scan

SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present:

HON. DANIEL PALMIERI
Acting Justice Supreme Court

----------x

ELIZABETH SCHWARTZ and MARC SCHWARTZ, individually and as Parents and Natural Guardians of HARRISON SCHWARTZ, an infant,

Plaintiff,

-against-

NEW YORK UNIVERSITY MEDICAL CENTER, JON ROBERT SNYDER, M.D., JON ROBERT SNYDER, M.D., P.C., NEW YORK UNIVERSITY SCHOOL OF MEDICINE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, MATERNAL FETAL MEDICINE ASSOCIATES, DANIEL ROSHAN, M.D., ANNA MOTEAGUDO, M.D., and ILAN TIMOR, M.D.,

Defendant.

----------x

TRIAL TERM PART: 45

INDEX NO.: 011797/08

MOTION DATE:2-5-10
SUBMIT DATE:4-8-10
SEQ. NUMBER - 002 & 003

The following papers have been read on this motion:

Notice of Motion, dated 1-7-10.....1
Notice of Cross Motion, dated 1-12-10.....2
Affirmation in Opposition, dated 3-12-10.....3
Memorandum of Law in Opposition, undated.....4
Reply Affirmation, dated 3-29-10.....5
Reply Affirmation, dated 3-31-10.....6
Sur-Reply Affidavit, dated 4-7-10.....7

This motion by the defendants New York University Medical Center ("Medical Center"), Jon Robert Snyder, M.D., and Jon Robert Snyder, M.D., P.C., and this motion by the defendants Maternal Fetal Medicine Associates, ("Antepartum Testing Unit"), New York

University School of Medicine, Department of Obstetrics and Gynecology ("Antenatal Testing Unit"), Daniel Roshan, M.D., Anna Monteagudo, M.D. and Ilan Timor, M.D., for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint against them, or, in the alternative, for an order directing a hearing pursuant to *Frye v United States,* (293 F. 1013 D.C.Cir. 1923) and *Parker v Mobil Oil Corporation,* 7 NY3d 434 (2006) are granted to the extent that the complaint is dismissed.

In this action, the plaintiffs seek to recover damages for medical malpractice and lack of informed consent. They allege that as a result of the defendants' negligent prenatal care of Elizabeth Schwartz ("Mrs. Schwartz"), the infant plaintiff Harrison Schwartz suffered from fetal complications including oxygen deprivation which caused him brain damage and resulting complications.

The infant plaintiff was born on April 29, 2004 at Jamaica Hospital. As of December 28, 2004 he has been diagnosed with cerebral palsy, left-sided hemiparesis, motor deficits, delayed speech and cognitive deficits. The defendant Dr. Snyder was Mrs. Schwartz's attending obstetrician. He treated her both at his office and at the antenatal testing unit several times during the last few weeks of her pregnancy. The defendants Drs. Roshan, Timor and Monteagudo and Dr. Rebarber are perinatologists specializing in caring for high risk pregnant woman. Drs. Roshan, Timor and Monteagudo were members of the Medical School's Division of Obstetrical and Gynecology Ultrasound and employees of the defendant School of Medicine. Dr. Rebarber was employed by Maternal Fetal Medicine Associates. These doctors conducted numerous tests on Mrs. Schwartz and the fetuses, specifically

ultrasound studies, nonstress tests and biophysical profiles, and interpreted and conveyed the results thereof to Dr. Snyder during Mrs. Schwartz's pregnancy, in particular, the last few weeks. They also examined Mrs. Schwartz on Dr. Snyder's behalf when she was seen at their Units instead of Dr. Snyder's office.

The plaintiffs allege that Dr. Snyder was negligent in not adequately monitoring Mrs. Schwartz; in failing to forewarn them of conditions which would be of concern because of possible compromise of the fetus; failing to recognize the signs of pre-eclampsia, i.e., high protein in her urine, elevated blood pressure, low Amniotic Fluid Indexes, abnormal nonstress tests which revealed a lack of movement and/or lack of breathing, the results of Biophysical Profile studies and abnormal Doppler studies; failing to deliver the infant plaintiff sooner; and, allowing Mrs. Schwartz's condition to progress from gestational hypertension to pre-eclampsia to eclampsia to the point where she suffered an eclamptic seizure which the plaintiffs allege was a predominant cause of the infant plaintiff's ischemic hypoxic insult, i.e., lack of oxygen to the brain, which allegedly caused his cerebral palsy and left-sided hemiparesis.

The plaintiffs allege that in light of Mrs. Schwartz's condition, Drs. Roshan, Timor and Monteagudo were negligent in not accurately and thoroughly relaying the results and significance of their examinations of her and their tests to Dr. Snyder, specifically, persistent oligohydramnios, repetitive nonreactive nonstress tests, minimal fetal heart rate variability and decrease in the fetus' growth percentile, and in failing to coordinate a treatment plan with Dr. Snyder. They also fault the accuracy of some of the results yielded by some of the tests.

The plaintiffs allege that the Medical Center and School are vicariously liable for Drs. Snyder, Monteagudo, Roshan and Timor's negligence.

All of the defendants seek summary judgment dismissing the complaint against them. In the alternative, they challenge the admissibility of the plaintiffs' proposed expert testimony under *Frye v United States, supra*, and *Parker v Mobil Oil Corporation, supra.*

All of the moving defendants have established their entitlement to summary judgment. They have established that their treatment of Mrs. Schwartz and the fetus was in full accord with the prevailing medical standards and that assuming, *arguendo*, that it wasn't, neither their acts nor omissions proximately caused the infant plaintiff's injuries.

