Barrocales v The N.Y. Methodist Hosp.
2012 NY Slip Op 33735(U)
August 20, 2012
Supreme Court, Kings County
Docket Number: 6320/04
Judge: Marsha L. Steinhardt
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At an IAS Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, located at Civic Center, Borough of Brooklyn, City and State of New York, on the 20th day of August 2012

PRESENT:

HON. MARSHA L. STEINHARDT

JUSTIN BARROCALES and DIOR BARROCALES, Infants by their Mother and Natural Guardian SHAWNETTE WIGGIN, and SHAWNETTE WIGGAN, Individually

Plaintiffs,

- against -

THE NEW YORK METHODIST HOSPITAL, IFEANYI OBIAKOR, M.D., IFEANYI OBIAKOR, M.D., P.C., MADHU B. GUDAVALLI, M.D., BARBARA GORDON, M.D., MADELEINE LAMARQUE, M.D., and SUMANA MYNENI, M.D.

Defendants

Index No. 6320/04

The following papers numbered 1 to 5 read on this motion

	Papers Numbered
Notice of Motion-, Amended Notice, Order to Show Cause and Affidavits (Affirmations) Annexed	1, 2
Answering Affidavit (Affirmation)	3
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Defendant IFEANYI OBIAKOR, M.D. moves pursuant to CPLR §3212 for an Order granting summary judgment in his favor. Defendants THE NEW YORK METHODIST

HOSPITAL (NYMH), MADHU B. GUADAVALLI, M.D. and SUMANA MYNENI, M.D. move pursuant to CPLR §3212 for an Order granting summary judgment in their favor. Plaintiff submits opposition to the motions. The action against MADELEINE LAMARQUE, M.D. was discontinued rendering her motion for summary judgment moot. Defendant BARBARA GORDON, M.D. does not move or take a position as to the motions of the other defendants.

NOW, upon the foregoing and oral argument on June 7, 2012 and due deliberation had thereon, the motion of Defendant IFEANYI OBIAKOR, M.D. is GRANTED in its entirety and the action is dismissed as against him; the motion of THE NEW YORK METHODIST HOSPITAL, MADHU B. GUADAVALLI, M.D. and SUMANA MYNENI, M.D. is GRANTED only to the extent of dismissing the claims against NYMH regarding the admission of May 1 to 7, 2001 and all claims for lack of Informed Consent as against the moving defendants.

This is an action sounding in medical malpractice against defendants for the care and treatment plaintiff Shawnette Wiggan received during admissions to NYMH from May 1 to May 7, 2001 and from May 9 to May 19, 2001. The first admission was for treatment of preterm labor at 22 weeks gestation and the second admission involved treatment following premature rupture of membranes, on May 9th, through the delivery of twins at 24 weeks gestation on May 19, 2001. Plaintiff's central claim against the movants is that they failed to prevent the preterm delivery of the infants. It is also claimed that the neonatal care and treatment rendered to the newborns at NYMH deviated from the standard of care and caused injury to the infants.

Plaintiff sought the care of Drs. Obiakor and Gordon at Obiakor OB/GYN P.C. in April 2001 when she was approximately 18 to 19 weeks pregnant. Her prior OB/GYN determined that her estimated date of confinement was September 10, 2001 and established that she was carrying

twins. During her first visits to the Obiakor OB/GYN office, Ms. Wiggan's pregnancy was established to be high risk. During a pre-natal visit on May 1st, Dr. Obiakor sent Ms. Wiggan to NYMH to rule out pre-term labor and spontaneous rupture of membranes. Ms. Wiggan was admitted to the Obstetrical Department of NYMH as the private patient of Drs. Obiakor and Gordon. A physical examination revealed that she was 3-4 cm dilated with bulging membranes and that she was experiencing pre-term labor. During that admission, Dr. Obiakor saw Ms. Wiggan everyday until May 5, 2001. Ms. Wiggan was administered magnesium sulphate therapy for pre-term labor and antibiotic Clindamycin prophylactically. When Dr. Obiakor last treated Ms. Wiggan on May 5th, she was afebrile with stable vital signs and, on examination, her abdomen was non-tender and she reported good fetal movement. Her vaginal cultures were negative. At that time, Ms. Wiggan refused antibiotics and Clindamycin was discontinued. Dr. Obiakor did not evaluate the patient when Dr. Gordon discharged her on May 7, 2001. At the time of her discharge, Dr. Gordon noted the patient to be stable, afebrile, not leaking any fluids and was no longer experiencing pre-term labor.

