure levels were considered to be a result of her labor pains. By 3:00 a.m., Ms. Silverio's labor had progressed to 5cm dilated, and the fetal heart rate was assessed by Dr. Reese to be a category 1, normal. After a finger prick blood glucose test showed Ms. Silverio's glucose level to be 141, two units of regular insulin were administered to her by Nurse Brenda Shyngle, who was her primary nurse from 9:00 p.m. on July 26 through the night into July 27. At approximately 4:00 a.m., Ms. Silverio's labor had progressed to 8cm with the fetal head at 0 station, and Dr. Shelly-Ann James, a fourth-year resident, noted "reassuring" fetal heart patterns. At approximately 5:45 a.m., Ms. Silverio was fully dilated with the fetal head at 0 station. Dr. Reese and Dr. Desai devised a plan of care to treat Ms. Silverio with an epidural to allow her to "labor down," descent of the fetal head into the vaginal canal, and then to proceed with an operative vaginal delivery with either vacuum or forceps assistance due to Ms. Silverio's exhaustion and ineffective pushing. An internal scalp electrode ("ISE") was placed at approximately 5:24 a.m. to further monitor the fetal heart rate, and it was noted that the fetal position was left occiput posterior with contractions every four minutes. In addition, Dr. Desai noted that the fetal heart rate was in the "150s with moderate variability and decelerations to the 90s 1-2 minutes then return to baseline," that Ms. Silverio's previous delivery was with vacuum assistance, and that the plan of care was to resume pushing after the epidural was placed. At approximately 6:00 a.m., anesthesiology was notified and an epidural was placed, and fetal tracing improved without expulsive efforts. Pitocin was discontinued at approximately 6:25 a.m., and by 6:36 a.m., Ms. Silverio again was pushing with contractions.

At approximately 7:00 a.m., the nursing and medical staff changed shifts, and at about 7:50 a.m., Dr. Winifred Tovar, the attending physician, noted the fetal heart rate and station, which was significant for a persistent decrease to about 90 beats per minute shortly before delivery, and that Ms. Silverio had been counseled on the risks, benefits, and alternatives to a primary cesarean section versus an operative delivery. Dr. Tovar also noted that she chose to have an operative vaginal delivery with low forceps application. Neonatal Intensive Care Unit ("NICU") staff was called to be present for the operative vaginal delivery, because of fetal bradycardia and maternal exhaustion. Nurse Noreen Dennehy, the primary nurse, wrote in the delivery note that "the patient had no complaints of pain and was unable to feel contractions, an external monitor was placed on the patient's abdomen for monitoring contractions, [and that] the NICU team was at the bedside to prep for delivery." Furthermore, the operative note dictated by Dr. Lan Na Lee, a fourth-year resident, states that "she arrived at the delivery room to prepare for a forceps delivery, that Dr. Tovar already was present, that her examination confirmed Dr. Tovar's assessment of the fetus, that at 8:01 a.m. forceps were applied to the fetal vertex, which was in the Occiput Posterior position, the head facing up, that after delivering the shoulders, a body cord was appreciated, and that at 8:17 a.m. a live male infant was delivered." Dr. Lee further noted that the infant was handed off to the awaiting neonatal team.

Following the delivery of the infant plaintiff Evan Kontos, Dr. Tovar escorted Ms. Silverio to the operating room to repair a second degree perianal laceration and right sulcus tear, without complications, and at approximately 11:30 a.m., Ms. Silverio was transported to the postpartum unit after stopping in the NICU to see her son. On July 29, 2009, Ms. Silverio was discharged home from Stony Brook University Hospital. Dr. Leia Card, a second-year resident, in the discharge summary noted that the mother was discharged home with no postoperative complications, that Ms. Silverio's blood sugar levels were within normal limits, and that she no longer required oral medication for her gestational diabetes. Dr. Card also informed Ms. Silverio to followup for a postpartum visit in six weeks.

Following the birth of the infant plaintiff, Dr. Eunice Hagen, a first-year pediatric resident who was on the assembled NICU team and was present for the birth of the infant plaintiff, wrote the birth report, which states that "the 7 pound, 12 ounce infant male was delivered without respiratory effort, was cyanotic and had poor tone." Dr. Tovar also documented that the infant had suffered an hypoxic event as a result of compression of the nuchal cord found around the shoulder and body at the time of delivery, and that the NICU team supplied oxygen to the infant plaintiff via applied positive pressure ventilation ("PPV") while attempting to intubate the newborn for several minutes. The infant plaintiff's documented APGAR score at one, five, and ten minutes were one, four and seven. The report also documented that the infant had suffered cephalic edema and bruising to his left eyelid, and that he was transferred to the NICU. A head computerized tomography ("CT") scan was performed immediately on the infant plaintiff, because neonatal respiratory depression and seizure activity, as well as rapid eye movement, were observed. The head CT scan revealed subdural hemorrhage, which prompted the initiation of head cooling therapy by Dr. DeCristofaro, a pediatric neonatologist, approximately three-and-a-half hours after birth, which continued for 72 hours after birth. Antibiotic treatment also was begun and lasted for approximately one week. In addition, the blood work that was performed on the infant plaintiff showed that he had acidosis at the time of birth. Afterwards, the infant plaintiff's care was overseen by the pediatric neurology staff, who documented that the infant plaintiff had suffered hypoxic ischemic encephalophy, that his seizures subsided early, resulting in the discontinuance of the seizure medication, and that overall the infant plaintiff did well during his hospital stay.

