A.H. v Fiasconaro
2022 NY Slip Op 32808(U)
August 17, 2022
Supreme Court, Kings County
Docket Number: Index No. 511880/15
Judge: Bernard J. Graham
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At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 17th day of August, 2022.

P R E S E N T:

HON. BERNARD J. GRAHAM
Justice

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A.H., an infant by his mother and natural guardian, A.B., and A.B., individually,

Plaintiffs,

-against-

Index No.: 511880/15

SANTO FIASCONARO, M.D.,
UNIQUE PERINATAL CARE, P.C.,
JAQUELINE BUSH, M.D.,
RICHARD ZUNIG, M.D.
DAPHNE LANDAU, M.D.
AMIR FAZELL, M.D., AND
NEW YORK METHODIST HOSPITAL,

Defendants.

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The following e-filed papers read herein:	NYSCEF No.:
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	132-162, 184-208
Opposing Affidavits (Affirmations)	218-229, 244-257
Affidavits/ Affirmations in Reply	264-265,270, 266-269
Other Papers:	

Upon the foregoing papers in this action alleging medical malpractice and lack of informed consent, defendants Jacqueline Bush, M.D., s/h/a Jaqueline Bush, M.D., (Dr. Bush), Richard Zuniga, M.D., Daphne Landau, M.D., Amir Fazeli, M.D., and New York Methodist Hospital (Methodist)[1] move (in motion [mot.] sequence [seq.] number [no.] seven), for an order, pursuant to CPLR 3212, dismissing the complaint of plaintiffs A.H., an infant by his mother and natural guardian, A.B., and A.B., individually (hereinafter the infant plaintiff and plaintiff, respectively); and severing the action against these defendants. Defendant Unique Perinatal Care, P.C. ("UPC") moves (in mot. seq. no. eight) for summary judgment dismissing plaintiffs' complaint in its entirety as against it.[2] Defendant Santo Fiasconaro, M.D., (Dr. Fiasconaro) moves (in mot. seq. no. nine) for an order pursuant to CPLR 3212: (1) granting summary judgment dismissing plaintiffs' complaint and any and all claims, including the claim of informed consent; and/or (2) awarding partial summary judgment dismissing the claims of lack of informed consent in their entirety; and/or (3) awarding partial summary judgment dismissing the third cause of action for derivative claims as asserted by the plaintiff mother.

Background Facts and Procedural History

On January 16, 2014, plaintiff A.B. (plaintiff), then 30 years old, saw Dr. Fiasconaro, an obstetrics and gynecology doctor (OB-GYN). She was examined and tests

[1] Pursuant to this court's order, dated May 12, 2022 (MS-11), the cross motion to discontinue this action as against Dr. Zuniga, Dr. Landau and Dr. Fazeli was granted and the caption has been amended to reflect that they are no longer parties to this action. Accordingly, Dr. Bush and Methodist remain as defendants.

[2] Also, pursuant to the 5/12/22 order, UPC's motion (MS-10) seeking to discontinue the action as against it was granted and the caption has been amended accordingly.

were performed that confirmed that she was pregnant with an expected due date of September, 2014. Dr. Fiasconaro had delivered plaintiff's older child in 2012. Laboratory results taken on February 15, 2014, by Dr. Fiasconaro revealed that plaintiff had an elevated white blood cell (WBC) count of 13.2. She continued seeing Dr. Fiasconaro for her prenatal care but as he did not perform sonograms in his office, he referred her to Radiology Associates of Brooklyn, where she had sonograms performed in January and February. On March 1, 2014, plaintiff began receiving further prenatal care and sonograms at New Beginnings Perinatal Center where she was seen by Dr. Hassan Wehbeh. She was seen by Dr. Wehbeh on April 5 & 26, 2014 and May 17, 2014. At the May 17, 2014 visit, plaintiff's cervical length was measured at 10 millimeters (1 centimeter), which he informed her presented an increased risk of spontaneous delivery before 33 weeks. Dr. Wehbeh recommended a repeat ultrasound in a few days and prescribed Crinone 8% vaginal gel. Plaintiff saw Dr. Fiasconaro on May 20, 2014, and he gave her a referral slip to Yevgeniya Pozharny, M.D. (Dr. Pozharny) at UPC for a second opinion. On May 22, 2014, plaintiff went to New Beginnings for a transabdominal and transvaginal ultrasound and her cervical length was again measured at 10 millimeters (1 centimeter). A fetal fibronectin[3] test was also conducted with negative results.

[3] "Fetal fibronectin is a protein that's believed to help keep the amniotic sac "glued" to the lining of the uterus . . . If this connection is disrupted, fetal fibronectin can be released into secretions near [the] cervix. The connection can be disrupted by an infection, inflammation, the separation of the placenta from the wall of the uterus, uterine contractions or shortening of the cervix. . . [if a] health care provider is concerned about preterm labor, he or she might test a swab of these secretions for the presence of fetal fibronectin between week 22 and week 34 of pregnancy. A positive fetal fibronectin test is a clue that the "glue" has been disturbed and . . . [there is an]increased risk of premature birth within seven days." (https://www.mayoclinic.org/tests-procedures/fetal-fibronectin/about/pac-20384676).

Plaintiff saw Dr. Pozharny on May 23, 2014, for a second opinion due to the diagnosis of a short cervix. Dr. Pozharny performed an ultrasound, and informed plaintiff that she had an increased risk of pre-term delivery given her shortened cervix length and prescribed Prometrium (Progesterone). On May 26, 2014, a transabdominal and a transvaginal ultrasound were performed at UPC which showed that plaintiff's cervical length was 1.5 centimeters. On June 2, 2014, a transabdominal ultrasound and a transvaginal ultrasound performed at UPC revealed that the closed cervical length was 1 centimeter with no funneling noted. A fetal fibronectin test performed that day was negative. Plaintiff saw Dr. Fiasconaro for visits on June 5, 2014, and June 12, 2014, and Dr. Pozharny for visits on June 9, 2014, and June 13, 2014.

On June 16, 2014, plaintiff presented to Dr. Pozharny with complaints of abdominal discomfort and a fetal fibronectin test was conducted that came back positive, which, according to Dr. Pozharny, meant that the odds of delivery in 2 weeks were 50/50, perhaps higher as plaintiff's cervix was shortened. Plaintiff returned to the office on June 17, 2014, and Dr. Pozharny recommended that she take steroids. Dr. Pozharny testified that this was important as plaintiff was at risk for a preterm delivery and the steroids would help to increase fetal lung development, decrease the occurrence of neonatal intracranial bleeds or brain bleeds (Dr. Pozharny's tr at p. 95, lines 2-15). Plaintiff declined and requested that another fetal fibronectin test be conducted, the result of which was negative. On June 23, 2014, plaintiff returned to see Dr. Pozharny, and transabdominal and transvaginal ultrasounds were performed which revealed that her cervical length was 1.3 centimeters and stable and that the cervix was closed. A fetal fibronectin test was conducted at this

visit which was negative, and Dr. Pozharny again asked plaintiff to take steroids and she declined. Plaintiff had a regularly scheduled visit with Dr. Fiasconaro on June 26, 2014. On July 1, 2014, plaintiff presented to Dr. Pozharny with complaints of abdominal and back discomfort. Transabdominal and transvaginal ultrasounds were performed which revealed a cervical length of 1.2 centimeters. However, upon examination, Dr. Pozharny found irritability on toco and some contractions, as well as dilation of 2 to 3 centimeters. A fetal fibronectin test was also conducted on this date and the result was positive. Dr. Pozharny directed plaintiff to immediately go to Methodist, as this was where Dr. Fiasconaro had privileges.