In response, the plaintiffs have established the existence of a material issue of fact concerning all of the defendants' care of Mrs. Schwartz and the fetus. However, the plaintiffs have not established the existence of a material issue of fact with respect to proximate cause.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept. 2004), *aff'd. as mod.*, 4 NY3d 627 (2005), *citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v King, supra*, at p. 74; *Alvarez v Prospect Hosp., supra*; *Winegrad v New York Univ. Med. Ctr., supra*. Once the movant's burden is met, the burden shifts to the opposing party to establish

the existence of a material issue of fact. *Alvarez v Prospect Hosp., supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 AD3d 518, 521 (2d Dept. 2006), citing *Secof v Greens Condominium*, 158 AD2d 591 (2d Dept. 1990).

"To establish a prima facie case of liability for medical malpractice, a plaintiff must prove that the defendant deviated from accepted practice, and that such deviation proximately caused his or her injuries." *Dehaarte v Ramenovsky*, 67 AD3d 724, 725 (2nd Dept. 2009), citing *Novik v Godec*, 58 AD3d 703 (2nd Dept. 2009); *Monroy v Glavas*, 57 AD3d 631 (2nd Dept. 2008); *Rabinowitz v Elimian*, 55 AD3d 813 (2nd Dept. 2008); *see also, Ellis v Eng*, 70 AD3d 887 (2nd Dept. 2010). "On a motion for summary judgment dismissing the complaint in a medical malpractice action, a defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or, if there was a departure, that the plaintiff was not injured thereby." *Shectman v Wilson*, 68 AD3d 848 (2nd Dept. 2009), citing *Murray v Hirsch*, 58 AD3d 701 (2nd Dept. 2009), *lv den.*, 12 NY3d 709 (2009); *Shahid v New York City Health & Hospitals Corp.*, 47 AD3d 800 (2nd Dept. 2008); *Alvarez v Prospect Hosp., supra*; *see also, Ellis v Eng, supra*. "[B]are allegations which do not refute the specific factual allegations of medical malpractice in the bill of particulars are insufficient to establish entitlement to judgment as a matter of law." *Grant v Hudson Valley Hosp. Center*, 55 AD3d 874 (2nd Dept. 2009), citing *Berkey v Emma*, 291 AD2d 517, 518 (2nd Dept. 2002); *Drago v Chung Ho King*, 283 AD2d 603, 603-604 (2nd Dept. 2001); *Terranova*

v Finklea, 45 AD3d 572 (2nd Dept. 2007); *Kuri v Bhattacharya*, 44 AD3d 718 (2nd Dept. 2007).

If the moving defendant meets his burden, "[i]n opposition, a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." *Shectman v Wilson, supra*, citing *Sweezey v Montague Rehab & Pain Management, P.C.*, 59 AD3d 431 (2nd Dept. 2009); *Murray v Hirsch, supra*; *Shahid v New York City Health & Hospitals Corp., supra*; *see also, Ellis v Eng, supra*. "[G]eneral allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" do not suffice. *Shectman v Wilson, supra*, citing *Alvarez v Prospect Hosp., supra*; *Shahid v New York City Health & Hospitals Corp., supra*; *see also, Diaz v New York Downtown Hosp.*, 99 NY2d 542 (2002); *Romano v Stanley*, 90 NY2d 444 (1997); *Amatulli by Amatulli v Delhi Const. Corp.*, 77 NY2d 525 (1991). The plaintiff's expert must set forth the medically accepted standards or protocol and explain how it was departed from. *Geffner v North Shore University Hosp.*, 57 AD3d 839, 842 (2nd Dept. 2008), citing *Mustello v Berg*, 44 AD3d 1018, 1019 (2nd Dept. 2007), *lv den.*, 10 NY3d 711 (2008); *Behar v Coren*, 21 AD3d 1045, 1047 (2nd Dept. 2005), *lv den.*, 6 NY3d 705 (2006); *LaMarque v North Shore Univ. Hosp.*, 227 AD2d 594, 594-595 (2nd Dept. 1996). The plaintiff's expert must address all of the key facts relied on by the defendant's expert. *See, Kaplan v Hamilton Medical Associates, P.C.*, 262 AD2d 609 (2nd Dept. 1999); *see also, Geffner v North Shore University Hosp., supra*; *Rebozo v Wilen*, 41 AD3d 457 (2nd Dept. 2007).

"To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." *Alicea v Liguori*, 54 AD3d 784, 785 (2nd Dept. 2008), quoting *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 (2nd Dept. 2005), citing *Sprain Brook Manor Nursing Home*, 253 AD2d 852 (2nd Dept. 1998), *lv den.*, 92 NY2d 818 (1999). The plaintiff's expert need not quantify " 'the extent to which the defendant's act or omission decreased the plaintiff's chance of better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury.' " *Alicea v Liguori, supra*, at p. 786, quoting *Flaherty v Fromberg*, 46 AD3d 743 (2nd Dept. 2007), citing *Barento v Winthrop University Hosp.*, 305 AD2d 623, 624 (2nd Dept. 2003); *Wong v Tang*, 2 AD3d 840, 841 (2nd Dept. 2003).

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting expert opinions . . . . Such credibility issues can only be resolved by a jury." *Feinberg v Feit*, 23 AD3d 517, 519 (2nd Dept. 2005), citing *Barbuto v Winthrop University Hosp., supra*; *Halkias v Otolaryngology-Facial Plastic Surgery Assoc.*, 282 AD2d 650 (2nd Dept. 2001); *see also, Roca v Perel*, 51 AD3d 757, 759 (2nd Dept. 2008); *Graham v Mitchell*, 37 AD3d 408 (2nd Dept. 2007).

