Michalowski v Greenstein
2018 NY Slip Op 31798(U)
July 24, 2018
Supreme Court, Suffolk County
Docket Number: 13-15309
Judge: Peter H. Mayer

SHORT FORM ORDER

INDEX No. 13-15309
CAL. No. 16-01277MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 17 - SUFFOLK COUNTY

PRESENT:

Hon. PETER H. MAYER
Justice of the Supreme Court

MOTION DATE 4-6-17 (005)
MOTION DATE 4-5-17 (006)
MOTION DATE 4-14-17 (007)
MOTION DATE 9-1-17 (008)
ADJ. DATE 9-1-17
Mot. Seq. # 005 - MG
006 - MG
007 - MG; CASEDISP
008 - XMD

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KIMMY MICHALOWSKI, As Mother and Natural Guardian of J.S., an Infant,

Plaintiff,

- against -

MARC GREENSTEIN, HUNTINGTON HOSPITAL, DEBORAH ZITNER, SYED TUSNEEM-AHMED SHIBLI & NATALIE MEIROWITZ, M.D.,

Defendants.

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Upon the reading and filing of the following papers in this matter: (1) Notice of Motion/Order to Show Cause by the Huntington defendants, dated March 6, 2017 ; the defendant Greenstein, dated March 6, 2017; and by the defendant Meirowitz, dated March 7, 2017, and supporting papers (including Memorandum of Law dated____); (2) Notice of Cross Motion by the plaintiff, dated July 3, 2017, and supporting papers; (3) Affirmation in Opposition by the plaintiff, dated

August 7, 2017, and supporting papers; (4) Reply Affirmation by the Huntington defendants, dated August 29, 2017, and supporting papers; (5) Other ___ (~~and after hearing counsels' oral arguments in support of and opposed to the motion~~); and now

UPON DUE DELIBERATION AND CONSIDERATION BY THE COURT of the foregoing papers, the motion is decided as follows: it is

ORDERED that the motion (#005) by the defendants Huntington Hospital and Syed Tusneem-Ahmed Shibli, M.D., for summary judgment, that the motion (#006) by the defendant Marc Greenstein, M.D., for summary judgment, that the motion (#007) by the defendant Natalie Meirowitz, M.D., for summary judgment, and that the cross motion (#008) by the plaintiffs to preclude are consolidated for the purposes of this determination; and it is

ORDERED that the motion (#005) by the defendants Huntington Hospital and Syed Tusneem-Ahmed for summary judgment dismissing the complaint against them is granted; and it is

ORDERED that the motion (#006) by the defendant Marc Greenstein, M.D., for summary judgment dismissing the complaint against him is granted; and it is

ORDERED that the motion (#007) by the defendant Natalie Meirowitz, M.D., for summary judgment dismissing the complaint against her is granted; and it is further

ORDERED that the cross motion (#008) by the plaintiff Kimmy Michalowski for an order precluding any remaining defendants from seeking Article 16 limited liability benefits from any defendant who has been granted summary judgment is denied.

The plaintiff, Kimmy Michalowski, commenced this action on behalf of her son, J.S., against defendants Dr. Marc Greenstein, Huntington Hospital, Dr. Deborah Zitner[1], Dr. Syed Tusneem-Ahemd Shibli, and Dr. Natalie Meirowitz to recover damages for injuries he allegedly sustained as a result of medical malpractice. By her complaint, Michalowski alleges, among other things, that the care and treatment rendered to her by the defendants during her pregnancy resulted in the delivery of the infant prematurely at 34 weeks gestation, and that such negligent care proximately caused him to sustain a severe brain injury.

The following facts are not in dispute. On December 24, 2006, Michalowsi, who was 32 years of age, presented to the Dolan Family Health Center at Huntington Hospital ("Dolan Center") with complaints of spotting and reported that she had taken a pregnancy test on November 24, 2005, which was positive. Michalowski's medical history included the birth of a full-term baby boy with pyloric stenosis via caesarean section in March 1994, preeclampsia with pregnancy, two spontaneous abortions in 2005, increased blood pressure ("BP") with pregnancy, mitral valve prolapse, migraines with aura, complaints of headaches, and smoking half a pack a day, which she had stopped five months prior to her

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[1] By stipulation, dated October 13, 2015, the action was discontinued only as against defendant Dr. Deborah Zitner.

recent pregnancy. During this visit, she was examined by Dr. Mitchell Kramer, who confirmed her pregnancy and a positive fetal heart rate via a transvaginal sonogram, and noted that the gestational age was six weeks. Dr. Kramer's diagnosis was "threatened abortion," and he recommended that Michalowski decrease her activity, get pelvic rest, and return for a follow up within two weeks. On January 6, 2006, at her follow-up appointment, Michalowski's due date was established as August 9, 2006 and she indicated she wished to deliver via caesarean section ("C-section"). On January 10, 2006, Michalowski had her initial prenatal visit with Dr. Greenstein, a private obstetrician/gynecologist with Suffolk OB/GYN contracted by Huntington Hospital to provide women's health care services at the Dolan Center. Following an examination of Michalowski, which showed her BP was normal and her urine was negative, and the performance of a sonogram, which determined that the fetus' gestational age was 9 weeks, she was referred to the medical clinic regarding the mitral regurgitation for possible echocardiogram ("EKG") and told to return in four weeks. On February 1, 2006, when she was 13 weeks gestation, she returned to the clinic and was evaluated by Dr. Greenstein. On February 13, when she was 14 weeks and 5 days gestation, Michalowski presented to the Dolan Center with complaints of a headache, which she stated was relieved with Tylenol. Michalowski returned to the clinic the next day with complaints of brown spotting. She was seen examined by Dr. Kramer, who noted that the cervix was long and closed with slight brown staining, that the urine test was negative, and that her BP was 120/77. Following the performance of a transabdominal sonogram, which showed a positive fetal heart rate and low lying placenta, and the determination that her liver function tests ("LFTs") were normal, Dr. Kramer recommended pelvic rest and advised Michalowski to return in one week. On February 15, 2006, Michalowski presented to the Adult Medical Center for a cardiac follow-up. Her BP was 128/90 on the right side and 130/90 on the left side, and an EKG test performed showed she had a normal sinus rhythm. Michalowski was diagnosed with hypertension and palpitations.

