Kurlekar v Zilberstein
2014 NY Slip Op 30396(U)
February 10, 2014
Sup Ct, New York County
Docket Number: 800358/2011
Judge: Joan B. Lobis

[* 1]

SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: _____ PART 6
Justice

Ashlan Kurlekar

-v-

Inga Zilberstein

INDEX NO. 800358/11

MOTION DATE _____

MOTION SEQ. NO. 002

MOTION CAL. NO. _____

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

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

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION & ORDER

UNFILED JUDGMENT

This judgment has not been entered by the County Clerk and notice of entry cannot be served based hereon. To obtain entry, counsel or authorized representative must appear in person at the Judgment Clerk's Desk (Room 141B).

Dated: 2/10/14

JOAN B. LOBIS J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☐ FINAL DISPOSITION ☐ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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AHILAN KURLEKAR, an Infant by his Mother and Natural Guardian PRADNYA JOSHI,

Plaintiff,

-against-

INGA ZILBERSTEIN, M.D., and LENOX HILL HOSPITAL,

Defendants.

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Index No. 800358/2011

Decision and Order

JOAN B. LOBIS, J.S.C.:

This action arises out of the prenatal, labor and delivery, and neonatal care of infant Ahilan Kurlekar. On his behalf, Pradnya Joshi, his mother, brings this action alleging medical malpractice against Inga Zilberstein, M.D., and Lenox Hill Hospital. Defendant Lenox Hill Hospital ("LHH") moves for summary judgment pursuant to Section 3212 of the Civil Practice Law and Rules. For the following reasons, the motion is granted in part and denied in part.

On July 11, 2007, Ms. Joshi first saw Dr. Zilberstein, her private obstetrician, for pre-natal care. During her pre-natal care, Ms. Joshi saw several other doctors, in part because her pregnancy was considered a high risk pregnancy due to idiopathic thrombocytopenic purpura ("ITP")[1]. Ms. Joshi was also diagnosed with gestational diabetes in December 2007. In March 2008, a final sonogram showed normal amniotic fluid index and Doppler values. None of Ms. Joshi's sonograms or treatments between July 2007, and March 2008, took place at LHH.

[1]ITP is a disorder in which the immune system destroys platelets. It is characterized by a rash and an increased tendency to bleed.

Ms. Joshi was admitted to LHH on March 9, 2008, for induction of labor, still under the care of Dr. Zilberstein. Dr. Zilberstein states that in such a situation she would have notified hospital staff and provided admission orders. A half hour after admission, a fetal heart rate monitor was placed. At 12:43am on March 10, 2008, Ms. Joshi's platelet count was at 71. Ms. Joshi's medical records indicate that her hematologist, James Bussel, M.D., a non-party not employed by LHH, recommended a stress dose of steroids followed by a repeat complete blood count, and only recommended an epidural if platelets were above 80.

At 12:53 am and 1:06 am, the fetal heart rate monitor showed variable decelerations. During the first deceleration, the fetal heart rated dropped to 85 beats per minute for 90 seconds with a gradual return baseline. Between 1:06 am and 5:00 am, there were no further decelerations. Ms. Joshi's contractions started at 6:45 am, but the fetal heart rate remained stable. At 10:00 am, in response to a platelet count of 67, Dr. Bussel ordered human immune globulin for Ms. Joshi.

Dr. Zilberstein artificially ruptured Ms. Joshi's membrane at 12:44 pm. A small amount of light meconium fluid with amniotic fluid odor was noted. Ms. Joshi was in active labor at 4:00 pm, and fetal heart rate readings were noted every fifteen to twenty minutes. At 5:40 pm and 5:59 pm early decelerations were noted. The first stage of labor ended at 6:49 pm, and the cervix was fully dilated. The fetal heart rate was monitored every five minutes but not routinely documented. LHH indicates that this was because the nurse was attending to the patient. Ahilan Kurlekar was born at 7:20 pm on March 10, 2008. The umbilical cord was wrapped around the neck loosely and moderate meconium was present.

The infant had an AGPAR score of 3. The heart rate was above 100, respiratory effort was absent, and the infant was blue/pale. Neonatology Nurse Practitioner Sabrina Opiola-McCauley and Mariann Kelty, R.N., resuscitated the infant. Ahilan was stimulated with a heart rate maintained at over 100bpm and suctioned to clear the airway. Positive pressure ventilation and blow-by oxygen were administered via bag and mask. By five minutes after delivery, the AGPAR score was 6 with an irregular and slow respiratory effort and blue extremities. Ten minutes after delivery, the AGPAR score improved to 8, with good respiratory effort, vigorous cry, and blue extremities.

