At an I.A.S. Term, Part MMTRP, of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 27th day of July, 2007.

P R E S E N T:

HON. GERARD H. ROSENBERG,
Justice.

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NYRELL JOYNER-PACK, an Infant by his Mother and Natural Guardian, IVY JOYNER-PACK, and IVY JOYNER-PACK, Individually,

Plaintiffs,

-against-

JOSEPH SYKES, M.D., DIANA WEAVER, M.D., GLORIA VALENCIA, M.D., and ANATOLY ILIZAROF, M.D.,

Defendants.

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DECISION & ORDER

Index No. 28761/04

Cal. No. 2006-016472T

Motion Seq. Nos 003, 004.

The following papers numbered 1 to 12 read on this motion.

	Papers Numbered
Notice of Motion, Affirmation(s)/Affidavit(s) and Exhibits Annexed	1 - 3
Notice of Cross-Motion, Affirmation(s)/Affidavit(s) and Exhibits Annexed	4 - 8
Affirmation(s) in Opposition and Exhibits Annexed	9
Reply Affirmation(s) and Exhibits Annexed	10, 11-12

Upon the foregoing papers, and upon oral argument, defendant Joseph Sykes, M.D. (Dr. Sykes) moves pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint. Defendants Diana Weaver, M.D. (Dr. Weaver) and Gloria Valencia, M.D. (Dr. Valencia) cross-move for the same relief.

This is an action alleging medical malpractice. The infant plaintiff was born on February 21, 2002 at SUNY Downstate Medical Center (University Hospital of Brooklyn)

(hereinafter "SUNY Downstate") with a congenital condition known as tracheobronchomalacia, defined as a degeneration of the elastic and connective tissue of the tracheal windpipe and bronchi (Stedman's Medical Dictionary, 28th Ed.), which can cause central airway collapse with respiration. He also suffered with a second congenital condition of diaphragmatic paralysis, in which problems arise with the movement of the diaphragm.

Shortly after delivery the infant was admitted to the Neonatal Intensive Care Unit (NICU) for respiratory distress. He was thereafter transferred to Presbyterian Hospital where it was determined that his condition was not surgically correctable. He was readmitted to SUNY Downstate's NICU, and at the approximate age of three months was transferred to the Pediatric Intensive Care Unit (PICU). While in the PICU the infant plaintiff suffered a cardiorespiratory arrest which required resuscitation. The infant plaintiff was resuscitated after almost one hour, but he had sustained severe neurological damage.

Dr. Sykes was the pediatric intensivist at the PICU at SUNY Downstate during the period in question: June 1 - 6, 2002. Dr. Weaver, a pediatric pulmonologist, was on duty for the department of pediatric pulmonology for patients at SUNY Downstate, and was consulted by the intensivist at the PICU concerning the infant's pulmonary status. Dr. Valencia was an attending neonatologist, and claims that her only contact with the infant plaintiff was during a code called by Dr. Sykes on June 6, 2002.

Briefly stated, plaintiff alleges in part that Drs. Sykes, Weaver and Valencia failed to respond to indications of respiratory distress and disregarded tonic limb extension which was

indicative of central nervous system involvement, resulting in the infant suffering a prolonged cardiac arrest with bilateral pneumothorax, and failed to properly resuscitate the infant. Plaintiff also alleges that Dr. Sykes failed to respond to various signs, failed to properly diagnose, treat, and medicate; failed to timely administer a therapeutic means of respiratory support; and undertook placement of a peripheral line which was contraindicated, instead of undertaking an alternative IV line placement.

The Timeliness of the Cross-Motion

The "cross-motion" of Drs. Weaver and Valencia for summary judgment is dated April 3, 2007 and was served by mail on March 23, 2007. This is 126 days after the filing of the note of issue on November 17, 2006.