On February 21, 2006, at 15 weeks and 5 days gestation, she returned to the Dolan Center and was seen by Dr. Kramer. At this visit, Michalowski's BP was 119/59, the urine test was negative for protein and glucose, but there were 5-10 red blood cells ("RBCs") in her urine, the alpha-fetoprotein ("AFP") screening was negative, and the height of the fundus was 15 centimeters. On March 21, 2006, she presented at Huntington Hospital for an ultrasound, which had been ordered by Dr. Greenstein during her March 17, 2006 visit, and it was revealed that the fetus was developing normally and had a gestational age of "19 weeks, 6 days +/- 10 days." On April 13, 2006, when she was 23 weeks 3 days gestation, Michalowski fell, but following her visit with Dr. Greenstein it was determined that she was asymptomatic and that her BP and urine were normal. On May 4, 2006, Dr. Greenstein examined Michalowski and her glucose screening test was negative, fetal heart was heard, and her BP was 127/87. On May 5, 2006, at 26 weeks 2 days gestation, Michalowski returned to the Dolan Center with complaints of swollen hands and headache. She was seen by Dr. Karen Gronau. At the examination, Michalowski's BP was 143/78, a urine test was negative, the fetal heart was positive, the signs and symptoms of preeclampsia were reviewed with her, and a low-salt diet was recommended. On May 19, 2006, Michalowski continued to report ongoing hand swelling. On May 29, 2006, she presented to the emergency room of Huntington Hospital, and reported not feeling the baby move for several hours, as well as complaints of swollen and numb fingers. She did not have any discharge, bleeding or contractions, and her urine was negative. After examining her and reading the fetal monitoring traces, Dr. Greenstein discharged her home with Tylenol and instructions to follow-up the next day at the clinic.

On May 30, 2006, Michalowski presented to the Dolan Center, where she underwent a scheduled growth scan sonogram, which determined the fetus was 30 weeks gestation. On that day Michalowski's BP was 88/52, her urine was negative, and she continued to have complaints of swelling. She was advised to increase her fluid intake, to adhere to a low-salt diet, and to appear for a follow up examination in two weeks. On June 6, 2006, she presented to Huntington Hospital for a sonogram to evaluate fetal anatomy and growth. The sonogram revealed that the fetus was 31 weeks 6 days gestation and weighed "1735 grams +/- 257 grams," and that her amniotic fluid index was normal. On June 13, 2006, Michalowski returned to the Dolan Center for a follow-up appointment. On June 21, 2006, at 33 weeks gestation, trace protein and 5-10 RBCs were observed in her urine, her BP was 143/79, and she had swelling in her hands. Dr. Garonu ordered Macrobid and instructed her to return in two weeks. On June 23, 2006, Ms. Michalowksi presented to the Dolan Center with complaints of a left-side earache and sore throat for one day. She was noted to be in her eight month of pregnancy, her ankles were puffy, her BP was 136/91 and 140/86. The throat culture that was performed tested negative, and Michalowski was diagnosed with pharyngitis and prescribed Amoxicillin.

On June 24, 2006, Michalowski presented to the emergency room at Huntington Hospital with complaints a earache and a sore throat. She was transferred to the Labor and Delivery Department, and following an examination by Dr. Greenstein, she was admitted for observation of her BP and signs of pregnancy-induced hypertension ("PIH"). It was noted that she was 33 weeks and 6 days gestation, that her uric acid level was elevated and that her BP was 158/72. On June 25, 2006, following an examination of the plaintiff, which noted "+2 edema and BP levels ranging from 130-150/60-80," Dr. Greenstein requested a maternal fetal consult. The nurses' notes indicate that Michalowski complained of left temporal headache into the left eye, that her BP was 159/88, and that the fetal heart rate was "130-140s with accelerations with no contractions." On June 26, 2006, as requested by Dr. Greenstein, Dr. Meirowitz, a maternal-fetal medicine specialist, conducted a level 3 ultrasound biophysical profile and Doppler study of the umbilical artery on the plaintiff, determined that abdominal circumference and the fetal length of the fetus were "lagging by two weeks," and that the fetus had grown by less than 200 grams since the sonogram on June 6, 2006. Dr. Meirowitz also noted an elevated umbilical Doppler, which indicated abnormal blood flow to the fetus. As a result of her examination and observations, Dr. Meirowitz noted that Michawolski's BP was elevated with a systolic range of 131-159 and a diastolic range of 61-97, and that the fetus was displaying abnormal growth on the sonograms caused by placental insufficiency and intrauterine growth restriction ("IUGR"). Dr. Meirowitz diagnosed Michalowski with atypical preeclampsia, and recommended a course of steroids followed by delivery, and repeating LFTs and platelet count, which were normal upon retesting. Later that same day, Dr. Gronau examined the plaintiff, as well as explained to her what was occurring and the procedures that would follow, and ordered that the plaintiff be given "Celestone 12 mg now and in 24 hours" as directed by Dr. Meirowitz. Between June 27th and June 29th, the plaintiff underwent stress testing, her BP and the fetal heart rate were continually monitored, and she signed the consent form for the performance of the C-section delivery on June 29, 2006.

