Waring v Matalon
2016 NY Slip Op 32516(U)
September 27, 2016
Supreme Court, Suffolk County
Docket Number: 11-10248
Judge: W. Gerald Asher
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SHORT FORM ORDER

INDEX No. 11-10248
CAL. No. 15-02121MM

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 4-21-16
ADJ. DATE 6-7-16
Mot. Seq. #002 - MG
#003 - MG
#004 - MG

KAYMARIE WARING,

Plaintiff,

- against -

MARTIN MATALON, M.D., JONATHAN GOLDSTEIN, M.D., RANDI M. ROTHSTEIN, M.D., ELIZABETH SCHMIDT, M.D., SOUTHSIDE HOSPITAL, NORTH SHORE UNIVERSITY HOSPITAL - LONG ISLAND JEWISH HEALTH SYSTEM, INC., and NORTH SHORE UNIVERSITY HOSPITAL,

Defendant.

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Upon the following papers numbered 1 to 75 read on these motions for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1 - 15; 16 - 33; 34 - 49 ; Notice of Cross Motion and supporting papers ____; Answering Affidavits and supporting papers 50 - 67 ; Replying Affidavits and supporting papers 68 - 69; 71 - 73; 74 - 75 ; Other ____; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion by defendant Martin Matalon, M. D., for summary judgment in his favor dismissing the complaint asserted against him is granted; and it is further

ORDERED that motion by defendants Randi M. Rothstein, M.D., Elizabeth Schmidt, M.D., Southside Hospital, North Shore University Hospital-Long Island Jewish Health System, Inc., and North Shore University Hospital for summary judgment in their favor dismissing the complaint asserted against them is granted; and it is further

ORDERED that the motion by Jonathan Goldstein, M.D., for summary judgment in his favor dismissing the complaint asserted against him is granted.

Plaintiff commenced this action to recover damages as a result of alleged medical malpractice that caused her to prematurely deliver her daughter, Corinne Angelica Rose-McIntosh, stillborn. Plaintiff also alleges lack of informed consent for an emergency Cesarean section at North Shore University Hospital, and negligence in hiring and supervising medical personnel. A related action, brought under index number 19768-12, which alleged the same causes of action against additional defendants, was consolidated with this action. Discovery has been completed and a note of issue filed.

Defendant Dr. Martin Matalon moves for summary judgment in his favor dismissing the complaint asserted against him on the ground that the baby was born alive and, therefore, no action for a stillborn birth can be maintained (***Broadnax v Gonzalez***, 2 NY3d 148, 777 NYS2d 416 [2004]). In support of the motion he submits, among other things, the summons and complaint under index number 19768-12; the answer, demand for a verified bill of particulars and amended verified bill of particulars under index number 10248-11; the deposition transcript of plaintiff, Dr. Yevgeniya Pozharny, and Devon Macintosh, the baby's father; his own deposition testimony; medical records from North Shore University Hospital; the baby's birth certificate; and an affirmation of defendant Dr. Randi M. Rothstein.

Defendants Dr. Randi M. Rothstein, Dr. Elizabeth Schmidt, Southside Hospital, North Shore University Hospital-Long Island Jewish Health System, Inc., and North Shore University Hospital (collectively referred to as the hospital defendants) move for summary judgment in their favor dismissing the complaint on the same ground. The hospital defendants also contend that they cannot be held liable for the acts or omissions of plaintiff's private attending physician, that North Shore University Hospital acted in accordance with good and standard accepted medical practice, that the claim for lack of informed consent must be dismissed, as no treatment was rendered by North Shore University Hospital-Long Island Jewish Health System, Inc., and that the negligent hiring claim must be dismissed. In support of the motion they submit an expert affirmation of Dr. Frank A. Manning, the summons and complaint under index number 10248-11; the answer and amended answer under index number 19768-12; the verified bill of particulars; plaintiff's medical records from Southside Hospital and North Shore University Hospital; the birth certificate; the deposition transcripts of plaintiff, Dr. Martin Matalon, Dr. Jonathan Goldstein, and Dr. Yevgeniya Pozharny; the note of issue; the so-ordered stipulation of consolidation, dated March 5, 2013; the affirmation of Dr. Rothstein; and the affidavit of Mercedes Toro of Northwell Health, Inc.

