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SHORT FORM ORDER

INDEX No. 06-23749
CAL. No. 09-00748-MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Justice of the Supreme Court

MOTION DATE 8-19-09 (#003)
MOTION DATE 9-18-09 (#004)
ADJ. DATE 11-20-09
Mot. Seq. # 003 - MG
004 - MD

ROBERT F. MARTIN, III and JUDEE M. MARTIN, individually, and as the Administrator of the Estate of AMEE MARTIN, deceased, Plaintiffs, - against - JOHN RICOTTA, M.D., ZVI JACOB, M.D., DAVID Y. LO, M.D., JONATHAN RUBIN, M.D., KIMBERLY FENTON, M.D., DANIEL CRUZ, R.N., JACK LEVINE, O.R.T., and others not presently know to plaintiffs, Defendants.	MICHAEL J. REGAN, ESQ. Attorneys for Plaintiffs 1370 RexCorp Plaza Uniondale, New York 11556 BROWN & TARANTINO, LLC Attorneys for Defendant John Ricotta, M.D. 1 North Broadway, Suite 1010 White Plains, New York 10601 KELLY, RODE & KELLY, LLP Attorneys for Defendants Zvi Jacob, M.D. & Kimberly Fenton, M.D. 330 Old Country Road, Suite 305 Mineola, New York 11501

Upon the following papers numbered 1 to 32 read on this motion for summary judgment by Notice of Motion/Order to Show Cause and supporting papers (003) 1 - 12 ; Notice of Cross Motion and supporting papers (004) 13-24 ; Answering Affidavits and supporting papers 25-28; Replying Affidavits and supporting papers 29-32; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is

ORDERED that this motion (003) by the defendants, Zvi Jacob, M.D. and Kimberly Fenton, M.D., pursuant to CPLR 3212 for an order granting summary judgment dismissing plaintiffs' complaint, is granted and the complaint is dismissed with prejudice as asserted against them; and it is further.

ORDERED that this motion (004) by the defendant, John Ricotta, M.D., pursuant to CPLR 3212 for an order granting summary judgment dismissing plaintiffs' complaint, is denied.

The complaint of this action sets forth a cause of action sounding in medical malpractice, gross negligence, and wrongful death of the decedent infant, Amee Martin, arising out of the alleged negligent and intentional departures from accepted standards of medical care by the defendants resulting in the infant's cardiac arrest and death. On July 24, 2006, Letters of Administration were issued to the plaintiffs, Robert F. Martin, III and Judee M. Martin by the Surrogates Court, County of Suffolk (Czygier, J.).

The decedent, born on May 6, 2005, was admitted on April 12, 2006 to Stony Brook University Hospital, PICU, to the service of the attending PICU specialis, Kimberly Fenton, M.D., to determine why the infant developed respiratory dysfunction. During that admission, the infant underwent a tracheostomy based on the need for chronic ventilation. She also had placement of a gastrostomy tube for nutritional support for failure to thrive. She was seen by a pulmonologist, a critical care specialist, neurologists and geneticists to rule out various genetic/neuro/muscular /pulmonary disease or disorders, including myasthenia gravis. A muscle biopsy had been planned, but on May 12, 2006, the infant developed tremoring of the right side of her body, and Dr. Fenton ordered several interventions, including placement of a central venous line necessary for the administration of various medications. On May 12, 2006, Kimberly Fenton, M.D. performed a right femoral central line placement, but inadvertently cannulated the artery and immediately removed the line. Thereafter, the infant's right leg was allegedly pale but with a positive femoral pulse, however, decreased and inadequate perfusion of blood through the arterial system of the leg was noted. Dr. Fenton's plan was to consult a vascular surgeon if there was no improvement in the perfusion of the leg or if pulses were lost. Ultimately, about midnight, the infant was seen by John Ricotta, M.D., the vascular surgeon, who performed an emergent thrombectomy of the infant's right lower extremity on May 13, 2006, but no clot was found. Dr. Jacob was the anesthesiologist who administered anesthesia to the infant plaintiff.