On June 29, 2006, Dr. Greenstein, assisted by Dr. Zitner, performed a C-section delivery on Michalowski without any complications. Prior to the performance of the C-section, Dr. Greenstein requested that a neonatologist be present for the delivery, since the baby was being delivered prematurely at 34 weeks gestation. Dr. Shibli, a neonatologist, was present during the C-section

delivery. Immediately following the delivery, the infant was handed over to Dr. Shibli for neonatal care. Dr. Shibli placed the infant on an isolette under a radiant warmer and, while supporting the baby's head, suctioned the nose and mouth, and cleaned and stimulated the baby's body. Dr. Shibli, in his consult note, stated that Dr. Greenstein requested his attendance at the C-section delivery of "a 32-year old Gravida 4, para 1,0, 2,1 mother, who was 34 weeks gestation, with an expected date of confinement of August 9, 2006." Dr. Shibli further noted that a sonogram taken on June 26, 2006 showed IUGR, that the estimated fetal weight of the baby was 4 pounds, 3 ounces, and that the mother had previously received two doses of steroids to aid in the baby's lung maturity.

During his examination of the infant in the operating room, Dr. Shibli noted that the baby was pink and perfused with a spontaneous cry, that the heart rate was more than 100 beats per minute ("bpm"), that there were mild intercostal retractions and nasal flaring, that blow-by oxygen was given for 30 seconds, and that the APGAR score of the baby was 9 at one minute and 9 at five minutes. Dr. Shibli further noted that the heart sounds were normal with no murmur, that the abdomen was soft with no mass, the genitalia were normal, that the extremities had full range of motion and the hips were stable, and that there were no defect of the back and no skin lesions. Dr. Shibli's examination of the baby's head revealed that the anterior fontanel was open and flat, that the fontanels were normal, that there was no indication of an infection or a bleed, and that the baby had normal tone and reflexes for gestational age. Following his examination, Dr. Shibli's diagnosis was a preterm baby at 34 1/7 weeks gestation, and appropriate for gestational age. Thereafter, a plan was developed to admit the infant to the Special Care Nursery, since he was premature and in mild respiratory distress. Dr. Shibli ordered monitoring of the infant's vital signs and blood glucose level, along with cardiorespiratory monitoring and pulse oximetry, and nasal cannula oxygen administered as needed. In addition, Dr. Shibli ordered a complete blood count ("CBC") panel plus differential and arterial blood gases, blood cultures, intravenous ("IV") fluids, and a head ultrasound on June 30, 2006. Dr. Shibli indicated that oral feeding could begin in six hours if the infant was not in respiratory distress, and he included an addendum to the note to document the infant's arterial blood gas results, which were all normal.

Thereafter, the infant, accompanied by Dr. Shibli, was transferred to the Special Care Unit, where a monitor was placed to observe his vital signs, including his heart rate, respiratory rate, and pulse oximetry, and a peripheral IV was begun with 10% dextrose in water ("D10W") at 6.6 milliliters per hour. At approximately 5:50 p.m., five hours after his birth, the infant developed respiratory distress. His oxygen saturation level dropped to 59% and he experienced an episode of apnea. Blow-by oxygen was administered for 5 to 10 seconds, his oxygen saturation level increased to "95 to 99," and the infant responded with a cry to the tactile stimulation he was given. Dr. Shibli was notified and the scheduled 6:00 p.m. feeding was put on hold. Dr. Shibli assessed the episode as being related to the infant's prematurity, since the episode was brief and he responded well to the blow-by oxygen, but wanted to rule out sepsis. Dr. Shibli ordered IV ampicillin, 200 milligrams ("mg"), every 12 hours, and IV gentamicin, 8.9 mg every 36 hours, and infusions of dextrose 5% in water for the infant. At approximately 6:50 p.m., the infant had another episode of oxygen desaturation. The infant was apneic and oxygen saturation decreased to 56%. Once again, blow-by oxygen was administered at 100% with tactile stimulation. The infant responded with a cry, but proceeded to have another apneic episode, and blow-by oxygen was administered at 100 percent. Dr. Shibli was notified and he initiated oxygen, two liters, with humidification via nasal cannula, and the infant improved and was without apnea.

At approximately 7:00 p.m., Dr. Shibli ordered two liters of oxygen via nasal cannula, a chest X-ray, and an arterial blood gas for the infant. At approximately 7:15 p.m., a chest X-ray was performed and showed no evidence of pneumothorax or infiltrate. Dr. Shibli then ordered that the nurses wean the baby from the oxygen as tolerated. At approximately 9:00 p.m., the infant's blood glucose measurement was 109 and Dr. Shibli was notified. An Arterial blood gas test was performed, the results were given to Dr. Shibli, and the infant remained nothing by mouth ("NPO"). On June 30, 2006, at approximately 1:30 a.m., the infant experienced another episode of oxygen desaturation, and Dr. Shibli, who was present, increased the infant's oxygen to two liters and the infant recovered immediately. The infant plainitff's oxygen then was weaned to one liter as tolerated, and he did not experience any additional apneic or desaturation episodes during Dr. Shibli's shift, which ended at 8:00 a.m. on June 30, 2006. The receiving neonatologist was Dr. Isaac Gyasi. At approximately 9:00 a.m., the infant had another apneic episode, but recovered with tactile stimulation.

On June 30, 2006, at approximately 3:00 p.m., an ultrasound of the infant showed a large abnormal area, increased echotexture located in the posterior right brain in the parietal temporal region adjacent to the right lateral ventricle, measuring approximately three centimeters in transverse diameter. The findings were comparable with a Grade IV hemorrhage or other etiologies, such as periventriuclar luekomalacia. In addition, there was minimal dilatation of the left lateral ventricle with an echogenic area located at the posterior aspect of the left lateral ventricle at the level of the atrium compatible with choroid plexus. Shortly thereafter, a computed tomography ("CT") scan revealed large areas of hemorrhage and edema in the right temporal parietal brain distribution, which caused a mass effect and a shift of the ventricle to the left of the midline. The CT scan's findings were reported to the neonatologist. At approximately 7:00 p.m. on June 30, 2006, a transport team was called, and the infant, based upon the finding of intracranial hemorrhage, was transferred to Schneider Children's Hospital at Long Island Jewish Medical Center at approximately 7:20 p.m. to receive pediatric neurological care. On July 8, 2006, the infant was discharged from Schneider Children's Hospital with a diagnosis of bleeds from the middle cerebral artery and subdural regions, seizures, apnea, and presumed sepsis. Additionally, the discharge summary noted that an magnetic resonance imaging ("MRI") examination performed on July 2, 2006 showed acute temporal/parietal right-sided subdural hemorrhage with chronic necrotic change consistent with in utero infraction involving the middle cerebral artery.