The day after the birth of the infant plaintiff, the plaintiffs Silverio and Kontos requested a meeting to understand why their son was in the NICU. Present at the meeting was Dr. Tovar, Dr. Desai, Dr. DeCristofaro, and Dr. Swati Aleti-Jacobs, a pediatric neonatal fellow. The doctors explained that the use of the forceps during the delivery had been correctly indicated and performed, that the fetus had descended with ease down the birth canal, and that the outcome their infant had suffered was not generally associated with forceps deliveries. The doctors further explained that the hypoxic event that the infant plaintiff experienced most likely was due to the umbilical cord being wrapped, multiple times, around the infant's shoulders and abdomen, and being compressed by the vaginal walls during the infant's descent through the vaginal canal, which impeded the normal flow of oxygenated blood to the fetus during labor. Dr. Tovar and Dr. Desai further explained that prior to informing the parents on the acuity of the infant's distress in the birth canal at approximately 7:00 a.m., there had been no indication, in their judgment, for a primary cesarian section, since the fetal heart rate was a category II, only warranting close observation.

On August 7, 2009, the infant plaintiff was discharged from the hospital with instruction to follow-up with neurology, physical therapy, and early intervention. The discharge summary stated that the infant plaintiff had been diagnosed with, among other things, hypoxic-ischemic encephalopathy, subarachnoid hemorrhage, septicemia, late metabolic acidosis, and facial nerve injury due to birth trauma. The infant plaintiff after his discharge had outpatient physical examinations with Stony Brook University Hospital neurologists on September 3, 2009, September 9, 2009, and March 25, 2010, which were all normal examinations. Ms. Silverio reported to the doctors that everything was going well, that there were no seizures, infections or fevers, and that an evaluation for early intervention services found the infant plaintiff did not qualify, since he was able to bring his hands to midline, smile spontaneously and lift his head 45 degrees. At the infant plaintiff's last visit to Stony Brook University Hospital neurologists, his mother informed the doctors that the family was moving to upstate New York, and the doctors encouraged her to followup with a neurologist in approximately six months.

Thereafter, the plaintiffs Kimberly Silverio and James Kontos commenced this action on behalf of themselves, individually, and their son, the infant plaintiff Evan Kontos, against defendants Dr. Tovar, Dr. Lee, Dr. James, Dr. Quirk, Dr. Card, Dr. Cecilia Avila, Dr. Paul Ogburn, Dr. Randi Turkewitz, Dr. Reese, Dr. Desai, Nurse Dennehy, Nurse Shyngle, Dr. DeCristofaro, Dr. Hagen, and Dr. Aleti-Jacobs to recover damages for medical malpractice. The gravamen of the complaint is the defendants were negligent in the obstetric care rendered to the plaintiff Silverio and the pediatric neonatal care rendered to the infant plaintiff, and that the defendants were negligent in the care and treatment rendered to the infant plaintiff post delivery. The plaintiffs, by their bill of particulars, allege, among other things, that the infant plaintiff suffered numerous personal injuries as a result of the defendants' negligence, including brain damage; hypoxic-ischemic encephalopathy; cephalic edema; seizure activity; motor, cognitive, and developmental delays; and severe shock to the nervous system.

Dr. DeCristofaro now moves for summary judgment on the basis that he did not depart from accepted standards of medical care in his treatment of the infant plaintiff, and that the care rendered to the infant plaintiff did not proximately cause his alleged injuries. Specifically, Dr. DeCristofaro argues that the infant plaintiff's alleged injuries stem from Ms. Silverio's failure to follow her obstetrician's orders to stop smoking and to control her gestational diabetes while she was pregnant with him, and that the brain cooling procedure he performed on the infant plaintiff was medically necessary and within the requisite standard of care. In support of the motion, Dr. DeCristofaro submits copies of the pleadings, the parties' depositions transcripts, uncertified copies of Ms. Silverio's medical records, and the affirmations of his experts, Dr. Andrew Steele and Dr. Nicholas Roussis.

