Feeney v Schroeter
2008 NY Slip Op 30064(U)
January 10, 2008
Supreme Court, Suffolk County
Docket Number: 0012073/2005
Judge: Robert W. Doyle
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[* 1]

SHORT FORM ORDER

INDEX No. 05-12073
CAL. No. 07-01525-MM

SUPREME COURT - STATE OF NEW YORK
POST-NOTE MOTION PART - SUFFOLK COUNTY

PRESENT:

Hon. ROBERT W. DOYLE
Justice of the Supreme Court

MOTION DATE 10-25-07
ADJ. DATE 12-13-07
Mot. Seq. # 001 - MD
002 - XMD

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GRACE FEENEY, an infant by her mother and natural guardian, TRACY FEENEY and TRACY FEENEY, individually,

Plaintiffs,

- against -

KEN SCHROETER, DO., SHANTHY SRIDHAR, M.D., JOSEPH D. DECRISTOFARO, M.D., THOMAS WISWELL, M.D. and STONY BROOK CHILDREN'S SERVICE, P.C.,

Defendants.

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Upon the following papers numbered 1 to 49 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1 - 21 ; Notice of Cross Motion and supporting papers 30 - 38 ; Answering Affidavits and supporting papers 17 - 26; 39 - 47 ; Replying Affidavits and supporting papers 27 - 29; 48 - 49; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is

ORDERED that this motion (001) by defendant, Joseph D. Decristofaro, M.D., pursuant to CPLR 3212 for summary judgment dismissing plaintiff's complaint, opposed by plaintiffs, is denied; and it is further

ORDERED that this motion (002) by defendant, Ken Schroeter, D.O., pursuant to CPLR 3212 for summary judgment dismissing plaintiff's complaint, opposed by plaintiffs, is denied.

The complaint of this action sets forth causes of action sounding in medical malpractice and lack of informed consent on behalf of the infant plaintiff, Grace Feeney, with a derivative cause of action for loss of services asserted on behalf of Tracy Feeney, mother of the infant plaintiff. The infant plaintiff was born prematurely on June 25, 2003 at Stony Brook University Hospital and remained hospitalized there

through August 30, 2003.

In plaintiffs' bill of particulars, it is asserted that defendants, Ken Schroeter, D.O., Shanthy Sridhar, M.D., Joseph D. Decristofaro, M.D., Thomas Wisell, M.D. and Stony Brook Children's Service, P.C. rendered care and treatment to the plaintiffs during labor and delivery, and upon birth of the infant plaintiff, treatment of the infant plaintiff for, including but not limited to, prematurity, respiratory distress syndrome and sepsis. Plaintiffs allege defendants failed to timely and properly diagnose and treat the infant plaintiff for hydrocephalus; failed to timely provide shunting of the fluid from the infant plaintiff's brain causing loss of function of the brain tissue; failed to timely refer the infant plaintiff to a neurosurgeon for treatment for insertion of a ventricular shunt; caused permanent seizure disorder; failed to timely diagnose and treat respiratory distress and cardiovascular decompensation; failed to properly place a PICC line, causing, inter alia, erosion of a vessel with infusion of intravenous fluid into the chest cavity increasing the burden on her lungs and cardiovascular system; failed to supervise the care rendered by the fellows, residents, nurses and other health care personnel; failed to inform the infant plaintiff's parents of the PICC line complication and erosion of the PICC line through the vein wall; caused iatrogenic injury to the infant plaintiff's eyes, including retinopathy of prematurity and cortical blindness; failed to properly administer and monitor oxygen; and caused the infant to suffer hypoxia. Plaintiffs claim that as a result of these departures, the infant has suffered profound and global developmental deficiencies with no hope for meaningful improvement, has required multiple hospitalizations, has undergone stem cell implants in an attempt to replace the lost functioning of the white matter, and that she will require 24 hour care for the remainder of her life with constant medical supervision.