The defendants Huntington Hospital and Dr. Shibli (hereinafter referred to as the "Huntington Hospital" defendants) now move for summary judgment on the basis that the care and treatment rendered by them to the infant did not deviate from acceptable standards of medical care, and was not proximate cause the injuries sustained by the infant. In particular, the Huntington Hospital defendants assert that neither Dr. Shibli's nor the staff's handling of the infant immediately after his birth caused the Grade IV hemorrhage sustained by him. In support of their motion, the Huntington Hospital defendants submit copies of the pleadings, the parties' deposition transcripts, Michalowski and the infant's medical records concerning the injuries at issue, and the affirmation of their expert, Dr. Lance Parton.

Dr. Greenstein moves for summary judgment on the basis that the care and treatment he provided to Michalowski did not deviate from the applicable standards of medical care and did not proximately cause the injuries sustained by the infant. Specifically, Dr. Greenstein asserts that his care and treatment of Michalowski while she was pregnant did not result in the infant plaintiff sustaining a traumatic brain

injury. In support of the motion, Dr. Greenstein submits copies of the pleadings, the parties' deposition transcripts, uncertified copies of Michalowski and the infant's medical records, and the affirmation of his expert, Dr. Henry Prince. Dr. Meirowitz also moves for summary judgment on the basis that the medical treatment she rendered to Michalowski during her admission to Huntington Hospital while she was pregnant with the infant adhered to good and accepted medical standards and did not cause or contribute to any of the injuries the infant allegedly sustained. In support of the motion, Dr. Meirowitz relies upon the same evidence as Dr. Greenstein, and the affirmation of her expert, Dr. Iffath Hoskins.

Michalowski does not oppose the motion by the Huntington defendants, but does opposes the motions by Dr. Greenstein and Dr. Meirowitz on the grounds that there are triable issues of fact as to whether they deviated from the applicable medical standard of care in rendering treatment to her while she was pregnant, and whether that deviation was the proximate cause of her son's premature delivery and resultant brain injury. In opposition to the motion, Michalowski submits the redacted and unsigned affidavits of her expert, and uncertified copies of her and the infant's medical records. Michalowski also cross-moves to preclude any defendant who has not obtained summary judgment from seeking limited liability benefits under Article 16 from any defendant who has been granted summary judgment.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a 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 any deviation or departure was not the proximate cause of the 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]). A physician owes a duty of reasonable care to his patients and will generally be insulated from liability where there is evidence that he 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]). Where the defendant has met his or her burden, the plaintiff, in opposition, must demonstrate the existence of a triable issue of fact through the submission of evidentiary acts or materials, but only as to the elements on which the defendant met the prima facie burden (*see* ***Schmitt v Medford Ctr.***, 121 AD3d 1088, 996 NYS2d 75 [2d Dept 2014]; ***Gillespie v New York Hosp. Queens***, 96 AD3d 901, 947 NYS2d 148 [2d Dept 2012]; ***Savage v Quinn***, 91 AD3d 748, 937 NYS2d 265 [2d Dept 2012]; ***Stukas v Streiter***, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]). Further, an expert witness must possess the requisite skill, training, knowledge, or experience to ensure that an opinion rendered is reliable (*see e.g.* ***Brady v Westchester County Healthcare Corp.***, 78 AD3d 1097, 912 NYS2d 104 [2d Dept 2010]; ***Geffner v North Shore Univ. Hosp.***, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]; ***Mustello v Berg***, 44 AD3d 1018, 845 NYS2d 86 [2d Dept 2007]). General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential

elements of medical malpractice, are insufficient to defeat a medical provider's summary judgment motion (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 508 NYS2d 923 [1986]; ***Garbowski v Hudson Val. Hosp. Ctr.***, 85 AD3d 724, 924 NYS2d [2d Dept 2011]).

Moreover, the primary duty of a hospital's nursing staff is to follow the physician's orders, and that a hospital, generally, will be protected from tort liability if its staff follows the orders" (***Toth v Community Hosp. at Glen Cove***, 22 NY2d 255, 265, 292 NYS2d 440 [1968]; *see* ***Sledziewski v Cioffi***, 137 AD2d 186, 538 NYS2d 913 [3d Dept 1988]). "A hospital may not be held vicariously liable for the malpractice of a private attending physician who is not an employee and may not be held concurrently liable unless its employees committed independent acts of negligence or the attending physician's orders were contraindicated by normal practice such that ordinary prudence required inquiry into the correctness of the same" (***Toth v Bloshinsky***, 39 AD3d 848, 850, 835 NYS2d 301 [2d Dept 2007]; *see* ***Sela v Katz***, 78 AD3d 681, 911 NYS2d 112 [2d Dept 2010]; ***Cerny v Williams***, 32 AD3d 881, 882 NYS2d 548 [2d Dept 2006]). 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 of the patient's choosing" (***Schultz v Shreedhar***, 66 AD3d 666, 666, 886 NYS2d 484 [2d Dept 2009], quoting ***Salvatore v Winthrop Univ. Med. Ctr.*** 36 AD3d 887, 888, 829 NYS2d 183 [2d Dept 2007]; *see* ***Sampson v Contillo***, 55 AD3d 588, 865 NYS2d 634 [2d Dept 2008]). Furthermore, "not every negligent act of a nurse [is] considered medical malpractice, but a negligent act or omission by a nurse that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician constitutes malpractice" (***Bleiler v Bodnar***, 65 NY2d 65, 72, 489 NYS2d 885 [1985]; *see* ***Spiegel v Goldfarb***, 66 AD3d 873, 889 NYS2d 45 [2d Dept 2009]).