Defendant Dr. Jonathan Goldstein moves for summary judgment in his favor dismissing the complaint asserted against him, relying on the holding in on ***Broadnax***. In support of the motion he submits the pleadings, plaintiff's medical records, the affirmation of Dr. Rothstein, the birth certificate, and the death certificate.

In opposition to the motions, plaintiff submits the pleadings in both actions; an expert affirmation of a pediatric neurologist; an expert affirmation of an obstetrician and gynecologist; plaintiff's medical records; the deposition transcripts of plaintiff, Dr. Martin Matalon, Dr. Jonathan Goldstein, and Dr. Yevgeniya Pozharny. Plaintiff does not oppose dismissal of the claims against defendants Dr. Randi M.

Rothstein, Dr. Elizabeth Schmidt, and Long Island Jewish Health System, Inc. Plaintiff's primary arguments in opposition to the motions are that the baby was "legally and clinically dead" at the time of delivery, that defendants' experts do not opine that they did not deviate from accepted standards of medical care, and that her medical experts raise triable issues of fact.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant must establish through medical records and competent expert affidavits that it did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that it 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]).

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]).

Here, if the infant was born alive, and plaintiff has no independent injury to herself, she could not recover for emotional distress under the authority of ***Broadnax v Gonzalez***, 2 NY3d 148, 777 NYS2d 416 (2004), and ***Sheppard–Mobley v King***, 4 NY3d 627, 797 NYS2d 403 (2005), under the theory that the infant can maintain her own claim.

Plaintiff testified and the medical records show that on November 5, 2010, at approximately 2:00 p.m., plaintiff, who was then age 37, and 26 weeks pregnant, called her obstetrician/gynecologist Dr. Martin Matalon who had been treating her since August 27, 2010. Plaintiff had taken her blood pressure at her work as a nursing administrative assistant and obtained a blood pressure of 230/110. Dr. Matalon advised plaintiff to go to Southside Hospital where he was an attending physician in the Southside Hospital Department of Obstetrics and Gynecology. At 2:47 p.m., plaintiff was admitted to Southside Hospital, her blood pressure at admission was 230/128. She complained of seeing white spots before her eyes, swelling

in her face and feet, headache, slurred speech and nausea. Dr. Matalon called in Dr. Goldstein and Dr. Kadjifici. Plaintiff was diagnosed with pregnancy-induced hypertension and possible preeclampsia. At 7:25 p.m., plaintiff's urine was positive for protein (500 mg/dl). Sometime prior to 7:10 p.m., plaintiff saw maternal fetal medicine physician Dr. Goldstein. Her liver functioning, platelets and hematocrit were normal, and initial lab results were "essentially normal." At 9:00 p.m., a 24-hour urine protein test was ordered. After two IV pushes of Labetalol, her blood pressure was dropping to the 180s over 90s. Dr. Goldstein recommended a transfer to ICU for Labetalol drip. On November 6, 2010, at 8:24 a.m., a urine test was positive for protein (500 mg/dl).

On November 7, 2010, the 24-hour urine protein test found 11-grams of protein in plaintiff's urine. Plaintiff was diagnosed with preeclampsia. Her blood pressure was controlled with values in the 140s/90s. Preeclampsia labs were significant for creatine of 1.0, but were otherwise within normal limits. A decision was made to transfer plaintiff to North Shore University Hospital, as Southside Hospital was not equipped to care for a neonate of 26 weeks. Dr. Yevgeniya Pozharny, a maternal fetal medicine physician at North Shore University Hospital, was contacted and agreed to accept plaintiff. She recommended administering Betamethasone (a steroid to advance fetal lung maturity) and magnesium (to prevent seizures) to plaintiff. Plaintiff was transported and admitted to North Shore University Hospital on November 7, 2010 at 2:35 p.m.