Ahilan was not intubated but was transferred to the neonatal intensive care unit with continuous positive airway pressure ("CPAP") and oxygen. No cord blood gases were ordered or drawn. Antibiotics were started prophylactically. CPAP was discontinued at 10:30 pm. The infant was alert and active and remained stable between March 10 and March 11, 2008. At 4:00 pm on March 11, 2008, Ahilan desaturated with fist clenching and hand twitching. The seizure lasted for approximately ten minutes, and ten minutes later the infant had another seizure.

Attending neurologist John Wells, M.D., was contacted to evaluate the infant in the morning. His impression was clinical seizures. The infant was administered Phenobarbital. At 4:45 pm on March 12, 4 seizures were noted over a 30 minute span. The infant was again given a continuous infusion of Phenobarbital.

Following rounds with neonatology attending physician Marty Ellington M.D., a non-

party and the Chairman of the Department of Pediatrics at LHH, a neonatal nurse practitioner noted that Ahilan's normal CT scan, MRI, and head ultrasound, and all cultures, remained negative, but seizure activity continued with a suspected cause of sepsis. On March 13, Dr. Ellington had a family meeting and discussion with Ahilan's parents. He indicated that there was a probability that there was a chronic placental insufficiency resulting in poor tolerance of delivery and labor causing a limited but significant period of ischemia and brain edema.

No seizure activity was noted on March 14, 2008. Antibiotics were completed March 17, 2008. Dr. Wells noted that a neurological exam was normal. On March 19, 2009, Ahilan was discharged from the hospital. He was to transition to an oral dose of Phenobarbital and have a follow-up visit with neurology in three weeks. His assessment on discharge was medically controlled seizure activity.

This action was commenced on October 14, 2011. Plaintiff alleges two causes of action. First, Plaintiff alleges that Defendants were negligent and committed medical malpractice in their treatment of the infant and the infant's mother, including claims for failure to provide timely and proper prenatal, labor and delivery, and neonatal care; failure to properly diagnose, monitor, and treat intrauterine growth restriction; failure to timely and properly assess placental sufficiency; failure to timely and properly monitor the fetus in utero; failure to prevent fetal distress; failure to timely induce labor and delivery; failure to perform cord blood gases; failure to timely and properly diagnose and treat metabolic acidosis; and failure to timely and properly oxygenate the infant.

Plaintiff alleges that the infant sustained severe and permanent neurological and physical injuries including global developmental delays, brain damage, speech and language delays, neurological/cognitive deficits, motor delays, inability to live independently, diminished earning capacity, and loss of enjoyment of life. Plaintiff also alleges lack of informed consent as a second cause of action. Specifically, Plaintiff alleges that the Defendants failed to advise the Plaintiff's mother of the risks, dangers, and consequences associated with the performance or non-performance of various treatments, procedures, surgeries, and diagnostic procedures.

Defendant LHH now moves for summary judgment. LHH argues that there are no triable issues of fact. They claim that Ms. Joshi's prenatal care was not rendered by LHH or its employees. Furthermore, they state that all treatment and care provided during labor and delivery and neonatal care was within the good and accepted standards of medical care. They also argue that Dr. Zilberstein was responsible for the entirety of Ms. Joshi's labor and delivery as the attending physician. They contend that all neonatal care was within the standard of care.

In support of the motion, Defendant LHH provides the affirmation of Gary Mucciolo, M.D., a board certified obstetrician and gynecologist. Dr. Mucciolo opines that LHH's labor and delivery care and treatment were within the appropriate standards of medical practice and did not contribute to the infant's injuries. He asserts that Ms. Joshi's prenatal care was not provided by LHH or its employees or provided at any of LHH's facilities. Dr. Mucciolo argues that LHH appropriately followed Dr. Zilberstein's instructions and that the instructions were not so contraindicated as to warrant inquiry into her direction and supervision. Dr. Mucciolo affirms that according to Dr.

Zilberstein's testimony, she was fully aware at all times of the fetal heart rate and any possible fetal distress as she was either physically present in the room or watching the fetal strips herself.