Defendants, Ken Schroeter and Joseph Decristofaro, allege there were no departures from the appropriate medical standards of care and that they did not proximately cause the injuries from which the infant plaintiff suffers. Counsel for Dr. Decristofaro avers Dr. Decristofaro attended the infant plaintiff on June 25, 2003, and June 27, 2003 through July 3, 2003, that there was a series of events which occurred beginning July 10, 2003, and that prior to July 10, 2003, there were no problems or complications with the PICC line which allegedly gave rise to the infant plaintiff's problems suffered thereafter. Dr. Schroeter argues that during the period of time he cared for the infant plaintiff, she exhibited no signs of problems with the PICC line, demonstrated no pleural effusion and did not need to be seen by a pediatric neurosurgeon. Thus the moving defendants seek summary judgment dismissing the complaint as asserted against each of them.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see,* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [1996]) Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (***Joseph P. Day Realty Corp. v Aeroxon Prods.***, 148 AD2d 499, 538 NYS2d 843 [2nd Dept 1979]) and must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2nd Dept 1981]). Summary judgment shall only be granted when there are no issues of material fact and the evidence requires the court to direct a judgment in favor of the movant as a matter of law (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]).

In support of motion (001), defendant Dr. Decristofaro has submitted, inter alia, an attorney's affirmation; a copy of the pleadings and defendant's answer; plaintiffs' verified bill of particulars and supplemental verified bill of particulars; a copy of the infant plaintiff's hospital record from Stony Brook University Hospital; copies of the transcripts of the examinations before trial of Tracy Feeney, Louis Decristafaro, M.D., Kenneth Schroeter, D.O., Shanthy Sridhar, M.D., Thomas Wiswell, M.D., and Janine A. Mikulas, R.N.; a copy of plaintiff's expert witness disclosure of expert neonatologist; and the affidavit of Andrew M. Steele, M.D., defendant's expert neonatologist.

Plaintiff has submitted the following in opposing this motion: an attorney's affirmation; a copy of the On-Call Schedule for the Division of Neonatology for Stony Brook University Hospital; a copy of plaintiffs' expert affirmation of a physician certified in Pediatrics and Neonatal-Perinatal Medicine; a copy of plaintiffs' expert affirmation of a physician certified in Radiology; excerpts from the infant plaintiff's Stony Brook Hospital admission record; unaffirmed, unsworn report of Dr. Daniel Adler, M.D.; and a copy of the unaffirmed, unsworn report of the physical examination of Grace Feeney on January 10, 2007 by Ingrid Taff, M.D., exchanged by counsel for Kenneth Schroeter, D.O. Copies of the affirmations of plaintiffs' experts with the experts' names and signatures have been provided to this court under separate cover.[1]

In that the unaffirmed, unsworn report of Dr. Daniel Adler, M.D. and the unaffirmed, unsworn report of the physical examination of Grace Feeney on January 10, 2007 by Ingrid Taff, M.D. are not in

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[1]The Court has conducted an in-camera inspection of the original unredacted affirmations and finds them to be identical in every way to the redacted affirmations in plaintiff's opposition papers with the exception of the redacted experts' names. In addition, the Court has returned the unredacted affirmations to the plaintiff's attorney.

admissible form, they are not considered in this motion for summary judgment (*see,* ***Zuckerman v City of New York***, supra).

In reply, Dr. Decristofaro has submitted a "Reply Expert Affirmation" of Dr. Andrew Steele, M.D., in response to plaintiffs' opposition to his motion for summary judgment and in particular response to the Affirmations of plaintiffs' expert Radiologist and expert Neonatalogist-Perinatalogist. Accordingly, this affirmation received in a reply deprives plaintiffs from responding to such affirmation and is given no consideration by this court on this motion for summary judgment as all arguments in support of defendant's motion should have been made in the main motion to establish prima facie entitlement to summary judgment (***Santiago v Batista***, 25 AD3d 326, 807 NYS2d 340 [2nd Dept 2006]; ***Bjorke v Rubenstein,*** 38 AD3d 580, 833 NYS2d 115 [2nd Dept 2002]; ***McCullough et al v Russell Maurer et al,*** 268 A.D.2d 559, 702 N.Y.S.2d 622 [2nd Dept 2000]; ***Fischer v Weiland,*** 241 AD2d 439, 661 NYS2d 516 [2nd Dept 1997]; ***Ritt v Lenox Hill Hosp.,***182 AD2d 560, 582 NYS2d 712 [1st Dept 1992]).

Dr. Decristofaro testified at his deposition that he is employed by New York State as well as the Department of Pediatrics in the Pediatric Children's Services which is a private practice group, CPMP, which is the professional corporation for the Department of Pediatrics, also known as Stony Brook Children's Service, P.C. He testified that in June 2003, he was an associate professor of pediatrics, fellowship director in neonatology, the medical director or the infant apnea program, and chair of the hospital medication safety committee. As the fellowship director of the neonatology program, his duties in general were to have a general education program for the fellows which included physiology lectures, conferences, monthly review of the fellows' progress, screening of candidates for fellowship, interviewing of fellows candidates, writing final evaluations for fellows completing the program, and other administrative duties as a fellowship director.

On June 25, 2003, when Grace Feeney was born, Dr. Decristofaro states he was scheduled as the daytime attending of NICU, and made rounds in the morning on all the patients on the resident team, and rounds with the residents and the fellows (which, he states, means they hear what the baby's progress is, make plans about tests, treatment and diagnoses). For the first week after the infant plaintiff was born, he was also the attending on call after 5 p.m. He testified that in June, 2003 there was a custom or practice in which he would write his own notes when he was the attending that made rounds with the fellows in the NICU. He stated he was not on the schedule for NICU from July 7, 2003 to August 3, 2003.

Dr. Decristofaro further testified that the infant, Grace Feeney, who was born on June 25, 2003, was placed on the ventilator after birth to assist her breathing. On June 26, 2003, he testified, his note indicates the infant had RDS (Respiratory Distress Syndrome) continuing since birth, hyperbilirubinemia, and sepsis. On June 28, 2003, she was noted to have metabolic acidosis due to an acid build-up in her system, which, he stated, was treated with bicarbonate. He also stated she was noted to have a wide pulse pressure, but the blood pressure improved with PIP and PEEP increases on ventilation. On June 29, 2003, he stated, "the chest x-ray showed bilateral haziness with a slight increase or--normal heart size," but then stated the "slight increase was a mistake." On June 30, 2003, he stated she was transfused for anemia; on July 1, 2003, she was noted to have a wide pulse pressure with falling diastoles again; and the ultrasound of her head was negative for any bleeds at the time of her birth since the ultrasounds showed she did not have a grade 3 or 4 bleed. On July 2, 2003, he stated, she had a period of apnea and bradycardia, but her breathing and heart rate resumed with touching or stimulation. She was also noted to have a wide pulse

pressure. Dr. Decristofaro testified that on July 3, 2003 the infant extubated herself and the endotracheal tube had to be reinserted. He also testified that if there had been any problems with the PICC line while he was treating her, he would have made a note of an obvious problem. He further stated that the chest x-ray was not completely clear, that there was right lower lobe infiltrate, and that it "looked like there may be something in it." He stated he was weaning her to low vent settings, he was ready to feed her, and he had removed some of her invasive lines.

Dr. Decristofaro testified he next saw the infant plaintiff on August 17, 2003 at which time her active problems were left retinopathy of prematurity, BPD (bronchopulmonary dysplasia), hydrocephalus, and prematurity; she was now breathing room air. As for the hydrocephalus, he stated that the first abnormal head ultrasound was on July 21, 2003 which showed the infant had a severe bilateral cystic PVL (periventricular leukomalacia), more extensive on the left, but, he stated, he did not know why she had it. He further testified he did not call neurosurgery because there was no evidence that the hydrocephalus was getting worse and that it was not due to an exvacuo condition (wherein the brain was getting smaller and the cavity was filling up with more fluid, but rather that the fluid is getting bigger and is impairing normal brain function and the entire cranium is getting too large). He further stated that untreated hydrocephalus, in a patient such as Grace the degree of PVL read in the report, would perhaps cause worsening of her neurological and cognitive development.

Dr. Decristofaro further testified that on August 30, 2003, a discharge physical exam, written by the resident, indicated the baby had hydrocephalus, but the fontanels and sutures were flat, suggesting that the hydrocephalus etiology was from an exvacuo condition where the brain itself was not really growing to the full potential or that it was stable (that is the brain is growing, the cranium is growing and that the hydrocephalus is not getting worse). He stated the infant was being discharged home to her parents and was to follow up with neurosurgery in two to three weeks.

Dr. Decristofaro further testified that the retinopathy of prematurity was not a complication of oxygen therapy, but was from prematurity as it is not seen in term newborns, and that it is a condition that affects the retina independent of the hydrocephalus or independent of the head ultrasound of cystic PVL, or anything in the occipital area. He further stated, however, that the infant's visual acuity will be affected by lesions in the occiptital area, such as PVL in the occipital area, as well as retinopathy of prematurity, as either can affect her visual acuity.

Dr. Andrew Steele, M.D., Dr. Decristofaro's expert, set forth he is board certified in Pediatrics and in the subspecialty of Neonatal-Perinatal Medicine. He states he reviewed the admission record of the infant plaintiff maintained by University Hospital at Stony Brook from June 25, 2003 through August 30, 2003, the verified Bill of Particulars and Supplemental verified Bill of Particulars, as well as the deposition transcripts of Tracy Feeney, Joseph Decristofaro, M.D., Ken Schroeter, D.O., Shanthy Sridhar, M.D., Thomas Wisell, M.D. and nurse Mikulas, the summons and complaint, and plaintiffs' neonatology Expert Disclosure. It is Dr. Steele's opinion, within a reasonable degree of medical certainty, that Dr. Decristofaro did not depart from accepted standards of care with respect to either the treatment he personally provided to the infant plaintiff or the treatment provided by residents, fellows and other medical personnel to the infant plaintiff under his supervision.

Dr. Steele sets forth that it is plaintiff's theory that all of the infant plaintiff's injuries are

secondary to events transpiring during the period of July 10, 2003 through July 12, 2003, and that during that time frame, a series of events occurred, which caused the infant to sustain an hypoxic injury to the infant plaintiff's brain, leading to the development of bilateral cystic periventricular leukomalacia (PVL), hydrocephalus, cortical blindness, retinopathy of prematurity, exacerbation of pre-existing bronchopulmonary dysplasia, permanent seizure disorder, global developmental deficiencies and severe neurological injury. Dr. Steele states that Dr. Decristofaro had absolutely no contact with the infant plaintiff during the relevant time frame either in a direct or supervisory capacity.

Dr. Steele sets forth that the infant was born on June 25, 2003 at approximately 10:00 a.m. following a gestation of approximately twenty six weeks, seven days, with a birth weight 855 grams.[2] He states that as a result of her extreme prematurity, she was diagnosed with numerous medical conditions including respiratory distress syndrome, hyperbilirubinemia, and sepsis. He further states that Dr. Decristofaro, the infant's attending neonatologist, performed his initial examination of the infant plaintiff approximately four hours after her birth, and by the time of his initial examination, her condition was such that she had already been placed on a ventilator and given Survanta to treat the respiratory distress syndrome. He then issued orders for the infant plaintiff's care. Dr. Steele states that Dr. Decristoraro did not attend the infant plaintiff on June 26, 2003, and instead the infant was seen by Dr. Sridhar; he then saw the infant plaintiff for the subsequent seven days from June 27, 2003 through July 3, 2003, during which time he examined the infant plaintiff, entered a note describing her continuing problems and issued orders for her care. He did not see the infant plaintiff again until August 8, 2003 as he had no clinical responsibilities regarding the infant plaintiff during the period of July 7, 2003 through August 3, 2003, pursuant to the schedule maintained in the Neonatal Intensive Care Unit.

Dr. Steele states that on July 3, 2003, the last date Dr. Decristofaro attended the infant prior to the PICC line incident, the infant was critical and unstable and had a questionable right lower lobe infiltrate. The PICC line, he states, had been surgically implanted shortly after the infant's birth on June 25, 2003. He described the PICC line as a plastic IV tube used as a means by which various fluids are delivered directly to the infant, and during the period of June 25, 2003 through July 3, 2003, Dr. Decristofaro did not observe any clinical symptoms that would indicate there were any complications with the PICC line or that anything had occurred to affect its integrity, or that had their been any problems with the PICC line. Dr. Steele states that Dr. Decristofaro's notes would have reflected that. Dr. Steele states he reviewed Dr. Decristofaro's notes and the notes of the other physicians, fellows, residents, physician assistants or nurses to indicate a problem with the PICC line during that time frame. His review of the laboratory results, he states, do not reflect any change which would be suggestive of a problem with the PICC line. Dr. Steele further opines that the allegations of medical malpractice asserted against defendants stem from the incidents of July 10, 2003 through July 12, 2003 and that Dr. Decristofaro did not attend the infant plaintiff for a period of one week prior to that time and there was absolutely no indication that there was any problem with the PICC line while Dr. Decriatofaro was attending the infant.

Dr. Steele further sets forth that it is alleged that the infant plaintiff suffered permanent injuries to her lungs, BPD (bronchopulmonary dysplasia) and eyes (retinopathy of prematurity) related to the

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[2] Dr. Steele then sets forth several lines later in his report that the infant plaintiff was born at 6:08 a.m at a gestational age of 26 weeks, 6 days.

improper administration of oxygen, and that these claims are entirely without merit as there is no evidence whatsoever to indicate that either the retinopathy of prematurity or the bonchopulmonary dysplasia were secondary to the improper administration of oxygen.

Based upon the foregoing, it is determined that defendant Joseph Decristofaro, M.D. has demonstrated prima facie entitlement to summary judgment dismissing the complaint against him.

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendant, plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see*, ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.,*** 7 AD3d 759, 776 NYS2d 907 [2nd Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.,*** 242 AD2d 282, 660 NYS2d 739 [2nd Dept 1997]).

Plaintiffs' expert, who is licensed to practice medicine in the State of California and who is board certified in Pediatrics with an additional certification in Neonatal-Perinatal Medicine, has rendered opinions with a reasonable degree of medical certainty as to the care rendered by Dr. Joseph Decristofaro. Plaintiffs' expert states that in June, 2003, Dr. Decristofaro was an Associate Professor of Pediatrics and the Fellowship Director of the Neonatology Program at Stony Brook University Hospital whose duties, among other things, included the general education program for the Fellows, including physiology lectures, conferences, monthly review of the Fellow's progress, and as such, was involved in the development of the program and the standards of care followed by the Fellows. Plaintiffs' expert further states that as an attending in the Department of Pediatrics and at the NICU, Dr. Decristofaro was responsible for the direct supervising of the care provided to the neonates when he was assigned to the NICU as the attending, and that he was the attending assigned to the NICU from June 25, 2003 through July 3, 2003.

It is plaintiffs' expert opinion that Dr. Decristofaro departed from accepted medical practice by allowing the infant to receive inappropriately high concentrations of oxygen in order to maintain an unnecessarily high blood oxygen saturation, and that he further deviated from accepted medical practice by failing to monitor the position of the PICC line and recognize that it was no longer in the superior vena cava.

Plaintiffs' expert states that during her admission, the infant Grace was permitted to receive inappropriately high concentrations of oxygen as the Doctor's orders (written on June 25, 2003 when Dr. Decristofaro was the attending physician in charge of the NICU and oversaw all orders written by the residents and fellows) required the nurses to adjust the ventilator setting of the oxygen concentration so that it would maintain the infant's blood oxygen concentration at a level equal to or greater than 95%. Plaintiffs' expert states this is unacceptable as it is known in the medical community that for infants in this gestational range and birth weight range, that oxygen levels from 82% to 93% were acceptable, as exposure to such high concentrations of oxygen increased the infant's risk for development of injury to her tissues, including her brain, eyes and lungs. Plaintiffs' expert further states that in 2003, it was accepted by the medical community that oxygen saturation levels in the range of 82% to 93% were not only acceptable but also desirable. As the attending, opines plaintiffs' expert, Dr. Decristofaro had the obligation to review, among other things, the orders and flow sheets for Grace documenting the ventilator

settings, vital signs, blood gases and oxygen concentrations in the blood; and as the Director of the Fellowship Program, he had the obligation to be knowledgeable about the developments in neonatal care, including the effect of hyperoxia on a neonate. From reviewing the flow sheets, plaintiffs' expert states that it is evident that the oxygen concentrations delivered were changed frequently to achieve the goal of maintaining oxygen concentration levels of 95% or higher and that the flow sheets further demonstrate that the oxygen saturations for Grace were maintained at 98% to 100% during Dr. Decristofaro's tenure as NICU attending.

Plaintiffs' expert further opines that because of Grace's birth weight and gestational age, Grace was already at risk for developing white matter injury to the brain, and that Dr. Decristofaro's endorsement of the order for oxygen at that level allowed her to receive the aforementioned oxygen concentrations which made the white matter more susceptible to any injury. Plaintiffs' expert opines that by maintaining the higher concentrations of oxygen in Grace, it created oxygen free radicals, which in turn created cytokines, a substance that increases the inflammatory process causing an oxidative injury. Plaintiffs' expert states that it is this process that increases the risk of injury to the white matter of the brain. He states this is one of the factors in the underlying pathology for periventricular leukomalacia (PVL) or a softening of the white matter of the brain adjacent to the ventricles in the brain, resulting from a decrease of blood flow to the area, known as ischemia. Plaintiffs' expert states that a premature infant has an immature auto-regulation of blood flow to the brain and it is vulnerable to changes in blood pressure, oxygen levels and carbon dioxide levels, and as a premature infant with an infection of the placenta present at the time of her birth, Grace was at increased risk for PVL development. Plaintiffs' expert further states that Grace did not have any sign of a brain injury, including PVL or hemorrhage at birth and during the first week of her life. Plaintiffs' expert further states that before July 21, 2003, Grace had no evidence of such an injury on the head ultrasounds that were done, and it was the repeated exposure to the aforesaid oxygen concentrations that made her more susceptible to PVL development, making her unable to withstand the insult of the respiratory distress and the resultant hypoxemia, caused by the infusion of the intravenous fluid into her chest.