Part 13 of the Uniform Rules of the Civil Term, Supreme Court, Second Judicial District, Kings County, provides that motions for summary judgment shall be made within sixty days of the filing of the note of issue. Courts may only entertain an untimely summary judgment motion when the movant demonstrates "good cause" for his or her delay, which the Court of Appeals has deemed to entail "a satisfactory explanation for the untimeliness" (*Brill v City of New York*, 2 NY3d 648, 652 [2004]; *see also Miceli v State Farm Mut. Auto Ins. Co.*, 3 NY3d 725 [2004]), " rather than simply permitting meritorious, non-prejudicial filings, however tardy" (*Brill*, id., at 652). Stated otherwise, "[w]hether there is merit to the late motion for summary judgment is not a relevant consideration" (*Czernicki v Lawniczak*, 25 AD3d 581 [2006]).

In addressing the issue of timeliness, defendant's counsel claims good cause based upon law office failure, specifically lack of awareness of King's County's 60-day rule. In addition, defendant's counsel argues that the cross-motion is timely as per CPLR 2215 since it was filed at least three days prior to the return date of Dr. Syke's motion (i.e., March 27, 2007).

The court notes that to the extent that Drs. Weaver and Valencia are attempting to rely upon an allegedly timely motion for summary judgment by a co-defendant by denominating their motion as a "cross motion," it cannot be considered as such given that it seeks relief against the plaintiff, who is a non-moving party (*see Gaines v Shell-Mar Foods, Inc.*, 21 AD3d 986 [2005]). In addition, they have not explained why this motion needed to be filed as a cross-motion, nor why it should not have been filed as a summary judgment motion in the first instance. As the Court of Appeals noted in *Andrea v Arnone, Hedin, Casker, Kennedy & Drake, Architects & Landscape Architects [Habiterra Assoc.]* (5 NY3d 514, 521[2005]): " Litigation cannot be conducted efficiently if deadlines are not taken seriously, and we make clear again, as we have several times before, that disregard of deadlines should not and will not be tolerated (*see Miceli v State Farm Auto. Ins. Co.*, 3 NY3d 725 [2004]; *Brill v City of New York*, 2 NY3d 648 [2004]; *Kihl v Pfeffer*, 94 NY2d 118 [1999])."

However, in *Grande v Peteroy* (39 AD3d 590, 591-592 [2007]), the Second Department recognized that "an untimely motion or cross motion for summary judgment may be considered by the court where, as here, a timely motion for summary judgment was made

on nearly identical grounds (*see Bressingham v Jamaica Hosp. Med. Ctr.*, 17 AD3d 496, 497 [2005]; *Boehme v A.P.P.L.E.*, 298 AD2d 540 [2002]; *Miranda v Devlin*, 260 AD2d 451 [1999]). In such circumstances, the issues raised by the untimely motion or cross motion are already properly before the court and thus, the nearly identical nature of the grounds may provide the requisite good cause (*see* CPLR 3212[a]) to review the untimely motion or cross motion on the merits." In light of this narrow exception to the *Brill* case which is recognized by the Appellate Division, the court will consider the cross-motion on the merits.[1]

Analysis

The burden on a motion for summary judgment rests initially upon the moving party to come forward with sufficient proof in admissible form to enable a court to determine that it is entitled to judgment as a matter of law. If this burden cannot be met, the court must deny the relief sought (CPLR 3212; *Zuckerman v City of New York,* 49 NY2d 557 [1980]). However, once a moving party has made a prima facie showing of its entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Garnham & Han Real Estate Brokers v Oppenheimer*, 148 AD2d 493 [1989]; *see also Zuckerman,* 49 NY2d at 562). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat the motion (*Gilbert Frank Corp. v*

[1] In light of this determination, the court need not decide cross-movants' claim that they have established "good cause" based upon a claim of being unaware of the 60-day rule.

Federal Ins. Co., 70 NY2d 966 [1988]).

The essential elements of a medical malpractice claim are a departure from good and accepted medical practice and evidence that such departure was a proximate cause of the plaintiff's injury (*see DiMitri v Monsouri*, 302 AD2d 420, 421 [2003]). Therefore, on a motion for summary judgment, a defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]).

The Motion by Dr. Sykes

In support of the motion Dr. Sykes, a board certified pediatric critical care intensivist, submits his own affirmation. Dr. Sykes notes that when the infant plaintiff first came down from the NICU to the PICU on May 20, 2003 examination revealed that he had coarse breath sounds bilaterally and significant expiratory stridor (a noise when he breathes) at rest on continuous positive airway pressure (CPAP), demonstrating that his respiratory issues were very severe. Dr. Sykes states that the infant already had significant head lag, bilateral hypotonia and very decreased head growth, which are signs of a very compromised central nervous system. He also had many episodes of bradycardia (i.e., a low heart rate).