Drs. Lee, James, Card, Turkewitz, Reese, Hagen, and Aleti-Jacobs, and Nurses Dennehy and Shyngle (hereinafter collectively referred to as the "Stony Brook University Hospital defendants") move for summary judgment in their favor, arguing that the plaintiffs and the infant plaintiff are unable to establish a prima facie case that they departed from accepted standards of medical care in their treatment of the plaintiff Silverio and the infant plaintiff, or that their treatment proximately caused the injuries sustained by the infant plaintiff. In particular, Drs. Card, Turkewitz, Reese, Hagen and Aleti-Jacobs argue that they are entitled to summary judgment on the basis that as resident physicians and fellow physicians they did not make any independent medical decisions regarding the treatment and care of the plaintiff

Silverio or the infant plainitff, and that they were not required to intervene, because their supervising physicians' treatment plans were appropriate and within accepted medical practice. Nurses Dennehy and Shyngle assert that they were not negligent in managing the obstetrical care of Ms. Silverio. In support of the motion, the Stony Brook University Hospital defendants submit copies of the pleadings, the parties' deposition transcripts, certified copies of Ms. Silverio's and infant plaintiff's medical records, and the affirmations of their experts, Dr. Marc Engelbert and Dr. Howard Heiman.

Drs. Quirk and Ogburn also move for summary judgment on the basis that they did not depart from acceptable standards of medical care in their treatment of Ms. Silverio, and that the care they rendered to her did not proximately cause her alleged injuries. In particular, Drs. Quirk and Ogburn assert that they were not negligent in failing to plan for a cesarean section to deliver the infant plaintiff, since the plaintiff Silverio previously had a vacuum assisted vaginal delivery, and that they were not involved in the monitoring of the plaintiff Silverio's labor or the delivery of the infant plaintiff. In support of the motion, Drs. Quirk and Ogburn submit copies of the pleadings, the parties' deposition transcripts, uncertified copies of the plaintiffs' medical records, and the affirmation of their expert, Dr. Daniel Skupski

Lastly, Dr. Avila moves for summary judgment on the basis that the care and treatment she provided to Ms. Silverio did not depart from acceptable standards of medical care, and that the care and treatment she rendered to her did not proximately cause the infant plaintiff's alleged injuries. Particularly, Dr. Avila argues that she only treated Ms. Silverio on two occasions, and that she was not involved in Ms. Silverio's prenatal care and did not make any recommendations in regards to the management of said care or formulate the labor and delivery plan. In support of the motion, Dr. Avila submits copies of the pleadings, uncertified copies of the plaintiff's medical records, her own affidavit, and the affirmation of her expert, Dr. Adiel Fleischer.

The plaintiffs do not oppose the motions made by the Stony Brook defendants or Dr. Avila. The plaintiffs also do not oppose the application for summary judgment in favor of Drs. Quirk and Ogburn. However, the plaintiffs do oppose the branch of the motion by the Stony Brook defendants seeking summary judgment in favor of Dr. Aleti-Jacobs on the grounds that there are triable issues of fact as to whether Dr. Aleti-Jacobs made independent treatment decisions regarding the care of the infant plaintiff, and whether such treatment decisions deviated from the applicable medical standard of care and were a proximate cause of the infant plaintiff's alleged injuries. The plaintiffs also oppose Dr. DeCristofaro's motion for summary judgment on the grounds that there are material issues of fact as to whether Dr. DeCristofaro deviated from acceptable standards of medical care when rendering treatment to the infant plaintiff, and whether such deviations were the proximate cause of the infant plaintiff's alleged injuries. In opposition to the motion, the plaintiffs submits the redacted and unsigned affidavit of their expert, the certified medical records of the plaintiff Silverio and the infant plaintiff, and Dr. Aleti-Jacobs' deposition transcript.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant physician must establish through medical records and competent expert affidavits that he or she did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that he or she was not the proximate cause of plaintiff's injuries (*see* ***Castro***

v New York City Health & Hosps. Corp., 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2010]; ***Deutsch v Chaglassian***, 71 AD3d 718, 896 NYS2d 431 [2d Dept 2010]; ***Plato v Guneratne***, 54 AD3d 741, 863 NYS2d 726 [2d Dept 2008]; ***Jones v Ricciardelli***, 40 AD3d 935, 836 NYS2d 879 [2d Dept 2007]; ***Mendez v City of New York***, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). To satisfy this burden, the defendant must present expert opinion testimony that is supported by facts in the record and addresses the essential allegations in the bill of particulars (*see* ***Roques v Noble***, 73 AD3d 204, 899 NYS2d 193 [1st Dept 2010]; ***Ward v Engel***, 33 AD3d 790, 822 NYS2d 608 [2d Dept 2006]). Conclusory statements that do not address the allegations in the pleadings are insufficient to establish entitlement to summary judgment (*see* ***Garbowski v Hudson Val. Hosp. Ctr.***, 85 AD3d 724, 924 NYS2d [2d Dept 2011]). A physician owes a duty of reasonable care to his or her patients and will generally be insulated from liability where there is evidence that he or she conformed to the acceptable standard of care and practice (*see* ***Spensieri v Lasky***, 94 NY2d 231, 701 NYS2d 689 [1999]; ***Barrett v Hudson Valley Cardiovascular Assoc., P.C.***, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]; ***Geffner v North Shore Univ. Hosp.***, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]). A doctor is not a guarantor of a correct diagnosis or a successful treatment, nor is a doctor liable for a mere error in judgment if he or she has considered the patient's best interest after careful evaluation (*see* ***Nestorowich v Ricotta***, 97 NY2d 393, 740 NYS2d 668 [2002]; ***Oelsner v State of New York***, 66 NY2d 636, 495 NYS2d 359 [1985]; ***Bernard v Block***, 176 AD2d 843, 575 NYS2d 506 [2d Dept 1991]).

