To commence the statutory time for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

----------x

C-L-C, JR., AN INFANT, BY HIS MOTHER AND NATURAL GUARDIAN, SYLVIA GREEN,

Plaintiff,

-against-

DECISION AND ORDER
Sequence Nos. 4 and 5
Index No. 51356/2014

WESTCHESTER MEDICAL CENTER, MICHAEL KESSLER, M.D., GEETHA RAJENDRAN, M.D. and ADVANCED OB/GYN ASSOCIATES,

Defendants.

----------x

RUDERMAN, J.

The following papers were considered in connection with the defendants' motions for summary judgment dismissing the complaint pursuant to CPLR 3212:

Papers	Numbered
Motion Sequence No. 4	
Notice of Motion, Affirmation, Exhibits A - V	1
Affirmation in Opposition, Affidavits, Exhibits 1 - 20	2
Reply Affirmation, Exhibits A - G	3
Motion Sequence No. 5	
Notice of Motion, Affirmations, Exhibits A - U	4
Affirmation in Opposition, Affidavit, Exhibits 1 - 20	5
Reply Affirmation	6

In this medical malpractice action concerning the prenatal care and labor and delivery of the infant plaintiff's mother, defendants Michael Kessler, M.D., Geetha Rajendran, M.D. and Advanced OB/GYN Associates (Motion Sequence No. 4), and Westchester Medical Center (Motion Sequence No. 5), move for summary judgment pursuant to CPLR 3212 dismissing

plaintiffs' complaint. Plaintiff opposes the motions.

Facts and Background

This action concerns care and treatment Sylvia Green, the mother of the infant plaintiff, received at Westchester Medical Center between July 9 and July 16, 2010, the date of the infant's premature birth. After several months of routine, unremarkable prenatal development, Green complained of abdominal pain first on June 27, 2010, and then on July 1, 2010. At the July 1, 2010 physical examination, for the first time, her cervix appeared slightly dilated. On July 6, 2010, Dr. Helen Hostin, Green's obstetrician, arranged for her to be admitted to Nyack Hospital. By that time she was at approximately 22 weeks gestation, with a variable cervical dilation of 1-3 cm. She was placed on electronic fetal monitoring, and bed rest in the Trendelenburg position, and weekly injections of progesterone were directed.

On July 9, 2010, when Ms. Green reached 23 weeks gestation, Dr. Hostin, arranged for her to be transferred to Westchester Medical Center (WMC). The attending OB/GYN at WMC accepted the transfer. At 1:15 p.m. that day she was evaluated by an obstetrical resident, Dr. Karen Whitted, who noted that Ms. Green's chief complaint was "management of an incompetent cervix." Her findings on physical examination were that Ms. Green's cervix was soft, 1 cm dilated, and 50% effaced, with a fetal station of -3. The treatment plan reflected in those notes was to admit Ms. Green to the antepartum unit for routine blood tests and the administration of a second dose of progesterone the next day, and for Neonatal Intensive Care Unit (NICU) and Maternal Fetal Medicine (MFM) consults.

Defendant Dr. Geetha Rajendran, the physician covering the antepartum unit on July 9, 2010, evaluated Ms. Green that evening. Her plan was to rule out pre-term labor and subclinical

chorioamnionitis (an inflammation of the fetal membranes, due to bacterial infection), and to discharge Ms. Green the next day if her condition was unchanged and no infectious markers found. Dr. Rajendran performed a sonogram-guided diagnostic amniocentesis on the morning of July 10, 2010. When the results were negative for infection markers, defendant Dr. Michael Kessler, attending OB/GYN, agreed with Dr. Rajendran's plan to discharge Ms. Green. She was informed that she could not be admitted because her insurance company would not pay for her to be admitted for bed rest. She was instructed to return to WMC if she developed pain, bleeding, or fluid leakage.

On July 13, 2010, Ms. Green experienced bleeding and returned to WMC. Upon examination, she was 1 cm dilated and 80% effaced, with bulging membranes. Dr. Kessler ordered blood and urine tests. Other than a slightly elevated white blood cell count, the test results were normal. After several hours of observation and fetal heart monitoring, during which the fetal heart rate was noted as 160-155 with a deceleration down to 65, Green was discharged at 3:15 a.m. on July 14, 2010, again with instructions to return if she experienced pain, bleeding or leakage of fluids.

On July 15, 2010 at approximately 10:48 p.m., Green again presented to WMC with complaints of contraction pain and vaginal spotting. Her cervix was found to be soft, dilated, and 100% effaced. Her fetal station was -3. Dr. Kessler requested MFM and NICU consults.