Dr. Sykes opines with reasonable medical certainty that the cause of the bradycardia was respiratory issues and the severe tracheobronchomalacia, which was a condition the infant was born with and for which he was getting treatment before Dr. Sykes ever saw him. Dr. Sykes notes that the infant plaintiff's trachea and bronchi were so affected that he needed

not only a tracheostomy, but ventilation as well. However, one of the infant's problems was that he had significant bradycardia regardless of the ventilator settings. Without treatment in the form of ventilator support, the infant's life was at risk from secretions and the low oxygen saturation.

Dr. Sykes disputes each of the plaintiff's claims of malpractice against him in great detail as follows:[2]

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[2] Several of those claims are not addressed in the plaintiff's opposition and are briefly listed as follows:

- Dr. Sykes states that he did not fail to monitor and treat "Sepsis/Infection." Rather, the infant's symptoms of May, 2003 were not suggestive of sepsis/infection. The chart indicates that the pulmonary consultant felt that the infant had a localized viral infection in the respiratory system, and there was and is no specific medication to speed up the resolution of the presumed viral infection.

- Dr. Sykes opines that he was not negligent in the treatment of the infant's tracheobronchomalacia, which was the worst kind of congenital laryngeotracheobronchomalacia he had ever seen. The infant had needed a tracheostomy and always some kind of ventilatory support since birth, and this was appropriate treatment, along with the regular input from the pediatric pulmonologists and neonatologists.

- Dr. Sykes disputes plaintiff's claims regarding not giving phenobarbital, as it is not the treatment for tonic limb extensions due to low saturations.

- Dr. Sykes opines that the administration of Lorazepam (Ativan) via the nasogastric tube to relieve anxiety was not malpractice. The administration of this medication did not cause the infant's cardiac arrest or code, nor his pneumothorax. It was appropriate to make the baby more comfortable prior to continuing the PIV attempt, and the infant was already on enteral Ativan every six hours, so an extra dose for agitation for a painful procedure that was taking a bit longer than expected was compassionate, competent and very appropriate.

- Dr. Sykes opines that High Frequency Oscillatory Ventilation (HFOV) was initiated in a timely manner. In this specific scenario of pneumothorax/congenital tracheobronchomalacia, it was up to the PICU attending to use ventilator strategy to give the lungs maximum rest and time to recover, and hence HFOV was chosen because it was felt it would help the lungs to rest maximally.

He opines that he did not cause or fail to manage the infant's seizure disorder. The infant's neurological examination showed significant microcephaly (small head), significant hypotonia bilaterally and significant head lag. All these neurological signs point to a baby who will, at best, have a very delayed neurological development. The electroencephalogram (EEG) was negative for seizure and the CAT scan of the brain was negative for structural lesions, so neither seizures nor space-occupying lesions in the brain were the cause for the small brain and other abnormal neurological findings.

In order to look for the causes of the microcephaly and other abnormal neurological findings, an MRI of the brain was requested by the pediatric neurologist, and was attempted on May 29, 2003 under conscious sedation. It was cancelled as the infant would not fall asleep and remain still, and rescheduled for June 6, 2003.

The infant was noted to have tonic limb extension, which was related to his low oxygen saturation and to unpredictable exacerbations of his congenital tracheobronchomalacia where his airways would close off or almost close off and not allow oxygen to get into his body. Tonic limb extension was managed by immediately disconnecting the infant

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(footnote 2 continued)

- Dr. Sykes opines that he did not depart from accepted standards of practice by failing to administer Xopenex, which is a short-acting bronchodilator which relaxes the tightened muscles around the airways. This drug, along with Albuterol, is controversial in treating tracheobronchomalacia, as there is the risk that it may cause relaxation of whatever small amount of cartilage there is and so worsen the tracheomalacia.

from the ventilator and immediately ambu- bagging him and then reconnecting him to the ventilator with increased ventilatory settings as needed. Often his desaturations/tonic limb extensions happened when he was agitated, so attempts were made to keep him comfortable with enteral benzodiazepines.