Here, the Huntington Hospital defendants have established, prima facie, their entitlement to judgment as a matter of law by submitting an affidavit from Dr. Lance Parton, a board certified neonatologist, which demonstrated, prima facie, that neither Dr. Shibli nor their nursing staff deviated or departed from acceptable standards of medical care in their treatment of the infant, and that their treatment was not a proximate cause of the infant's injuries (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 508 NYS2d 923 [1986]; ***Muniz v Mount Sinai Hosp. of Queens***, 91 AD3d 612 [2d Dept 2012]; ***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]; ***Myers v Ferrara***, 56 AD3d 78, 864 NYS2d 517 [2d Dept 2008]). Dr. Parton avers, within a reasonable degree of medical certainty, that Dr. Shibli and the nursing staff of Huntington Hospital, at all times, acted within the appropriate standard of care in providing care and treatment to Michalowski's son, and that no act or omission by Dr. Shibli or the nursing staff contributed or proximately caused the infant's injuries. Dr. Parton states that Dr. Shibli's handling of the infant's head during his examination, as well as his examination of the baby immediately after the birth, was completely appropriate, and that he properly safeguarded the baby's head while performing the examination. Dr. Parton states that Dr. Shibli's examination of the infant immediately after birth showed completely normal results, including the neurological examination, and, other than an observation of nasal flaring and mild intercostal retractions, there were no signs or symptoms of a central nervous issue. Dr. Parton explains that the fact that a baby has mild respiratory distress alone is not an indication of a neurological pathology, because, typically, mild respiratory distress is related to the baby's poor transition from the womb to the outside environment, prematurity or a possible infection. Dr. Parton states that Dr. Shibli, based upon his examination of the infant after his birth, implemented

the appropriate plan of care, including blood glucose monitoring for prematurity and IUGR, a CBC with differential and blood cultures to rule out infection, a head ultrasound, which is standard for premature babies, pulse oximetry, and arterial blood gases within 30 minutes. Dr. Parton further states that the transfer of the infant to the Special Care Unit was appropriate, that the baby was connected to the appropriate medical equipment to monitor his vitals, that there was one-to-one nursing in the Special Care Unit, which indicates that each baby was attended to by his or her own nurse, that there was no indication the nursing staff did not appropriately monitor the infant or failed to apprise Dr. Shibli of the infant's condition, and that all of Dr. Shibli's orders were timely and appropriately followed by the Special Care Unit staff.

In addition, Dr. Parton states that when the infant began experiencing apneic episodes, Dr. Shibli appropriately ordered blood work and a chest X-ray, and that the baby appropriately was given 100 percent blow-by oxygen with tactile stimuli followed by oxygen humidification via nasal cannula. Dr. Parton states that the infant's first oxygen desaturation occurred 5 ½ hours after birth, and that once the infant received blow-by oxygen while remaining in the incubator, he recovered quickly. Dr. Parton's states that Dr. Shibli's appropriately ordered antibiotics in consideration of the infant having an infection, since the apneic episodes were brief. He states that there was no reason for Dr. Shibli to suspect that the infant was having any type of neurological pathology, such as intracranial hemorrhage, because he was not showing any neurological symptoms, such as hypertonia, hypotonia, seizures, or jerking movements. Dr. Parton further states that the ultrasound was appropriately and timely performed on June 30, 2006, since there was no indication that it should have been performed sooner, and that Dr. Shibli closely monitored the infant throughout the night and no additional episodes of apnea or desaturation occurred before his shift ended.

Lastly, Dr. Parton opines, within a reasonable degree of medical certainty, that the care and treatment received by the infant during his admission in the Special Care Unit at Huntington Hospital was in accordance with accepted medical practice and was not a proximate cause of his Grade IV hemorrhage. Dr. Parton states that if the infant's intracranial hemorrhage had been caused by either the nursing staff or Dr. Shibli's handling of the infant there would be external signs of the trauma, such as severe bruising on the baby's skin, a fracture of the baby's skull and/or subdural bleeding, and that given the massive size of the bleed inside the infant's brain, it would have taken a lot of external force to cause the Grade IV hemorrhage. Dr. Parton explains that a Grade IV hemorrhage is a bleed into the parenchyma of the brain, and that had the infant's brain injury been caused by the C-section there would have been significant bruising and an increase in bilirubin production, but that the infant did not have any of these signs present. Dr. Parton opines that the apneic episodes suffered by the infant were representative of sequale of the infarct that he sustained in utero and did not represent the occurrence of an acute event while the baby was under the care of Dr. Shibli or the staff of Huntington Hospital. Indeed, Dr. Parton states that the MRI examination of the infant's brain taken at Schneider's Children Hospital on July 2, 2006 showed that he suffered an arterial presumed perinatal stroke in utero, as well as references necrotic changes in the affect part of the brain, which would not have developed three days post-delivery. Dr. Parton states that the signs and symptoms of the resultant stroke were not immediately apparent, that none of the typical signs and symptoms of hemorrhage presented in the infant immediately in the neonatal period, and that cause of the hemorrhage is unknown.