It is claimed that Dr. Ricotta administered 162 mg Papaverine, intraoperatively, which dosage was 27 times the recommended dose. It is further claimed that in addition to the alleged incorrect dose of Papaverine being administered, that the Papaverine was contraindicated as the infant was receiving beta blockers. Shortly after the administration of the Papaverine, the infant plaintiff went into cardiac arrest. Attempts at resuscitation were unsuccessful and the infant was pronounced dead in the operating room. It is claimed that these aforementioned alleged departures proximately caused the death of the infant plaintiff. The plaintiffs subsequently commenced the instant action against Dr. Fenton, Dr. Jacob, and Dr. Ricotta.

In motion (003), the defendants, Zvi Jacobs, M.D. and Kimberly Fenton, M.D., seek summary judgment dismissing the complaint on the basis they were not negligent and bear no liability for the alleged injuries. They claim that although Dr. Fenton inadvertently cannulated the artery during placement of a central venous line, the infant's leg was thereafter monitored until it was determined that exploratory surgery was appropriate; the defendant, John Ricotta, M.D., performed the surgery and found no clot; and at the end of the procedure, the infant went into cardiac arrest. Dr. Fenton and Dr. Jacob claim that it was later learned that the surgical technician employed by Stony Brook University Hospital, Jack Levine, O.R.T., had improperly accepted a vial containing Papaverine, requested by Dr. Ricotta, and that Levine was not authorized to accept or prepare medications but failed to advise Dr. Jacob, the anesthesiologist, of that fact and that Levine drew the contents of the vial into a syringe and placed it at the end of the operating table and was administered by Dr. Ricotta. Levine allegedly never diluted so the patient received a lethal dose of medication. Dr. Jacob had advised Dr. Ricotta of the proper dosage of the Papaverine for the infant when asked by Dr. Ricotta. Jacobs and Fenton argue that it was the duty of the circulating nurse, Daniel Cruz, to dilute the medication, and Cruz did not do so that day. Therefore, Jacobs and Fenton argue that they bear no liability in this action.

In motion (004), John Ricotta, M.D. seeks summary judgment dismissing the complaint on the basis that about five hours after the artery had been cannulated, he was contacted to evaluate the infant in the PICU, and arrived shortly before midnight, examined the infant and advised the parents of the need to

evaluate the arterial system in the operating room to determine the most probable cause of the lack of adequate perfusion of leg and to correct the same. It is claimed by Dr. Ricotta that he determined in the operating room that there was no specific blood clot causing the lack of perfusion and ordered Papaverine to dilate the blood vessel to increase the blood flow. He therefore requested that anesthesia determine the correct dosage of the Papaverine for the infant, and Dr. Jacob, the anesthesiologist determined a dosage of upwards of 9 mg. Dr. Ricotta claims it is the responsibility of the operating room staff, specifically the circulating nurse, to procure the medication and to ensure the appropriate dosage was aspirated into the syringe for administration, and that the person who scrubbed in, later determined to be a surgical technician, prepared the syringe in violation of hospital policy. Dr. Ricotta claims he administered the Papaverine provided in the syringe intravenously over a 5 to 10 minute period not knowing of the incorrect dosage. When he thereafter left the operating room to speak with the infant's mother, the infant experienced cardiac arrest. Therefore, Dr. Ricotta argues he bears no liability in this action.

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 (003), the defendants, Dr. Jacob and Dr. Fenton, have submitted, inter alia, an attorney's affirmation; the affirmation of defendants' experts William Seth Schecter, M.D. and Catherine Caronia, M.D.; copies of the pleadings, answer and verified bill of particulars; and copies of the transcripts of the examinations before trial of Kimberly Fenton, M.D. dated November 11, 2008, John Ricotta, M.D. dated October 7, 2008, Zvi Jacob, M.D. dated November 11, 2008, and Daniel Cruz dated October 26, 2006. A copy of the relevant hospital record has not been provided.

In support of motion (004), the defendant, Dr. Ricotta, has submitted, inter alia, an attorney's affirmation; the affirmation of defendant's expert William D. Suggs, M.D.; copies of the pleadings, answer and verified bill of particulars; and copies of the transcripts of the examinations before trial of John Ricotta, M.D. dated October 7, 2008, Zvi Jacob, M.D. dated November 11, 2008; a partial copy of the hospital record; and a copy of the affirmation by Camille Nieves, counsel for defendants Jacob and Fenton.

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]).