"Although physicians owe a general duty of care to their patients, that duty may be limited to those medical functions undertaken by the physician and relied on by the patient." *Dockery v Sprecher,* 68 AD3d 1043 (2nd Dept. 2009), citing *Chulla v DiStefano*, 242 AD2d 657, 658 (2nd Dept. 1997), *lv dism.* 91 NY2d 921 (1998); *Markley v Albany Med. Ctr. Hosp.*,

163 AD2d 639 (3rd Dept. 1990); *see also, Wasserman v Staten Island Radiological Associates*, 2 AD3d 713 (2nd Dept. 2003).

While Dr. Snyder had previously delivered Mrs. Schwartz's two children, she originally saw Dr. Kagan for this pregnancy because of the proximity of her home to Dr. Kagan's office but when Mrs. Schwartz learned that she had hyperthyroidism, she returned to Dr. Snyder in New York City despite the distance. Dr. Snyder first saw Mrs. Schwartz for the subject pregnancy on December 16, 2003. At that time, Mrs. Schwartz was also being treated by an endocrinologist to whom Dr. Snyder had referred her, Dr. Loren Greene, for her hyperthyroidism. An ultrasound performed that day confirmed that Mrs. Schwartz was 14 weeks pregnant. Her blood pressure was 118/80 and her urine was free from protein and glucose. On December 31st, Dr. Timor interpreted an ultrasound at the antenatal testing unit which had been ordered by Dr. Snyder. He found it to be normal. On January 9, 2004, Dr. Roshan assisted Dr. Snyder in performing amniocentesis which revealed a normal male. A visit to Dr. Snyder on January 14, 2004 at 19 weeks gestation was also normal. On February 3rd, Dr. Monteagudo interpreted an ultrasound at the antenatal testing unit which had been ordered by Dr. Snyder and again found no abnormalities. The estimated fetal weight was in the 50th percentile. An office visit with Dr. Snyder on February 11th, at 23 weeks gestation was normal. Between February 17th and February 25th, Dr. Snyder treated Mrs. Schwartz for sinus congestion and noted that she had an Afrin addiction. On February 25th, Dr. Snyder's office prescribed hand splints for Mrs. Schwartz's wrists due to puffiness and discomfort in her fingers. Mrs. Schwartz's office visit with Dr. Snyder on March 8th at 27 weeks gestation was also routine. Her blood pressure was normal and her urine was negative for protein but

her hands were still swollen. On March 18th, Dr. Greene called Dr. Snyder to tell him that Mrs. Schwartz was very puffy and that blood tests and a 24-hour urine test were being conducted. The urine test turned out to be a routine screening but it was normal.

At her visit on March 26th, at 29 weeks gestation, Mrs. Schwartz's urine was negative for protein, but she was puffy and her blood pressure was mildly elevated, leading to the initial diagnosis of mild gestational hypertension. Dr. Snyder's exam revealed that the fundal height of the fetus was consistent with gestational age and the heart rate and movements were present. An ultrasound conducted by Dr. Rebarber at the Antepartum Testing Unit revealed a normal fetal development and Amniotic Fluid Index which, however, was in the lower end of normal, 8.29 cm. Dr. Snyder planned to monitor the fetal growth and to obtain a 24-hour urine test. At her examination-before-trial, Mrs. Schwartz testified that she had seen her primary care doctor, Dr. Carcaterra, the day before who called Dr. Snyder out of concern about her elevated blood pressure. However, Dr. Snyder's chart does not reflect that and Dr. Snyder testified that he did not know that Mrs. Schwartz had been treated by her primary care physician. Dr. Carcaterra's records reflect that she saw Mrs. Schwartz on March 25th and that she had mild pitting edema and an elevated blood pressure and that she had so notified Dr. Snyder.

Two days later on March 28th, Dr. Snyder admitted Mrs. Schwartz to the Medical Center because of her mildly elevated blood pressure and puffiness. While there, Mrs. Schwartz' condition was closely monitored. She was given IV fluids for hydration as well as steroids to promote the fetus' lung development. A Biophysical Profile was performed at the Antenatal Testing Unit and interpreted by Dr. Monteagudo to assess the fetal well being

on March 29th. When a Biophysical Profile is done, the fetus' heart rate, muscle tone, breathing and level of amniotic fluid are measured, and a nonstress test is usually done, too, but not required, netting four or five tested categories. Dr. Monteagudo concluded that the Amniotic Fluid Index was 7.7 cm. and Mrs. Schwartz's Biophysical Profile test score was 8/8, which is "normal." A non-stress test was not done. He recommended a follow-up in one week. Mrs. Schwartz was discharged on March 29th. Dr. Snyder testified at his examination-before-trial that Mrs. Schwartz was instructed to return if she felt decreased fetal movement or vaginal bleeding, increased cranial pressure, blurred vision, or epigastric pain because they were signs of pre-eclampsia. In fact, Dr. Snyder testified at his examination-before-trial that he discussed this with the Schwartzes numerous times. Dr. Snyder's plan was to closely monitor Mrs. Schwartz on an out-patient basis via Biophysical Profiles, frequent urine and blood testing and clinical evaluations. Early delivery was planned in the event of significant elevated blood pressure, urine protein over 5 grams, reports of visual disturbances, headaches, abdominal pain or HELLP syndrome.