Additionally, LHH provides the affirmation of Edmund LaGamma, M.D., who is board certified in pediatrics and neonatal-perinatal medicine. Dr. LaGamma asserts to a reasonable degree of medical certainty that LHH and its staff rendered neonatal care and treatment that was within the appropriate standards of medical practice that existed at the time and did not contribute to the infant's injuries. He maintains that Sabrina Opiola-McCauley, N.P., and Marian Kelty, R.N., properly resuscitated the infant upon delivery. He opines that due to the improvement in the infant's AGPAR score 5 to 10 minutes post-delivery, that intubation was never medically indicated for the infant and that he was appropriated transferred to the neonatal intensive care unit ("NICU")with CPAP and oxygen.

He also argues that LHH did not fail to timely observe and diagnose meconium passage or prevent meconium aspiration as the medical records indicate that there was no evidence of meconium aspiration. He affirms that LHH promptly treated metabolic acidosis in the infant and monitored his blood gases. LHH administered appropriate amounts of sodium bicarbonate and normal saline as an antidote to acidosis. Capillary blood gases drawn at 11:00 pm on March 10 and 6:40 am on March 11 demonstrated that the infant's acidosis had resolved.

Dr. LaGamma maintains that LHH did not fail to perform a full sepsis assessment of the infant. He claims that LHH did a complete sepsis work up, including blood cultures,

administration of prophylactic antibiotics, and a lumbar puncture at the first sign of abnormal neurological activity. Since blood cultures and lumbar puncture ultimately revealed no growth, sepsis was ruled out. Dr. LaGamma argues that since there was no evidence of infection or sepsis, no further assessment was indicated.

Additionally, he contends that a complete neurological work up and assessment was performed. Since there was no abnormal neurological activity prior to 4:00 pm on March 11, 2008, a full work up was not indicated prior to that time. After 4:00 pm, neurology was promptly contacted and a CT scan of the head was administered in a timely fashion. Dr. Wells was notified of the abnormal neurological activity and consulted the following day. Dr. LaGamma affirms that this was the proper course of care and that Dr. Wells appropriately diagnosed clinical seizures.

Dr. LaGamma also maintains that cranium cooling and the administration of neuroprotective agents were not generally accepted medical practices in 2008. He asserts that the technology for cranium cooling was not universally available and that it would not have been part of the standard of care to utilize cranium cooling for infants with suspected hypoxic ischemic encephalopathy. He also claims that there were no generally accepted neuroprotective agents for treatment of hypoxic ischemic encephalopathy in 2008, or any treatment other than the administration of antibiotics in the event of infection or sepsis. Lastly, he contends that neonatal neurological syndrome describes non-specific physical findings and is not a diagnosis so LHH could not have failed to diagnose neonatal neurological syndrome. He claims that LHH records reflect thorough documentation of physical observation of the infant upon delivery and reflects appropriate

resuscitative efforts immediately undertaken to address these physical findings, which yielded a positive response.

Plaintiff argues that LHH has not established a prima facie case for summary judgment and that there are triable issues of fact. She contends that the LHH obstetrical staff failed to recognize or take any action in response to a prolonged pattern of nonreassuring fetal heart rate patterns. She alleges that Dr. Zilberstein was not properly informed by LHH staff about the fetal heart rate patterns. Furthermore, she maintains that there is an issue of fact as to whether the infant plaintiff sustained acute hypoxic-ischemic brain injury during the mother's labor. She asserts that there is no information on the record that indicates that nurses ever contacted Dr. Zilberstein or that Dr. Zilberstein was closely managing the patient.

In support of Plaintiff's opposition to Defendant's motion, Plaintiff offers the affirmation of Dr. Bruce L. Halbridge, M.D., a board certified obstetrician and gynecologist. Dr. Halbridge states that according to the LHH chart, Dr. Zilberstein was not present or directly supervising the obstetric nurses and medical staff. He asserts that the record indicates that Dr. Zilberstein was not present during or notified of any late decelerations. He contends that the nurses' notes concerning the fetal heart rate patterns was boilerplate. Though he admits that there is nothing wrong with the boilerplate, he believes that the entries, as they were keyed in by nurses using a commercial charting system, indicate that the nurses were not actually scrutinizing the monitor tracings or did not understand their significance. Dr. Halbridge claims that it is the duty of hospital obstetrical staff, including nurses, to carefully monitor the condition of the mother and fetus and to

pay particular attention to nonreassuring heart rate patterns shown on the monitor.