On July 16, 2010, at approximately 1:00 a.m., Green was admitted to Labor and Delivery at WMC. Her white blood cell and neutrophil counts were elevated. At 5:15 a.m. her cervix was 3cm dilated and 100% effaced; the fetal station was -2. At 9:50 a.m., a sterile speculum examination revealed bulging membranes. At 10:50 a.m., the infant was delivered vaginally.

The placental pathology showed early acute chorionitis, and retroplacental adherent blood clot (5.5 cm) consistent with clinical placental abruption.

The infant plaintiff, who was delivered at gestational age 24 weeks, was born with no spontaneous respiration and no heart rate. After receiving CPR with chest compressions and positive pressure ventilation, his heart rate increased, and he was intubated and taken to the NICU where he was placed on a high frequency oscillating ventilator. He remained intubated for 59 days, after which he was placed on respiratory support with Continuous Positive Airway Pressure (CPAP). Four months after his birth he was discharged from the NICU, with follow-up appointments with various specialist physicians. The infant's permanent injuries that are alleged to have resulted from defendants' treatment of Ms. Green include brain damage, global developmental delays, motor delays, central nervous system injury, neurological and cognitive deficits, cerebral palsy, spastic diplegia, visual impairment, with the need for speech, language, feeding and physical therapies, special education, and the inability to live independently.

The Parties' Contentions

In moving for summary judgment (sequence 4), defendants Michael Kessler, M.D. and Geetha Rajendran, M.D. rely on the affirmation of Maternal Fetal Medicine expert Dr. Lynn Simpson to establish that their care of Green did not depart from the applicable standard of care or cause the infant plaintiff's alleged injuries. In her affirmation, Dr. Simpson considers each treatment decision in the course of Green's care, and opines that each decision made by these defendants in their handling of Green comported with the applicable standard of care. Defendant Advanced OB/GYN Associates additionally maintains that in the absence of viable claims against Dr. Kessler and Dr. Rajendran, the claim against it must also be dismissed since plaintiff

offers no articulable basis for the claim that it failed to properly screen, hire and supervise its employees.

In motion sequence 5, defendant WMC relies on the expert affirmation of Dr. Peter S. Bernstein, a Maternal Fetal Medicine physician, who asserts that the care and treatment provided to Green by WMC and its agents and employees comported with the applicable standards of care, and of Dr. Michael Giuliano, an expert in Neonatal-Perinatal Medicine, who reviewed the records of the care and treatment provided to the infant plaintiff and asserts that it comported with the applicable standards of neonatal care, and that no acts or omissions of hospital personnel caused or contributed to the infant's alleged injuries.

In opposition, plaintiff relies on the expert opinion of Dr. Kolawole Olayinka Oyelese, who asserts that the infant plaintiff's injuries were caused and contributed to by the defendants' failure to timely offer a cervical cerclage and to timely deliver the infant by cesarean section. In addition, plaintiff offers the affidavit of Dr. Daniel Adler, who asserts that the infant's injuries are the direct result of prolonged partial hypoxia that occurred in the context of his birth.

Specifically, while Dr. Rajendran had asserted that it was too risky to put in a cerclage on July 10, 2010, "in a situation where it's brewing preterm labor," Dr. Oyelese said that the records reflected no signs of pre-term labor at that time, since Green had no uterine contractions or further cervical changes. Additionally, WMC's expert, Dr. Bernstein, maintains that "women whose cervical length is determined to be short in the second trimester and who have not previously had a perterm single birth, as in Ms. Green's case, are poor candidates for cerclage. Dr. Oyelese disagrees, contending that in the absence of signs of pre-term labor, and when the results of amniocentesis showed no markers for infection, Green should have been offered a

cervical cerclage, and that the failure to do so under the circumstances was a departure from the applicable standard of care. He says that the performance of cerclage has been shown to prolong gestation and improve neonatal survival, and that it was a departure from the standard of care by Dr. Rajendran not to offer the procedure. Dr. Oyolese explicitly disagrees with defendants' assertions that a cervical cerclage was not indicated because Ms. Green did not have a prior history of second trimester loses, explaining that in addition to "history indicated cerclage," a cervical cerclage is indicated where a patient presents with cervical dilation at Green's point of gestational development, in the absence of preterm labor and infection. He explains that "[t]his departure deprived Ms. Green of the only opportunity available to her to prolong her pregnancy, to avoid the delivery of an extremely premature infant, and caused and contributed to the injuries suffered by the infant plaintiff as a result of prematurity."

