B.G. v Cabbad
2016 NY Slip Op 33003(U)
August 4, 2016
Supreme Court, Kings County
Docket Number: 28565/11
Judge: Laura Lee Jacobson
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At an IAS Term, Part 21 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 4th day of August, 2016.

PRESENT:

HON. LAURA LEE JACOBSON,
Justice.

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B.G., an Infant under the age of 14 years,
by his Mother and Natural Guardian, YOVANKA DACOSTA,
and YOVANKA DACOSTA, Individually,

Plaintiffs,

- against -

MICHAEL F. CABBAD, M.D.,
MICHAEL F. CABBAD, M.D., PLLC,
BROOKLYN HOSPITAL CENTER, AND
BELEN A. FINEZA, M.D.,

Defendants

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DECISION AND ORDER ON REARGUMENT

Index No. 28565/11

Mot. Seq. No. 8

The following papers numbered 1 to 5 read herein:	Papers Numbered
Notice of Motion and Affirmations Annexed	1-2; 3
Attorney Affirmation in Opposition	4
Reply Affirmation	5

In this action to recover damages for medical malpractice, the defendant Belen A. Fineza, M.D. (the defendant), moves for leave to reargue her motion for summary judgment (the prior order) and, upon granting such leave, for summary judgment dismissing the complaint insofar as asserted against her. The Court denied the prior motion, among others, by decision and order, dated July 30, 2015 and entered on September 2, 2015 (the prior order). This portion of the prior order is currently on appeal, awaiting briefing (*see B.G. v Cabbad*, 2016 NY Slip Op 77059[U] [2d Dept 2016]).

Leave to reargue is granted (*see e.g. Gonzalez v Arya*, 140 AD3d 928 [2d Dept 2016]) and, upon reargument, the Court adheres to its prior order insofar as it denied the prior motion. The defendant contends that the Court overlooked the fact that the infant plaintiff's chart reflected – albeit erroneously – that the mother had a dichorionic-diamniotic twin gestation (one placenta per twin), rather than the monochorionic gestation (a single placenta for both twins). According to the defendant, this fact is significant because the twin-to-twin transfusion syndrome (TTTS) occurs, if it occurs at all, only in monochorionic gestations. The defendant maintains that, based on the information available to her at the time the infant plaintiff was delivered, it would have been impossible for him to be suffering from TTTS and therefore she had no reason to suspect it. While it may be true that, at the time of delivery, the defendant had no reason, *based solely on the infant plaintiff's prenatal ultrasound records*, to suspect that he was suffering from TTTS, she had ample time postnatally to either diagnose TTTS or rule it out. The defendant's unsuccessful resuscitation attempts of the infant plaintiff lasted for approximately 12 hours: from 2:40 pm on the day of the infant plaintiff's birth when he was admitted to the neonatal intensive care unit (NICU) with a very low Apgar score of one at nine minutes post-birth, to the early morning of the following day when he received his second blood transfusion. The defendant is a physician with training and experience as a neonatologist. She had the power to question the validity of the erroneous ultrasound readings. She could not turn a blind eye to this fundamental error. The erroneous prenatal ultrasound readings of one placenta per twin became irrelevant

once the twins *and their single placenta* were delivered, and the infant plaintiff was admitted to NICU in critical condition.

Contrary to the defendant's contention, the Court was not mistaken in its assessment of proximate causation. Whereas the defense expert opined (in ¶ 17 of his affidavit) that "[p]rematurity and hypoxia in utero medically account for the Infant's injuries and present condition," the plaintiffs' expert neonatologist opined (in ¶ 11 of his or her affirmation) that (1) the delays in obtaining the infant plaintiff's complete blood count values, in diagnosing him with anemia, and in administering blood transfusions, resulted in "*cumulative* hypoxic insult to his brain," and (2) a "more timely [blood transfusion] would have significantly benefited [him] in terms of *lessening* the severity of the hypoxic insult to his brain" (emphasis added). The experts disagree as to whether the *entirety* of the infant plaintiff's injury occurred in utero (the defense position) or whether the infant plaintiff suffered an *additional* (and, presumably, preventable) injury after birth as the result of the defendant's failure to timely transfuse him (the plaintiffs' position). This presents a genuine issue of fact as to the proximate causation (*see Fritz v Burman*, 107 AD3d 936 [2d Dept 2013]).[1]

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[1] In *Fritz*, the Second Department ruled (at pages 941-942) that:

> "With respect to the issue of proximate cause, . . . the defendants' experts concluded that the infant plaintiff's developmental disorder may have been caused by his hemolytic disease at birth, and relied on the fact that this disease constitutes a 'chronic process' that in all probability affected the infant plaintiff before the alleged medical malpractice occurred. The plaintiffs' experts, in opposition, stated with reasonable medical certainty that the alleged medical malpractice *worsened* the infant plaintiff's condition, causing both cerebral hypoxia and the subsequent symptoms of pervasive developmental disorder. . . . Accordingly, the plaintiff raised triable issues of fact with respect to the issue of proximate cause" (emphasis added).