He opines that recurrent variable and late decelerations of the heart rate were a substantial contributing factor to the infant's brain injury. He claims that the decelerations are particularly dangerous when the parent is at risk for gestational diabetes and ITP. Dr. Halbridge alleges that there was unquestionably intrauterine growth restriction, which substantially contributed to the poor fetal perfusion and oxygenation. He explains that excessive decelerations impair fetal cerebral auto-regulation, and blood pressure to the white matter in the fetal brain drops. The lowered blood pressure recurrences during labor lead to ischemia and destruction of white matter in the fetal brain. He asserts that the fetus does not have completely developed autoregulatory capacity. Specifically, the fetus's arterioles have a limited ability to vary their tone in response to changes in perfusion pressure. As a result, during a period of intermittent ischemia with decelerations the entire brain cannot remain sufficiently perfused. Dr. Halbridge states that when severe variable decelerations are present, vigorous efforts should be made to abolish them.

Dr. Halbridge claims that the duty of care requires that if Dr. Zilberstein could not respond to deliver the infant, the staff was required to notify a member of the resident staff to do so. Because decelerations started at 1:00 pm and Dr. Zilberstein only returned at 6:18 pm, the staff should have responded differently. He opines that the failure of the LHH staff to intervene in the presence of recurrent late and variable decelerations over several hours during Ms. Joshi's labor was a substantial contributing factor in the infant sustaining hypoxic-ischemic brain injury. He argues that the cause of the metabolic acidosis had to do with the decreased blood flow or ischemia to the

infant, a conclusion, he notes, held also by Dr. Marty Ellington.

Dr. Halbridge contends that the standard of care required bringing the fetal heart rate monitor strips to Dr. Zilberstein's attention, calling her to examine the patient, and arranging for prompt caesarean delivery in Dr. Zilberstein's absence. He concludes that the failure to deliver the infant plaintiff by caesarean section was a substantial contributing factor in hypoxic-ischemic fetal brain injury resulting neonatal depression, seizures, and encephalomalacia seen on the MRI at three years of age.

In addition, Plaintiff provides the affirmation of Gregory Lawler, M.D., who is board certified in radiology and neuroradiology. Dr. Lawler reviewed several documents for his affirmation: the infant's CT scan of the brain from March 11, 2008, the MRI of the brain performed on March 12, 2008, and the associated hospital radiology reports, and the MRI of the brain performed at New York Presbyterian Hospital on February 4, 2011. Dr. Lawler claims that the March 12, 2008, MRI shows "unmistakable hyperintensity" within the left frontal lobe, not a "faint high signal" as reported by an LHH radiologist. He argues that the diffusion weighted images reveal an acute ischemic infarct and that there is restricted diffusion of water molecules, which is evidence of ischemic tissue injury. He asserts that the encephalomalacia described in the 2011 MRI is in the s ame area as the ischemic infarct seen on the March 12, 2008, MRI.

Dr. Lawler states that the March 11, 2008, CT scan, taken 26 hours after the infant's birth, appears normal. He claims that the CT images would be abnormal if the ischemic insult had

occurred in utero before labor. He explains that ischemic injury in the middle cerebral artery territory, as visible on the March 12, 2008, image, is generally not visible on a CT scan within 24 hours. Dr. Lawler concludes that because the injury is visible on the March 12, 2008, image, ischemic brain injury must have occurred at or about the time of labor and delivery.

In reply, LHH argues that Plaintiff fails to set forth any evidence demonstrating the existence of a genuine issue of material fact with respect to any alleged departure from the standard of care. Furthermore, the Defendant argues that Plaintiff does not address either prenatal care or neonatal care. LHH claims that Plaintiff implies that Dr. Zilberstein was misleading in regards to her claims that she monitored and supervised Ms. Joshi's labor and delivery. LHH contends that hospital records either state or are silent to Dr. Zilberstein's presence and that Plaintiff's assertions are merely suppositions without evidence. Defendant claims that insufficiency in charting or keeping complete records is not malpractice. LHH states that it would be patently unreasonable to infer that Dr. Zilberstein falsely testified because there is not "a single shred of evidence in the record which contradicts" her testimony.