Dr. Oyelese also disagreed with Dr. Kessler's suggestion, and Dr. Simpson's opinion, that a cerclage was not indicated due in part to the risks of rupturing membranes and infection, explaining that the risk did not justify the failure to offer a cerclage, since that was Ms. Green's only chance to prolong her pregnancy and avoid extreme prematurity, and that the placement of a cerclage may reduce the risk of ascending infection created by the dilated cervix. Because in his view a cervical cerclage should have been offered and, if agreed to, performed before her discharge on July 10, 2010, Dr. Oyelese also disagreed with Dr. Bernstein's opinion that Ms. Green's discharge from the hospital on July 10, 2010 was within the standard of care. Dr. Oyelese added that the standard of care required the continued admission of the patient based on the risk of a precipitous delivery outside the hospital.

With regard to the decisions made by defendants regarding Ms. Green's care and

treatment on July 13-14, 2010, Dr. Oyelese stated that because Ms. Green presented with complaints of vaginal spotting and cervical effacement increased to 80%, and fetal monitoring reflected a fetal heart rate deceleration down to 65, good and accepted standards of care required that she be admitted to the hospital at that time, with decreased activity and fetal monitoring. He cited the risk of a spontaneous delivery of a very premature infant outside the hospital.

Finally, regarding defendants' care of Green on July 15-16, 2010, Dr. Oyelese opines that when she presented to the hospital with complaints of contractions and vaginal spotting, and the fetal heart rate baseline measuring at 170-175 bpm following her admission at 10:48 p.m., and again measuring 170 bpm at 11:30 p.m., defendants should have suspected a lack of oxygen to the fetus caused by "uteroplacental insufficiency in labor, chorioamnionitis, or a placental abruption." Dr. Oyelese points out that there was a neonatologist at Ms. Green's bedside, who noted the fetal heart fate of 170 and suspected chorioamnionitis. Dr. Oyelese explains that this heart rate was abnormal because the normal parameters for the fetal heart rate baseline are from 110-160 beats per minute, and that a rate over that reflects fetal tachycardia. He asserts that "[i]mmediate delivery by emergency cesarean section is the appropriate response to spare the fetus central nervous system injury as the result of an ongoing hypoxic insult." Dr. Adler's affidavit added that the infant's injuries are "the direct result of being born prematurely along with central nervous system injury from prolonged partial hypoxia that occurred in the context of his birth."

WMC has been unable to locate the fetal heart monitoring strips for this patient visit, and there are no chart notations regarding the fetal heart rate between 11:30 p.m. on July 15 and 6:23 a.m. on July 16. It has been stipulated that plaintiff would not be precluded from "any testimony

related to the implications, if any, to the fetal monitoring and/or the missing fetal heart monitoring strips at the time of trial." Accordingly, the Court cannot summarily reject Dr. Oyelese's assertion that, given the lack of chart notations regarding the elevated fetal heart rate at 11:30 p.m. and 6:23 a.m. and the subsequently-discovered maternal conditions of chorioamnionitis and placental abruption, "the [missing] fetal heart tracings in this case more likely than not [would] reflect a non-reassuring pattern that would have indicated the need to deliver this infant earlier by Cesarean section."

Analysis

The elements of proof in a medical malpractice action are a deviation or departure from accepted practice, and evidence that the departure was a proximate cause of injury or damage (*see Thompson v Orner*, 36 AD3d 791 [2d Dept 2007]). On a motion for summary judgment, the defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or the absence of injury as a result of any alleged malpractice (*see Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). "A plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing" (*Stukas v Streiter*, 83 AD3d 18, 30 [2d Dept 2011]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Aronov v Soukkary*, 104 AD3d 623, 624 [2d Dept 2013] [internal quotation marks and citation omitted]). "Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury" (*DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]; *see also Roca v Perel*, 51 AD3d 757, 759 [2d Dept 2008] [citing *Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). However, conclusory and unsupported allegations not

supported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat summary judgment (*see Alvarez v Prospect Hosp.*, 68 NY2d 320 [1986]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]).

Here, the defendants have made a prima facie showing through evidence in the form of affidavits from their experts, who opined that defendants' care and treatment of Ms. Green did not deviate or depart from accepted medical practice, and did not cause the infant plaintiff's injuries. However, in opposition to both defendants' motions, plaintiffs have raised triable issues of fact, primarily through the affidavit of their expert, Dr. Oyelese, as to whether defendants departed from good and accepted medical practice, and whether that departure was a proximate cause of the infant plaintiff's injuries. His assertions are not, as defendants' suggest, merely conclusory and unsupported and lacking support in the evidence.