Plaintiff arrived at the Methodist Emergency Room (ER) on July 1, 2014, at 4:21 p.m. and was assessed in triage by Drs. Fazeli and Landau. She was noted to be 29 weeks and 2 days pregnant at this time. Plaintiff was examined and found to be 4 centimeters dilated with 50% effacement and was experiencing contractions every 1 to 2 minutes. She was admitted to the Labor and Delivery unit after discussion between Drs. Fazeli and Fiasconaro. At 5:20 p.m., Betamethasone, a steroid for fetal lung maturity, was administered to plaintiff. Terbutaline, a tocolytic used to decrease contractions, was administered at 5:36 p.m. and magnesium sulfate was administered for neuro-prophylaxis at 5:44 p.m. At 5:46 p.m., plaintiff's uterus was noted to be irritable, and the fetal heart rate (FHR) was 130 beats per minute. Laboratory results taken at 6:24 p.m. revealed an elevated WBC count of 21.3 and lower hemoglobin/hematocrit levels of 10.0 and 30.5 respectively. Plaintiff's heart rate was noted to be slightly elevated at 104 beats per minute at 10:00 p.m.

Dr. Bush, a maternal-fetal medicine specialist was consulted and examined plaintiff at 11:27 p.m. on July 1, 2014, for pre-term labor and elevated WBC. Plaintiff informed Dr. Bush that she was under the treatment of Dr. Alan Dosik, a hematologist, since September 2013 in connection with diagnosed leukocytosis in September of 2013, when her WBC count was 16. Upon examination of plaintiff, Dr. Bush found a gravid uterus with mild tenderness, a pulse rate ranging from 115 to 129, and a Category 1 FHR. Dr. Bush found that there was clinical evidence of chorioamnionitis[4] because plaintiff's WBC count had increased from 13 at her first visit with Dr. Fiasconaro to 21.3, and because there was mild uterine tenderness and tachycardia. Dr. Bush advised that the antibiotics Ampicillin and Gentamycin be administered and recommended to Dr. Fiasconaro that the delivery process should be commenced. A neonatal intensive care unit consult also appears to have taken place at this time. Dr. Bush testified that she discussed the risks of prematurity and infection with plaintiff at this time. (NYSCEF Doc No. 143, Dr. Bush's tr. at p. 73, line 13; p. 74, line 14; p.76, lines 5-20).

Laboratory results taken at 12:52 a.m. on July 2, 2014, seven hours after steroids were administered, showed an increased WBC of 25.0. Pitocin was administered at 1:33 a.m. Shortly thereafter, Dr. Fiasconaro examined plaintiff and found that the cervix was dilated 6 centimeters, the fetus was 100% effaced, and the fetal station was -3. She was experiencing contractions 2 to 3 minutes apart, and the FHR was 135 beats per minute with moderate variability, and positive accelerations and no decelerations. Plaintiff's heart rate

[4] Chorioamnionitis or intraamniotic infection is an acute inflammation of the membranes and chorion of the placenta, typically due to ascending polymicrobial bacterial infection in the setting of membrane rupture (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008318/).

remained elevated at 116 beats per minute. Dr. Fiasconaro examined plaintiff at 4:53 a.m., and observed that the labor was not progressing and decided to stop administering Pitocin in preparation for a cesarean section delivery. The record reveals that plaintiff signed a consent form for the cesarean section delivery at 5:31 a.m. Dr. Fiasconaro noted that the indication for cesarean delivery was labor dystocia and suspected chorioamnionitis with a failure to progress during the first stage of labor.

The male infant plaintiff was delivered by Dr. Fiasconaro via cesarean section, at 6:31 a.m., on July 2, 2014, weighing 3 pounds. The infant plaintiff's respiration was noted to be labored with grunting, nasal flaring, with mild subcostal retractions, and resuscitation was accomplished by oxygen and suction via bulb syringe. His Apgar scores were 6 at 1 minute and 7 at 5 minutes, and he was immediately taken to the Neonatal Intensive Care Unit after birth. Laboratory results taken after plaintiff had given birth on July 2, 2104, showed that plaintiff had a WBC of 34.8 at 9:18 a.m.; 25.9 at 10:12 p.m.; and 22.0 at 7:07 a.m. on July 3, 2014. On July 3, 2014, a hematology/oncology consult by Dr. Zuniga occurred and, after reviewing plaintiff's blood work, Dr. Zuniga diagnosed her with leukocytosis with neutrophilia and recommended continuing to monitor her for signs of infection.

On July 3, 2014, the infant was intubated and placed on a ventilator due to continued desaturations, tachypnea, and retraction. A chest X-ray taken suggested respiratory distress syndrome. An ultrasound of the infant plaintiff's head was performed, due to the premature delivery, which showed a right Grade IV intraventricular hemorrhage with rupture into the surrounding white matter, a right lateral ventricle and frontal horn effaced by hemorrhage

and no midline shift. Another head ultrasound was performed on July 30, 2014, which revealed two small Grade I hemorrhages adjacent to the left lateral ventricle. The infant plaintiff remained at Methodist from his birth until his discharge on September 11, 2014. At that time, he weighed 8.3 pounds, was on room air, and was feeding well by mouth. The infant plaintiff continued to receive home nursing visits after his discharge from Methodist.

Summary Judgment Standard

Medical Malpractice

"To prevail on a motion for summary judgment in a medical malpractice action, a defendant must make a prima facie showing either that there was no departure from the accepted community standards of medical care, or that his or her acts were not a proximate cause of the plaintiff's injuries" (*Pinnock v Mercy Med. Ctr.*, 180 AD3d 1088, 1090 [2d Dept 2020] [internal citations omitted]; *see Rosario v Our Lady of Consolation Nursing & Rehabilitation Care Ctr.*, 186 AD3d 1426, 1430 [2d Dept 2020]; *Korszun v Winthrop Univ. Hosp.*, 172 AD3d at 1344-1345 [2d Dept 2019]; *Hernandez v Nwaishienyi*, 148 AD3d 684 [2d Dept 2017]; *McCarthy v N. Westchester Hosp.*, 139 AD3d 825 [2d Dept 2016]).