At North Shore University Hospital, plaintiff continued on the Labetalol drip and her blood pressure was in the 140s/90s range. Plaintiff was seen by Dr. Pozharny 15 to 20 minutes after admission. An ultrasound showed a live fetus and a fetal heart rate in the 120s. Dr. Pozharny confirmed the diagnosis of severe preeclampsia. Preeclampsia, a disorder of pregnancy characterized by high blood pressure and a large amount of protein in the urine, usually occurs in the third trimester of pregnancy and worsens over time. In severe cases of preeclampsia there may be red blood cell breakdown, a low blood platelet count, impaired liver function, kidney dysfunction, swelling, shortness of breath due to fluid in the lungs, or visual disturbances. Preeclampsia increases the risk of poor outcomes for both the mother and the baby. If left untreated, it may result in seizures at which point it is known as eclampsia. Dr. Pozharny ordered the placement of a central line and aterial line. Umbilical Doppler velocimetry noted reversed end-diastolic flow with normal amniotic fluid volume. In a normal situation, umbilical arterial flow should always be in the forward direction in both systole and diastole. The treatment plan was for external fetal monitoring and delivery in case of non-reassuring fetal heart tracings. Preeclampsia labs were to be repeated and magnesium to be continued to prevent seizures. Labetalol was continued. Dr. Pozharny testified that since the mother was stable and her blood pressures were in the mild range, the plan of treatment was to obtain as much time in uterus for the fetus and administer a second dose of Betamethasone to maximize fetal outcome; but if fetal heart rates were not reassuring or the mother's condition deteriorated, then a quick delivery of the baby. Dr. Pozharny charted that she explained to plaintiff that she had developed severe preeclampsia, that the presence of reversal end-diastolic flow was indicative of a longstanding disease process and a poor prognosis for the fetus. She explained that delivery should be held off until additional Betamethasone was administered, but if the fetal heart beat was non-reassuring, or if her blood pressure went up or there were lab abnormalities or low urine output, the delivery would be sooner.

On November 7, 2010, at approximately 4:45 p.m., fetal heart rate monitoring indicated late decelerations with minimum variability that required delivery. Plaintiff was transported to the delivery room at 4:58 p.m. Dr. Rothstein, assisted by Dr. Elizabeth Schmidt, an obstetrical resident, delivered the baby

by Cesarean section. At 5:05 p.m. the baby had a spontaneous heart beat of "less than 60 bpm," and her Apgar score was 1 at one minute. She did not have spontaneous respiratory effort and was suctioned, stimulated and given positive pressure ventilation by face mask and bag value. The baby was intubated and good chest movement was noted. Chest compressions were initiated and Epinephrine was administered. Apgar scores were reassessed at 5 minutes and again at 10 minutes, both with a score of 1. Her muscle tone was flaccid, her reflexes showed no response, and her color was "blue/pale." The "infant's heart rate continued to be appreciated at 1 minute, 5 minutes, and 10 minutes after delivery." Sadly, at 5:17 p.m., the baby died. Pursuant to Public Heath Law § 4130 (1), the baby was issued a birth certificate.

Plaintiff remained at North Shore University Hospital until November 11, 2010. She was treated with oral Labetalol and when her blood pressure improved she was released. In 2011, plaintiff became pregnant again and, on December 21, 2011, she delivered a child by Cesarean section without complication.

Moving defendants have established their prima facie entitlement to summary judgment based upon the affirmation of Dr. Rothstein that the baby was born alive by Cesarean section at 5:05 p.m. "with a spontaneous heart beat that was present without any life supporting efforts." The position that the baby was born alive is also supported by the Apgar scores as well as Public Health Law § 4130 (1) as a certificate of live birth was issued.