Based on his review of the medical records, Dr. Oyelese asserted that it was a departure from the applicable standard of care by both Dr. Rajendran and Dr. Kessler to fail to offer to perform a cervical cerclage on Green on July 10, 2010, once the results of amniocentesis showed no markers for infection, to perform the procedure, if she consented, before discharging her from the hospital. Dr. Oyelese further concluded that "[t]his departure deprived Ms. Green of the only opportunity available to her to prolong her pregnancy, to avoid the delivery of an extremely premature infant, and caused and contributed to the injuries suffered by the infant plaintiff as a result of prematurity." He explicitly disagreed with Dr. Rajendran and Dr. Kessler that a cervical cerclage was not indicated in the absence of a prior history of second trimester loses, because a cervical cerclage is also indicated where a patient presents with cervical dilation at the gestational age of Ms. Green, in the absence of preterm labor and infection. Dr. Oyelese also disagreed with

Dr. Kessler's suggestion that a cerclage was not indicated due in part to the risks of rupturing membranes and infection. He added that in his view, rather than adding to the risk of infection, the placement of a cerclage may reduce the risk of ascending infection created by the dilated cervix.

With regard to the decisions made by defendants regarding Ms. Green's care and treatment on July 13-14, 2010, Dr. Oyelese stated that because Ms. Green presented with complaints of vaginal spotting and cervical effacement increased to 80%, and fetal monitoring reflected a fetal heart rate deceleration down to 65, good and accepted standards of care required that she be admitted to the hospital at that time, with decreased activity and fetal monitoring. He adds that the decision not to admit her was prompted by lack of insurance coverage rather than by medical considerations.

Regarding defendants' care of Ms. Green on July 15, 2010, Dr. Oyelese offered his opinion that when she presented to the hospital with complaints of contractions and vaginal spotting, and the fetal heart rate baseline measuring at 170-175 bpm following her admission at 10:48 p.m., and again measuring 170 bpm at 11:30 p.m., that defendants should have suspected a lack of oxygen to the fetus caused by "uteroplacental insufficiency in labor, chorioamnionitis, or a placental abruption." Dr. Oyelese therefore asserted that, in his opinion, "[i]mmediate delivery by emergency cesarean section is the appropriate response to spare the fetus central nervous system injury as the result of an ongoing hypoxic insult." Defendant WMC, through the affidavit of Dr. Bernstein, relies on the absence of clinical indicators of chorioamnionitis or fetal distress to assert that Cesarian delivery was not called for here. However, Dr. Oyelese observes that the neonatologist at Ms. Green's bedside that night both noted the elevated fetal heart fate and

expressed a suspicion of chorioamnionitis.

Dr. Oyelese's opinion is based in part on his suggestion that "the fetal heart tracings in this case more likely than not [would] reflect a non-reassuring pattern that would have indicated the need to deliver this infant earlier by Cesarean section." This suggestion relies on WMC's inability to locate the fetal heart monitoring strips for this patient visit, and the provision of the stipulation between plaintiff and WMC that it did not "preclude any testimony related to the implications, if any, to the fetal monitoring and/or the missing fetal heart monitoring strips at the time of trial." Under these circumstances, Dr. Oyelese's suggestion that the strips would show fetal distress cannot be rejected as speculative in this context.

These foregoing assertions of opinion create issues of fact regarding whether the care and treatment provided by Dr. Kessler, Dr. Rajendran and WMC deviated from accepted practice, and whether such a departure was a proximate cause of injury to the infant plaintiff. Defendant Advanced OB/GYN Associates may be liable for the actions of Dr. Kessler and Dr. Rajendran under a theory of vicarious liability.

Summary judgment is granted to both defendants, however, with regard to plaintiff's cause of action based on an alleged lack of informed consent, as plaintiff has failed to submit any support for that claim, or alleged any specific invasive procedure for which informed consent would have been required (*see Etkin v Marcus*, 74 AD2d 633 [2d Dept 1980]). Plaintiff's negligent hiring and supervision claim against defendant Advanced OB/GYN Associates is also dismissed as lacking any factual support.

Based upon the foregoing, it is hereby,

ORDERED that the motion of defendants Michael Kessler, M.D., Geetha Rajendran,

M.D., and Advanced OB/GYN Associates (sequence 4) for summary judgment dismissing plaintiff's complaint pursuant to CPLR 3212 is is granted only insofar as the claims for lack of informed consent and negligent hiring and supervision are dismissed, and is otherwise denied; and it is further

ORDERED that the motion of defendant Westchester Medical Center for summary judgment dismissing plaintiff's complaint pursuant to CPLR 3212 is granted only insofar as the claim for lack of informed consent is dismissed, and is otherwise denied; and it is further

ORDERED that the parties are directed to appear on Tuesday, June 27, 2017 at 9:15 a.m., in the Settlement Conference Part of the Westchester Supreme and County Courthouse located at 111 Dr. Martin Luther King, Jr. Boulevard, White Plains, New York 10601.

This constitutes the Decision and Order of the Court.

Dated: White Plains, New York
May 26 2017

HON. TERRY JANE RUDERMAN, J.S.C