Dr. Greenstein also has established his prima facie entitlement to judgment as a matter of law by proffering the deposition testimony of the parties, additional exhibits, and the affirmation of Dr. Henry Prince, in which he opined that the care and treatment rendered to Michalowski during her pregnancy did not deviate or depart from good and acceptable standards of medical care, and that his treatment was not the proximate cause of the brain injury sustained by the infant (*see* ***Belak-Redl v Bollengier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; ***Tuorto v Jadali***, 62 AD3d 784, 878 NYS2d 457 [2d Dept 2009]). Dr. Prince, who is board certified in obstetrics and gynecology, states it is his opinion, to a reasonable degree of medical certainty, that the care and treatment rendered by Dr. Greenstein to Michalowski during her pregnancy with the infant J.S. was in all respects reasonable and did not depart from good and accepted standards of medical or obstetrical practice. Dr. Prince also states that it is his opinion that nothing Dr. Greenstein did, or did not do, with regards to the care and treatment of Michalowski during her pregnancy with the infant caused or contributed in any way to any of his alleged injuries or conditions. Dr. Prince states that the infant was delivered prior to term at 34 weeks gestation due to concerns regarding preeclampsia, and because the evidence in the weeks prior to the infant's delivery indicated that he was not growing normally. Dr. Prince states that Michalowski's pregnancy with the infant basically was uneventful until her admission to Huntington Hospital with symptoms compatible with PIH or preeclampsia. Dr. Prince states that Michalowski underwent the appropriate tests and evaluations, including blood glucose screening, alpha-protein study and ultrasounds, that no additional laboratory or radiological studies were necessary, and that the gestational age of the fetus was always consistent with ultrasounds, which were consistent with her gestational age by dates based upon her reported last menstrual period date of November 2, 2005. He also states that estimated confinement date or due date correctly was established as August 9, 2006, and that there was no miscalculation of the gestational age or Michalowski's due date.

Dr. Prince further states the ultrasound study that Michalowski underwent on June 6, 2006 to evaluate fetal growth showed a normal amniotic fluid level, that fetal measurements were taken and the gestational age was consistent with 31 weeks, 6 days, that the fetal weight was 1735 +- 257 grams, and that the fetal growth and anatomy were normal. However, Dr. Prince states that by the time Michalowski presented to Huntington Hospital on June 24, 2006, she had a documented history of PIH or preeclampsia in her prior pregnancy, which put her at an increased risk for preeclampsia during her pregnancy with the infant, and that, based upon her history, reported complaints and symptoms, and physical findings, including elevated BP, her admission to the hospital was indicated and the need to rule out PIH or preeclampsia was warranted. Dr. Prince states that Dr. Greenstein acted appropriately when he admitted Michalowski into the hospital for monitoring and to rule out PIH or preeclampsia. He explains that hypertension in pregnancy can present a danger to the mother as well as the baby, and that visual changes and headaches may present warning signs that hypertension is affecting the central nervous system, and may be a warning or impending stroke or seizure, i.e., eclampsia, both of which may be fatal to the mother and the unborn child. He further states that once Michalowski was admitted into the hospital, she was appropriately placed on PIH protocol, that her BP and signs and symptoms of preeclampsia were closely monitored, and that she was appropriately placed on bed rest to control her symptoms and elevated BP.

Additionally, Dr. Prince states that Dr. Greenstein acted appropriately and in accordance with good and accepted obstetrical practice when he sought a consult with a maternal fetal medicine

specialist. He explains that Michalowski's complaints of headaches, her elevated BP, edema, and uric acid level, were warning signs of preeclampsia. Dr. Prince explains that preeclampsia is a complication of pregnancy characterized by high BP usually occurring after 20 weeks of pregnancy that can affect blood supply to the fetus through the placenta and causes placental damage, resulting in uteroplacental insufficiency and can lead to diminished blood flow to the developing infant. Dr. Prince states that headaches and visual changes are suggestive of the fact that the disease process is affecting the mother's brain, and that a finding of protein in the urine is not necessary for a diagnosis of preeclampsia. He states that Dr. Meirowitz, the maternal fetal specialist, performed a comprehensive evaluation of Michalowski and of the fetus, which showed that there was abnormal fetal growth, and that Dr. Greenstein was justified was relying on the findings and recommendations of the maternal fetal specialist. Dr. Prince states that the discordant growth observed by Dr. Meirowitz as a result of the comprehensive testing and examination of Michalowski suggested placental insufficiency, and that abnormal fetal growth was not ruled out because the amniotic fluid level was normal. Dr. Prince explains that when there is decreased blood flow to the fetus, "a brain sparing effect" occurs whereby the fetus diverts circulation to the most vital organs, such as the heart and brain, consequently reducing blood flow from the less critical organs, including the abdomen and extremities. He states this "brain sparring effect" explains the normal head circumference measurement on the June 26, 2006 ultrasound while the abdominal circumference and femur length lagged by more than two weeks. Dr. Prince states that while Dr. Meirowitz reported less than 200 grams of fetal growth in her report, there actually was less than 237 grams of fetal growth. However, Dr. Prince opines that the crucial factors in Michalowski's case are the discordant growth with the abdominal circumference and femur length lagging the head circumference by more two weeks, and the elevated systolic/diastolic ratio on the umbilical artery doppler, and that such factors make absolutely clear that there was restriction and abnormal growth of the fetus as of June 26, 2006.

Moreover, Dr. Prince opines that delivery of the infant by C-section was warranted as soon as the fetus was given a proper dose of steroids to mature the fetal lungs and reduce the risk of intraventricular hemorrhage. He states that removing the baby from the hostile intrauterine environment via C-section was indicated to prevent further compromise, and that Michalowski was given the proper recommended course of steroids prior to the delivery of the baby by C-section delivery. He states that Dr. Greenstein's performance of the C-section was timely and in accordance with appropriate and proper medical practice, as well as in accordance with the recommendation of the maternal fetal medicine specialist. Dr. Prince states that there was no reason for Dr. Greenstein to question the findings of Dr. Meirowitz or to disregard the recommendation for steroids or delivery via C-section, since there was clear evidence, based on the testing and evaluation of Michalowski and the fetus, of abnormality in fetal growth and placental blood flow warranting the administration of steroids and C-section delivery. In addition, Dr. Prince states that it is accepted practice within the medical field that when a general obstetrician seeks a consult within maternal fetal medicine to evaluate a patient, form a clinical diagnosis and make recommendations for treatment of the patient, that the general obstetrician is to rely on those findings, impressions and diagnosis to follow the recommendations for further treatment unless the findings are absolutely unreasonable and contrary to obstetrical training. Dr. Prince states that in this case, Dr. Meirowitz's impressions that Michalowski had atypical preeclampsia, that there was a lag in fetal growth, and that there was compromised fetal prefusion was reasonable, and that Dr. Greenstein acted in accordance with medical practice in following Dr. Meirowitz's findings and recommendations. He

further states that Michalowski's resolution of the headaches and visual complaints did not rule out preeclampsia or indicate that the BP was not impacting the pregnancy. Dr. Prince states that, in his opinion, the resolution of the headaches and visual changes were due ot the medical treatment with bed rest and increased fluids in the days leading up to the delivery and was not an indication in the reduction of risk to the mother or the baby. He states that Michalowski's elevated BP, headaches and visual complaints were a manifestation of the vascular changes affecting the mother and baby, and that the disease process remained a threat to the mother's well-being even though her systems resolved.