In opposition, plaintiff maintains that Corinne Angelica Rose-McIntosh, had "already suffered irreversible brain death" prior to the Cesarean section and was, therefore, "legally and clinically dead at the time of [her] delivery." Plaintiff relies on the opinion of one of her two experts, the condition of the placenta at the time of delivery and the autopsy report. Dr. Albert Yeh, the pathologist and author of the autopsy reports that "[t]his is a case of a 26 weeks old female fetus ***born*** to a 34 year-old G21001 mother on Nov. 07, 2010." (emphasis added) "***Baby*** was delivered with a heart rate of < 60. Resuscitation with chest compressions and positive pressure ventilation was initiated but despite resuscitation efforts, heart rate remained below 60 and ***baby expired***." (emphasis added) Dr. Yeh concluded, "[i]n summary, the cause of fetal demise is probably due to poor maternal-fetal perfusion as a complication of pre-eclampsia." He also found that microscopic sections of the baby's brain "reveals no significant change." Dr. Yeh reports "fetal demise," but also indicates the "baby" was delivered and that the female fetus was "born."

In ***Amin v Soliman***, 67 AD3d 835, 889 NYS2d 629 (2d Dept 2009), the plaintiffs raised a triable issue of fact as to whether the fetus was stillborn as the infant had no respiratory response, the Apgar score was zero at one, five and ten minutes after birth and the infant died within ten minutes after being removed from a ventilator. Unlike ***Amin***, the Apgar scores here were 1 at one, five and ten minutes after birth. In ***Levin v New York City Health and Hospitals Corp.***, 119 AD3d 480, 990 NYS2d 490 (1st Dept 2014), *lv denied* 25 NY3d 962, 28 NYS3d 258 (2015), the infant had a heart rate of 70 to 80 beats per minute and weak movement of the extremities. Her Apgar scores were 1 at one and five minutes, with no respiratory effort, limp muscle tone, no response to stimuli and pale or blue color. While in a neonatal intensive care unit (NICU), no resuscitation was attempted, and after 3 ½ hours after delivery, the infant died. Plaintiff's expert in ***Levin*** concluded that the infant was not viable and was "brain dead" within 15 minutes after birth.

Here, plaintiff's pediatric neurology expert speculates that at 5:05 p.m. "the fetus was brain dead." At the time of delivery her placenta was friable (easily crumbled or pulverized), discoid (shaped like a disc),

and grossly infarcted (tissue that is dying or dead having been deprived of its blood supply). The expert contends that "[a]lthough the fetus has a lingering heart rate of 60 beats per minute at the time of delivery, this was an autonomic response and not indicative of brain stem activity." Plaintiff's expert's opinion is not based upon any test of brain activity and can only offer conjecture of the time the infant's brain activity stopped. On November 7, 2010, there were in utero fetal heart monitoring showing heartbeats up to the time of delivery. Plaintiff's expert opinion that the infant's "brain activity" ceased is belied by the affirmation of the delivery room doctor, who avers " that the infant female was delivered alive by Cesarean section with a spontaneous heart beat that was present without any life supporting efforts. The infant's heart rate continued to be appreciated at 1 minute, 5 minutes and 10 minutes after delivery."

Plaintiff's obstetrician and gynecologist expert opines that on November 5, 2010, plaintiff was suffering from severe preeclampsia when she presented at Southside Hospital, and that treating her for hypertension associated with pregnancy was a deviation from accepted standards of medical care. Her two urinalysis tests were positive for proteinuria at 4:11 p.m. and 8:35 p.m. on November 5, 2010, and again at 8:00 a.m. on November 6, 2010. The expert opines that it was malpractice to fail to timely transport plaintiff to a hospital with a level three NICU. He opines it was an additional deviation from accepted standards of medical care in failing to order a 24-hour urine test stat and to place plaintiff on continuous electronic fetal monitoring. He also alleges it was a deviation from accepted medical care by North Shore University Hospital in failing to immediately place plaintiff on fetal heart monitoring upon her arrival and waiting almost 40 minutes after fetal heart tracings with absent variability and deep prolonged decelerations to deliver by C-section. He avers "[t]he fetal heart strips are indicative of a baby that is terminal based upon lack of variability and deep prolonged decelerations, indicating an agonal condition. The delivery records show that the fetus never had consciousness of any kind and was not viable." He does not opine that the baby was stillborn or "brain dead."