A Biophysical Profile was performed on April 2nd at 30 weeks gestation at Mrs. Schwartz's request at the Antepartum Testing Unit by Dr. Rebarber. The results were normal including an Amniotic Fluid Index of 7.5 cm. Dr. Snyder saw Mrs. Schwartz at his office. Her 24 hour urine test from March 30th had minimal protein but Mrs. Schwartz's dip stick that day was negative. She remained mildly hypertensive. Dr. Snyder's exam revealed good fetal movement and activity.

On April 9th, Mrs. Schwartz went to the Antepartum Testing Unit complaining of decreased fetal movement. A Biophysical Profile was done there that day again by Dr.

Rebarber at 31 4/7 weeks gestation. It revealed that the Amniotic Fluid Index had decreased to below normal, to 4.7 cm. with 5 cm. allegedly being normal, and so Dr. Rebarber diagnosed Mrs. Schwartz with oligohydramnios, or low amniotic fluid. In addition, the nonstress test was nonreactive. The fetus therefore scored 6 out of 10 on its Biophysical Profile. After reviewing those findings with Dr. Rebarber and telling her that he was going to admit Mrs. Schwartz to the Medical Center, Dr. Snyder diagnosed Mrs. Schwartz with pre-eclampsia and readmitted her for observation and "fluid resuscitation" on account of oligohydramnios.

During her admission to the Medical Center, Mrs. Schwartz was hydrated. She denied headaches, visual changes, epigastric pain, nausea and vomiting. Mrs. Schwarz's blood pressure varied from normal to slightly elevated and her 24-hour urine test fell just short of the criteria for pre-eclampsia. Fetal heart rate monitoring revealed minimal to average variability. Mrs. Schwartz had edema of her face, hands, feet, ankles and thighs. The Amniotic Fluid Index on April 10th was 5.7 cm. and on April 11th it was 5.8 cm. A Biophysical Profile was done by Dr. Timor at the Antenatal Testing Unit on April 12th. Mrs. Schwartz's Amniotic Fluid Index was 9.6 cm. Because a nonstress test was not done, the Biophysical Profile score was 8 out of 8. Since her amniotic fluid level was restored to normal, her urine protein level decreased and the fetus scored 8 out of 8 on its Biophysical Profile, Mrs. Schwartz was discharged on April 12th.

A Biophysical Profile of the fetus was again performed at the Antenatal Testing Unit by Dr. Roshan on April 15th at 32 3/7 weeks gestation and for a nonreactive nonstress test, it was normal. While both Mrs. Schwartz's blood pressure and urine protein levels were

mildly elevated, it did not warrant a diagnosis of preeclampsia. Her Amniotic Fluid Index had dropped from 9.6 cm. to 6.8 cm. in just three days, but the fetus had changed position, reflecting adequate amniotic fluid levels. While Dr. Roshan noted this index to be mildly decreased (less than fifth percentile), it appears that Dr. Snyder may not have been so informed or advised of Mrs. Schwartz's blood pressure.

Mrs. Schwartz returned to the Antenatal Testing Unit four days later on April 19th and another Biophysical Profile was done by Dr. Timor which, again, but for a nonreactive nonstress test, was normal, netting a score of 8/8. While the Amniotic Fluid Index and urine were termed normal, the Amniotic Fluid Index was only 6.7 cm. reflecting adequate amniotic fluids, but again, less than the fifth percentile. However, the fetus had changed position again. Mrs. Schwartz's blood pressure remained mildly elevated. An accurate assessment via a nonstress test could not be done because of the fetus' position. That day, Dr. Snyder examined Mrs. Schwartz, too. Her urine was negative for protein and glucose. Dr. Snyder planned to continue to see Mrs. Schwartz twice a week for testing and to deliver the fetus at 35 or 36 weeks.

An ultrasound growth scan done at the antenatal testing unit on April 20th at 33 1/7 weeks gestation revealed a fetus of normal weight and a normal Amniotic Fluid Index of 6.3 cm. An umbilical artery doppler study that day was normal, too.

A Biophysical Profile done at the Antenatal Testing Unit on April 22nd at 33 3/7 weeks gestation revealed a nonreactive stress test with nonreactive accelerations and inadequate respirations. The Amniotic Fluid Index was 7.5 cm, again, although normal, less than the fifth percentile. The Biophysical Profile score was 6 out of 10. Mrs. Schwartz' hands were

swollen and she complained of decreased fetal movement. Mrs. Schwartz's blood pressure remained mildly elevated. When so advised by Dr. Roshan, of some but not all of these conditions, Dr. Snyder instructed Mrs. Schwartz to return for a follow up Biophysical Profile the next day. Dr. Snyder testified at his examination-before-trial that Dr. Roshan advised him that the baby could be monitored the next day and delivered if testing was still abnormal.

The Biophysical Profile performed by Dr. Roshan on April 23rd at the Antenatal Testing Unit revealed a healthy fetus but the nonstress test remained nonreactive, generating a score of 8 out of 10. The Amniotic Fluid Index was 7.7 cm. and Mrs. Schwartz's blood pressure decreased but she reported some vomiting.