Failure to demonstrate a prima facie case requires denial of the summary judgment motion, regardless of the sufficiency of the opposing papers (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 5088 NYS2d 923 [1986]). Once the defendant makes a prima facie showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of triable issues of fact which require a trial of the action (*see* ***Alvarez v Prospect Hosp.***, *supra*; ***Kelley v Kingsbrook Jewish Med. Ctr.***, 100 AD3d 600, 953 NYS2d 276 [2d Dept 2012]; ***Fiorentino v TEC Holdings, LLC***, 78 AD3d 911 NYS2d 146 [2d Dept 2010]). Specifically, in a medical malpractice action, a plaintiff opposing a motion for summary judgment need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing (*see* ***Bhim v Dourmashkin***, 123 AD3d 862, 999 NYS2d 471 [2d Dept 2014]; ***Hayden v Gordon***, 91 AD3d 819, 937 NYS2d 299 [2d Dept 2012]; ***Stukas v Streiter***, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; ***Schichman v Yasmer***, 74 AD3d 1316, 904 NYS2d 218 [2d Dept 2010]).

Upon review of the affirmations of Dr. DeCristofaro's experts, Dr. Andrew Steele and Dr. Nicholas Roussis, and the additional exhibits submitted in support of the motion, the Court finds that Dr. DeCristofaro has established, as a matter of law, that he did not deviate from good and acceptable medical practice in rendering care to the infant plaintiff, and that the treatment provided by him was not the proximate cause of the alleged injuries sustained by the infant plaintiff (*see* ***Omane v Sambaziotis***, 150 AD3d 1126, 55 NYS3d 345 [2d Dept 2017]; ***Gattling v Sisters of Charity Med. Ctr.***, 150 AD3d 701, 53 NYS3d 665 [2d Dept 2017]). Dr. Steele states that he is board certified in pediatrics and neonatal-perinatal medicine, and licensed to practice medicine in the State of New York. Dr. Steele states that in his opinion, within a reasonable degree of medical certainty, Dr. DeCristofaro, at all times, acted within the appropriate standard of care in providing care and treatment to the infant plaintiff, and that no act or omission on Dr. DeCristofaro's behalf contributed or proximately caused the infant plaintiff's injuries. Dr. Steele states

that the presence of a significant metabolic acidosis with a pH level of 7.08 and base deficit of -13, as well as the bradycardia identified at birth, indicated that the infant plaintiff had suffered an acute, complete umbilical cord compression with onset shortly before delivery, and that the presence of compressed slit-like ventricles on the head ultrasound and CT scan, along with the abnormal laboratory test results, were indicative of liver and kidney injuries due to an hypoxic-ischemic event that occurred 24 hours or more prior to delivery. In addition, Dr. Steele states that upon arrival in the NICU the infant plaintiff was diagnosed with hypoxic-ischemic encephalopathy ("IHE"), Stage II Sarnat and CFM moderate abnormality, and that, in light of evidence of an acute hypoxic-ischemic event causing and/or contributing to his abnormal neurologic state, Dr. DeCristofaro correctly evaluated the infant plaintiff for possible therapeutic hypothermia, and appropriately initiated the head cooling protocol within six hours of the infant plaintiff's birth, which continued for approximately 72 hours. Dr. Steele states, within a reasonable degree of medical certainty, that Dr. DeCristofaro correctly determined that the infant plaintiff met the criteria for cool cap therapy, as he exhibited continued need for resuscitation, moderate to severe encephalopathy with hypotonia, clinical seizures, and he was less than six hours old. He states that Dr. DeCristofaro also appropriately treated the infant plaintiff with phenobarbital for seizures, mechanical ventilation for six days, and antibiotics for seven days to prevent any infection. Dr. Steele states that it is his opinion, within a reasonable degree of medical certainty, that Dr. Cristofaro's actions in initiating brain cooling therapy potentially mitigated the injuries to the infant plaintiff. Lastly, Dr. Steele states that in his opinion, within a reasonable degree of medical certainty, Dr. DeCristofaro responded appropriately to all of the medical problems presented by the infant plaintiff, and that the records clearly indicate that the infant plaintiff suffered some form of trauma and/or was injured prior to delivery.