"In order to sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (*Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 726 [2d Dept 2016], citing *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *Bhim v Dourmashkin*, 123 AD3d 862, 865 [2d Dept 2014]; *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 1045 [2d Dept 2010]). A defendant claiming that treatment did not depart from accepted

standards, must provide an expert opinion that is detailed, specific and factual in nature (*see Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *see also Daniele v Pain Mgt. Ctr. of Long Is.*, 168 AD3d 672, 674 [2d Dept 2019]). The opinion must be based on facts within the record or personally known to the expert (*see Roques v Noble*, 73 AD3d 204, 207 [1st Dept 2010]).

"'In opposition, a plaintiff then must submit material or evidentiary facts to rebut the defendant's prima facie showing that he or she was not negligent in treating the plaintiff'" (*Dolan v Halpern*, 73 AD3d 1117, 1118-1119 [2d Dept 2010], quoting *Langan v St. Vincent's Hosp. of N.Y.*, 64 AD3d 632, 633 [2d Dept 2009] [internal quotation marks and citations omitted]). "[P]laintiff need only raise a triable issue of fact regarding 'the element or elements on which the defendant has made its prima facie showing'" (*McCarthy*, 139 AD3d at 826, quoting *Mitchell v Grace Plaza of Great Neck, Inc.*, 115 AD3d 819, 819 [2d Dept 2014]; *see Wagner v Parker,* 172 AD3d 954, 954 [2d Dept 2019]). However, a plaintiff's expert's affidavit that is conclusory or speculative is insufficient to raise a triable issue of fact in opposition to a defendant's prima facie showing where the expert fails to set forth any basis for his or her opinion and fails to address the specific assertions made by defendant's expert (*see Choida v Schirripa*, 188 AD3d 978, 980 [2d Dept 2020]; *Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020]; *Rivers v Birnbaum*, 102 AD3d 26, 45-46 [2d Dept 2012]). Summary judgment may not be awarded in a medical malpractice action where the parties offer conflicting expert opinions, which present a credibility question requiring a jury's resolution (*see Lefkowitz v Kelly,* 170 AD3d

1148,1150 [2d Dept 2019]; *Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]; *Dandrea v Hertz*, 23 AD3d 332, 333 [2d Dept 2005]).

Finally, in a medical malpractice action, where causation is often a difficult issue, a plaintiff seeking to establish proximate cause, "must demonstrate 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that the defendant's deviation was a substantial factor in causing the injury'" (*Daniele*, 168 AD3d at 675, quoting *Flaherty v Fromberg*, 46 AD3d 743, 745[2d Dept 2007]; *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883[2d Dept 2005]; *see Holton v Sprain Brook Manor Nursing Home*, 253 AD2d 852,852 [2d Dept 1998]). "[T]he plaintiff's evidence may be deemed legally sufficient even if its expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased his injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased his [or her] injury" (*Daniele*, 168 AD3d at 675, quoting *Flaherty*, 46 AD3d at 745; *see D.Y. v Catskill Regional Med. Ctr.*, 156 AD3d 1003, 1005 [3d Dept 2017]; *Neyman v Doshi Diagnostic Imaging Servs., P.C.*, 153 AD3d 538, 545 [2d Dept 2017]; *Clune v Moore*, 142 AD3d 1330, 1332 [4th Dept 2016]; *Alicea v Ligouri*, 54 AD3d 784, 786 [2d Dept 2008]).

Lack of Informed Consent

"To establish a cause of action [to recover damages] for malpractice based on lack of informed consent, [a] plaintiff must prove (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a

reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same 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'" (*Palmeiro v Luchs*, 202 AD3d 989, 991-992 [2d Dept 2022], quoting *Lavi v NYU Hosps. Ctr.*, 133 AD3d 830, 832 [2d Dept 2015], quoting *Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]). "The fact that a plaintiff signed a consent form, alone does not establish a defendant's prima facie entitlement to judgment as a matter of law" (*Palmeiro*, 202 AD3d at 991-992; *see Walker v Saint Vincent Catholic Med. Ctrs.*, 114 AD3d 669, 670 [2d Dept 2014]).

Dr. Bush and Methodists' Motion (MS-7)

Dr. Bush and Methodist[5] move for summary judgment dismissing plaintiffs' complaint which alleges that Dr. Bush failed to properly/timely: treat premature labor; prescribe/administer steroids; perform/interpret sonograms; treat short cervical length/cervical insufficiency; administer medications to arrest labor; prescribe bed rest; perform maternal/fetal monitoring; administer oxygen; recognize fetal distress; perform medical examinations; treat hydrocephalous/respiratory difficulties; diagnose/treat maternal infection; recognize the significance of elevated white blood count; postpone a cesarean section and allow the plaintiff the chance to deliver vaginally; take necessary steps to prolong the plaintiff's pregnancy; and repeat white blood cell count testing/testing for maternal infection. In addition, plaintiffs assert that Dr. Bush misdiagnosed plaintiff,

[5] All claims asserted against Methodist relate to its vicarious liability for the actions of Dr. Bush.

improperly performed a cesarean section when the infant plaintiff was premature, failed to prevent respiratory distress, failed to prevent intraventricular hemorrhage, failed to ensure fetal lung maturity prior to delivery, failed to consider, recommend and/or perform a cerclage, failed to timely administer tocolytics, failed to prolong the pregnancy, and failed to obtain informed consent, among other allegations. Plaintiff seeks to impose vicarious liability upon Methodist based upon the actions of its employee, Dr. Bush.

As a result of these departures, plaintiffs claim injuries including, but not limited to: premature birth, Grade IV interventricular hemorrhage right side, Grade I interventricular hemorrhage left side, Grade IV hydrocephalus, respiratory distress syndrome, prolonged intubation, ventilation, anemia, feeding problems, fine and gross motor delays, cognitive delays, severe difficulties in sensory processing, low muscle tone, developmental delays, language delays, oxygen deprivation at birth, multiple blood transfusions, apnea, hemangioma of face, refractive amblyopia, anisometropia, vascular lesion of midline upper neck/chin, bronchopulmonary dysplasia, chronic lung disease, delayed milestones of childhood development, loss of enjoyment of life, and pain and suffering.

Dr. Bush argues that she did not deviate from the relevant standard of care in her care and treatment of plaintiff. In support of the instant motion, Dr. Bush has submitted the expert affirmation of Joanne Stone, M.D. (Dr. Stone), a physician duly licensed to practice medicine in the State of New York, Board Certified in Obstetrics and Gynecology and Maternal-Fetal Medicine. Dr. Stone affirms that she reviewed all of the relevant documents, records and films related to this matter. She opines, with a reasonable degree of medical certainty, that at all times Dr. Bush adhered to accepted standards of medical

practice, and that any alleged injuries are not causally connected to the care and treatment rendered by Dr. Bush.