The Court is not bound by the parties' citation to the defendant's pretrial deposition where, as here, the entire transcript of her testimony is in the record. Viewing the evidence in the light most favorable to the plaintiffs as the non-moving parties, the Court construed the defendant's pretrial testimony as supporting their position that she should have considered a blood transfusion as one of the first-line measures, instead of as the last-resort measure. As the defendant's pretrial testimony illustrates, she was engaged in a trial and error, adjustment and re-adjustment, experiment and worsening:

> Q. What was it that prompted [your] order for packed red blood cells?
>
> A. Baby was already given everything, we gave three boluses of normal saline, the baby had bicarbonate to correct the metabolic acidosis, the baby was started on pressors . . . – and there has not been any clear improvement that we have seen and there was an episode wherein the baby's oxygen saturation from a hundred percent . . . dropped down to [what] I think it's in the fifties and *we already gave everything, let's go and give this baby blood.*"

(Fineza Tr at 36, line 14 – 27, line 3 [emphasis added]).[2]

CPLR 3212 (b) provides that affidavits supporting and opposing motions for summary judgment must do more than present something that will be admissible in evidence. They "shall recite all the material facts" and by implication in the case of expert witnesses, a process of reasoning beginning from a firm foundation. "It will not do to say that it must

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[2] By her pretrial testimony, the defendant acknowledged what the plaintiffs' expert neonatologist opined to in his affirmation in opposition to the prior motion – that the consistent lack of the infant plaintiff's positive response to the defendant's resuscitation efforts mandated that something more needed to be done. The defense expert's positive spin on a bad situation does not change the underlying facts.

all be left to the skill of experts. Expertise is a rational process and a rational process implies expressed reasons for judgment" (*FPC v Hope Natural Gas Co.*, 320 US 591, 627 [1944] [Frankfurter, J., dissenting]). An "opinion has a significance proportioned to the sources that sustain it" (*Petrogradsky Mejdunarodny Kommerchesky Bank v National City Bank*, 253 NY 23, 25 [1930]). Here, the undisputed medical record establishes that (1) the infant plaintiff, on admission to NICU, was diagnosed with respiratory distress, metabolic acidosis, hypotension, and cardiogenic shock;[3] (2) he had two consecutive abnormal readings of arterial blood gases; (3) his oxygen saturation at one point dropped to 50% despite being on 100% oxygenation via a ventilator; and (4) when his first blood transfusion was performed, he was found to be severely anemic while his twin brother was polycythemic. Given this undisputed medical record, the opinion of the plaintiffs' medical expert that the defendant's failure to timely transfuse the infant plaintiff "allowed [his] hypoxic state to be prolonged resulting in cumulative hypoxic insult to his brain," was not conclusory or without evidentiary value.

The cases relied upon by the defendant are distinguishable on several grounds. Insofar as the question presented here is concerned, each one of those cases holds no more than that upon particular facts in that case, the court concluded that a plaintiff in a medical malpractice case, by submitting an expert affirmation with conclusory or speculative

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[3] As the defendant testified (at page 79, lines 10-12 of her pretrial deposition), the infant plaintiff "was this critical on admission and at birth."

assertions, failed to rebut a defendant's prima facie showing.[4] None of them involved a neonatologist utilizing a trial-and-error approach in arriving at a twin newborn's medical condition which could have been quickly and easily diagnosed with a simple blood test that, according to her own medical expert in ¶ 14 of his affidavit, is "routinely ordered" for all newborns.[5]

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[4] *See Sukhraj v New York City Health & Hosps. Corp.*, 106 AD3d 809 (2d Dept 2013) (no facts recited in the memorandum decision); *Graziano v Cooling*, 79 AD3d 803, 805 (2d Dept 2010) (holding that the affidavit of the plaintiff's expert was conclusory, speculative, and failed to address the specific assertions of the defendants' expert, in that "the plaintiff's expert did not assert that the plaintiff exhibited key symptoms such as photophobia and neck stiffness, or other 'cardinal signs,' which would have led to a [timely] diagnosis of meningococcal meningitis. . . . The plaintiff's expert also did not assert that any further testing was indicated at the time that [defendant] examined the plaintiff."); *Simmons v Brooklyn Hosp. Ctr.*, 74 AD3d 1174, 1178 (2d Dept 2010) (the plaintiffs' medical expert's opinion that a sonogram . . . would have detected hydrops fetalis, is based on the speculative assumption that the in utero infection that caused this condition was present at that time. Indeed, [the defense] expert observed that the medical record is void of any indication that the mother was suffering from an in utero infection during her two visits with [defendant]), *lv denied* 16 NY3d 707 [2011]).

[5] The First Department's decision in *Scalisi v Oberlander*, 96 AD3d 106 (2012), undercuts, rather than supports, the defendant's position. There, the First Department, in reversing the motion court's grant of summary judgment to the defendant physicians, held (at page 122) that:

> "The motion court's opinion, while long, underscores the difficulties of courts grappling with complex medical evidence and trying to identify triable issues of fact, as opposed to propositions that lack medical foundation. In making this assessment, a motion court is not to substitute its own medical judgment for that of the parties' experts, or *to surmise, as did the court here, that because the infant plaintiff appeared normal shortly after birth, she had not sustained a brain injury, or a severe enough injury, so as to result in the neurological sequelae she now exhibits today"* (emphasis added).

Similarly, this Court may not (and did not in the prior order) surmise that because the infant plaintiff suffered hypoxia in utero, he had not suffered an additional injury on account of the defendant's delay in transfusing him.

The defendant's remaining contentions either are without merit or need not be addressed in light of the Court's determination.

This constitutes the decision and order of the Court.

ENTER,

J. S. C.

HON. LAURA JACOBSON