A review of the infant's partial admission record from Stony Brook University Hospital reveals that the infant was admitted on April 12, 2006, with the admitting diagnosis of acute respiratory failure. The infant had been initially seen at Brookhaven Memorial Hospital on the evening of admission when her parents noted she had perioral cyanosis occurring at mealtime with no respiratory distress and no report of choking. She had some listlessness on the day of admission. Her oxygen saturation was in the 80's on room air and inspiratory stridor and increased work at breathing was noted, with the breathing rate decreasing to 4, for which she was emergently intubated and transferred to Stony Brook University Hospital PICU to the service of Dr. Kimberly Fenton. The infant had a history of failure to thrive, respiratory failure, bilateral ptosis and opthalmplegia and was being worked up for myasthenia gravis, which was excluded after testing. The infant experienced hypertension in the PICU and was diagnosed with obstructive cardiomyopathy. She had a failed extubation secondary to apnea and was unable to be weaned from the ventilator. A tracheostomy was performed and she was maintained on chronic mechanical ventilation. Due to difficulty swallowing, a gastrostomy tube was placed.

On May 12, 2006, the infant began having high fevers, increased respiratory secretions and right-sided clonic-tonic activity due to hyponaturemia which was corrected with normal saline and sodium chloride via the G tube. A central line was placed by Dr. Fenton due to difficulties in obtaining peripheral venous access, however, the right femoral artery was unintentionally cannulated and the line removed, however, the infant developed a pale and cool right lower extremity. A vascular surgery consult was called with Dr. Ricotta who indicated an occlusion of the right femoral artery likely secondary to the line with no significant changes over the last five to six hours for which an exploratory of the right groin and thromboembolectomy or lytic infusion was recommended emergently. The infant's prognosis was noted to be guarded. Her diagnosis was ischemia of the lower extremity.

Dr. Jacob administered anesthesia during the procedure. Dr. Jacob's post operative note of May 13, 2006 at 3:28 a.m. notes that at the conclusion of the procedure the infant experience asystole and cardiac arrest and ALS protocol was instituted. The infant expired at 2:46 a.m. The relevant section of the unsigned operative note dictated by Dr. Ricotta reveals that a 24 gauge catheter was placed into the common femoral artery and Papaverine 7 mg was infused, and another 10,000 units of Urokinase was administered over a ten minute period and the infant tolerated it well. The catheter was removed and the wound closed. When Dr. Ricotta left to talk to the family, he was called back to the operating room as the infant suffered a cardiac arrest. A thirty minute resuscitation was unsuccessful. The copy of the anesthesia record indicates Papaverine 5.4cc (30 mg/cc) was administered.

Daniel Cruz testified at his examination before trial to the effect that he was a registered nurse employed at Stony Brook University Hospital and participated in the surgery of the infant plaintiff on May 13, 2006 on the 11p.m.-7 a.m. shift. His duties were to help prepare the room, assist the anesthesiologist, surgical tech, get instrumentation, check equipment, and make sure the proper personnel-surgical team are in the room. He left the room approximately four times once the procedure started: once after the patient was draped as Dr. Ricotta requested instrumentation (a smaller vascular retractor) which was not in the room; the second time was to get instrumentation (a Henley retractor) that did not come up from central sterilizing which they could not locate; a third time for about thirty seconds, but he did not know why; and a fourth time to get an embolectomy catheter and Papaverine towards the middle of the procedure. However, as he was leaving the room, Dr. Jacob suggested that he would get the Papaverine from the medication closet and he (Cruz) should get the catheter which was located further away. He stated he returned with the catheter and about twenty or twenty five minutes lapsed before the code ensued. During that time he was entering information into the computer to generate a record of the case. Mr. Levine was the surgical technician who assisted handing instrumentation to the doctor during surgery and was in a better position to observe the patient than he was. He stated that the infant never came out of anesthesia.