A Biophysical Profile performed at the Antenatal Testing Unit on April 26th by Dr. Monteagudo at 33 weeks 6 days gestation was normal but for a continued nonreactive nonstress test with minimal variability, again generating a score of 8 out of 10. The 24-hour urine test collected on April 21st revealed a protein level which for the first time met the minimum level for mild pre-eclampsia. Even defendants' expert Dr. Sibai admits that Mrs. Schwartz could have been considered preeclampsic. Mrs. Schwartz's blood pressure had decreased, and she was not hypertensive and her Amniotic Fluid Index was stable at 7.3 cm, albeit once again in less than the fifth percentile. Dr. Snyder instructed Mrs. Schwartz to follow up on April 29th. There is no record of Mrs. Schwartz being weighed, her blood pressure being taken, being examined for edema or her urine checked that day.

On April 28th, Mrs. Schwartz suffered a headache at night but she did not notify her doctor or her husband. She took Tylenol and went to bed. When she woke up the next day, her headache had worsened and she was experiencing visual disturbances. Her husband

contacted Dr. Snyder and relayed these facts and was instructed to come immediately to the Medical Center in Manhattan for delivery of the baby. However, Mrs. Schwartz suffered a seizure en route to the hospital from her home on Long Island.

When her husband notified Dr. Snyder that Mrs. Schwartz was listless, he instructed them to go to the nearest hospital, Jamaica Hospital. Upon arrival there, Mrs. Schwartz was convulsing. The hospital records indicate that she was confused and combative. An emergency Cesarean section was performed. The infant plaintiff weighed 4 pounds and had an APGAR score of 7 at one minute and 8 at five minutes. He was given oxygen via face mask and responded favorably shortly thereafter. His cord blood gases were unacceptably low at birth but subsequent arterial blood gases came back normal approximately two hours later. The infant plaintiff was treated at the Neonatal Intensive Care Unit. A head ultrasound performed on May 5th was normal. He was discharged on May 7th.

In December of 2004, at approximately eight months old, the infant plaintiff was diagnosed with left hemparesis and other deficits. An MRI of his brain conducted on February 28, 2005 revealed an old infarction on the right internal capsule.

The defendants maintain that their acts and omissions comported with the prevailing medical standards and that assuming, *arguendo*, that they did not, they nevertheless did not proximately cause the infant plaintiff's injuries.

In support of their motion, Dr. Snyder and the Medical Center have submitted the expert affidavit of Dr. Sibai, who is Board Certified in Obstetrics and Gynecology with a subspecialty in Maternal and Fetal Medicine. Having reviewed the Bills of Particulars, the pertinent deposition transcripts and medical records, he opines to a reasonable degree of

medical certainty that (i) the Medical Center and Dr. Snyder's care and treatment of Mrs. Schwartz and the infant plaintiff were at all times in accordance with accepted standards of practice in 2004, (ii) nothing that they did or failed to do caused the infant plaintiff's injuries, (iii) Dr. Snyder properly managed Mrs. Schwartz's pregnancy. Dr. Sibai states that pre-eclampsia cannot be reliably predicted or therefore prevented. All that can be done is close monitoring of the mother and fetus, which, he declares, was adequate here. He notes that Dr. Snyder testified that he was not informed of Mrs. Schwartz's headache on April 28th.

He states that Mrs. Schwartz's eclamptic seizure could not have been foreseen or prevented and that it did not cause hypoxic brain damage to the infant. Dr. Sibai acknowledges that gestational hypertension can lead to preeclampsia, which is diagnosed when hypertension is coupled with a certain level of protein in the urine, or proteinuria. This can lead to eclampsia, which occurs when a woman with preeclampsia suffers seizures that cannot be attributed to other causes. Dr. Sibai further opines that (i) Mrs. Schwartz never exhibited any signs warranting medication or additional hospitalization, (ii) the standard of care for a woman in Mrs. Schwartz's position was serial fetal and maternal testing at least once a week which was done here, (iii) out-patient management of Mrs. Schwartz's gestational hypertension and mild preeclampsia was proper given Mrs. Schwartz's and the fetus' presentation throughout the pregnancy, (iv) hospitalization would not have prevented the seizure because it can occur even when a patient is closely supervised. As for the occasionally low Amniotic Fluid Indexes, he notes that Mrs. Schwartz was properly hydrated and states that a low Amniotic Fluid Index does not cause injury to a fetus. As for the nonreactive nonstress tests, Dr. Sibai opines that there are many reasons for those, i.e.,

inadequate oxygenation, fetal sleeping patterns and use of medications, which only indicates an in sufficient number of fetal heart rate accelerations during the observation period, only one element of the Biophysical Profile. Neither delivery nor hospitalization were indicated as the other criteria indicated that the fetus was healthy. With respect to Mrs. Schwartz's status on April 26th, Dr. Sibai opines that her mild preeclampsia did not warrant delivery or hospitalization: The baby was healthy and Mrs. Schwartz had only mildly elevated blood pressure, minimal protein in her urine, a stable Amniotic Fluid Index and consistent Biophysical Profile Scores. He notes that thereafter, she exhibited no other signs of preeclampsia, such as headaches, visual disturbances, persistent epigastric or right upper quadrant pain.

As for causation, Dr. Sibai submits that Mrs. Schwartz's seizure "did not result in any of the infant [plaintiff's] neurological deficits." He declares that his "research indicates that babies who are followed after the mother has experienced eclamptic seizures do not exhibit symptoms of suffering compromise as a result of the seizures." Furthermore, that "it is not generally accepted in the medical community that an intrapartum hypoxic event can cause hemiparesis and that only spastic quadriplegic and dyskinetic cerebral palsy have been linked to hypoxic events." He opines that an intrapartum hypoxic event is known to cause only spastic quadriplegic and dyskinetic cerebral palsy. Furthermore, he opines that it is generally not accepted in the medical community that cerebral palsy can result from an intrapartum hypoxic event in the absence of evidence of hypoxic ischemic encephalopathy, which pursuant to the four criteria set forth in the American College of Obstetrics and Gynecology's ("ACOG") guidelines, the infant plaintiff did not display.