Specifically, Dr. Stone opines that it was Dr. Fiasconaro, as plaintiff's private treating OB-GYN, who was responsible for all of the pre-operative, intra-operative and post-operative maternal-fetal and OB-GYN care and treatment rendered to plaintiff at Methodist, including the decision to deliver the infant plaintiff on July 2, 2014, as a result of the finding of clinical evidence of suspected chorioamnionitis made by Dr. Bush during her maternal-fetal medicine consult at 11:27 p.m. on July 1, 2014. She further opines that Dr. Fiasconaro was responsible for the decision to deliver the infant by cesarean section on July 2, 2014, as a result of his findings of labor dystocia and a failure to progress during the first stage of labor, and that he was responsible for all decisions made during the delivery. In addition, Dr. Stone opines that Dr. Fiasconaro, was responsible for obtaining informed consent from plaintiff related to the delivery of the infant plaintiff by cesarean section. In this regard, she notes that the Methodist record includes a written consent form signed by plaintiff at 5:31 a.m. on July 2, 2014, and witnessed, and signed by Dr. Fiasconaro which indicates that he discussed the benefits, risks, and alternatives to the procedure prior to obtaining consent. Moreover, Dr. Stone opines that it was Dr. Fiasconaro's responsibility to: recognize and respond to plaintiff's signs and symptoms; diagnose and treat her conditions; order timely and appropriate diagnostic testing, and to obtain all relevant consultations, and that this was not the responsibility of Dr. Bush or any of the Methodist personnel.

Dr. Stone opines that "the maternal-fetal medicine consultation by Dr. Bush at 11:27 p.m. on July 1, 2014, at the request of Dr. Fiasconaro was properly and timely conducted, and was necessary due to the suspicion of pre-term labor and maternal tachycardia, which was first noted at 10:40 p.m., and an elevated WBC level, which was 21.3 as of 6:24 p.m. and was significantly elevated from a baseline or either 13 or 16" (NYSCEF Doc No. 135, Dr. Stone aff at ¶28). She further opines that Dr. Bush properly obtained a full and complete medical history during her consultation with plaintiff, including that she had been evaluated by Dr. Alan Dosik in connection with leukocytosis in September of 2013 with a WBC count of 16. Dr. Stone further opines that Dr. Bush performed an appropriate examination of plaintiff and appropriately noted that her examination was significant for a gravid uterus with mild tenderness, a pulse rate of 115 to 129, and Category 1 FHR. Thus, Dr. Stone opines that in light of this presentation, Dr. Bush appropriately determined that there was clinical evidence of chorioamnionitis, given the fact that plaintiff's WBC count had increased from 13 at her first visit with Dr. Fiasconaro to 21.2 on July 1, 2014, there was mild uterine tenderness and tachycardia, which she opines are classic signs and symptoms of chorioamnionitis, a condition that can only be diagnosed clinically. She opines that Dr. Bush properly ordered that antibiotics be administered to plaintiff in light of her elevated WBC count, correctly recommended starting the delivery process given the clinical evidence of chorioamnionitis, and appropriately discussed the risks of prematurity and infection with plaintiff.

Dr. Stone further opines that it was proper to obtain a consult from Dr. Richard Zuniga on July 3, 2014, and that it was not necessary to have said consult earlier to properly

assess and determine plaintiff's medical condition. Further, Dr. Stone opines that Dr. Zuniga properly diagnosed plaintiff as suffering from leukocytosis with neutrophilia, based upon her extremely elevated WBC of 34.8 at 9:18 a.m. shortly after giving birth on July 2, 2014, which had declined to a still elevated level of 22.0 as of 7:07 a.m. on July 3, 2014.

As relates to causation, Dr. Stone opines that:

> the risk of the injury which occurred to the premature infant was inevitable by the time the mother initially presented to . . . [Methodist] at 4:21 p.m. on July 1, 2014, and that no medical treatment could have been performed at the hospital which would have decreased that risk. In particular, there is a significant risk of intraventricular hemorrhage that exists at 29 weeks which does not significantly diminish until 32 weeks; as such, extending the pregnancy by even 24 hours or 48 hours would have not decreased the risk of intraventricular hemorrhage (NYSCEF Doc No. 135, Dr. Stone aff at ¶34).

She notes that steroids for fetal lung maturity and tocolytics to stop the contractions were appropriately administered at Methodist in light of her pre-term labor symptoms. Dr. Stone opines that given the elevated WBC level of 21.3, in combination with maternal tachycardia and mild uterine tenderness, Dr. Fiasconaro, after consultation with Dr. Bush, made the appropriate judgment upon a confirmed clinical suspicion of chorioamnionitis to deliver the infant plaintiff in light of the unavoidable risk of intraventricular hemorrhage noted above. In this regard, she contends that:

> a chorioamnionitis infection can cause injury to the white matter of the brain, leading to cerebral palsy", [thus] [o]nce a clinical determination of chorioamnionitis was confirmed, as it was by the consultation of Dr. Bush at 11:27 p.m. on July 1, 2014, it was a matter of clinical judgment about whether to remove the significantly premature infant from a potentially hostile uterine environment, as opposed to allowing it to remain in the womb for as long as possible (NYSCEF Doc No. 135, Dr. Stone aff at ¶34).

Accordingly, Dr. Stone opines that the risk for intraventricular hemorrhage could not be eliminated and was not caused by any act or omission of Dr. Bush.

Based upon the foregoing, the court finds that Dr. Bush has set forth a prima facie case in favor of dismissal of plaintiffs' claims as asserted against her, and the vicarious claims asserted against Methodist, and has demonstrated that there was no departure from accepted standards of medical practice by these defendants that proximately caused plaintiffs' injuries (*see Townsend v Vaisman*, 203 AD3d 1199, 1203 [2d Dept 2022]; *Stiso v Berlin,* 176 AD3d 888, 890 [2d Dept 2019]; *Aliosha v Ostad*, 153 AD3d 591, 593 [2d Dept 2017]; *Senatore v Epstein*, 128 AD3d 794, 796 [2d Dept 2015]). This prima facie showing has shifted the burden to plaintiffs to demonstrate the existence of a factual issue with respect to Dr. Bush's care.

Plaintiffs oppose Dr. Bush and Methodist's motion arguing that material issues of fact exist with regard to whether there was a departure from good and accepted standards of medical care and practice which proximately caused the infant plaintiff's injuries, thereby precluding summary judgment in defendants' favor. In support, plaintiffs submit a redacted affidavit from a physician licensed to practice medicine in the State of New York, board certified in Obstetrics and Gynecology. Plaintiffs' expert affirms that they:

> are familiar with the accepted standards of care and practice in the fields of obstetrics and gynecology as they existed in 2014 and I am also familiar with management of prenatal care, labor and delivery complicated by reactive leukocytosis, shortened cervical length, premature labor, labor dystocia, chorioamnionitis, amnionitis, and other related conditions and complications. By virtue of my experience and training, I am also familiar with accepted standards of care and practice as they relate to maternal fetal medicine consults in the setting of suspected chorioamnionitis, leukocytosis

> and preterm labor and delivery" (NYSCEF Doc No. 228 plaintiffs' OB/GYN expert aff at ¶ 2).