Plaintiffs' expert further opines that Dr. Decristofaro had an acknowledged obligation to review the chest x-rays of the infant and that the affirmation of plaintiffs' radiological expert documents the chest x-rays showed that the PICC line did not remain in the desired location of the superior vena cava as early as July 1, 2003 and had moved back into the innominate vein. Plaintiffs' expert further states there was no indication that this was recognized by Dr. Decristofaro or any other physician. Plaintiffs' expert further states this placement could be acceptable as a deep vein intravenous, but not for a central line. If it was used as a deep vein intravenous, opines plaintiffs' expert, this should have been done intentionally with knowledge of the location of the distal end of the PICC line by the NICU physicians. Plaintiffs' expert states all orders for fluids and medications to be infused through the PICC line have to be made with an understanding of the location of the tip of the catheter and the potential effects of the infused fluid. Plaintiffs' expert opines it was the PICC line erosion which caused Grace to have an acute respiratory deterioration which led to hypoxemia and an added insult to the white matter of her brain. Plaintiffs' expert further opines that although the erosion did not become manifest until July 10, 2003, Dr. Decristofaro's actions prior to that date allowed a potentially dangerous condition to exist which could have been avoided.

Plaintiffs have also submitted the affirmation of their Radiology expert which affirmation sets

forth that such expert is board certified in Radiology and is an examiner for the American Board of Radiology. Plaintiffs' expert radiologist set forth the documents reviewed and provides an opinion based upon a reasonable degree of medical certainty concerning the placement of the PICC line.

Plaintiffs' radiology expert states that a PICC line (percutaniously inserted central catheter) is a special line placed for the purpose of long term infusion of intravenous fluids. In this instance, plaintiffs's expert opines, the needle was placed into a small peripheral vein in this premature infant's right arm, and the catheter was then threaded through the needle and advanced centrally until the tip was positioned in the superior vena cava, the large vein which returns the blood to the heart from the top half of the body. Plaintiffs' expert states that while the tip of the PICC line is correctly positioned in the superior vena cava, concentrated solutions of hypertonic or caustic fluids can be safely infused as the fluid is rapidly diluted by large volumes of surrounding blood; but with the tip of the PICC malpositioned in a smaller vein with less blood flow, the infused solutions are not rapidly diluted and can remain at dangerous levels of concentration damaging the adjacent vein wall by the action of the catheter or the effect of the infused substance; this can cause the erosion of the PICC through the wall of the vein wherein the infused fluid, instead of entering the blood stream as intended, may instead accumulate in the chest cavity compromising breathing, as happened in this case. This infusion into Grace's chest cavity, an infant weighing only 855 grams, caused devastating consequences.

Plaintiffs' expert opines that the NICU physicians must carefully evaluate the chest x-rays with concern for the location of the tip of the PICC line, and withhold fluid when the placement of the tip of the catheter is uncertain. Initially, opines plaintiffs' expert, the tip of the PICC line was correctly positioned on June 25, 2003, as confirmed by chest x-ray on June 26, 2003. On July 1, 2003, the PICC line was no longer in the superior vena cava, but rather in the innominate vein. By July 4, 2003, the chest x-ray showed the tip had retracted even further peripherally and was now in the subclavian vein. On July 5, 2003, the PICC line had migrated back to the right innominate vein. On July 8, 2003, and more obviously on July 9, 2003, the chest x-rays showed that the PICC line had an abnormal peripheral position and an abnormal curvature pointing upward and away from the heart, and revealed some right-sided atelectasis and right pleural effusion, demonstrating that fluid infused through the PICC line was beginning to collect in the right chest cavity because by this time the PICC had eroded through the vein wall. Two chest x-rays dated July 10, 2003 continued to show the upturned tip of the PICC which was now malpositioned at the junction of the right subclavian and right internal jugular veins, clearly an unacceptable position. The chest x-ray of July 11, 2003 showed a large right pleural effusion for which a chest tube was inserted into the infant, but not until July 12, 2003. White fluid recovered from the chest tube was identified to be the same Intralipid the physicians had been infusing through the PICC to provide nourishment to the infant.