On November 7, 2010, the baby, Corinne Angelica Rose-McIntosh, was issued a "Certificate of Live Birth" pursuant to Public Health Law § 4130 (1), which section provides:

> 1. Live birth is defined as the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born.

The court finds that the baby was born alive based upon the undisputed beating of the baby's heart, the Apgar scores of 1, and the affirmation of Dr. Rothstein, the delivery room doctor, who avers "that the infant female was delivered alive by Cesarean section with a spontaneous heart beat that was present without any life supporting efforts. The infant's heart rate continued to be appreciated at 1 minute, 5 minutes and 10 minutes after delivery." Accordingly, the plaintiff's first cause of action against all defendants alleging "pain, great agony, suffering, mental anguish and emotional distress" is dismissed (***Sheppard-Mobley v King***, 4 NY3d 627, 797 NYS.2d 403 [2005]).

As tp plaintiff's claim for lack of informed consent, Public Health Law § 2805-d (1) defines lack of informed consent as "the failure of the person providing the professional treatment * * * to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make knowledgeable evaluation." To establish a medical malpractice claim based on lack of informed consent, a plaintiff must show (1) that the defendant failed to disclose alternatives to the proposed treatment and the foreseeable risks associated with such treatment, that a reasonable medical practitioner under similar circumstances would have disclosed, (2) that a reasonably prudent person in the patient's position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury (*see* Public Health Law § 2805-d [3]; ***Manning v Brookhaven Mem. Hosp. Med. Ctr.***, 11 AD3d 518, 782 NYS2d 833 [2d Dept 2004]; ***Trabal v Queens Surgi-Center***, 8 AD3d 555, 779 NYS2d 504 [2d Dept 2004]; ***Foote v Rajadhyax***, 268 AD2d 745, 702 NYS2d 153 [3d Dept 2000]). To establish the proximate cause element, a plaintiff must show that the operation, treatment or procedure for which there was no informed consent was a substantial cause of the injury (*see* ***Thompson v Orner***, 36 AD3d 791, 828 NYS2d 509 [2d Dept 2007]; ***Trabal v Queens Surgi-Center***, 8 AD3d 555, 779 NYS2d 504; ***Mondo v Ellstein***, 302 AD2d 437, 754 NYS2d 579 [2d Dept 2003]).

Here, defendants' submissions, particularly the deposition testimony of Dr. Pozharny, are sufficient to establish a prima facie case of entitlement to judgment in defendants' favor as a matter of law on the cause of action for lack of informed consent (*see* ***Kunic v Jivotovski***, 121 AD3d 1054, 995 NYS2d 587 [2d Dept 2014]; ***Belak-Redl v Bollingier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]). In particular, Dr. Pozharny testified, in relevant part, that plaintiff was advised that the plan was made for external fetal monitoring and delivery in case of non-reassuring fetal heart tracings. The medical records indicate "[t]he patient was informed that delivery was to occur after the patient was steroid complete." "Additionally, the patient was informed that we would deliver the patient more expeditiously for nonreassuring fetal heart status, maternal uncontrolled hypertension, lab abnormalities or oliguria (the production of abnormally small amounts of urine). All questions were answered." Moreover, it is undisputed that the Cesarean section occurred on an emergency basis. For the claim to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d [2]). The record establishes the treatment rendered by the hospital was on an emergency basis. Defendants have established their prima facie entitlement to dismissal of this cause of action and in opposition plaintiff has not raised a triable issue of fact. Accordingly, plaintiff's second cause of action is dismissed as to all defendants.