The expert affirms that they reviewed all relevant documents in rendering this opinion, including the pleadings, the Bill of Particulars, the Methodist medical records, all of the deposition transcripts, and the affirmations of Drs. Stone and Fleischer.

Plaintiffs' expert opines that Dr. Bush and Methodist departed from good and accepted standards of medical care and practice in the care and treatment of plaintiff during her labor and delivery of the infant plaintiff and that those departures proximately caused the infant plaintiff to suffer severe personal injuries. The expert opines that it was a departure to abandon attempts to forestall the premature delivery of the infant plaintiff, noting that tocolytics to inhibit contractions was appropriately administered when she arrived at Methodist and notes that this can delay delivery for as long as 48 hours, which is critical to allow for the administration of a properly timed course of steroids to promote fetal lung maturity prior to delivery. In this regard, the expert states that the administration of antenatal corticosteroids produces a considerable reduction in the risks of complications of prematurity, including respiratory distress syndrome, intracranial hemorrhage, necrotizing enterocolitis, and death. Specifically, the expert states that the administration of antenatal corticosteroids should consist of either two 12 mg doses administered intramuscularly, 24 hours apart or four 6 mg doses administered intramuscularly every 12 hours. Plaintiffs' expert opines that it was a departure to not administer a full course of antenatal corticosteroids prior to inducing the premature delivery of the infant plaintiff, noting that the first dose of a corticosteroid was administered on July 1, 2014, at 5:20 p.m.,

and the second dose was administered just 8 hours later on July 2, 2014, at 2:20 am. Thus, the expert opines that the failure to reduce the risk of respiratory distress syndrome and intracranial hemorrhage was a proximate cause of the infant plaintiff's injuries.

Plaintiffs' expert further opines that the premature delivery of the infant plaintiff could have been forestalled for as long as one week or more, noting that plaintiff's prior pregnancy was similarly complicated by a shortened cervix at 33 weeks and early cervical changes, and when she experienced premature labor, her delivery was forestalled for nine days. Thus, the expert opines that interventions with tocolytics would have successfully delayed the birth for at least 24 hours to allow for the appropriate course of steroid administration.

Next, plaintiffs' expert opines that it was a departure to fail to draw labs to obtain a WBC prior to administering the first dose of corticosteroids, as "Betamethasone, administered in women at high risk for preterm labor to promote fetal lung maturity, can cause maternal WBC counts to rise as much as 33% on day one" (NYSCEF Doc No. 227, plaintiffs' OB/GYN expert aff at ¶39). The expert notes that plaintiff suffered from reactive leukocytosis which typically involves an increase in WBC counts in the range of 11 to 30, and can be caused by emotional stress or an inflammatory state such as that produced by pregnancy. Further, the expert points out that antenatal steroid therapy in the setting of reactive leukocytosis produces a further significant increase in total WBC counts. Thus, plaintiffs' expert opines that Dr. Bush failed to appreciate that the rise in plaintiffs' WBC count to 21 on July 1, 2014, was caused by the steroid administration in a patient

with reactive leukocytosis and was not the result of chorioamnionitis. Significantly, the expert notes that:

> [c]horioamnionitis is an infection that can affect the amniotic fluid, placenta and uterus. Diagnosis of suspected chorioamnionitis is made when maternal fever is greater than 39 degrees Celsius (102.2 degrees Fahrenheit) and at least one other clinical risk factor is present such as: maternal leukocytosis, fetal tachycardia, foul smelling or stained amniotic fluid, and uterine tenderness. Tachycardia may be present in the absence of chorioamnionitis, and thus, in the absence of maternal fever, there must be careful assessment of alternative etiologies of a rise in heart rate. Maternal WBCs are not diagnostic of histologic chorioamnionitis (NYSCEF Doc No. 227, plaintiffs' OB/GYN expert aff at ¶ 41).

Thus, plaintiffs' OB/GYN expert opines that Dr. Bush departed from good and accepted standards of medical care and practice when she found "clinical evidence of chorioamnionitis" and recommended delivery of the infant plaintiff. In this regard, the expert notes that plaintiff was not experiencing a fever, and although Dr. Bush noted uterine tenderness this is subjective and not a reliable indicator given that plaintiff was experiencing labor pains. Additionally, plaintiffs' expert contends that Dr. Bush incorrectly noted in her consultation note that the white blood count of 21 was before the administration of the steroid, Betamethasone, when the records indicate that the blood work was performed after the steroid had been administered.

Plaintiffs' expert acknowledges that chorioamnionitis places the fetus at risk for neonatal sepsis, seizures, low APGAR score and cerebral palsy, but contends that the administration of intrapartum antibiotics decreases neonatal sepsis and infections, and that good and accepted standards of medical care and practice required continued surveillance for maternal and fetal well-being rather than induction of labor to deliver the infant plaintiff

before completing a 24 hour course of corticosteroids to promote fetal lung maturity and a reduction the risk for respiratory distress syndrome and intracranial hemorrhage. Thus, the expert opines that Dr. Bush's misdiagnosis of clinical chorioamnionitis proximately caused premature delivery of the infant plaintiff at 29 weeks and 2 days, prior to proper steroid administration, and resulted in the respiratory distress syndrome, intraventricular hemorrhage and the related injuries suffered by the infant plaintiff.

Additionally, the expert opines that it was a departure to fail to obtain a hematology consult emergently and prior to deciding to proceed with delivery of the infant plaintiff, as plaintiff was known to be under the care of a hematologist for reactive leukocytosis and was experiencing an increased WBC count. The expert opines that this departure resulted in a misdiagnosis of plaintiff's condition and proximately caused the premature delivery of the infant plaintiff and the related injuries he sustained.

Finally, the expert opines that Dr. Bush failed to obtain a proper informed consent as there is no indication that plaintiff was given the alternative of further monitoring prior to proceeding with a vaginal delivery or cesarean section delivery, or that she was informed of the risks of the premature delivery prior to the full course of steroids being administered.

In further support of their opposition, plaintiffs submit an affirmation from Dr. David Adler, a New York State licensed physician, Board Certified in Pediatrics and Neurology with a Special Qualification in Child Neurology. Dr. Adler affirms that he has over thirty years of experience in the practice of pediatric neurology and has treated and evaluated children who were born preterm and went on to suffer long-term neurodevelopmental disabilities as alleged herein. He states that he has reviewed the

plaintiff's medical records from her pregnancy and delivery of the infant plaintiff, and the subsequent medical records of the infant plaintiff. In 2020, Dr. Adler examined the then six-year-old infant plaintiff and diagnosed: respiratory distress syndrome; Grade 4 intraventricular hemorrhage; motor and language delay; behavioral variability; left hemiparesis; seizure; left porencephalic cyst; fine and gross motor incoordination.