Relying on the ACOG guidelines and The American Academy of Pediatrics, Neonatal Encephalopathy and Cerebral Palsy- Defining the Pathogenesis and Pathophysiology, Jan. 2003 ("January 2003 ACOG Guidelines"), all of the defendants maintain that the essential criteria which must exist for hypoxic-ischemic-encephalopathy–which must exist for hypoxia–were not met. They are:

> (1) evidence of metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery, specifically a pH of less than 7 and a base deficit greater than 12, and
>
> (2) the early onset of moderate-severe neonatal encephalopathy as characterized by abnormalities in cortical function (lethargy, stupor, coma with or without seizures) and brainstem function (pupillary and cranial nerve abnormalities), muscle tone and reflexes;
>
> (3) cerebral palsy of the spastic quadriplegic or dyskinetic type; and
>
> (4) exclusion of other identifiable etiologies such as trauma, coagulation disorders, infectious conditions or genetic disorders. See, January 2003 ACOG Guidelines, at 74; see also, Volpe, JJ, *Hypoxic-Ischemic Encephalopathy: Clinical Aspects.*

In addition, Dr. Sibai further opines that there are "suggestive" criteria that collectively suggest an intrapartum timing (not more than 48 hours before delivery) but are nonspecific to asphyxial results. These include Apgar scores between 0-3 beyond 5 minutes, the onset of multi-system involvement within 72 hours of birth, or an early imaging study showing evidence of an acute nonfocal cerebral abnormality. January 2003 ACOG Guidelines, supra; see also, Volpe, JJ, *Hypoxic-Ischemic Encephalopathy: Clinical Aspects.*

Dr. Sibai notes that the infant plaintiff did not meet this criteria. He had normal APGAR scores and his CO2 levels decreased immediately upon resuscitation. He notes that

his arterial blood gases were normal after two hours and that true metabolic acidosis is evident for at least four to six hours after delivery, so the infant plaintiff did not have it. And, he was not hypoxemic as there was not low oxygen in his blood. Dr. Sibai further opines that had the infant plaintiff suffered hypoxic-ischemic encephalopathy, his deficits would have been global and that intrapartum hypoxic events did not cause a stroke in the right internal capsule manifesting as deficits to one side of the body like the infant plaintiff suffered here. Dr. Sibai further opines that intrapartum hypoxic events did not cause left hemiparesis and that the old infarction found on the MRI on February 28, 2005 could alone be the etiology of the infant plaintiff's condition. Thus, it is his conclusion to a reasonable degree of medical certainty that this infant's neurological deficits are due to a spontaneous focal infarction or stroke of the posterior limb of the right internal capsule of the brain which was wholly unrelated to the eclamptic seizure experienced by Mrs. Schwartz.

The defendants Dr. Snyder and the Medical Center have also submitted the expert affirmation of Dr. Atluru, who is certified by the American Board of Pediatrics and the American Board of Psychiatry and Neurology with a specialty in Child Neurology. He affirms to having examined the infant plaintiff as well as the Bills of Particulars, and the infant plaintiff's medical records of Dr. Zipora Fefer and Dr. David Kaufman. He includes to a reasonable degree of medical certainty that the current condition of the infant plaintiff was not caused by birth asphyxia that occurred on the date of his delivery secondary to a maternal eclamptic seizure suffered by plaintiff mother shortly before his birth. He states that:

"[t]he lesion described on the infant plaintiff's brain MRI of

> February 28, 2005 accounts for the infant plaintiff's left hemiparesis found on examination." and that "[t]he infant's diagnosis of isolated left hemiparesis and the MRI finding of an old infarction of the posterior limb of the right internal capsule are not consistent with a diffuse cerebral insult." Like Dr. Sibai, he explains that "[i]t is not generally accepted in the medical community that an intrapartum hypoxic event can cause left hemiparesis, as seen in this infant. Indeed, the only types of cerebral palsy which have been linked to intrapartum hypoxic events are spastic quadriplegia and dyskinetic cerebral palsy, which this infant clearly does not have" and that "[t]here is no evidence that the infant plaintiff has global neurological deficits that are associated with an intrapartum hypoxic event. To the contrary, his clinical symptoms reflect left-sided hemiparesis, as plaintiffs' expert in pediatric neurology acknowledges, and his brain MRI shows a focal, unilateral small vessel abnormality."

In support of their motion, the Antenatal and Antepartum Testing Units and Drs. Roshan, Monteagudo and Timor have submitted the affidavit of Harold Edward Fox. He is Board Certified in Obstetrics and Gynecology and has a subspecialty in Maternal/Fetal Medicine. Having reviewed the pertinent medical records, the deposition transcripts, and the Bills of Particulars, he opines to a reasonable degree of medical certainty that "each and every diagnostic test performed on the plaintiff mother by the moving defendants was interpreted correctly and timely conveyed to plaintiffs' privately retained obstetrician, and thus comported with good and accepted medical practice" and that "based on [his] review of plaintiff's expert witness responses and bill of particulars, there are no allegations that the moving defendants *improperly* performed or interpreted said tests (as they were interpreted correctly)." He further opines to a reasonable degree of medical certainty that these defendants did not participate and were not responsible for the obstetrical aspects of Mrs. Schwartz's care. He opines that per their roles and testimony at their examination-before-

trial, their sole responsibility was to ensure that the diagnostic tests were properly performed, that the results were properly interpreted and that they were timely and accurately communicated to Dr. Snyder. He opines that these defendants were never asked to assist in the management of Mrs. Schwartz's care and that Dr. Snyder himself admitted at his examination-before-trial that ultimately the decision regarding Mrs. Schwartz's care was his alone. While discussions may have taken place between the antepartum and antenatal unit physicians and Dr. Snyder regarding Mrs. Schwartz's and the fetus' status and care, ultimately any decisions were Dr. Snyder's, as he testified at his examination-before-trial.