In considering a motion for summary judgment, this Court reviews the record in the light most favorable to the non-moving party. E.g., Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 308 (1st Dep't 2007). A movant must support the motion by affidavit, a copy of the pleadings, and other available proof, including depositions and admissions. C.P.L.R. Rule 3212(b). The affidavit must recite all material facts and show, where a defendant is the movant, that the cause of action has no merit. Id. This Court may grant the motion if, upon all the papers and proof submitted, it is

established that the Court is warranted as a matter of law in directing judgment. Id. It must be denied where facts are shown "sufficient to require a trial of any issue of fact." Id.

In a medical malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. E.g., Joyner-Pack v. Sykes, 54 A.D.3d 727, 729 (2d Dep't 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Roques, 73 A.D.3d at 206. The expert cannot make conclusions by assuming material facts not supported by record evidence. Id. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must "explain 'what defendant did and why.'" Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 (1st Dep't 2003)). Conclusory medical affirmations or expert opinions that fail to address a plaintiff's essential factual allegations are insufficient to establish prima facie entitlement to summary judgment. 73 A.D.3d at 206. Once a defendant establishes a prima facie case, a plaintiff must then rebut that showing by submitting an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure proximately caused the alleged injuries. Id. at 207.

As to Ms. Joshi's prenatal care, the Court finds that the Defendant has established a

prima facie case for summary judgment. Furthermore, Plaintiff has not responded to LHH's prima facie case. Because it is uncontroverted that prenatal care was not at LHH's facility or administered by any employee of LHH, there are no triable issues of fact as to whether LHH was responsible for any treatment or injuries that occurred prior to Ms. Joshi's admission to LHH on March 9, 2008.

Next, the Court addresses LHH's labor and delivery care and treatment. The Court finds that LHH has established a prima facie case for summary judgment. Dr. Mucciolo establishes that LHH appropriately followed instructions from Dr. Zilberstein, and that, based on Dr. Zilberstein's testimony, she was fully aware of the fetal heart rate and any possible fetal distress. Plaintiff's expert, however, rebuts Defendant's prima facie case. Plaintiff explains that the medical affirmation does not address Plaintiff's essential factual allegations. Though Defendant LHH argues that the record either states or is silent to Dr. Zilberstein's presence or management of Ms. Joshi, the silence creates a triable issue of fact when combined with Dr. Zilberstein's testimony. In particular, Dr. Zilberstein repeatedly states that she cannot tell based off the medical chart whether she was or was not present or informed at any time. Dr. Zilberstein never attests that she was or wasn't present during decelerations or whether or not she was actually contacted by LHH staff. Instead, she asserts that she is "generally" present or watching strips and that it is customary that resident staff would call her attention. In other words, there is no testimony that attests that when a specific deceleration occurred, Dr. Zilberstein was either notified or was present. Plaintiffs establish that neither the records nor Defendant's expert's medical affirmation make clear what LHH specifically did or did not do during decelerations.

Lastly, the Court addresses the infant's neonatal care. The Court finds that LHH has

established a prima facie case for summary judgment. Dr. LaGamma establishes that the LHH staff met the standard of care. In particular, he claims that LHH properly resuscitated the infant and treated the infant. He also addresses the specific factual allegations of the Plaintiff by detailing how evidence did not support certain findings, such as sepsis, or how certain treatments were simply not part of the standard of care in 2008, such as cranium cooling.

Plaintiff fails to rebut LHH's prima facie case for summary judgment regarding the infant's neonatal care. Dr. Halbridge claims that the failure to timely deliver the infant by caesarean section was a substantial factor in causing the infant's injuries, but he does not address whether any neonatal treatment was a contributing factor. Dr. Halbridge establishes that metabolic acidosis was present at delivery, which LHH's expert concedes, but he does not address whether LHH's treatment of metabolic acidosis was improper. Dr. Lawler, Plaintiff's second expert, is a radiologist and neuroradiologist, but not a neonatologist. He does not respond to any of LHH's claims about neonatal treatment. His affirmation focuses purely on the general timing of the injury without addressing any alleged violations of the standard of care by LHH. Accordingly, it is

ORDERED and ADJUDGED that summary judgment is granted as to any claims involving prenatal or neonatal treatment; and it is further

ORDERED that summary judgment is denied as to any claims regarding treatment during labor and delivery; and it is further

ORDERED that the parties appear for a pre-trial conference on March 18, 2014 at 2:30 p.m.

Dated: Feb 10, 2014

ENTER:

JOAN B. LOBIS, J.S.C.