Dr. Adler opines that the infant plaintiff's neurological and neurodevelopmental disabilities are the result of the significant complications sustained as a result of his preterm delivery at 29-30 weeks gestation. He notes that preterm infants are at greatest risk for long-term neurodevelopmental disability such as the Grade IV intraventricular hemorrhage he suffered and that the risk of developing this type of hemorrhage decreases with increasing gestational age and falls to close to zero by 32 weeks. Dr. Adler further opines that a delay in the delivery of the infant plaintiff in order to provide the proper administration of antenatal steroids would have significantly mitigated if not wholly prevented the neurological and neurodevelopmental disabilities experienced by the infant plaintiff.

Finally, in further support of their opposition, plaintiffs point out that the pathology report prepared by Dr. Salafia confirms that plaintiff did not have chorioamnionitis and that Dr. Zuniga's July 4, 2014, consultation note states that plaintiff's elevated WBC could have been caused by steroid administration.

In reply, Dr. Bush and Methodist argue that plaintiff has failed to raise an issue of fact to defeat their prima facie demonstration of entitlement to summary judgment dismissing plaintiffs' claims as asserted against these defendants. In this regard, they

contend that plaintiffs' expert affirmation should be disregarded as it is speculative and conclusory. Specifically, they contend that the expert's opinion as to plaintiff's prior pregnancy and any prior history of leukocytosis is conclusory and irrelevant; that the diagnosis of clinical chorioamnionitis was appropriate due to the presence of preterm labor, uterine tenderness, maternal tachycardia, and elevated white blood count; the expedited steroid administration was appropriate; a hematology consult should not have been obtained prior to delivery; the informed consent was proper and appropriate; and Dr. Salafia's report confirmed a finding of inflammation in the choriodecidua.

In further support of the motion, Dr. Bush and Methodist submit a reply affirmation from Dr. Stone. Dr. Stone states that in patients who are in preterm labor with the symptoms plaintiff presented with, intraamniotic infection and/or inflammation is present in approximately 40-70 percent of such patients, thus a diagnosis of chorioamnionitis was appropriate as she presented with several of the known symptoms. Dr. Stone asserts that plaintiffs' OB/GYN expert opinion that plaintiff's WBC was elevated due to leukocytosis is incorrect as it is called reactive leukocytosis because it is reactive to something, such as an infection or inflammation, and in the setting of preterm labor, a clinician must assume the worst case scenario that it is related to an intraamniotic infection or inflammation, and act appropriately to ensure the fetus is not jeopardized. Thus, she opines that the standard of care is to assume that in preterm labor, an elevated WBC is potentially related to chorioamnionitis. Moreover, she contends that plaintiffs' expert assertion that a maternal fever is required in order to make a diagnosis of chorioamnionitis is incorrect as a fever

might not be present at the outset, and thus is not required to make a diagnosis of chorioamnionitis.

Dr. Stone contends that it is unclear from the record whether plaintiff's blood was drawn after the steroids had been administered, and that even if that was the case, the assertion by plaintiffs' expert that this could cause plaintiff's WBC count to rise as much as 33 percent, in day one, ignores the close proximity of time between the time the steroids were administered and the time that the blood was drawn, which was likely within an hour or two and not 24 hours.

Dr. Stone further opines that the decision to administer steroids expeditiously, two doses within nine hours was appropriate in the setting of an intraamniotic infection, which would cause neurologic injury, and that "[t]he risk of delay in delivery outweighed the potential benefit of giving the two doses of steroids 24 hours apart (NYSCEF Doc No. 269, Dr. Stone's reply aff at ¶ 16).

Additionally, Dr. Stone contends that plaintiff's OB/GYN expert's assertion that the failure to obtain a hematology consult resulted in the misdiagnosis of chorioamnionitis, is incorrect as it is out of a hematologist's expertise to diagnose chorioamnionitis. Finally, she reiterates her opinion that it was Dr. Fiasconaro's responsibility to obtain informed consent from plaintiff.

Where as here, the parties to a medical malpractice action offer conflicting expert opinions, issues of credibility arise requiring jury resolution (see *Palmeiro v Luchs*, 202 AD3d 989, 991 [2d Dept 2022]; *Russell v Garafalo*, 189 AD3d 1100 1101 [2d Dept 2020];*Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]). The opinions of the plaintiffs'

experts conflict with the opinion of Dr. Bush and Methodist's expert on issues such as whether there was clinical evidence of chorioamnionitis, whether the delivery should have been forestalled to allow for the proper administration of a course of steroids to promote fetal lung development and whether a consultation with a hematologist should have occurred prior to the delivery of the infant plaintiff and whether these departures proximately caused the infant plaintiff's injuries (*see Petrik v Pilat*, 119 AD3d 760,761 [2d Dept 2014]; *Martin v Siegenfeld*, 70 AD3d 786, 788 [2d Dept 2010]). Accordingly, Dr. Bush and Methodists' motion seeking summary judgment dismissing plaintiffs' claims as asserted against them is denied. In addition, the court finds that the conflicting expert opinions raise triable issues of fact precluding summary judgment on plaintiffs' lack of informed consent claim against Dr. Bush and Methodist.

Dr. Fiasconaro's Motion (MS-9)

Dr. Fiasconaro seeks summary judgment dismissing plaintiffs' complaint and any and all claims asserted against him, and/or for an order awarding him partial summary judgment dismissing the claim of lack of informed consent, and/or dismissing the third cause of action for plaintiff's derivative claims. The allegations asserted against Dr. Fiasconaro include claims that during his treatment of plaintiff between March 1, 2014 and July 2, 2014, he failed to: properly manage her pregnancy; timely diagnose, manage, treat and stop premature labor; properly prescribe and/or administer steroids; properly perform and interpret sonograms; measure cervical length and recognize the significance of the

cervical length; timely and properly prescribe medications; to hospitalize plaintiff; recommend bed rest; perform, interpret fetal monitoring; treat and manage cervical insufficiency; recognize the significance of an elevated WBC; postpone a Cesarean Section and prematurely performed a Cesarean Section. In addition, plaintiff contends that Dr. Fiasconaro misdiagnosed plaintiff; failed to repeat WBC count testing and testing for maternal infection, and failed to obtain informed consent. Plaintiffs assert that these departures proximately caused the injuries suffered by the infant plaintiff.

Dr. Fiasconaro argues that he did not depart from the standard of care and that his actions did not proximately cause the injuries alleged. In addition, he asserts that informed consent was obtained from plaintiff with regard to his recommendation to deliver the infant-plaintiff. In support of his motion, Dr. Fiasconaro submits an affirmation from Adiel Fleisher, M.D., (Dr. Fleischer), a physician licensed to practice medicine in the State of New York, board certified in obstetrics and gynecology and maternal-fetal medicine. The expert affirms that "by virtue of my education and training and active practice in the field of obstetrics and gynecology and more specifically maternal fetal medicine for greater than 30 years, I am qualified to render an opinion with respect to the care and treatment rendered in this case by Dr. Fiasconaro" (NYSCEF Doc No. 187, Dr. Fleischer's aff at ¶ 4). Dr. Fleischer affirms that he reviewed all relevant documents in rendering this opinion, including the pleadings, the Bill of Particulars, the Methodist medical records, and all of the deposition transcripts and that all of his opinions are rendered to a reasonable degree of medical certainty.