Kimberly Fenton testified at her examination before trial to the effect that she is a physician licensed to practice medicine in New York since 1998 or 1999 and is board certified in pediatrics and pediatric critical care. She was employed with Stony Brook University Hospital as a pediatric critical care physician. When Amee Martin was admitted in April 2006, it was for respiratory failure and she was the attending physician. During the admission, the infant's condition became progressively worse and she was critically ill, but was stabilized until several hours preceding May 12, 2006. The infant developed some cold symptoms, was more tired, and had to remain on the ventilator all day. Towards the late afternoon she was tremoring on the right side of her body so and EEG was performed, some basic labs, and an IV was inserted which came out. Unable to get an IV to stay well, she decided, about 5:30-6:00 p.m., to place a central venous line in the infant's right femoral vein, but inserted the catheter into the right femoral artery and noted the blood flow in the catheter was pulsatile. She drew blood gases which took about two minutes, and which revealed that the line was in her artery, so she removed the catheter. After a few minutes, she noticed that the infant's right leg appeared cooler than her left leg, so she asked the nurses to keep an eye on it. She felt the artery went into spasm and would resolve spontaneously. She placed another central line into the infant's left femoral vein. She told the resident that if the leg did not improve in two hours then they were to obtain a vascular surgery consult. She then left and was later called advising the condition had not improved and the resident had called the vascular surgeon. She spoke to the vascular attending, Dr. Ricotta, about 11:00 p.m. She was satisfied with the response time of the vascular surgery team. Dr. Ricotta felt there was a thrombus in the infant's artery based upon the pulse oximetry test, examination, and Doppler study, and he wanted to take her to the operating room to explore the artery and remove the thrombus. She testified that Dr. Ricotta was not a pediatric vascular surgeon and that there are just vascular surgeons. She did not ask him if he ever performed pediatric vascular surgery. He asked her the pediatric low molecular weight heparin dose and she called him back after she spoke to the pediatric resident for the dose to advise him. The next call she received was from Dr. Jacob who advised her the infant had gone into cardiac arrest. She went to the hospital and arrived in the operating room, at which time the code was called off. An autopsy was not performed. She was later informed by Dr. Biancaniello, the medical director, that there was a suspicion of an overdose of Papaverine.

Dr. Ricotta testified to the effect that he is licensed to practice medicine in New York State but did not indicate whether or not he was board certified in any area of medicine. He was a member of Stony Brook Surgical Associates, P.C. and also chair of the Department of Surgery for Stony Brook Hospital. Amee Martin first came under his care and treatment on the night of May 12, 2006 into the morning of May 13, 2006 when he performed surgery on the infant. Prior to the events that occurred on May 12, 2006, the child was being prepared for discharge to home. He had been called in about 11:00 p.m. by one of the residents concerning the infant's circulation in her right leg. He spoke with Dr. Fenton, and after examining the child, he spoke to her mother and advised her that he made an assessment that there was a significant risk of permanent limb damage if he didn't do anything and that it might even result in an amputation. Any diagnostic testing, other than what he had done, he stated, would have been relevant, in light of the physical examination and Doppler examination. In the operating room, Dr. Jacob administered anesthesia to the infant who remained under the effects anesthesia until she was pronounced dead. He made an incision over the artery and noted very little blood flow in the artery and thought there could be a clot upstream or spasm in the artery. He spoke with Dr. Jacob about getting some Papaverine and checking with pharmacy for the proper dosage. He was aware the infant was receiving beta blockers and had administered Papaverine to patients on beta blockers, but not pediatric patients on beta blockers, without adverse events related to it as long as the blood pressure is adequately maintained. It was his opinion that the presence of beta blockers was not a contraindication to the use of Papaverine. He usually asked the nurse to get the medication, but in this case, because it was a child and Dr. Jacob had some special expertise in pediatric anesthesia, and he is not a pediatric surgeon, he wanted to be sure that a physician checked on the appropriate dosage, so he asked Dr. Jacob to do so. They verbally agreed on the dosage of 7 mg of Papaverine. Dr. Ricotta did not know who was discharged with the responsibility of drawing up the 7 mg of Papaverine, and stated that normally the nurse draws up the medication. He subsequently leaned that the Papaverine was drawn up by the scrub technician, Mr. Levine, who is not a nurse. He believed that Mr. Levine stepped out of protocol by drawing up the medication. Dr. Ricotta testified that the operating room nurse was not in the operating room at the time. He did not ask Levine if it was the Papaverine when it was handed to him, and he did not confirm the dosage as it was not part of the usual and customary practice at Stony Brook at the time. He did not ask Dr. Jacob to draw up the medication. The syringe he received had 7 cc's in it. He stated that usually the Papaverine is diluted to 1 mg per cc, so when he saw the 7cc syringe and knew they were going to give 7 mg of Papaverine, he made an assumption that it was 7 mg of Papaverine. He infused the drug slowly over about 8 to 10 minutes. He and Dr. Jacobs were watching the infant's blood pressure and there were no changes in her vital signs. He let Dr. Rubin, the resident, close the wound and left to speak to Mrs. Martin when he was called back in as the infant went into cardiac arrest. Dr. Fenton was called in. Resuscitation was not successful. He, Dr. Fenton, and Dr. Jacob thereafter spoke to Mrs. Martin. He later came to learn that the Papaverine was not diluted. After that, he was told by the hospital not to have further contact with the Martins. Dr. Biancaniello, the pediatric cardiologist and chief medical officer of the hospital, took over management of the situation and spoke to the infant's pediatrician, Dr. Martinez, and they came to the conclusion that there had been a medication error. Dr. Biancaniello, he stated, then strongly encouraged that no one speak with the family. He had no reason not to do an autopsy and had every expectation that the medical examiner would do an autopsy. Dr. Ricotta testified that he was interviewed by the Department of Health in connection with Amee Martin.