With respect to the Cardiac Arrest/Code, a peripheral intravenous line-PIV (vascular access) in situ is the standard of care for all patients undergoing sedation in the United States. This is also how emergency drugs would be given to the baby should an emergency arise during the sedation procedure. Therefore, the PIV was well within the standard of care and absolutely indicated and necessary. Moreover, it was well within reason for IV access to be attempted in the PICU, by the PICU attending and residents, as these PICU doctors and staff are competent and qualified to place such intravenous lines.

Dr. Sykes notes that most babies who get stuck with needles get agitated, and it is unlikely that there would be a time when the infant plaintiff would not have been agitated by needles. This infant was on enteral feeding (i.e., using the gastrointestinal tract for the delivery of nutrients). The sedation given to him was not designed to fully sedate him but to make him less aware of the PIV attempts and make him a bit more comfortable. He was always going to move, and in any event, the sedation was requested, it was indicated and it was properly administered.

Dr. Sykes opines that there is no basis for the claim that the PIV placement was either contraindicated or done negligently, and that Dr. Sykes persisted in placing a peripheral line

when the infant showed agitation, instead of undertaking an alternate IV line placement. This PIV line was placed for conscious sedation, before placing a central venous line (CVL). Dr. Sykes opines that using a PIV line, and not a CVL, as the first line for vascular access is totally appropriate. Plaintiff's claim that a subclavian line should have been used is wrong, as using a subclavian CVL is inappropriate for sedation only.

Dr. Sykes further opines that the claim that the CPR on June 6, 2003 was done negligently has no merit. While preparing to go to Radiology for an MRI of the brain, as requested by Neurology, and the chest MRI, as requested by Pediatric Pulmonary, a PIV needed to be inserted for sedation. Dr. Sykes states that while he and the Pediatric resident were attempting the PIV, the infant became limp and then he went into cardiac arrest. An infant on a ventilator can, at any time, decompensate and have a cardiac arrest due to:

D: Dislodgement of the tracheostomy

O: Obstruction of the tracheostomy by a mucus plug

P: Pneumothorax (accumulation of air between the lung and rib case causing compression of the lungs and then great vessels and heart)

E: Equipment disconnection

Dr. Sykes states that dislodgement, obstruction and equipment failure were eliminated by him as possible causes, since he claims that he checked the area and the equipment, and there was no malfunction and there was no obstruction, such as a mucous plug. Further, it is well known that pneumothorax can happen to a patient on a ventilator, such as this infant,

at any time.

Dr. Sykes states that he and the pediatric resident were present when the arrest happened. Chest compressions and Epinephrine were initiated immediately with the establishment of the fact that the tracheosteomy was not dislodged or obstructed and making sure that the equipment did not develop a problem. There was no delay in the initiation of CRP as claimed by the plaintiff, as Dr. Sykes was there when the infant went into cardiac arrest and called the code immediately. Since there was no PIV Dr. Sykes started resuscitation Epinephrine via the tracheostomy. Tracheostomy-administered Epinephrine is the standard of care and the appropriate mode of administering Epinephrine if vascular access/PIV is not readily available. (Dr. Sykes further opines that it would have been an unacceptable delay to try and administer Epinephrine via the PIV which would have had to have been inserted first).

Dr. Sykes opines that he was not negligent with respect to the fact that a "surgical cut down" was performed, as it is appropriate to call for this during an emergency like a cardiac arrest. In an emergency, the attending physician may perform any procedure deemed necessary to stabilize the patient and sustain life. The surgical cut down was performed by the surgical team that responded to the code. Dr. Sykes was the code leader so he was running the code in a supervisory role. There was no complication from the surgical cut down and it was removed as soon as possible.

Dr. Sykes disputes plaintiff's claim that the subclavian line placement during the

cardiac arrest was malpractice. Rather, especially in this emergency situation, the placement of a subclavian central line was in accordance with good and accepted medical practice. Femoral line placement had been attempted a number of times unsuccessfully, and the infant's internal jugular vein was not available by virtue of the tacheostomy dressing/ties. The surgical cut down needed to be, and was, removed as soon as the central line was successfully established as it is a big repository for infection and thrombus. Additionally, the infant was on a lot of blood pressure medications post arrest including an Epinephrine and Dopamine drip which could not have been safely administered peripherally as it can cause terrible chemical burns if extravasation had occurred.