Dr. Fleischer opines that at all times Dr. Fiasconaro cared for the plaintiff within the standard of care, noting that he referred plaintiff to a high risk center from the commencement of the pregnancy for sonograms which he reviewed. In addition, Dr. Fleischer opines that Dr. Fiasconaro appropriately referred plaintiff for a second opinion when she was diagnosed with a shortened cervix, and that it was consistent with the standard of care for plaintiff to be prescribed PV progesterone to reduce the chances of preterm labor with a diagnosed shortened cervix, and to have frequent sonograms to follow the cervical length. Thus, he opines that Dr. Fiasconaro appropriately attempted to reduce the risk of preterm labor and delivery with careful monitoring, administration of progesterone gel and rest. Dr. Fleischer further opines that on June 17, 2014, plaintiff was appropriately offered steroids following a positive fetal fibronectin test, which indicated the likelihood of preterm labor. He notes that despite Dr. Fiasconaro's efforts to reduce the risk of preterm labor, which is a known risk where there is cervical shortening, when plaintiff presented to UPC on July 1, 2014, it was evident that she was experiencing pre-term labor, and thus it was appropriate that she was directed to Methodist to come under the care of Dr. Fiasconaro.

Dr. Fleischer notes that upon plaintiff's presentation to Methodist, tocolytics were administered to forestall delivery, however he contends that given that she was 2-3 centimeters dilated, it was unlikely that intervention to delay delivery would be successful. Thus, he opines that it was appropriate that magnesium sulfate for neuro protection for the infant-plaintiff and corticosteroids for lung maturity were administered. Dr. Fleischer states that "[t]he literature is clear that successful tocolytic therapy helps gain the two to

three days necessary to administer steroids but has not been proven to decrease the morbidity and mortality associated with prematurity" (NYSCEF Doc No. 187, Dr. Fleischer's aff at ¶38). Dr. Fleischer opines that a maternal fetal medicine consultation was within the standard of care and that Dr. Bush's diagnosis of chorioamnionitis was appropriate based upon a finding of uterine tenderness, maternal tachycardia, and an elevated WBC.

Dr. Fleischer opines that plaintiff's claim that her elevated WBC count was not indicative of infection lacks merit. In this regard, he notes that her WBC count was historically in the 13,000-16,000 range with 13,000 documented at the beginning of the pregnancy. Thus, he opines that it was perfectly appropriate for Dr. Bush to diagnose chorioamnionitis, when plaintiff's WBC count rose to 21,300, in addition to the other indica that she presented with. Moreover, he contends that her WBC count of 25,000 at or around midnight demonstrated further evidence of chorioamnionitis. Thus, he opines that it was appropriate for Dr. Fiasconaro to follow Dr. Bush's recommendation to deliver the infant and that it was appropriate to administered Pitocin to facilitate the delivery process. Further, Dr. Fleischer opines that it was appropriate for Dr. Fiasconaro to deliver the infant by caesarean section on the morning of July 2, 2014, when plaintiff's labor failed to progress, in light of the suspected chorioamnionitis.

With regard to plaintiffs' claim sounding in lack of informed consent, Dr. Fleischer opines that appropriate informed consent was obtained from plaintiff pointing to notes contained in the medical record documenting Dr. Fiasconaro's discussion with plaintiff. Specifically, he contends that plaintiff was advised of the risks and benefits associated with

early delivery versus delaying delivery and that she testified to being told that it was necessary to deliver due to her elevated WBC count. Additionally, he states that "[a] reasonable person, confronted with the morbidity to mother and child as a result of infection, would choose delivery at the time it was recommended" (NYSCEF Doc No. 187, Dr. Fleischer's aff at ¶43).

Dr. Fleischer opines that plaintiffs' claim that the diagnosis of chorioamnionitis was incorrect, in light of the placental pathology findings, is without merit. He acknowledges that maternal fever is an important clinical sign of chorioamnionitis, but opines that a diagnosis of chorioamnionitis was appropriately made based upon the findings of maternal tachycardia, uterine tenderness, and an elevated WBC. Moreover, he contends that the placental pathology report showed that there was inflammation in the choriodecidua, the tissue containing the outer layer of the gestational sac. Dr. Fleischer opines that the fact that there was no intraamniotic infection detected was due to the fact that there was not enough numbers of bacteria or there was not bacteria present for a long enough period of time to see inflammatory cells in that area. He points to Dr. Salafia's testimony in this regard, that absence of acute intra-amniotic infection does not negate the infection and can be explained by the timely delivery that stopped the infectious process from spreading to the amniotic layer. Dr. Fleischer opines that the timely delivery of the infant thus prevented an ascending infection from invading the amnion and causing the fetus to become infected, which would have caused catastrophic maternal and neonatal complications.

Based upon the foregoing, the court finds that Dr. Fiasconaro has set forth a prima facie case in favor of dismissal of plaintiffs' claims as asserted against him, and has

demonstrated that there was no departure from accepted standards of medical practice by Dr. Fiasconaro that proximately caused plaintiff's injuries (*see Townsend*, 203 AD3d at 1203; *Stiso,* 176 AD3d at 890; *Aliosha*, 153 AD3d at 593; *Senatore*, 128 AD3d at 796). This prima facie showing has shifted the burden to plaintiffs to demonstrate the existence of a factual issue with respect to Dr. Fiasconaro's care.

Plaintiffs oppose Dr. Fiasconaro's motion arguing that material issues of fact exist with regard to whether he departed from good and accepted standards of medical care and practice, and whether such departures proximately caused the infant's injuries. In support of this opposition, plaintiffs submit the redacted affidavit from a physician licensed to practice medicine in the State of New York, board certified in obstetrics and gynecology. The court notes that it is the same affirmation submitted in opposition to the motion of Dr. Bush and Methodist.

With regard to Dr. Fiasconaro, the expert opines that Dr. Fiasconaro departed from good and accepted standards of medical care and practice in the care and treatment of plaintiff during her labor and delivery of the infant plaintiff and that those departures proximately caused the infant plaintiff to suffer severe personal injuries. The expert further opines that Dr. Fiasconaro failed to obtain a proper informed consent prior to the cesarean section delivery of the infant plaintiff. Specifically, the expert opines that it was a departure from good and accepted standards of medical care and practice for Dr. Fiasconaro to abandon attempts to forestall premature delivery of the infant plaintiff, for a week or longer, so that a properly timed course of steroids could be administered to lower the risk

of negative outcomes related to prematurity, including respiratory distress syndrome and intracranial hemorrhage, as detailed above in relation to Dr. Bush and Methodist's motion.