Dr. Jacob testified at his examination before trial to the extent that he became licensed to practice medicine in New York State in 2004, was board certified in anesthesiology, and is employed by the State of New York and by Stony Brook Anesthesiology, a private corporation. He had been at Stony Brook since

August 2005 as an attending. Amee Martin came under his care and treatment around midnight on May 12, 2006, as he was on call. He met with Dr. Ricotta who informed him of his intentions for the procedure, went to the OR and got a full report from his resident, Dr. Lo, made sure the equipment in the room and the team were ready. He then went to see the infant and was given report on the elevator on the way to the holding area in the operating room. He examined the child and instructed his residents about the plan. The infant had a manual bag for ventilation connected to her tracheostomy tube so he continuously watched her. Prior to anesthesia, she responded "some how to his movement," but did not cry. From the time general anesthesia was administered until she was pronounced dead, she did not come out of the effects of the anesthesia. Dr. Ricotta performed his procedure. Dr. Jacob testified that the Doppler machine was not functioning so he asked his resident, Dr. Lo, to take over the anesthesia for a minute so he could bring the second Doppler from the recovery room. On his way back to the operating room, Daniel Cruz was standing by the medication closet and handed him a vial of Papaverine. He replaced the Doppler machine with the new one, when the surgical team asked for the Papaverine to be dispensed to the field. He had it in his hand and held the vial of medication for Jack Levine, the operating room tech, to aspirate from the vial with a sterile syringe. He pronounced the medication to Levine and to everybody in the OR; the medication was identified by Levine, reading the label for the name and concentration and the expiration date. Levine then aspirated the medication from the vial into the syringe in a sterile fashion, and the syringe was placed in a sterile cup on the field. He testified that the anesthesiologist does not calculate the dosage of the medication as that is done by the person who administers the medication to the patient, in this case, Dr. Ricotta. He testified that Dr. Ricotta did not know the dosage of the medication to begin the case and asked the anesthesia team to find out the proper dose. Therefore, he went online to a medical reference, and Dr. Lo called the hospital pharmacy, and they both came out with the same dose of one half mg per KG of weight for a total of 9 mg. He stated an OR tech is not permitted to mix medications but did it in this case. When asked what he mixed, Dr. Jacob testified that he did not know what Levine did with the medication because he never witnessed it, and it was the job of the nurse to prepare the medication and Levine did not indicate he was a technician. He did not know Levine was not an RN. If he knew, he would not have permitted him to mix the medication. Thereafter, the monitor showed the infant had an arrhythmia, a supraventricular tachycardia at a rate of 180 beats per minute. He asked the team what they did and Dr. Rubin or Dr. Ricotta said they were not doing anything, just closing the wound. He started carotid massage to treat the arrhythmia and the heart rate came back to baseline at 100 to 130 beats per minute, but then dropped to under 100, then to 40 and then there was a flat line on the monitor. He had already given atropine, but she did not respond; he administered intravenous epinephrine in boluses and started pediatric ALS and a code blue situation was called. Dr. Ricotta was not in the room when the code was started. Dr. Fenton was called in. The code was unsuccessful. He thereafter called for an investigation because Dr. Lo later told him that he believed the entire vial or the entire syringe was given to the infant and thought that the Papaverine was the cause of the problem. He had been aware the infant was receiving beta blockers, but testified that it was Dr. Ricotta's decision to give the Papaverine for the purpose of the procedure. He stated that he believed that Papaverine was actually the medication of choice in the appropriate dose, although relatively contraindicated.