Lastly, Dr. Sykes opines that he did not fail to timely administer bicarbonate. Bicarbonate was administered in the cardiac arrest despite the fact that routine administration of sodium bicarbonate does not consistently improve outcome after a cardiac arrest. It is not a class one resuscitation drug like Epinephrine which has been clearly been shown to enhance outcome in cardiac arrest. It is at the discretion of the "code team Leader" whether to use sodium bicarbonate or not during a code.

The Cross-Motion by Dr. Weaver and Dr. Sykes

In support of the cross-motions Dr. Weaver and Dr. Valencia submit, as did Dr. Sykes, their own affirmations.

Dr. Weaver is board certified in pediatrics and board eligible in pediatric pulmonology. On June 1, 2002 Dr. Weaver was on duty for the department of pediatric

pulmonology, and on this basis was consulted by the intensivist at the PICU concerning the pulmonary status of the infant.

Dr. Weaver's first contact with the infant was a consultation on June 3, 2002 in order to review the infant's severe tracheobronchomalacia condition. On June 3rd and June 4th Dr. Weaver assessed the infant's medical status, reviewed his past care, and ascertained his ventilatory support system in place in the PICU. Dr. Weaver states that whereas the infant appeared to be stable on June 3, 2002, when Dr. Weaver saw him on June 4, 2002 his condition had changed in that his respiratory abilities had become intermittently diminished. Hence, recommendations were made to PICU staff, including the consideration of a change in the ventilatory management of the patient, as well as the administration of medication to further attempt to correct a chronic metabolic abnormality which was secondary to his underlying condition. Dr. Weaver opines that these recommendations were made in accord with good and accepted pediatric pulmonology practice in that the child's condition had changed and the foregoing constituted modalities of therapies which could be employed in response to these changes.

On June 5, 2002 Dr. Weaver returned to the PICU and examined the infant with a pediatric resident. It was noted that the infant had periodically sustained additional episodes of desaturation (decreased oxygen level in the blood) and bradycardia (decreased heart rate) overnight and into the 5th of June. Based upon their examination Dr. Weaver and the resident recommended additional testing including a chemistry panel and arterial blood gasses in

order to permit the staff to ascertain further information regarding the level of oxygen exchange of the infant.

Dr. Weaver notes that the PICU staff had modified the ventilatory modality to the child because he appeared to be suffering from an intercurrent respiratory infection, which was causing increased viscosity of secretions, as well as the desaturation episodes. It was noted that Pediatric Pulmonology agreed with the administration of various medications for broncho spasm and for inflammation.

Dr. Weaver states that the PICU was considered a "closed" unit. This means that the intensivist in the PICU is the attending physician for the patient, and other physicians, including physicians from Pediatric Pulmonology, are considered "consultants" to the intensivist. Under this system a pediatric pulmonologist is permitted to perform a physical examination of the patient, review the hospital chart, review the ventilatory maintenance of the child, and to then make "recommendations" to the intensivist as to how, if at all, to further support the pulmonary status of the patient. The consultants are not permitted to change the management of the patient, nor are they allowed to write direct orders for any change of the patient's medical management Once the recommendation is made to the intensivist staff, it is within the sole discretion of the attending intensivist to accept, modify or decline the recommendations of the consultants.

Based upon the foregoing, it is Dr. Weaver's opinion with a reasonable degree of medical certainty that she acted in accord with good and accepted standards of medical

practice in her role as a pediatric pulmonology consult. On the days that she was in the PICU and examining the infant plaintiff, she appropriately examined him, ascertained his medical status, reviewed the care and management by the PICU staff, reviewed the ventilatory modalities employed, and made the appropriate recommendations to the PICU staff so as to further support his ventilatory abilities and status. It was appropriate to perform a physical examination of the infant, review the medical records, determine what additional modalities of therapy may be available with the PICU staff, and to make the recommendations to the staff for their consideration. Since the PICU was a closed unit, the pediatric pulmonology consult could not change the medical management and/or write orders.

Additionally, Dr. Weaver states that she did not participate in the running of the code on June 6, 2002, and claims that her care and treatment was not a proximate cause or a substantial factor in any of the infant's alleged injuries.

Dr. Valencia is board certified in pediatrics, neonatal and perinatal medicine. She did not work in the PICU during the week in question of June 1 - 6, 2002, and her only contact with the infant was during the code called by Dr. Sykes on June 6, 2002. Dr. Valencia was in the hospital providing neonatal care to patients in NICU when the call of a code and request for assistance was made. Dr. Valencia states that in circumstances where a call is made to neonatal assistance, it is not unusual for any attending physician who is available to respond to the code so as to be available to render assistance to the attending physician caring for the patient.

Dr. Valencia opines that Dr. Sykes, as the attending PICU physician, ran the code and directed the care and treatment of the infant. Upon Dr. Valencia's arrival in the PICU she ascertained that Dr. Sykes was resuscitating the infant without staff members. Dr. Valencia assisted in the resuscitation of the infant by placing chest tubes to correct collapsed lungs (pneumothorax). Dr. Valencia opines that it is in keeping with good and accepted medical practice to place a chest tube under these circumstances so as to re-inflate the lungs. Once this care was completed, Dr. Valencia stood by and awaited any further requests by Dr. Sykes, who determined the further activities of the code including the length of the code, which she maintains is also in keeping with good and accepted medical practice.

Dr. Valencia opines with a reasonable degree of medical certainty that she acted in accord with good and accepted medical practice in her limited role as a provider during the code to resuscitate the infant, and that her limited care was not a cause or a proximate cause of any alleged injuries of the infant. Specifically, Dr. Valencia opines that the claimed injury of neurological dysfunction is not the product of the insertion of chest tubes during the code (during which the infant was not independently breathing and was pulseless for most of the code). She states that the placement of the chest tubes served to inflate the collapsed lungs and promote an exchange of gases in the lungs while the patient was being artificially ventilated through an endotracheal tube, and that this is part of any code to resuscitate any person, including an infant. Dr. Valencia opines that since the lung expansion improved after the placement of the chest tube, she can state to a reasonable degree of medical certainty that

the chest tubes were properly inserted.

Plaintiff's Opposition

In opposition to the defendants' motion, plaintiff submits the affirmation of Dr. Stuart J. Danoff, a neonatologist and board certified pediatrician.

With respect to Dr. Sykes, Dr. Danoff opines that, Dr. Sykes, who had the sole authority to write orders and determine patient care, failed to appreciate a critical part of the neurologist's request for the MRI on May 29, 2002 to perform ". . . MRI head when more stable." Dr. Danoff states that the phrase "when more stable" is very significant. Because of his underlying medical condition, the infant was at risk for cardiopulmonary arrest. An MRI would necessarily involve the administration of sedation, and physical removal from the ICU to the Radiology department where the infant would have to be disconnected from most monitoring devices in order to be put into the MRI machine. This would certainly interfere with critical cardiopulmonary monitoring and agitate the infant and could lead to a cardiopulmonary arrest, as it did in this instance. The requested MRI is not therapeutic, and in simplest terms, there was simply no reason to rush with the performance of an MRI, as the Neurologist made clear in his request.

Dr. Danoff notes that from the time that the MRI was first attempted on May 29, 2003 up until the date of the code event, the infant's condition had worsened. As a result, the infant's ventilatory support was increased and he was placed on Prednisone, a steroid and anti-inflammatory, and Xopenex for bronchial spasms. As noted in the affirmations of Drs.

Sykes and Weaver, it appeared that the infant was suffering from a respiratory infection as evidenced by increasing thick secretions and episodes of oxygen desaturation, which continued up through the time of the code event on June 6, 2002.

Dr. Danoff opines that Dr. Weaver's characterization of the infant as "stable" on June 3, 2002 was incorrect, given that the infant experienced episodes of bradycardia and desaturation at 8 a.m., 12:30-1:30 p.m., 3:00 p.m., 3:20 p.m. and 4:30 p.m. requiring increased respiratory support. Dr. Weaver's notes indicate that the infant's condition worsened on June 4 and June 5, 2002. The infant appeared to have a viral respiratory infection, and it is Dr. Danoff's opinion that the infant's condition had been worsening (as corroborated by Dr. Weaver's affirmation) and that it was a departure from good and accepted standards of care not to advise that the MRI scheduled for June 6, 2002 be deferred.

Dr. Danoff states that the MRI would necessarily involve subcutaneous sedation, so that the risk of agitating the infant to the point of cardiopulmonary arrest was too great to merit proceeding with a diagnostic test while the infant was still physically unstable. Dr. Weaver's addendum of June 5, 2002, written subsequent to the "plan" for the MRI, explicitly notes two episodes of desaturations and increased thick whitish secretions since yesterday. Under these circumstances, it was Dr. Weaver's responsibility as the consulting pulmonologist to advise against performing the MRI due to the increasing risk of pulmonary complications. Instead Dr. Weaver, when consulted, approved the plan.

Notwithstanding Dr. Weaver's assertion that the PICU was a closed unit and that the

final decision was that of Dr. Sykes, given that a consult was requested, Dr. Danoff finds that it was a departure from good and accepted standards of practice for Dr. Weaver to approve of the MRI proceeding. She was required her to advise Dr. Sykes that the MRI should be deferred due to the infant's unstable respiratory status. If visualization of the brain was important to the physicians, a noninvasive head ultrasound could have safely been accomplished at the bedside.

On June 6, 2002, the infant had a stormy course prior to the attempted sedation. Roughly 7 hours prior to the procedure, the infant is described as agitated and experiencing desaturations, requiring bagging and stat doses of medications. Attempts to place an intravenous line failed. The infant is further described as irritable and with labored breathing, and at 6:00 a.m. is described as lethargic. Dr. Danoff opines that the child was not stable and it was contraindicated to undertake an elective invasive diagnostic procedure that would necessarily involve agitation of the child under these circumstances.

Dr. Danoff cites the anesthesiologist's preoperative assessment of the infant the day prior to the code event as "ASA3" and states that as Dr. Sykes correctly observed at his deposition this indicates that the administration of anesthesia "will be a reasonable threat to life." Dr. Danoff states that this indicates that the administration of anesthesia carried a significant threat of death to the infant. Dr. Danoff opines that given this threat to life and given that this was a diagnostic, rather than therapeutic procedure, it was a departure from good and accepted standard of care for Dr. Sykes to proceed with the MRI at this time with

the infant in an unstable condition.

Dr. Danoff cites the multiple attempts by the resident and Dr. Sykes to place an intravenous line in anticipation of the administration of anesthesia for the planned MRI. The record indicates that the attempts by Dr. Sykes to insert the peripheral line continued for approximately 20 minutes, which would necessarily involve multiple needle insertions into the infant's skin and increasing agitation due to pain. In fact, the infant had become so agitated that he experienced severe respiratory distress, became limp and bradycardic. Dr. Danoff opines that the severe cardiopulmonary arrest occurred as a result of the contraindicated repeated peripheral IV attempts by Dr. Sykes.

Although sparsely documented, the code event continued for over 30 minutes. During the course of the resuscitation, the infant was discovered to have bilateral tension; indicating air under pressure inside the chest cavity but outside of the lungs, which prevents the lungs from inflating adequately and places pressure on the heart, displacing it from its normal position in the chest and impeding the flow of blood to vital organs. Dr. Danoff opines that the cause of pneumothoraces was inappropriate ambu bagging: in attempting to resuscitate the infant from the cardiopulmonary arrest, Dr. Sykes administered oxygen through an ambu bag without paying appropriate attention to the pressure gauges and literally blew holes through the infant's lungs, causing air to leak into the chest cavity. Even in a code situation, it is imperative to ambu bag in a controlled fashion to avoid blowing holes through the infant's lungs and causing further damage. It is Dr. Danoff's opinion that the

pneumothoraces were caused by negligence in the resuscitation by Dr. Sykes as opposed to the pneumothoraces being the cause of the arrest, and that there is no adequate explanation in the record as to how the pneumothoraces could have occurred prior to the arrest.