Specifically, the expert contends that it was a departure to diagnose plaintiff as having "clinical evidence of chorioamnionitis" in the absence of maternal fever and that this misdiagnosis proximately caused the infant plaintiff to be prematurely delivered at 29 weeks, and to suffer from respiratory distress syndrome, intraventricular hemorrhage, and the other claimed injuries. The expert further opines that delaying the delivery of the infant by properly managing and arresting plaintiff's preterm labor would have provided the infant additional time in utero, allowing for the properly timed administration of steroids which would have substantially reduced the risk of his injuries. Thus, the expert opines that it was a departure for Dr. Fiasconaro to follow Dr. Bush's recommendation to deliver the infant and begin Pitocin augmentation for a vaginal delivery, rather than attempt to forestall the delivery to allow for the proper course of steroid administration. Moreover, the expert contends that in light of Dr. Fiasconaro's experience with delivering plaintiff's first child, after successfully forestalling premature delivery, he should have appreciated that arresting premature labor was indeed possible, and the failure to do so was a departure. The expert further opines that when plaintiff's labor failed to progress after the administering of Pitocin, good and accepted standards of medical care and practice required Dr. Fiasconaro to continue to monitor her for signs of maternal fever and chorioamnionitis and delay delivery to complete the course of corticosteroids, and that the rush to deliver by cesarean section was the proximate cause of the infant plaintiff's premature delivery and related injuries as claimed herein.

The expert further opines that Dr. Fiasconaro departed from good and accepted standards of medical care and practice when he failed to appreciate that plaintiff's WBC count rise to 21,000 on July 1, 2014, was due to the administration of the steroid Betamethasone and not the result of chorioamnionitis, especially given her history of leukocytosis. In this regard, the expert opines that it was a departure for Dr. Fiasconaro to fail to obtain a consult with a hematologist prior to making the decision to deliver the infant plaintiff, in light of the increase in her WBC count, and the unlikelihood that she had clinical chorioamnionitis given the lack of maternal fever. Thus, the expert opines that Dr. Fiasconaro's failure to obtain a hematology consult resulted in a misdiagnosis of plaintiff's condition that proximately caused the premature delivery of the infant plaintiff and the related injuries.

Additionally, the expert opines that Dr. Fiasconaro failed to get proper informed consent as there is nothing in the record indicating that plaintiff was given the alternative of further monitoring prior to proceeding with a vaginal delivery or cesarean section delivery. Specifically, the expert opines that:

> [i]n the absence of chorioamnionitis and in the setting of leukocytosis, a reasonable person confronted with the risks of delivery prior to completing a proper course of corticosteroids would have agreed to delay delivery while being monitored so as to reduce the risks associated with premature delivery. There is no indication in the records that an informed consent was obtained before commencing labor augmentation with Pitocin or before a cesarean section was performed. While a generic consent form was signed by . . . [plaintiff] on admission, her circumstances throughout the admission had changed and thus, good and accepted standards of care and practice required that the defendants, especially Dr. Fiasconaro, disclose to . . . [plaintiff] the risks of Pitocin augmentation and cesarean section delivery, the alternatives to Pitocin augmentation and cesarean delivery and the benefits to Pitocin augmentation and cesarean delivery. There is simply no evidence on this

> record to demonstrate that proper disclosures were made or that a proper informed consent was obtained. As a result of the defendants' failures to obtain a proper informed consent, the infant plaintiff was proximately caused to be delivered prematurely and suffer the related injuries caused herein (NYSCEF Doc No. 255, plaintiff's OB/GYN expert aff at ¶50).

Finally, the expert opines that the injuries sustained by the infant plaintiff due to his premature delivery at 29 weeks and 2 days, prior to the administration of two doses of corticosteroids, 24 hours apart, were not inevitable and were proximately caused by the departures of Dr. Fiasconaro and Dr. Bush as detailed above.

Additionally, plaintiffs submit Dr. Adler's affirmation in opposition to Dr. Fiasconaro's motion in which he opines that the infant plaintiff's neurological and neurodevelopmental disabilities are the result of the significant complications sustained as a result of his preterm delivery at 29-30 weeks gestation and that a delay in the delivery of the infant plaintiff in order to provide the proper administration of steroids would have significantly mitigated, if not wholly prevented, these injuries..

In reply, Dr. Fiasconaro correctly argues that plaintiffs' opposition, including plaintiffs' expert affirmation, raise no departures alleged with respect to the prenatal care rendered to plaintiff by Dr. Fiasconaro prior to July 1, 2014. Accordingly, the court finds that any claims of malpractice, with respect to the care and treatment by Dr. Fiasconaro, are limited to the care and treatment during her admission and treatment at Methodist commencing on July 1, 2014. As such, that branch of Dr. Fiasconaro's motion seeking dismissal of claims asserted against him related to the prenatal care that he rendered to plaintiff prior to July 1, 2014, are hereby dismissed.

Where as here, the parties to a medical malpractice action offer conflicting expert opinions, issues of credibility arise requiring jury resolution (see *Palmeiro v Luchs*, 202 AD3d 989, 991 [2d Dept 2022]; *Russell v Garafalo*, 189 AD3d 1100 1101 [2d Dept 2020];*Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]). The opinions of the plaintiffs' experts conflict with the opinion of Dr. Fiasconaro's expert on issues including whether there was clinical evidence of chorioamnionitis, whether the delivery of the infant plaintiff should have been forestalled to allow for the proper administration of a course of steroids to promote fetal lung development and whether a consultation with a hematologist should have occurred prior to the delivery of the infant plaintiff and whether these departures from the standard of care proximately caused the injuries to the infant plaintiff herein (*see Petrik v Pilat*, 119 A.D.3d 760,761 [2d Dept 2014]; *Martin v Siegenfeld*, 70 AD3d 786, 788 [2d Dept 2010]). Accordingly, Dr. Fiasconaro's motion seeking summary judgment dismissing plaintiffs' claims as asserted against him related to the care and treatment he rendered to plaintiff during her admission to Methodist commencing on July 1, 2014, is denied. In addition, the court finds that the conflicting expert opinions raise triable issues of fact precluding summary judgment on plaintiffs' lack of informed consent claim against Dr. Fiasconaro.

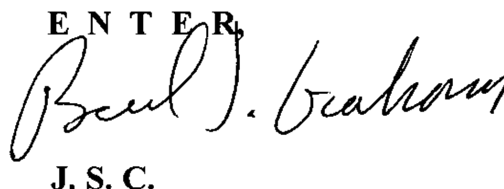
To the extent not specifically addressed herein, the parties' remaining contentions and arguments were considered and found to be without merit and/or moot. Accordingly, it is:

ORDERED that Dr. Bush and Methodist's motion is denied, and it is further

ORDERED that Dr. Fiasconaro's motion is denied, except as to that portion seeking dismissal of all claims related to the care and treatment of plaintiff by Dr. Fiasconaro prior to her admission to Methodist on July 1, 2014.

This constitutes the decision and order of the court

E N T E R,



J. S. C.

HON. BERNARD J. GRAHAM