Dr. William Seth Schechter, M.D. has submitted his affirmation on behalf of Dr. Jacob wherein he indicates that he is a physician licensed to practice medicine in the State of New York and is board certified in pediatrics and anesthesiology with a sub-board certification and qualification in critical care medicine and pain management and palliative medicine. He indicates a dose of 10,000 IU of Urokinase was administered in the field along with Papaverine 5.4 ml (dispensed at a concentration of 30 mg/cc) for a total

dose of 160 mg or 25 mg/kg by Dr. Ricotta, the field surgeon, at 0155 hours. He states that approximately 27 times the maximum recommended emergency dosage was administered. Papaverine is used by vascular surgeons and endovascular interventionalists in appropriate doses to relieve vascular spasm. He states that Dr. Jacob was asked by the surgeon to determine the correct pediatric dose of Papaverine, which correct dose of 1.5 mg/kg or a total dose of 9 mg was determined, as confirmed by the hospital pharmacy and announced in the OR on at least three occasions. He states that Dr. Jacob was handed the vial of Papaverine by the circulating nurse, Daniel Cruz and that Dr. Jacob then gave the vial of the medication to the individual scrubbing on the case by holding it so that scrubbed individual could aspirate the medication into a sterile syringe which was then placed into a sterile cup. Dr. Schechter states that Papaverine is not a drug which is considered part of the anesthesiologist's or pediatrician's pharmacopeia and that Dr. Jacob had no intrinsic responsibility for determining the dose, locating, dispensing, diluting or supervising the dilution of the drug nor did he assume any responsibility for its administration, and had no knowledge that the scrub was a technician not authorized to accept the drug and was not expected to have that knowledge. Knowing what is within nursing scope of practice and qualification is the responsibility of both the nurse who dispensed the drug to Dr. Jacob and the technician who accepted it. It is Dr. Schechter's opinion that the care rendered by Dr. Jacob exceeded the conventional standard of care; he complied with the surgeon's request to determine the correct dosage; confirmed the accuracy of the dose by two information sources; that Papaverine is not a drug which Dr. Jacob gave the patient and there was nothing that Dr. Jacob did or did not do that caused or contributed to the infant's death.

Based upon the foregoing, it is determined that Dr. Jacob has demonstrated prima facie entitlement to summary judgment dismissing the complaint and has demonstrated that there was no act or failure to act by him that proximately caused injury and/or death to the infant plaintiff. It has been established that Dr. Jacob did not order the medication, prepare the medication for administration, or administer the medication.

Catherine Caronia, M.D. affirms that she is a physician duly licensed to practice medicine in the State of New York and is board certified in Pediatrics and Pediatric Critical Care Medicine. It is her opinion within a reasonable degree of medical certainty, that Kimberly Fenton did not depart from acceptable standards of pediatric care in her care and treatment of the infant; that placement of a central venous line was a proper and necessary procedure to perform and was properly performed by Dr. Fenton; that the inadvertent cannulation of an artery is a risk of the procedure and was quickly recognized by Dr. Fenton who promptly removed the line; and that the patient was appropriately monitored for several hours until it was determined by the vascular surgeon that exploratory surgery was appropriate; and that there was nothing that Dr. Fenton did or did not do that resulted in the infant's death. Dr. Caronia sets forth that Mrs. Martin signed a consent form which lists arterial injury as a possibility. In a smaller than average patient, the risk of arterial injury is even greater and can occur in the absence of negligence. Dr. Fenton noted the arterial cannulation and removed it before medications were transfused through the line, and that the paleness in the right leg was monitored by the resident within the hour. Dr. Fenton did not make the decision to perform surgery or to administer Papaverine during the surgery. Dr. Caronia opines that Dr. Fenton did not deviate or depart from any acceptable standards of care.