Furthermore, Dr. Roussis, who is a licensed physician practicing obstetrics and gynecology, states, within a reasonable degree of medical certainty, that the injuries experienced by the infant plaintiff occurred before Dr. DeCristofaro began treating the infant plaintiff, and that Ms. Silverio's failure to properly care for her gestational diabetes, as well as her smoking cigarettes and marijuana use, contributed to the mental and physical injuries sustained by the infant plaintiff. Dr. Roussis explains that Ms. Silverio's gestational diabetes may have affected the infant plaintiff's kidney formation, that the plaintiff Silverio at her pre-natal appointment on July 2, 2009 was baseline hydronephrosis, which can lead to abnormalities in the amount of amniotic fluid and can impair fetal lung development, and that the most common complication associated with gestational diabetes is macrosomia, aka big baby syndrome, which occurred in this situation. Dr. Roussis states that macrosomia can lead to abnormally low blood sugar levels, which can result in seizures; that gestational diabetes can result in a fetus having an increased chance of respiratory distress syndrome, because the lungs take longer to mature when the mother has gestational diabetes; and that respiratory distress syndrome impacts the amount of oxygen flow to the brain, which also can cause seizures when the oxygen level is too low. Dr. Roussis states, within a reasonable degree of medical certainty, that a pH level of 7.0 and below is considered acidic; that when a baby is born with high acidity in his or her umbilical cord, the baby is at a greater risk for cerebral palsy, brain damage and infant death; and that if during the delivery the baby does not receive adequate oxygen, it's umbilical cord pH level declines, resulting in a host of issues that can cause brain damage. Dr. Roussis states that the umbilical cord pH level at the time of the infant plaintiff's birth was 7.08, that an ideal normal pH level is between 7.25 to 7.35, and that the low pH level can help to explain why the infant plaintiff had such complications after his birth. Dr. Roussis further states that in his opinion, within a reasonable degree of

medical certainty, Dr. DeCristofaro did not depart from accepted standards of medical care, that Dr. DeCristofaro's actions did not proximately cause or contribute to the infant plaintiff's injuries, and that the hospital records indicate that the infant plaintiff suffered from a trauma or injury that occurred prior to the delivery.

In addition, the Stony Brook University Hospital defendants have made a prima facie showing entitling them to judgment as a matter of law by demonstrating that they were either residents or fellows under the supervision of an attending physician at all times during the plaintiff Silverio's labor and delivery of the infant plaintiff, and the infant plaintiff's subsequent hospitalization in the NICU (*see* ***Quille v New York City Health & Hosp. Corp.***, __ AD3d __, 2017 NY Slip Op 05863 [2d Dept 2017]; ***Nasima v Dolen***, 149 AD3d 759, 51 NYS3d 189 [2d Dept 2017]; ***Leavy v Merriam***, 133 AD3d 636, 20 NYS3d 117 [2d Dept 2011]; ***Poter v Adams***, 104 AD3d 925, 961 NYS2d 556 [2d Dept 2013]). When supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene (***Bellafiore v Ricotta***, 83 AD3d 632, 633, 920 NYS2d 373 [2d Dept 2011]; *see* ***Crawford v Sorkin***, 41 AD3d 278, 839 NYS2d 40 [1st Dept 2007]; ***Soto v Andaz***, 8 AD3d 470, 779 NYS2d 104 [2d Dept 2004]). The Stony Brook University Hospital defendants proffered evidence showing that they implemented treatment plans created by their attending physicians that were not "'so clearly contraindicated by normal practice that ordinary prudence require[d] inquiry into these plans' 'correctness'" (***Costello v Kirmani***, 54 AD3d 656, 657, 863 NYS2d 262 [2d Dept 2008], quoting ***Cook v Reisner***, 295 AD2d 466, 467, 744 NYS2d 426 [2d Dept 2002]; *see* ***Bellafiore v Ricotta***, *supra*; ***Muniz v Katlowitz***, 49 AD3d 511, 856 NYS2d 120 [2d Dept 2008]; ***Velez v Goldenberg***, 29 AD3d 780, 815 NYS2d 205 [2d Dept 2006]; ***Roseingrave v Massapequa Gen. Hosp.***, 298 AD2d 377, 751 NYS2d 218 [2d Dept 2002]; *cf.* ***Pearce v Klein***, 293 AD2d 593, 741 NYS2d 89 [2d Dept 2002]). Furthermore, Dr. Marc Engelbert, who is board certified in obstetrics and gynecology, and Dr. Howard Heiman, who is board certified in pediatrics and neonatal-perinatal medicine, each state in his affirmation that in his opinion, within a reasonable degree of medical certainty, the Stony Brook University Hospital defendants, while working under the supervision and direction of attending physicians, provided good and proper medical care to the plaintiff Silverio and the infant plaintiff, and that none of the named physicians or nurses made any independent decisions concerning the plaintiff Silverio's or the infant plaintiff's medical care that resulted in the alleged injuries (*see* ***Elmes v Yelon***, 140 AD3d 1009, 34 NYS2d 470 [2d Dept 2016]; ***Guctas v Pessolano***, 132 AD3d 632, 17 NYS3d 749 [2d Dept 2015]).

Likewise, Dr. Quirk and Dr. Ogburn have established their prima facie entitlement to judgment as a matter of law by submitting an affirmation from Dr. Daniel Skupski, which demonstrated that the care and treatment rendered to Ms. Silverio did not deviate or depart from good and acceptable medical care, and that their treatment of the plaintiff Silverio was not the proximate cause of her alleged injury or the alleged injuries of the infant plaintiff (*see* ***Makinen v Torelli***, 106 AD3d 782, 965 NYS2d 529 [2d Dept 2103]; ***Poter v Adams***, 104 AD3d 925, 961 NYS2d 556 [2d Dept 2013]; ***Barrett v Hudson Val. Cardiovascular Assoc., P.C.***, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]). Dr. Skupski, who is a board certified obstetrician and gynecologist with a subspecialty in maternal-fetal medicine, states, within a reasonable degree of medical certainty, that the treatment rendered to the plaintiff Silverio by Dr. Quirk and Dr. Ogburn on July 14, 2009 was, at all times, within good and acceptable standards of medical care,

that there were no departures from accepted standards of medical care, and that their treatment did not proximately cause or contribute to the plaintiff's or the infant plaintiff's injuries (*see* ***Trauring v Gendal***, 121 AD3d 1097, 995 NYS2d 182 [2d Dept 2014]; ***Olgun v Cipolla***, 82 AD3d 1186, 920 NYS2d 175 [2d Dept 2011]; ***Rebozo v Wilen***, 41 AD3d 457, 838 NYS2d 121 [2d Dept 2007]). Dr. Skupski states that it was appropriate and well within the standard of care when Dr. Quirk planned for an induction and trial of labor when he last treated Ms. Silverio on July 21, 2009. Dr. Skupski explains that in 2009 obstetricians and maternal fetal medicine practitioners did not follow the concept of pelvimetry, which requires the obstetrician to try to ascertain whether the maternal pelvic anatomy is adequate for a vaginal delivery. Rather, he states that obstetricians followed the concept of "a previously tested and successful pelvis is a normal pelvis; thus, if a woman had a previous successful vaginal delivery, and the baby's head is in the cephalic presentation, then the standard of care required that a trial of a labor be attempted." Dr. Skupski further explained that with a prior vaginal delivery, the pelvis is considered "gynecoid" for purposes of attempting a vaginal delivery for a new pregnancy, and that, since the plaintiff Silverio previously delivered vaginally with vacuum assistance, and the baby was in the cephalic presentation, it was entirely appropriate for Dr. Quirk to plan for an induction. However, the standard of care did not require Dr. Quirk to anticipate that Ms. Silverio would have a difficult delivery, based on her obstetrical history, or to plan a cesarean section. Furthermore, Dr. Skupski states that, based on the fact that the plaintiff Silverio's biophysical profile and amniotic fluid level were normal, and her blood sugar level was controlled on the last date of treatment with Dr. Quirk, the standard of care required him to recommend an induction and vaginal delivery; therefore, Dr. Quirk did not depart from the standard of care in not planning for a cesarean section. Dr, Skupsi further states that Dr. Quirk's failure to plan for a cesarean section was not a proximate cause of or a substantial factor in the injuries suffered by either Ms. Silverio or the infant plaintiff, because the doctors at Stony Brook University Hospital were capable of performing a cesarean section if the need for one became necessary.

In addition, Dr. Skupsi states that Dr. Ogburn did not deviate from the accepted standard of medical care, and did not proximately cause the alleged injuries to the plaintiff Silverio or the infant plainitff, since his one and only interaction with the plaintiff Silverio was when he interpreted the biophysical profile performed on July 14, 2009, which confirmed fetal well-being. Dr. Skupski states that Dr. Ogburn appropriately interpreted the biophysical profile as normal, that the amniotic fluid level was normal, and that the standard of care did not require him to seek any additional testing or assessments of the fetus at the time. Lastly, Dr. Skupsi states that as Dr. Ogburn was not involved in the planning or management of the plaintiff Silverio's labor and delivery, there is no connection between Dr. Ogburn's interpretation of the biophysical profile on July 14, 2009 and Ms. Silverio's or the infant plaintiff's injuries, since his treatment and care of the plaintiff Silverio began and ended on that date.

Similarly, Dr. Avila has established her prima facie burden of entitlement to judgment as a matter of law by proffering the deposition testimonies of the plaintiffs Silverio and Kontos, and by submitting her own affidavit and the affirmation of Dr. Adiel Fleischer, in which he opined that the care and treatment rendered to Ms. Silverio by Dr. Avila did not deviate or depart from good and acceptable standards of medical care, and that her treatment of the plaintiff Silverio was not the proximate cause of any injuries she allegedly sustained or the infant plaintiff (*see* ***Muniz v Mount Sinai Hosp. of Queens***, 91 AD3d 612 [2d Dept 2012]; ***Belak-Redl v Bollengier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; ***Ellis v Eng***,

70 AD3d 887, 895 NYS2d 462 [2d Dept 2010]; ***Adjetey v New York City Health & Hosps. Corp.***, 63 AD3d 865, 881 NYS2d 472 [2d Dept 2009]; ***Tuorto v Jadali***, 62 AD3d 784, 878 NYS2d 457 [2d Dept 2009]). Dr. Fleischer, who is board certified in fetal medicine and maternal medicine, and the chairman of the Department of Obstetrics/Gynecology at North Shore University Hospital/Long Island Jewish Medical Center, states it is his opinion, to a reasonable degree of medical certainty, that the care and treatment rendered by Dr. Avila to Ms. Silverio was in all respects reasonable and did not depart from good and accepted standards of medical practice. Dr. Fleischer states that it is his opinion nothing Dr. Avila did, or did not do, with regards to the care and treatment of Ms. Silverio caused or contributed in any way to any of her alleged injuries or those of the infant plaintiff. Dr. Fleischer states that Dr. Avila's role in Ms. Silverio's prenatal care and treatment was to perform the biophysical profiles and report the findings, and that she did not have any further involvement in Ms. Silverio's care and treatment, since the findings never suggested an emergent condition requiring immediate intervention. Dr. Fleischer explains that a biophysical profile is a prenatal test performed to check on fetal well-being, and combines fetal heart rate monitoring, a non-stress test, and fetal ultrasound, and that during the test the baby's heart rate, breathing, movements, muscle tone, and amniotic fluid level are evaluated and given a score. Dr. Fleischer states that due to the plaintiff Silverio's history of gestational diabetes, there was an indication for the performance of biophysical profiles to monitor the fetus' growth. Dr. Fleischer states that Dr. Avila's interpretations of the biophysical profiles performed on July 6, 2009, and July 21, 2009, both of which had a the fetal score of eight, were accurate and confirmed the well-being of the infant plaintiff. Dr. Fleischer further states that Dr. Avila's interpretations and findings of the two biophysical profiles that she performed on the plaintiff Silverio were unrelated to the events that occurred during Ms. Silverio's labor and delivery or the infant plaintiff's condition.

Furthermore, Dr. Fleischer states that the thirteen images taken by Dr. Avila during the biophysical on July 6, 2009 did not indicate any need or immediate intervention, and that the images and measurements were consistent with what was written in the report prepared by Dr. Avila. Dr. Fleischer explains that the measurements obtained during the ultrasound were proper for evaluating fetal growth and well-being, and that they were used to calculate gestational age, which is based upon bipareteal diameter, head circumference, femur length, and abdominal circumference. Dr. Fleischer states that Dr. Avila correctly interpreted and confirmed fetal well-being, that the finding of the evaluation did not cause any harm or injury to Ms. Silverio or the infant plaintiff, and that there was no indication that the fetus was in distress or that immediate intervention was necessary. Dr. Fleischer states that on July 21, 2009, Dr. Avila, once again, accurately interpreted the biophysical profile as being completely normal, without any fetal distress requiring immediate intervention, and confirmed fetal well-being. Additionally, Dr. Fleischer states that since Dr. Avila was not involved in the labor and delivery, it is his opinion, within a reasonable degree of medical certainty, that the position of the fetus during the biophysical profiles on July 6, 2009 and July 21, 2009 were not relevant, since the fetal position on those days are not indicative of the fetal position at the time of delivery, because the fetus will rotate positions throughout the final weeks of pregnancy, even at the time of birth.

As mentioned above, the plaintiffs do not oppose the motions made by the Stony Brook University Hospital defendants or by Dr. Avila, nor do the plaintiffs oppose the application for summary judgment in favor of Dr. Quirk and Dr. Ogburn. Therefore, the plaintiffs failed to raise a triable issue of fact as to

whether these doctors deviated from the applicable standard of care in their treatment of the plaintiff Silverio and the infant plaintiff, and whether such deviation was a proximate cause of their alleged injuries (*see* ***Moore v St. Luke's Roosevelt Hosp. Ctr.***, 60 AD3d 828, 874 NYS2d 389 [2d Dept 2009]; *see also* ***Groeger v Col-Les Orthopedic Assoc., P.C.***, 149 AD2d 973, 540 NYS2d 109 [4th Dept 1989]).

In addition, the plaintiffs failed to raise a triable issue of fact in opposition to Dr. DeCristofaro's and Dr. Aleti-Jacobs' prima facie showings that they did not depart from acceptable standard of medical care in the treatment they rendered to the infant plaintiff, and that their treatment was not a proximate cause of the infant plaintiff's injuries (*see* ***Fitz v Burman***, 107 AD3d 936, 968 NYS2d 167 [2d Dept 2013]; ***Nyrell Joyner-Packer v Sykes***, 54 AD3d 727, 864 NYS2d 447 [2d Dept 2008]). The plaintiffs primarily rely upon the affidavit of their expert, who alleges to be board certified in pediatric medicine with a subspecialty in neonatology. The plaintiffs' expert concludes that Dr. DeCristofaro and Dr. Aleti-Jacobs deviated from acceptable standards of medical care in rendering treatment to the infant plaintiff, and that such deviation was the proximate cause of the infant plaintiff's injuries. In particular, the expert asserts that Dr. Aleti-Jacobs, a senior fellow, made independent decisions in regards to the care and treatment of the infant plaintiff during his stay in the NICU, and that those independent treatment decisions resulted in the alleged injuries sustained by the infant plaintiff.

However, the expert's affirmation is not notarized, the name and signature have been redacted, and the plaintiffs have failed to submit an unredacted original copy of their expert's affirmation for an in camera inspection (*see* ***Miller v Brust***, 278 AD2d 462, 717 NYS2d 663 [2d Dept 2000]; ***Gourdet v Hershfeld***, 277 AD2d 422, 716 NYS2d 714 [2d Dept 2000], *lv denied* 96 NY2d 853, 729 NYS2d 669 [2001]; *see also* ***Marano v Mercy Hosp.***, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). "A redacted physician's affidavit should not be considered in opposition to a motion for summary judgment where a plaintiff does not offer an explanation for the failure to identify the expert by name and does not tender an unredacted affidavit for in camera review" (***Colletti v Deutsch***, 150 AD3d 1196, 1198, 54 NYS3d 657 [2d Dept 2017]; *see* ***Derrick v North Star Orthopedics, PLLC***, 121 AD3d 741, 994 NYS2d 159 [2d Dept 2014]). Since summary judgment is the equivalent of a trial (*see* ***S.J. Caplin Assoc. v Globe Mfg Corp.***, 34 NY2d 338, 357 NYS2d 478 [1974]), an unredacted original copy of the plaintiffs' expert's affirmation must be submitted to the court for in camera review (*see* ***Turi v Birk***, 118 AD3d 979, 988 NYS2d 670 [2d Dept 2014]; ***Rose v Horton Med. Ctr.***, 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]; ***Marano v Mercy Hosp.***, *supra*). Thus, absent the submission of an unredacted expert's affirmation for the Court's in camera inspection and the failure to provide an explanation for the failure to identify the expert by name, the plaintiffs have failed to submit evidence in admissible form sufficient to raise a triable issue of fact (*see* ***Capobianco v Marchese***, 125 AD3d 914, 4 NYS3d 127 [2d Dept 2015]; ***France v Packy***, 121 AD3d 836, 994 NYS2d 364 [2d Dept 2014]). An in camera review of an unredacted expert's affirmation submitted by a medical malpractice plaintiff seeking to demonstrate a triable issue on a summary judgment motion "strikes an appropriate balance between the plaintiff's right to withhold the identity of an expert prior to trial and the defendant's interest in testing the validity of the plaintiff's cause of action and assuring that an expert exists" (*see* ***McCarty v Community Hosp. of Glen Cove***, 203 AD2d 432, 433, 610 NYS2d 588 [2d Dept 1994]).

In any event, even if the Court were to overlook the failure to submit an unredacted copy of the plaintiffs' expert's affirmation, the plaintiffs still failed to raise a triable issue of fact, since their expert's affirmation is conclusory, speculative, and without basis in the record (*see* ***Giacinto v Shapiro***, 151 AD3d 1029, __NYS3d __ [2d Dept 2017]; ***Shuck v Stony Brook Assoc.***, 140 AD3d 725, 33 NYS3d 369 [2d Dept 2016]; ***Senatore v Epstein***, 128 AD3d 794, 9 NYS3d 362 [2d Dept 2015]). Accordingly, Dr. DeCristofaro's, the Stony Brook University Hospital defendants', Dr. Avila's, and Drs. Quirk and Ogburn's motions for summary judgment dismissing the complaint are granted.

Dated: August 9, 2017

W. Gerard Asher
J.S.C.
HON. W. GERARD ASHER

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**

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