On May 9, 2001, the patient was re-admitted to NYMH with spontaneous rupture of membranes and contractions. Physical examination confirmed the premature rupture of membranes; the pregnancy was 22 weeks. The plan was to continue conservative management of the pregnancy which included observing and treating the symptoms as warranted. Dr. Obiakor ordered bed-rest and IV fluids. Clindamycin was continued until the time of her delivery on May 19th. The patient's white blood count was normal from May 11th through May 17th. All cultures were negative for infection. During this admission, Dr. Obiakor saw the patient on May 10 and 11th and again May 17 and 18th. Dr. Obiakor did not see the patient after May 18, 2001. During

this time, she denied contractions.

On May 18th, Ms. Wiggan complained of backache and contractions but was afebrile with stable vital signs. On May 19th, the patient went into labor complaining of contractions every 8 minutes. At approximately 3:20 p.m. a vaginal examination revealed a cord prolapse. The hospital chart documents that the cord prolapse was discussed with Dr. Gordon. The record notes that at 7:00 p.m. Dr Gordon was at Ms. Wiggan's bedside. The contractions were 4 minutes apart. Dr. Gordon delivered Twin A (Justin) in a breech position at 7:42 p.m. He weighed 590 grams with Apgar scores of 1,2 and 3. At 7:47 p.m. Twin B (Dior) was delivered weighing 640 grams with Apgar scores of 4,5 and 6. The infants were admitted to NICU for prematurity, respiratory distress syndrome, rule out sepsis and very low birth weight. They were placed on mechanical ventilation and treated with antibiotics and two doses of Surfactant. Justin was diagnosed with a grade III to IV intraventricular hemorrhage and subsequent development of periventricular leukomalacia. Dior was diagnosed with a grade I intraventricular hemorrhage. Both infants were also diagnosed with retinopathy of prematurity and have developmental delays and significant visual impairment. Justin has since been diagnosed with cerebral palsy.

As against Dr. Obiakor, plaintiff claims that he failed to order the proper antibiotics during the admission of May 1st and that he improperly discharged her on May 7th. She claims that Dr. Obiakor departed from the standard of care in failing to prevent the preterm labor and delivery of the twins on May 19, 2001. In support of Dr. Obiakor's motion is submitted the affirmation of Barry Kramer, M.D., a physician specializing in obstetrics and gynecology. Dr. Kramer opines that on May 1st the patient was appropriately started on Magnesium Sulphate, a tocolytic to stop contractions. Once the contractions ceased by May 3, 2001, tocolytics were no

longer warranted and discontinued. He opines that although her cervical/genital cultures were negative for infection, the patient was appropriately started on Clindamycin prophylactically. Notably, Dr. Kramer opines that a claim that Dr. Obiakor failed to order broad-coverage antibiotics allowing chorioamnionitis to develop and resulting in preterm labor is contradicted by the pathology finding that chorioamnionitis was acute. He states that " acute" means that the infection occurred within a few hours or days of the delivery and not 12 days prior to delivery as would be necessary to substantiate this claim.

As to the admission of May 9, 2001, Dr. Kramer states that the patient was appropriately started on Clindamycin as a prophylaxis for infection due to the fact that she now had ruptured membranes. Tocolytics were not given as they are contraindicated where the patient has ruptured membranes because there is a significant risk of infection. Clindamycin was appropriately continued until the time of her delivery on May 19, 2001. Dr. Kramer states that the patient remained afebrile and without tenderness to the uterus during the admission which confirms that signs and symptoms of chorioamnionitis were absent. He opines that there were no clinical manifestations of acute chorioamnionitis and therefor no reason for Dr. Obiakor to have suspected it. Dr. Kaplan opines that there was no way to prevent the premature delivery in this case. The mother's history of 8 pregnancies, with 2 live children and 5 abortions along with the twin gestation put her at risk for cervical incompetency which Dr. Kaplan opines, to a reasonable degree of medical certainty, triggered her pre-term labor.

Dr. Kramer opines that the claim that Dr. Obiakor failed to obtain the patient's informed consent is baseless. The record notes that Dr. Obiakor discussed the prognosis with the patient and her husband including the risks, benefits, results and alternatives. Dr. Kramer states that Dr.

Obiakor appropriately discussed with the patient that, given the extreme prematurity of the twin babies, their prognoses included severe neurological and motor dysfunction, mental retardation and other problems.

Plaintiff submits the affirmation of Bruce L Halbridge, M.D., a physician board certified in Obstetrics and Gynecology. Dr. Halbridge states that the records do not explain why gentamicin or another amino glycoside was not considered for suppression of gram negative organisms during the May 1st admission. He adds, however, that the other measures ordered by Dr. Obiakor during this admission were appropriate. Furthermore, despite maintaining that clindamycin alone was not sufficient, Dr. Halbridge states that the conservative treatment successfully prevented the onset of pre term labor during the admission of May 1 to May 7th. Dr. Halbridge opines that it was a departure to discharge the patient on May 7th because she could not be observed as carefully at home as in the hospital, her hips could not be elevated to the Trendelenburg position and she would not be able to use a bed pan and refrain from showering at home. However, Dr. Halbridge states that it is unclear whether Dr. Obiakor personally participated in the decision to discharge the patient home on May 7, 2001. He also states that "it is impossible to state with mathematical certainty that the patient being at home caused the premature, preterm rupture of membranes on May 9, 2001 and that had she remained in the hospital on close observation her membranes would not have ruptured." Despite this concession, Dr. Halbridge contradicts himself stating that the decision to discharge on May 7th substantially contributed to the rupture of membranes two days later.

In his discussion of the 2nd admission, Dr. Halbridge states that it was a departure for Dr. Obiakor to have failed to order broad spectrum antibiotics to this patient presenting with ruptured

membranes on May 9th. He opines that broad scale antibiotics more likely than not would have delayed the development of chorioamnionitis for more than 10 days. Despite this opinion, Dr. Halbridge concedes that although the pathology report confirms the presence of acute amnionitis, there were no clinical signs of infection.

Plaintiff's claims against NYMH are that the hospital participated in the decision to discharge the patient on May 7th and that the discharge was a departure from the standard of care. She also argues that the decision to discharge her was made in conjunction with a perinatalogist on staff at NYMH.

In support of its motion, NYMH submits the affirmation of Boris Petrikovsky, M.D. a physician board certified in Obstetrics and Gynecology and Maternal and Fetal Medicine. Notably, he opines that the hospital did not improperly discharge the patient on May 7, 2001 and that the decision to discharge the patient was made by the private physician, Dr. Gordon. The hospital records indicate that at the time of her discharge the patient was evaluated by Dr. Gordon who noted that she was stable, afebrile, not leaking fluids and not experiencing pre-term labor. The patient was not exhibiting any signs of ruptured membranes at this time. He states that there is no standard of care which requires a pregnant patient to remain hospitalized solely for purposes of bed rest. He opines that Dr. Gordon's decision to discharge the patient was not so clearly contraindicated as to require the hospital staff to intervene and prevent the discharge. Dr. Petrikovsky further opines that the discharge of the patient on May 7, 2001 did not contribute to any of the alleged injuries of the infant plaintiffs.

With regards to the second admission, plaintiff claims that NYMH failed to properly respond to the obstetrical emergency caused by the prolapse of one of the fetus' umbilical cord

on May 19, 2001. She claims that the hospital should have ordered a C-section despite the private obstetricians's plan to proceed with a vaginal delivery. She argues that the hospital's duty of care required its staff to push the prolapsed cord into the uterus from the time the prolapse was detected until such time as a C-section would be performed.

In support of NYMH's care and treatment of the patient leading up to and during her labor and delivery, Dr. Petrikovsky states that conservative management was effective in delaying the birth until May 19th when at 6:30 a.m. the patient had contractions every 8 minutes. The cord prolapse was properly managed during the labor and delivery and, in his opinion, did not require a C-section. While plaintiff claims that cord compression may have occurred causing a decrease of oxygen to the fetuses, Dr. Petrikovsky opines that there is no indication of in utero hypoxia. He adds that the were no signs of fetal distress such as significant decelerations on the fetal strips. There was no indication that cord compression resulted in oxygen deprivation to the fetuses. In utero hypoxia would have been seen as severe bradycardia on the fetal monitoring strips. Bradycardia was not present on the strips. He states that there is no established standard of care for dealing with a cord prolapse in preterm fetuses at 23 weeks gestation. He opines that the standard to perform a C section in circumstances of a cord prolapse applies when a fetus is full term. He adds that the standard to deliver via C section also applies to breech presentation of a full term fetus; this is not the standard for a breech preterm pregnancy. Dr. Petrikovsky states that the patient continued under the care of her private physicians and opines that during the care and treatment of the patient there was never any order or directive issued by the private physicians that was so clearly contraindicated as to warrant intervention by the NYMH staff.

Plaintiff's expert, Dr. Halbridge, submits opinions as to the claim that NYMH breached

its duty of care by discharging plaintiff on May 7, 2001. He claims that the discharge was approved by the perinatalogist on staff at NYMH. He also states that the hospital failed to provide plaintiff with a home attendant. However, as previously discussed, he cannot state with medical certainty that the plaintiff's home stay caused her premature rupture of membranes.

Plaintiff's expert opines that NYMH deviated from the standard of care when its staff failed to deliver the twins by C-section in light of the prolapsed cord. He also opines that when a cord prolapse is observed care must be taken so that the fetus does not press against the cord. This is accomplished by pushing the presenting part of the cord against the uterus; the C-section is to be performed while this is done. Dr. Halbridge opines that the failure to perform a C-section in the manner stated was a departure from the standard of practice. Furthermore, he opines that as Justin's presentation was breech, the cord was unavoidably compressed as the infant passed through the canal. Thus, Dr. Halbridge states that regarding Twin A's breech presentation the standard of practice dictates that a C-section be performed. The failure to do so was a departure from the standard of care. Dr. Halbridge opines that the prolonged cord prolapse contributed to Justin's significant neonatal depression which is a sign of hypoxic ischemic encephalopathy. Dr. Halbridge deferred to plaintiff's neonatologist's opinion as to whether Justin's breech vaginal delivery caused the intraventricular hemorrhage. Dr. Halbridge also deferred to the neonatologist to opine whether Twin B's intraventricular hemorrhage was caused by the failure to deliver by C-section. In this regard, the plaintiff's expert neonatalogist, Dr. Danoff, states that he concurs with Dr. Halbridge's opinion that the infants' prematurity was a substantial contributing cause of respiratory distress, IVH and PVL in both infants. Further, Dr. Danoff opines that the vaginal delivery associated with compression of the head during the

passage of the birth canal was also a substantial cause of injury to each infant, although to a lesser extent than their extremely low birth weight. Dr. Danoff adds that the prolonged period of Justin's umbilical cord prolapse substantially contributed to hypoxic-ischemic brain injury which was reflected by Justin's profoundly depressed state at birth and critically low Apgar score during 10 minutes of neonatal resuscitation.

Plaintiff also asserts claims against the hospital for the care and treatment rendered by Dr. Guadavalli, the neonatology attending who cared for the newborns in the NICU, and Dr.Myneni, a second year resident rotating through the neonatology department. As to Dr. Guadavalli and Dr.Myneni, she claims that these defendants departed from the standard of care by failing to diagnose and treat a right pneumothorax in Justin; by delaying administering Survanta to both infants; by failing to diagnose and treat hypoglycemia in Justin; by failing to maintain a normal body temperature in Dior.

The affirmation of Ronald Bainbridge, M.D. a physician board certified in Pediatrics and Neonatal-Perinatal Medicine is submitted in support of NYMH and Drs. Guadavalli and Myneni. Dr. Bainbridge opines that the care rendered by these defendants comported with the then existing standard of care and that the infants' poor neurologic outcome including motor, cognitive visual difficulties as well as Justin's cerebral palsy are related to extreme prematurity. Dr. Bainbridge opines that the pneumothorax is a known complication of the treatments to resuscitate and intubate the infant and that it was promptly recognized and treated. He opines that the pneumothorax was not massive and as such unlikely to be life threatening in nature. He states that it resolved with appropriate treatment.

Dr. Bainbridge opines that it cannot be stated with any degree of medical certainty that

the IVH (intraventricular hemorrhage)and PVL (periventricular leukomalacia) in Justin was caused by the pneumothorax and or hypoglycemia. PVL as well as IVH can be caused by a variety of factors including as occurred in this case, prematurity and the need for resuscitation at birth. PVL can also be due to ischemic events occurring in utero well prior to delivery. Dr. Bainbridge states that for these reasons it is difficult to determine individual causes of PVL and IVH in severely premature low birth-weight infants such as Justin.

Dr. Bainbridge opines that there is no merit to the claim that hypoglycemia was not recognized and treated. Furthermore, there is no scientific data to support the claim that hypoglycemia increases the harmful effects of hypoxia in premature infants. Dr Bainbridge also opines that the claim that Survanta was not timely administered is without merit. Survanta given within a few hours of birth has the same benefits as when it is given on an earlier basis and is not needed immediately. He states further that Survanta is kept chilled and is allowed to warm at room temperature before being administered. Additionally, Dr. Bainbridge opines that the claim that NYMH, Dr Guadavalli and Dr. Myneni departed from the standard of care by failing to maintain Dior's body temperature is without merit as body and brain cooling can minimize brain damage. Furthermore, a body temperature of 92.7 does not cause brain damage in premature infants.

Plaintiff submits the affirmation of Stuart Danoff, M.D., a physician board certified in Pediatrics. Dr. Danoff opines that Dr. Guadavalli and the hospital staff deviated from the standard of care in the care and treatment of Justin in the delayed diagnosis and treatment of Justin's right pneumothorax. He states that the standard of care is to immediately confirm the proper placement of the ET tube by obtaining a chest x-ray. The treatment for pneumothorax is

immediate thoracentesis and chest tube placement to evacuate the free air to relieve compression of the lung and allow it to reinflate. Dr. Danoff states that while Justin was delivered at 7:42 p.m., the first chest x-ray which indicated a right pneumothorax wasn't taken until 9:25 p.m. A second film taken at 10:25 p.m. still showed a right pneumothorax. Dr. Danoff points out that nurse's records indicate that Dr. Guadavalli, assisted by Dr. Myeni, placed a chest tube at 12:00 a.m. Dr. Danoff notes that the record indicates that the chest tube slipped out of place sometime after its placement. X-rays taken at 1:59 a.m. on May 20th showed that the right pneumothorax persisted. Deposition testimony of Dr. Guadavalli indicates that it was not certain whether this was a reaccumulation or a persistent pneumothorax. Dr. Danoff notes that the pneumothorax appeared to have resolved on x-rays taken at 3:54 a.m. In support of plaintiff's claim that Justin sustained respiratory distress while in NICU, Dr. Danoff notes that the first sample for blood gas analysis drawn at 10:00 p.m. indicated that Justin's pH at 7.01 was critically acidemic and pCO2 at 74 indicated severe hypoxia. Thus, Dr. Danoff opines that the delay in treating the pneumothorax was a departure substantially contributing to Justin's respiratory distress, systemic hypoxia, Grade 3-4 IVH, PVL and subsequent brain damage.

Dr. Danoff opines that these defendants departed from the standard of care in the delayed diagnosis and treatment of Justin's hypoglycemia. He notes that at 8:20 p.m. Justin's blood glucose was low by Dextrostrip testing, requiring immediate laboratory analysis of plasma. At 9:00 p.m. the blood glucose was still low. IV dextrose was not given until 10:00 p.m. Dr. Danoff opines that this departure further contributed to hypoxic brain injury.

Additionally, Dr. Danoff opines that the hospital delayed in administering Survanta to both twins as soon as the ET tube was placed. The standard of care was to administer Survanta as

soon as the ET tube is in place which in this case would have been in the delivery room. The records note that Survanta was first given at 9:30 p.m. In Dr. Danoff's opinion the delay in administering Survanta was a substantial factor in causing respiratory distress in both twins.

As to Dior,"Twin B," plaintiff clams that his body was not appropriately warmed upon delivery. Defendants' expert Dr. Bainbridge opines that this allegation is without merit as body and brain cooling can minimize brain damage in premature infants. Furthermore, he opines that a body temperature of 92.7 simply does not cause brain damage in premature infants. Plaintiff's expert, Dr. Danoff opines that Dior's body temperature suggests that the delivery room was not heated above the ordinary room temperature in anticipation of the infant's delivery. He states that "(t)his failure to maintain a normal body temperature in the extremely premature neonate significantly contributes to hypoxic tissue damage by increasing the metabolic rate and consuming much needed oxygen for internal heat production."

On a cause of action sounding in medical malpractice, "the requisite elements of proof in a medical malpractice action are a deviation or departure from accepted community standards of practice and evidence that such departure was a proximate cause of injury or damage." Flanagan v. Catskill Regional Medical Center, 65 A.D.3d 563 (2d Dept. 2009) citing, Geffner v. North Shore Univ. Hosp., 57 A.D.3d 839, 842 (2d Dept. 2008); see Deadwyler v. North Shore Univ. Hosp. at Plainview, 55 A.D.3d 780, 781 (2d Dept. 2008). "On a motion for summary judgment, a defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby. In opposition, the plaintiff must submit a physician's affidavit attesting to the defendant's departure from accepted practice, which departure was a competent producing cause of the injury. General allegations that are

conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat summary judgment." Rebozo v. Wilen, 41 A.D.3d 457, 458 (2d Dept. 2007); Flanagan v. Catskill Regional Medical Center, 65 A.D.3d 563 (2d Dept. 2009); see Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324-325 (1986); Sheenan-Conrades v. Winifred Masterson Burke Rehabilitation Hosp., 51 A.D.3d 769, 770 (2d Dept. 2008); Thompson v. Orner, 36 A.D.3d 791, 792 (2d Dept. 2007); DiMitri v. Monsouri, 302 A.D.2d 420, 421 (2d Dept. 2003). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. Stukas v. Streiter, 83 A.D.3d 18 (2d Dept. 2011). "Summary 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." Feinberg v. Feit, 23 A.D.3d 517, 519 (2d Dept 2005)[internal citations omitted]; Colao v. St. Vincent's Med. Ctr., 65 A.D.3d 660, 661 (2d Dept. 2009); Deutsch v. Chaglassian, 71 A.D.3d 718 (2d Dept. 2010).

In this case, plaintiff has not offered any opposition to Dr. Obiakor's prima facie entitlement to summary judgment on a number of claims. Dr. Obiakor established that he did not participate or was involved in the labor and delivery and in the neonatal care claimed herein. These claims must be dismissed as matter of law as plaintiff has not submitted any opposition to this prima facie showing. Furthermore, Dr. Obiakor establish his entitlement to summary judgment on the following claims, which also have not been opposed by plaintiff's expert: all allegations that Dr. Obiakor failed to perform appropriate pre-natal ultrasounds; all allegations that Dr. Obiakor failed to perform a cerclage; all allegations that Dr. Obiakor failed to order a perinatology consult; all allegations that Dr. Obiakor failed to order and/or administer steroids;

all allegations that Dr. Obiakor failed to provide informed consent regarding conservative management; allegation that Dr. Obiakor failed to administer tocolytics. These claims must be dismissed as a matter of law.

The remaining claims must also be dismissed as plaintiff's expert submissions are insufficient to rebut Dr. Obiakor's prima facie entitlement to summary judgment. Plaintiff's expert's opinions as to the claims against Dr. Obiakor are speculative and conclusory. The opinions are general and not based on the record. Many opinions are contradictory, negating other assertions contained therein. Notably, the opinions of her expert fail to establish how the claims against Dr. Obiakor proximately caused the premature rupture of membranes on May 9, 2001, the pre-term delivery on May 19, 2001 and the other injuries claimed. A conclusory expert affidavit, devoid of evidentiary foundation is insufficient to defeat summary judgment. Di Sanza v. City of New York, 11 N.Y.3d 766 (2008). Accordingly summary judgment is also granted in favor of Dr. Obiakor and the action against him is dismissed in its entirety.

NYMH established that the decision to discharge the patient on May 7, 2001 was made by her private physician, Dr. Gordon. A hospital may not be held vicariously liable for the malpractice of a private attending physician who is not its employee. Dragotta v. Southampton Hosp., 39 A.D.3d 697 (2d Dept. 2007). The claim that NYMH is responsible for patient's discharge because Dr. Gordon's decision was made in conjunction with the perinatalogist is of no avail as the responsibility for the care and treatment of the patient was ultimately Dr. Gordon's. Further, Dr. Halbridge's opinion that the hospital staff participated in the decision to discharge is without merit and unsubstantiated by the record.

It is well established that hospitals are shielded from liability when its employees follow

the orders of a private attending physician unless the latter's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into their correctness. Sela v. Katz, 78 A.D.3d 681 (2d Dept. 2010); Filippone v. St. Vincent's Hosp. & Med. Ctr. of N.Y., 253 A.D.2d 616, 618 (1st Dept. 1998). Here, the decision to discharge the patient was not so contrary to the standard of care as to require NYMH to intervene.

Moreover, plaintiff does not rebut NYMH's prima facie showing of entitlement to summary judgment for the care and treatment rendered by its staff during the first admission as her expert does not establish that there were any departures from the standard of care. Indeed, Dr. Halbridge states that the onset of preterm labor was successfully treated during the admission. Notably, the expert does not state with medical certainty that the alleged departures proximately caused the patient's premature rupture of membranes, pre-term labor, any infection or any of the claimed injuries. Accordingly, the claims against NYMH as to the admission of May 1-7, 2001 are dismissed. See generally, Di Sanza v. City of New York, 11 N.Y.3d 766 (2008).

Plaintiff, however, raised issues of fact as to the treatment rendered by NYMH by its staff during the labor and delivery of Ms. Wiggan. Her expert affidavit offers opinions regarding the care and treatment rendered during the patient's labor and delivery on May 19, 2001 which conflicts with NYMH's expert's opinions, thereby precludes summary judgement. Salient to this issue, the experts' opinions differ on the standard for managing a cord prolapse. "Summary 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." Feinberg v. Feit, 23 A.D.3d 517, 519 (2d Dept 2005)[internal citations omitted]; Colao v. St. Vincent's Med. Ctr., 65 A.D.3d 660, 661 (2d Dept. 2009); Deutsch v. Chaglassian, 71 A.D.3d 718 (2d Dept. 2010);

Barnett v Fashakin, 85 A.D. 3d 832, 835 (2d Dept. 2011). Therefor, NYMH's motion for summary judgment regarding the care rendered by its staff during Ms. Wiggans labor and delivery is denied.

Plaintiff also raised issues of fact as to the neonatal care and treatment rendered by NYMH, Dr. Guadavalli and Dr. Myneni of Twin A (Justin) precluding summary judgment. Plaintiff's expert's opinion that the NYMH staff departed from accepted practice by failing to promptly diagnose Justin's right pneumothorax and by failing to promptly treat it with a chest tube conflicts with NYMH's expert's opinion. While it is noted that Dr. Danoff opines that the infants' prematurity was a substantial contributing cause of respiratory distress, IVH and subsequent PVL in both infants, it is also Dr. Danoff's opinion that the departures as to the care and treatment of the pneumothorax by the neonatal movants substantially contributed to Justin's IVH, PVL and cognitive and motor deficits. The opposing expert affidavits regarding Justin's neonatal care are well developed and based on the record, nevertheless are conflicting and require denial of the summary judgment motion. Feinberg v. Feit, supra at 519; Colao v. St. Vincent's Med. Ctr., supra at 661; Deutsch v. Chaglassian, supra; Barnett v Fashakin, supra at 835. Therefore, the motion of NYMH, Dr. Guadavalli and Dr. Myneni requesting summary judgement as to the neonatal care rendered to Justin is denied.

Plaintiff, however, fails to raise an issue of fact precluding summary judgment as to all other claims regarding Justin's neonatal care and treatment. Similarly, plaintiff fails to raise an issue of fact regarding any and all of Dior's neonatal care and treatment. The opinions of plaintiff's expert on these claims are speculatory and insufficient to withstand movants' prima facie showing of entitlement to dismissal. Accordingly, with the exception of the claims

regarding the care and treatment of Justin's pneumothorax (as previously discussed), all claims that the neonatal care and treatment rendered to Justin departed from the standard of care are dismissed and all claims regarding Dior's neonatal care and treatment are also dismissed.

Moreover, movants established a prima facie entitlement to judgment as a matter of law dismissing the cause of action alleging lack of informed consent and the plaintiff failed to raise a triable issue of fact in opposition See, Public Health Law § 2805-d; see also, Schel v Roth, 242 AD2d 697 (2d Dept. 1997). Plaintiff claims do not fall within the confines of § 2805-d of the Public Health Law inasmuch as there is no claim that the patient has undergone "some affirmative violation of his physical integrity" in the absence of informed consent. Etkin v Marcus, 74 A.D.2d 633 (2d Dept.1980). Therefore, all claims for lack of informed consent against all defendants are dismissed.

Accordingly, the action against Dr. Obiakor is dismissed and the Clerk of the Court is directed to enter judgment in favor of IFEANYI OBIAKOR, M.D. accordingly.

This constitutes the decision, opinion and order of this court.

Enter,

MLD

HON. MARSHA L. STEINHARDT

J.S.C.

KINGS COUNTY CLERK
FILED
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