As to the cause of action for negligent hiring, hospitals are vicariously liable for the acts of their employees and may be vicariously liable for the malpractice of a physician, nurse, or other health care professional that it employs under the doctrine of respondeat superior (*see* ***Hill v St. Clare's Hosp.***, 67 NY2d 72, 499 NYS2d 904 [1986]; ***Bing v Thunig***, 2 NY2d 656, 163 NYS2d 3 [1957]; ***Seiden v Sonstein***, 127 AD3d 1158, 7 NYS3d 565 [2d Dept 2015]). Generally, a hospital is not vicariously liable for the malpractice of a physician who is not employed by the hospital and is not liable for injuries suffered a patient under the care of a private physician where the hospital staff carries out a private physicians orders (***Fink v DeAngelis***, 117 AD3d 894, 986 NYS2d 212 [2d Dept 2014]). However, "an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing" (***Smolian v Port Auth. of N.Y. & N.J.***, 128 AD3d 796, 801,

9 NYS3d 329, 334 [2d Dept 2015]). Under a theory of apparent or ostensible agency, a hospital may be vicariously liable for the malpractice of a physician, who is not an employee of the hospital, if a patient reasonably believes that the physicians treating him or her were provided by the hospital or acted on behalf of the hospital (***Hilsdorf v Tsioulias***, 132 AD3d 727, 17 NYS3d 655 [2d Dept 2015]; ***Loaiza v Lam***, 107 AD3d 951, 968 NYS2d 548 [2d Dept 2015]).

Southside Hospital has established that Dr. Martin Matalon is a private attending physician who is not employed by the hospital. Dr. Jonathan Goldstein, who was called by Dr. Matalon for a perinatology consultation, also rendered care to plaintiff as a private physician. Southside Hospital's expert, Dr. Frank Manning, avers that the care provided by the staff at Southside Hospital was within the standards of good and accepted care, and that the care provided by the staff at Southside Hospital was not a substantial factor in causing any injury to plaintiff. As to North Shore University Hospital, no claims are made against Dr. Randi M. Rothstein, the delivering physician, or Dr. Elizabeth Schmidt, the obstetrical resident. With regard to Dr. Yevgeniya Pozharny, defendants' expert opines that her recommendations of steroid treatment to advance fetal lung maturity and magnesium sulfate to decrease the risk of seizures were both appropriate. Upon admission to North Shore University Hospital, Dr. Yevgeniya Pozharny's evaluation indicated fetal movement and a heart rate in the 120 range. Dr. Manning opines that Dr. Pozharny's determination to treat plaintiff in the ICU to monitor the Labetalol IV was also appropriate. The plan of care was to stabilize plaintiff's blood pressure and maintain the fetus in utero for as long as possible to allow the steroid to advance fetal lung maturity. Dr. Manning opines that such plan was appropriate. The hospitals, therefore, have established a prima facie case that the treatment and care rendered to plaintiff did not depart from acceptable standards of medical practice.

In opposition, plaintiff's expert opines that the failure of Dr. Matalon and Dr. Goldstein to timely recognize that plaintiff was suffering from severe preeclampsia deviated from the standards of medical care. He also opines that Dr. Sevinc Kadayifici, an internal medicine physician, who was on call at Southside Hospital ICU, failed to appreciate a positive urine analysis at 7:25 p.m. on November 5, 2010, and again on November 6, 2010, and that such failure was a deviation from accepted standards of medical and obstetrical care, as was the failure to order a 24-hour urine protein test stat (resulting in a 12-hour delay). He also alleges that the failure to start the steroid treatment sooner, the failure to transport plaintiff to a level 3 NICO sooner, and the failure to monitor the fetal heart were departures from acceptable standards of medical care. Aa to North Shore University Hospital, plaintiff's expert opines that the failure to immediately place electronic fetal monitoring on plaintiff was a deviation of accepted standards of medical care. He also opines that the emergency C-section should have been ordered at 4:30 p.m., as opposed to 5:05 p.m. Plaintiff's experts do not, however, opine that any of the alleged deviations from accepted standards of medical care caused any injury to plaintiff. Plaintiff, thus, has failed to raise a triable issue of fact with respect to conduct of the hospitals or their staff. Accordingly, the motion by the hospital defendants for summary judgment dismissing the complaint as against them is granted. The unredacted expert affirmations submitted for in camera review are being mailed back to plaintiff's counsel.

Dated: Sept. 27, 2016

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

__X__ FINAL DISPOSITION ____ NON-FINAL DISPOSITION