In addition, all of the defendants maintain that because the infant plaintiff did not suffer from hypoxic-ischemic encephalopathy, he could not have suffered an intrapartum hypoxic event, absent which the medical community opines that hemiparesis cannot result.

The Antenatal and Antepartum Testing Units as well as its physicians concur in Dr. Snyder and the Medical Center's position regarding a lack of causation or, in the alternative seek a *Frye/Parker* hearing on the admissibility of the evidence offered by plaintiffs' experts. *Frye v United States,* 239 F 1013 (DC Cir 1923); *Parker v Mobil Oil Corp.,* 7 NY3d 434 (2006).

The defendant Dr. Snyder was not an employee of the Medical Center. Therefore, the Medical Center cannot be held vicariously liable for his acts. *Christopherson v Queens-Long Island Med. Group*, 17 AD3d 393 (2nd Dept. 2008). While vicarious liability may be predicated upon employees' independent acts of negligence or where the attending doctor's orders were contraindicated by normal practice such that ordinary prudence required inquiry into their correctness (*Booth v Bloshinsky*, 39 AD3d 848 [2nd Dept. 2007]), the plaintiffs have

not alleged any independent acts by the Medical Center's employees or acts or omissions on Dr. Snyder's part for which the Medical Center could be held liable. Accordingly, the action against the Medical Center is dismissed.

Pursuant to New York Public Health Law § 2805-d, a cause of action for lack of informed consent is limited to cases involving non-emergency treatment, procedure or surgery or a diagnostic procedure involving an invasion or disruption of the patient's body. Thus, the "plaintiff must allege that the wrong complained of arose out of some affirmative violation of [his or her] physical integrity." *Iazzetta v Vicenzi*, 200 AD2d 209 (3rd Dept. 1994), *lv den.*, 85 NY2d 857 (1995); *see also, Flanagan v Catskill Regional Medical Center*, 65 AD3d 563, 566-567 (2nd Dept. 2009); *Smith v Fields*, 268 AD2d 579 (2nd Dept. 2000); *Campea v Mitra*, 267 AD2d 190, 191 (2nd Dept. 1999); *Schel v Roth*, 242 AD2d 697 (2nd Dept. 1997). As this is not the case here, the plaintiff's claim for lack of informed consent is dismissed.

With regard to the claim sounding in medical malpractice, the Court finds that all of the remaining defendants have established their entitlement to summary judgment, shifting the burden to the plaintiffs to establish the existence of a material issue of fact. They have established that they at all times acted in accord with good and accepted medical standards, and, in any event, that any acts or omissions on their part did not cause the infant plaintiff's injuries.

In opposition, the plaintiffs have submitted the affidavit of a doctor (name redacted) who is Board Certified in Obstetrics and Gynecology with a subspecialty in Maternal-Fetal

Medicine ("California expert"). [1] He attests to having reviewed all of the pertinent medical records, the pertinent deposition testimony as well as the Bills of Particulars. He opines to a reasonable degree of medical certainty with detailed specifics supported by the record that with the exception of the Medical Center, the moving defendants' care and treatment of Mrs. Schwartz and the infant plaintiff fetus did not comport with good and accepted obstetrical and maternal-fetal medicine standards and that their negligence was a substantial contributing cause of the infant plaintiff's brain damage and resulting injuries. This expert refers to Dr. Sibai's reference to the infarction as a cause wholly unrelated to the eclamptic seizure as "speculation" and avers that it is not consistent with standard deductive scientific reasoning.

The plaintiffs have also submitted the affirmation of another physician (name redacted) Board Certified in Pediatrics, Psychology and Neurology with a special qualification in Child Neurology ("New York expert"). He, too, attests to having reviewed the pertinent medical and legal records, and opines that the findings made upon examination by the Nassau County Department of Health Early Intervention Program regarding the infant plaintiff's condition at approximately eight months of age are "consistent only with a brain injury to a preterm infant who was chronically stressed and vulnerable who then experienced a serious superimposed hypoxic brain insult."

In addition, he agrees with Dr. Zipora Fefer who examined the infant plaintiff on February 7, 2005 that "there is no identifiable alternative explanation consistent with standard medical deductive reasoning." He opines to a reasonable degree of medical certainty

---

[1] As the plaintiffs have submitted two expert statements, the Court will refer to them by the State in which their statements were made.

that the infant plaintiff's brain injuries were "a result of the chronic and then superimposed stresses associated with preeclampsia experienced by Mrs. Schwartz on April 29, 2004." He explains that "brain insults produce a spectrum of brain injuries and disabilities including the brain injury seen on [the infant plaintiff's MRI]" and that "cerebral palsy is a descriptive term for a disability produced by a static brain injury." He disagrees with Dr. Atluru that the only forms of cerebral palsy linked to an intrapartum hypoxic event are spastic quadriplegia and dyskinetic cerebral palsy. He conclusively declares that "the only explanation that can be given for [the infant plaintiff's] neurological disability is the severe asphyxial event he suffered related to eclampsia when he was already vulnerable and compromised." He also disagrees with Dr. Sibai's assertion that cerebral palsy cannot result from an intrapartum event in the absence of hypoxic ischemic encephalopathy as well as the ACOG criteria which he alleges was created solely for litigation purposes. He opines that infant plaintiff's brain injury was not the result of a spontaneous focal infarction or stroke but rather of the hypoxic stress.

Upon a review of the experts' statements and the record as a whole, the Court finds that the plaintiffs have established an issue of fact regarding a departure from good and accepted medical practice regarding the medical care afforded Mrs. Schwartz and the fetus by all of the defendants (except for the Medical Center). Among other things, the California expert states upon reference to the record that Mrs. Schwartz, at the end of a high-risk pregnancy, was seen an insufficient number of times by Dr. Snyder. He also notes that given the presence of pre-eclampsia, not hospitalizing her sooner for monitoring purposes was a departure given the uncertain and dangerous nature of that condition. He also indicates that

an earlier delivery was not but should have been considered, as the fetus was sufficiently developed to permit it, and delivery was the only way to end the possibility of an adverse result stemming from eclampsia.

However, the conclusions of plaintiffs' experts regarding the nexus between the malpractice and the injury are insufficient to stave off this motion. They are not based on an acknowledged, accepted and proven cause and effect relationship between the events surrounding the birth and the left hemiparesis and developmental deficits that were diagnosed months later. Rather, they are based on an association of the stresses described and brain injury generally. As noted by the Appellate Division, an association is not the same as causation. *Fraser v 301-52 Townhouse Corp.,* 57 AD3d 416, 417 (1st Dept. 2008). In the present case, there is no published medical literature referred to by the experts, or studies in which they were involved, or even a recitation of a specific, factually similar case handled by the experts in which events such as the case at bar (the eclampsia and seizure) were stated to be the cause of the specific injuries at issue here. This renders the affidavits conclusory in nature regarding proximate cause, and thus insufficient. *See, Arkin v Resnick,* 68 AD3d 692 (2nd Dept. 2009); *DiMitri v Monsouri,* 302 AD2d 420 (2nd Dept. 2003). In addition, plaintiffs' experts have not opined that their causation theory is generally accepted in the medical community.

Further, the conclusion that "the only explanation" for the injuries alleged "is the severe asphyxial event he suffered related to eclampsia" does not come with a sound factual recitation as to why the defendants' contention – that the infarction found on the MRI could alone be the cause of the infant plaintiff's condition – was wrong. The statement of the

California expert that this explanation was speculative, and "appears fanciful and inconsistent with medical deductive reasoning" is not equivalent to demonstrating by reference to the record how such an infarction could not be to blame. The Court therefore finds that this explanation by defendants as the cause of the infant's condition is effectively unrebutted. *Kaplan v Hamilton Medical Associates, P.C.*, 262 AD2d 609, *supra; Geffner v North Shore University Hosp.*, 57 AD3d 839, *supra*; *Rebozo v Wilen,* 41 AD3d 457, *supra.*

Although the plaintiffs' attorney's affirmation recites authority which calls into question both the medical community's acceptance of the defendants' theory that there was no causation here and supports the plaintiffs' experts' theory, that does not suffice to establish grounds for accepting the plaintiffs' experts' opinions as reliable and generally accepted in the medical community, nor to discount the defendants', as plaintiffs' counsel is not qualified to render medical opinions. *See, Hudson v Krukencamp*, 5 Misc3d 1029(A) (Supreme Court Suffolk County 2004), citing *Armstrong v Wolfe*, 133 AD2d 957 (3rd Dept. 1987). It also is worth noting that while Dr. Fefer, who examined the infant plaintiff on February 2, 2005, may have suspected that the infant plaintiff's left hemiparetic cerebral palsy was related to the mother's eclamptic seizure, that does not establish the reliability of the plaintiffs' experts' conclusion. *See, Fraser v 301-52 Townhouse Corp.*, 57 AD3d 416, *supra*. This is especially so in view of the fact that the "suspected" diagnosis was made before the MRI on February 28, 2005, which revealed the infarction.

Accordingly, the Court concludes that the plaintiffs have not successfully demonstrated the existence of a material issue of fact with respect to causation, a necessary element of medical malpractice, and the complaint is therefore dismissed in its entirety. In

view of this determination, the Court does not reach the alternative relief sought, the defendants' request for a *Frye/Parker* hearing.

This shall constitute the Decision and Order of this Court.

ENTER

DATED: May 28, 2010

HON. DANIEL PALMIERI
Acting Supreme Court Justice

TO: Pegalis & Erickson, LLC
Attorneys for Plaintiffs
1 Hollow Lane
Lake Success, NY 11042

Heidell, Pittoni, Murphy & Bach, LLP
By: Charles L. Bach, Jr., Esq.
Attorneys for Defendants
Jon Robert Snyder, M.D., Jon Robert Snyder, M.D., P.C.
and NYU Hospitals Center
99 Park Avenue
New York, NY 10016

Jay A. Rappaport, Esq.
Aaronson Rappaport Feinstein & Deutsch, LLP
Attorneys for Defendants
New York University School of Medicine, Department of Obstetrics
and Gynecology, Maternal Fetal Medicine Associates,
Daniel Roshan, M.D., Anna Monteagudo, M.D. and Ilan Timor, M.D.
757 Third Avenue
New York, NY 10017