Dr. Danoff states that in order to treat the pneumothoraces it is imperative to place bilateral chest tubes in order to remove the air from the chest cavity, which will in turn allow the lungs to inflate and relieve pressure on the heart. The placing of a chest tube is a sterile operative procedure, and the standard of care requires careful documentation and the generation of an operative report. These procedures were not followed here.

Dr. Valencia indicates that she placed the chest tubes but neglected or declined to document the procedure with a note and operative report. Dr. Danoff states that it is therefore necessary to view the result of the procedure to ascertain whether it was properly performed. From his review, it is his opinion that the chest tubes were not properly inserted by Dr. Valencia and that this departure caused the infant to further suffer from hypoxia for an extended period of time as the lungs could not inflate and the ability of the heart to pump blood was compromised.

He bases this opinion on the fact that it is not until 9:58 a.m. on June 6, 2002 that a near normal heart rate is reestablished. Given that Dr. Valencia has testified that the tubes were placed in approximately 8 to 10 minutes, it follows that it took in excess of one hour for the heart rate to normalize. Had the tubes been placed properly, the heart rate would normalize in minutes. In addition, it is critical that the tubes be properly secured, preferably

by sewing them in place. If the tubes are not secured, they can change position and become ineffective in relieving the accumulated air in the chest. In this instance, given the prolonged period required to reestablish a normal heart rate, it is Dr. Danoff's opinion that the chest tubes were not properly placed and secured. It is essential to immediately obtain a chest X-ray after chest tube insertion to ascertain the proper placement of the thoracotomy tube. This was not done in a timely manner in this case and is a departure.

Dr. Danoff states that he concurs with Dr. Sykes' deposition testimony that even if the infant had survived he would probably has sustained significant neurological injury as a result of the cardiopulmonary arrest. Dr. Danoff notes that prior to the code the infant had a normal EEG, but after the code it was abnormal. Dr. Danoff further notes that when, following the code, the infant was transferred from SUNY Downstate to Blythedale Children's Hospital, he was diagnosed with a seizure disorder, hypoxic ischemic encephalopathy and spastic quadriplegia, conditions which Dr. Danoff opines did not exist prior to the code and which were caused by the cardiopulmonary arrest. Dr. Danoff opines that while the infant had experienced desaturations on multiple occasions prior to the code, those desaturations were not so catastrophic as to result in a code event.

Dr. Danoff concludes that each of the named defendants departed from good and accepted standards of care and that said departures caused the infant to experience a cardiopulmonary arrest on June 6, 2002 and to sustain brain damage. As a result of these departures, the infant suffers from seizures, hypoxic ischemic encephalopathy and spastic

quadriplegia.

Conclusion

Here, upon the properly supported papers of both sides (*Marano v Mercy Hospital,* 241 AD2d 48 [1998]), the court finds that issues of fact exist which preclude the granting of summary judgment. Each of the moving defendant doctors has submitted his or her lengthy affirmation in which they state that they committed no departures from accepted standards of medical practice. In contrast, plaintiff's expert has opined that each movant did in fact depart, stating that Dr. Sykes undertook a contraindicated placement of a peripheral line in an unstable infant in an effort to perform an MRI which could have been deferred until the infant was stabilized, and as a result of multiple attempts to place the line, the infant became so agitated as to experience cardiopulmonary arrest significant enough to result in the calling of a code; that Dr. Weaver failed to advise against the MRI-accompanying sedation, even though she documented the infant's worsening respiratory condition and even though a pulmonary consult had been requested; and that Dr. Valencia failed to properly place and secure the chest tubes to relieve the pneumothoraces, resulting in an unnecessarily prolonged period of cardiopulmonary compromise, and failed to document those procedures she did perform.

While the movants have each submitted additional affirmations in reply to plaintiff's opposition, the court finds that the opinions raised therein present classic differences of opinion among medical experts. Where that occurs, a credibility question is presented

requiring a jury's resolution, and summary judgment may not be awarded (*Graham v Mitchell*,37 AD3d 408, 409 [2007]).

Accordingly, the motion by Dr. Sykes and the cross-motions by Drs. Weaver and Valencia are denied.

This constitutes the decision and order of the court.

ENTER,

HON. GERARD H. ROSENBERG

J. S. C.