Based upon the foregoing, it is determined that Dr. Fenton has demonstrated prima facie entitlement to summary judgment dismissing the complaint. It has been established that although Dr. Fenton inadvertently cannulated the artery rather than placing a central venous line, however, no proximate cause has been established between that act and the infant's death. Dr. Fenton did not order the Papaverine,

determine the dosage, prepare the medication for administration, or administer the medication.

William D. Suggs, M.D. sets forth that he is a physician duly licensed to practice medicine in the State of New York and is board certified in surgery with added qualifications in vascular surgery and submits this affirmation on behalf of Dr. Ricotta and opines that Dr. Ricotta acted in accord with good and accepted vascular surgery practice in his care and treatment of the infant. He sets forth that the initial evaluation of the infant's condition was appropriate, consent was obtained for the percutaneous intervention and evaluation in the operating room; and that the vascular procedure was in accord with good and accepted vascular surgery. Dr. Ricotta, however, towards the conclusion of the procedure, in his surgical judgment, determined that Papaverine was an appropriate medication to administer to Amee Martin. He opines that the drug was an appropriate medication to administer as a vasodilator to promote blood flow in the blood vessel and that the use of Papaverine is not contraindicated while a patient is receiving beta blockers. He states that Dr. Ricotta appropriately inquired of anesthesia for the correct dose of Papaverine and that he concurs that the correct dosage is 1.5 mg per kilo for a total of 9 mg and that Dr. Ricotta requested 7 mg, or slightly less than the aforementioned dosage to administer. He states that an OR staff member prepared the syringe and that it is the reasonable expectation of every vascular surgeon that the medication be prepared as requested and that it was reasonable for Dr. Ricotta to expect that approximately 7 mg of Papaverine was diluted in the approximate 5-7 cc amount of fluid in the syringe. He states it is not the standard of care for the vascular surgeon to ask the individual placing the syringe into the surgical field whether or not the syringe contained the requested dosage of medication. He further opines that the Papaverine was administered over a 5-10 minute period of time in accord with good and accepted medical practice; that the infant did not experience cardiac arrest until Dr. Ricotta left the operating room but quickly returned when he learned of the infant's adverse condition.

Based upon the foregoing, it is determined that Dr. Ricotta has not demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against him due to the existence of factual issues raised in the moving papers. Dr. Suggs sets forth that an OR staff member prepared the syringe and that it is the reasonable expectation of every vascular surgeon that the medication be prepared as requested and that it was reasonable for Dr. Ricotta to expect that approximately 7 mg of Papaverine was diluted in the approximate 5-7 cc amount of fluid in the syringe. However, there is no testimony by Dr. Ricotta, or in the incomplete copy of the hospital record submitted, which supports the expert's unsupported conclusion that Dr. Ricotta at any time requested that the Papervine be diluted to 1mg per 1cc or to any other concentration or dilution. Nor has the infant's weight been set forth in support of Dr. Sugg's conclusion that the proper dosage was administered. Although Dr. Suggs states it is not the standard of care for the vascular surgeon to ask the individual placing the syringe into the surgical field whether or not the syringe contained the requested dosage of medication, he has not set forth the proper standard of care for a surgeon administering an intravenous medication in the field, and thus his statement is unsupported and conclusory. Further, his statement that administration of Papaverine is not contraindicated in a patient receiving beta blockers is conclusory and unsupported by any medical or pharmacological reference.

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, 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 [2004]; ***Domaradzki v***

Glen Cove OB/GYN Assocs., 242 AD2d 282, 660 NYS2d 739 [1997]). The plaintiff has opposed this motion for summary judgment with a physician's affirmation, an attorney's affirmation, and a copy of the report from the New York State Department of Health.