Plaintiffs' radiology expert further opines that Dr. Decristofaro was the attending pediatrician in charge of the NICU until July 3, 2003, and that Dr. Decristofaro failed to recognized that the PICC line was unstable in its location, changing position from day to day, and that he further failed to insure the daily chest x-rays were correctly reviewed to be certain that the tip of the catheter was in the superior vena cava or at least in the innominate vein; and if there was uncertainty about its location, the PICC should have been removed and a new PICC line placed and secured in the correct position, or treat the existing PICC as a peripheral line. Specifically, opines plaintiff's expert, this was an avoidable complication as there was ample time to do this before the PICC line eroded through the vein wall.

In review of the foregoing, it is determined by this Court that plaintiffs' experts have raised material issues of fact in opposing defendant Dr. Decristofaro's motion to preclude summary judgment dismissing the complaint. The factual issues raised concern, inter alia, the alleged departures by Dr. Decristofaro from the standards of care in ordering blood oxygen saturation levels at a level greater than 82% to 93%; failure to review, among other things, the infant's orders and flow sheets documenting the ventilator settings, vital signs, blood gases and oxygen concentrations in the blood; failure to be knowledgeable about the developments in neonatal care, including the effects of hyperoxia on a neonate; failure to diagnose that the PICC line was displaced thus permitting and causing the PICC line erosion, the infusion of the intravenous fluid into the infant plaintiff's chest, and resulting acute respiratory deterioration and hypoxemia and insult to the white matter of the brain. Factual issues are also raised concerning cytokines wherein plaintiffs' expert gave a reason for their formation as being due to high concentrations of oxygen and Dr. Decristofaro, in his deposition testimony, stated the cytokines were activated through infection, traveled into the brain, causing damage. Dr. Decristofaro also testified that low PCO2 levels and pneumothorax could also cause increased incidence of PVL. There are factual issues relating to the etiology of the infant's retinopathy. There are factual issues concerning the cause of the infant's brain damage. Such factual issues preclude summary judgment.

Based upon the foregoing, it is determined that plaintiffs have demonstrated the existence of triable issues of fact attesting to departures from accepted practice by defendant Dr. Joseph Decristofaro, and that these departures were a competent producing cause of injuries to the infant plaintiff.

Accordingly, motion (001) by defendant Dr. Joseph Decristofaro for summary judgment dismissing the complaint against him is denied as there are material issues of fact which preclude the same.

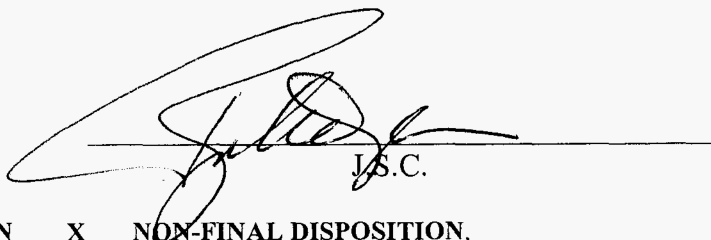
Motion (002) by defendant Kenneth Schroeter, M.D. is supported by, inter alia, an attorney's affirmation; copies of the pleadings, verified bill of particulars, supplemental bill of particulars; a copy of the Stony Brook University Hospital record of the infant plaintiff; and the affidavit of defendant's expert Richard Polin, M.D.

Counsel for defendant has set forth in his affidavit that he is adopting exhibits E though K submitted by Dr. Decristofaro in support of Dr. Schroeter's motion. However, CPLR 3212 does not provide that a party may adopt or incorporate those exhibits submitted by another in support of their moving papers. However, this court will search the records and consider those exhibits accordingly.

Dr. Schroeter has submitted the affidavit of Richard Polin, M.D., in which Dr. Polin has not sworn to tell the truth under the penalty of perjury, and which affidavit is not notarized. The affidavit is not in admissible form (*see*, ***Zuckerman v City of New York***, supra). Therefore, defendant Schroeter has failed to demonstrate prima facie entitlement to summary judgment dismissing the complaint.

Accordingly, motion (002) is denied.

Dated: JAN 10 2008



J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION,**