Dr. Prince further states that while the baby was preterm, at 34 weeks gestation, a baby is fully developed and, with the benefits of two doses of steroids to facilitate fetal lung maturation and decrease the risk of intraventicular hemorrhage, the risk-benefit analysis indicated that it was safe and appropriate to deliver the baby on June 29, 2006. Dr. Prince explains that the biophysical profile and the non-stress testing performed indicated that the baby was not hypoxic, and that it was important and necessary to deliver the baby before the decreased placental perfusion caused further compromise and possible neurologic damage. He states that in his opinion a delay in the performance of the C-section once informed consent was received would have likely subjected the baby to further compromise and put the mother at risk for significant complications, such as seizures and strokes. Dr. Prince states that in his opinion, within a reasonable degree of medical certainty, the injuries alleged to have been sustained by the infant were not caused by the delivery performed by Dr. Greenstein or by any alleged departure, and that following the transfer to Schneider's Children Hospital, the MRI examination of the infant's brain showed that some process occurred in utero which affected his growth and development prior to delivery. Dr. Prince states that the tests Michalowski alleges Dr. Greenstein and the other defendants should have performed were in fact performed as documented by her medical record and the infant's medical record, and that no further testing was necessary or indicated to evaluate gestational age or the size or condition of the fetus. Dr. Prince states that there is no evidence that Dr. Greenstein or any of the other defendants caused trauma to Michalowski's son's head following delivery, and that the APGAR scores and cord blood gases following his birth were excellent. Dr. Prince concludes, within a reasonable degree of medical certainty, that the care and treatment Dr. Greenstein rendered to Michalowski while she was pregnant with the infant was in accordance with accepted standards of medical and obstetrical practice, and that there was no departure or deviation from such practice that contributed to or caused the infant's injuries.

Similarly, upon review of the exhibits and the expert affirmation of Dr. Iffath Hoskin, the Court finds that Dr. Meirowitz has established a prima facie case that she did not depart from good and accepted standards of medical care in her treatment of Michalowski during her admission to Huntington Hospital while she was pregnant with the infant J.S., and that the treatment she provided was not the proximate cause of the alleged injuries sustained by the infant (*see* ***Moore v St. Luke's Roosevelt Hosp. Ctr.***, 60 AD3d 828, 874 NYS2d 389 [2d Dept 2009]; ***Bryan v Staten Is. Univ. Hosp.***, 54 AD3d 793, 864 NYS2d 466 [2d Dept 2008]; ***Mattis v Keen***, 54 AD3d 610, 864 NYS2d 6 [1st Dept 2008]). Dr. Hoskin states that he is board certified in obstetrics and gynecology, and specializes in maternal fetal medicine. Dr. Hoskin states that in his opinion, within a reasonable degree of medical certainty, the care rendered by Dr. Meirowitz to Michalowski while she was pregnant with the infant and admitted into Huntington Hospital was in accordance with good and accepted standards of medical practice and maternal fetal medicine, and that no act or omission by Dr. Meirowitz caused or contributed to the injuries alleged. Dr.

Hoskin states that when Michalowski presented to Huntington Hospital on June 26, 2006, the signs and symptoms she exhibited were consistent with atypical preeclampsia. He states that Michalowski was at an increased risk of preeclampsia since she suffered from the condition during her first pregnancy. He explains that the classic signs and symptoms of preeclampsia are high BP, swelling of the hands and feet, headaches, vision changes, proteinuria, and that, while Michalowski did not exhibit proteinuria, she presented with repeated headaches, high BP, and swelling of the hands and feet beginning on February 14, 2006. Dr. Hoskin states that when Michalowski presented to Huntington Hospital at 33 weeks, 3 days gestation, she had complaints of headache with visual disturbances, her BP was 158/72, she had generalized edema, and an umbilical artery Doppler flow confirmed that the blood flow to the fetus from the placenta was compromised. Dr. Hoskin explains that since the infant was receiving less oxygen and nutrients in the blood through the placenta, the infant's body ensured that the brain was receiving ample amounts of oxygen and nutrients by depriving them from other portions of the body as a mechanism to prevent brain injury, which is evidenced by a slowing of the fetal growth, and typically affects the abdominal circumference first. He further states that the elevated umbilical artery Doppler flow waveform was consistent with the other findings of decreased fetal growth since June 6, 2006. Dr. Hoskin opines that upon observing all of these findings and documentation, Dr. Meirowitz correctly concluded that Michalowski was suffering from atypical preeclampsia.

Moreover, Dr. Hoskin states that Dr. Meirowitz's role as a maternal fetal medicine consultant is to balance the risks and benefits to the mother and infant in continuing the pregnancy against the risks and benefits to the mother and infant in delivering the infant prematurely. Dr. Hoskins states that atypical preeclampsia puts the mother at risk of complications such as blindness, stroke, kidney failure, rupture of the liver, and death due to hypertension, and, as such, it is imperative to deliver the infant to avoid injury to the mother. However, Dr. Hoskin states that premature delivery negatively affects the infant, and that, when assessing the risks to the infant, the maternal fetal medicine specialist must consider the results of the umbilical artery Doppler flow, sonogram, biophysical profile, and non-stress test. Dr. Hoskin states that Dr. Meirowitz properly performed and interpreted the umbilical artery Doppler flow waveforms in assessing the risks and benefits. He states that the systolic to diastolic velocity ration was elevated, which demonstrated increased resistance in the umbilical artery resulting in a lack of nutrients being delivered to the infant, which was caused by Michalowski's hypertension. He further states that the lack of nutrients caused the infant's growth to slow, also known as IUGR, which was appropriately noted by Dr. Meirowitz. Dr. Hoskin states that IUGR was demonstrated by the fact that there was less than 200 grams of weight gain between June 6, 2006 at 30 weeks, 5 days gestation and June 26, 2006 at 33 weeks, 5 days gestation, as well as the abdominal circumference lagging by two weeks on the sonogram, which Dr. Meirowitz properly performed and interpreted. Dr. Hoskin opines that it was apparent the fetus was not receiving any added benefit from continuing the pregnancy, but instead was being severely compromised and needed to be delivered. In addition, Dr Hoskin states that the reassuring scores on the biophysical profile and the non-stress test showed that the infant at that point had not suffered any injury, and that the infant would be able to tolerate continuing the pregnancy to administer a course of steroids for lung maturation to ensure the infant would thrive in an extra-uterine environment. The course of steroids also is beneficial to the infant, because it reduces the risk of the infant having a stroke, since premature infants are at an increased risk of suffering strokes as a result of the structure of the brain not being fully developed. Dr. Hoskin notes that the severity of Michalowski's

hypertension did not require delivery on June 26, 2006, since her systolic BP ranged from 131 to 159 millimeter of mercury ("mmHg"). Dr. Hoskin opines that Dr. Meirowitz appropriately balanced the risks and benefits, and correctly recommended to continue the pregnancy until a course of steroids could be completed, at which point the infant would be delivered via C-section. He states that although steroids reduce the risk of stroke, premature infants remain at an increased risk of stroke, but in this case, the infant unfortunately suffered a stroke in utero.

Moreover, Dr. Hoskin opines that despite the fact that the infant suffered a stroke, Dr. Meirowitz's recommendations were appropriate and in accordance with good and accepted medical practice. Dr. Hoskin states that Dr. Meirowitz properly and timely completed the requested consult on June 26, 2006, that she appropriately and timely ordered the appropriate tests, that she appropriately reviewed and interpreted the tests performed on June 26, 2006, that she appropriately recommended the use of the steroid Celestone, and that she appropriately documented and communicated her recommendations to Dr. Greenstein, the attending OB/GYN, of a course of steroids following by C-section delivery. Furthermore, he states that since Dr. Meirowitz merely consulted on the case, she was not required to follow up with Michalowski after the completion of her consultation or to discuss the risks and benefits of a C-section. Rather, Dr. Hoskin states the duty to discuss the risks and benefits of the procedure was Dr. Greenstein's as the attending OB/GYN. Dr. Hoskin states that in his opinion, within a reasonable degree of medical certainty, the care and treatment provided by Dr. Meirowitz was at all times appropriate and within the standards of medical, obstetrical, and maternal fetal medicine care, and that the care and treatment provided did not cause of contribute to the alleged injuries suffered by the infant.

Michalowski, who does not oppose the motions made by the Huntington defendants, failed to raise a triable issue of fact as to whether the Huntington defendants deviated from the applicable standard of care in their treatment of the infant and whether such deviation was a proximate cause of the his 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, she failed to raise a triable issue of fact in opposition to Dr. Greenstein's and Dr. Meirowitz's prima facie showing (*see* ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]). Michalowski relies upon the affirmations of her experts to demonstrate that Dr. Greenstein and Dr. Meirowitz deviated from accepted medical care and practice while rendering care to her while she was pregnant with her son, and that such deviations resulted in him sustaining a brain injury due to his premature delivery. The affirmation of one of the plaintiff's experts alleges that the expert is board certified in obstetrics and gynecology, and concludes that both Dr. Greenstein and Dr. Meirowitz deviated from acceptable standards of medical care in by performing an unnecessary premature delivery of the infant, that the recommendation of a C-section delivery of the infant when Michalowski was 34 weeks gestation deviated from accepted standards of medical care, and that the diagnoses of IUGR, based upon the Michalowski's clinical presentation and testing was a deviation that proximately proximate cause or contributed to the infant suffering a brain injury. The affirmation of the other expert alleges that such expert is board certified in diagnostic radiology with a sub-certification in neuroradiology, and concludes, based upon radiographic images and studies of the infant, that the hemorrhage in his brain occurred during the first apneic episode that he had in the neonatal nursery, and

that there is no right infarct to the right temporal lobe. The affirmation of her last expert who alleges to be an expert in pediatrics and neonatal-perinatal medicine, and concludes, based upon the reports of Michalowski's other alleged experts, that, as a result of defendants' departure from standard medical practice, infant JS was deprived of the chance to avoid a brain hemorrhage and obtain a better outcome when defendants delivered him at 34 weeks gestation. However, neither expert's affirmation is notarized, the names and signatures have been redacted, and Michalowski has failed to submit an unredacted original copy of her experts' affirmations for the Court's 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]). Absent the submission of an unredacted experts' affirmation for the Court's in camera inspection, Michalowski has failed to demonstrate the merits of the action (*see* ***Rose v Horton Med. Ctr.***, 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]; ***Fuller v Tae Kwon***, 259 AD2d 662, 686 NYS2d 831 [2d Dept 1999]; ***Kruck v St. John's Episcopal Hosp.***, 228 AD2d 565, 644 NYS2d 325 [2d Dept 1996]). Accordingly, the defendants' motions to dismiss the complaint are granted, and the plaintiff's cross motion is denied.

Dated: 7/24/18

PETER H. MAYER, J.S.C.