The report of the New York State Department of Health sets forth in relevant part that the anesthesia record documented the vascular surgeon injected 162 mg of Papaverine, which equates to 27 times the recommended dose. The report further indicates that the infant received 162 mg of Papaverine was confirmed during the interviews on May 23, 2006 and May 25, 2006 by the anesthesiologist, the surgical technician, circulating nurse and vascular surgeon. The surgical technician during the interview stated that the anesthesiologist held up the vial of Papaverine and stated that it was Papaverine 30 mg/cc and the surgical technician then drew up about 5.4 to 6.0 cc of the Papaverine with a 10 cc syringe, labeled it and put it in the sterile field in a basin. The report continues that the surgical technician and the vascular surgeon did not confirm the dose of Papaverine prior to its administration and that the anesthesiologist introduced the Papaverine to the sterile field. It determined that the anesthesiologist did not function in accordance with the hospital's intraoperative medication policy. Additionally stated in the report is that Papaverine administration is contraindicated in the face of complete atrio-ventricular block or in situations where cardiac conduction is depressed (such as with the concomitant administration of beta blockers), which the infant was receiving (Propranolol and Labetolol) for cardiomyopathy during her hospital stay.

The plaintiffs' expert has affirmed to being a physician licensed to practice medicine in the State of New York and is certified by the American Board of Surgery with added qualifications in surgical critical care. It is the opinion of the plaintiffs' expert within a reasonable degree of medical certainty that Dr. John Ricotta departed from accepted standards in his care and treatment of Amee Martin on May 12 through 13, 2006. firstly, when he ordered and administered Papaverine for the infant, and secondly, when he failed to confirm the dose of Papaverine prior to administering the drug resulting in the administration of 162 mg, or 27 times the recommended dose. Plaintiffs' expert continues that Papaverine is generally used for the relief of cerebral and peripheral ischemia associated with arterial spasm and myocardial ischemia complicated by arrhythmias. It is contraindicated in situations where cardiac conduction is depressed such as with concomitant administration of beta blockers, such as Propranolol and Labetolol which the infant was receiving for cardiomyopathy during her hospital stay, and that it is well known that if Papaverine is administered while a patient is already taking beta blockers, it can depress atrioventricular and intraventricular conduction and thereby produce serious arrhythmias, exactly as experienced by the infant. The plaintiffs' expert sets forth after the Papaverine was administered, the infant developed tachycardia (accelerated heart rate), then bradycardia (heart rate too slow) and then she died. It is the expert's opinion that this departure of administering Papaverine to the infant while she was taking beta blockers caused the infant's death. It is the expert's further opinion that the failure of Dr. Ricotta to ascertain the correct dose of the Papaverine, and that his administration of the incorrect dose of Papaverine could have been avoided, and were a substantial factor in the cause of the infant's death.

Although a further affirmation of Dr. Suggs has been provided in Dr. Ricotta's reply papers, doing so deprives the plaintiff of responding thereto without leave of the court ***(Sherrer v Time Equities, Inc. and Emilia Grocery, Inc. v Time Equities, Inc.,*** 218 A.D.2d 116, 634 N.Y.S.2d 680). However, in reviewing the same. Dr. Suggs is raising issues not raised in his original affirmation concerning the administration of beta blockers and when the infant was received them (***Bobby D. Associates v Ohlson et al,*** 2009 NY Slip Op 51817OU, 2009 NY Misc Lexis 2195]; ***Wosyluk v LTL Dev. Inc.,*** 147 AD2d 475, 538 NYS2d 478 [2nd

Dept 1989]). Nor was a copy of the hospital record upon which this information is based provided with the moving papers. Despite the submission of Dr. Sugg's additional affirmation, there remain factual issues raised in the plaintiffs' experts affirmation as to Dr. Ricotta.

As set forth in ***Feinberg v Feit***, 23 AD3d 517, 806 NYS2d 661 [2nd Dept 2005], "[S]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury." Dr. Ricotta's expert and the plaintiffs' expert adduce conflicting medical expert opinions, thus precluding summary judgment. Based upon the foregoing it is determined that the plaintiff's have raised factual issues with regard to Dr. John Ricotta's use and administration of the Papaverine precluding summary judgment in this action concerning his use and administration of Papaverine. It is further determined, however, that the plaintiffs' expert does not raise a factual issue with regard to the defendants Dr. Fenton or Dr. Jacob to preclude summary judgment being granted to them.

Accordingly, motion (003) is granted and the complaint of this action is dismissed with prejudice as asserted against Dr. Fenton and Dr. Jacob, and motion (004) is denied in its entirety.

Dated: 12·15·09

J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION