

**Walker v Alamia**

2014 NY Slip Op 30776(U)

March 26, 2014

Supreme Court, Suffolk County

Docket Number: 11-6797

Judge: Arthur G. Pitts

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SUPREME COURT - STATE OF NEW YORK  
I.A.S. PART 43 - SUFFOLK COUNTY

**PRESENT:**

**COPY**

Hon. ARTHUR G. PITTS  
Justice of the Supreme Court

MOTION DATE 11-12-13  
ADJ. DATE 1-23-14  
Mot. Seq. # 001 - MG

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CARISSA WALKER, an infant by her mother  
and natural guardian MARISA BOOTHE, and  
MARISA BOOTHE, individually,

Plaintiff,

- against -

DR. VITO ALAMIA, KERRI DAMICO, R.N.,  
AMY HALL, R.N., CAROLINA SEBASTIAN,  
R.N., HAMPTONS OB/GYN and  
SOUTHAMPTON HOSPITAL,

Defendants.

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Upon the following papers numbered 1 to 23 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001) 1- 15; Notice of Cross Motion and supporting papers ; Answering Affidavits and supporting papers 16-19; Replying Affidavits and supporting papers 20-21; 22-23; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

**ORDERED** that motion (001) by the defendants Southampton Hospital, Kerri D'Amico, R.N., Amy Hall, R.N., and Carolina Sebastian, R.N. pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims as asserted against them is granted.

In this action for medical malpractice, the plaintiff, Marisa Boothe, individually and as the parent of the infant, Carissa Walker, seeks damages for personal injuries allegedly sustained by her infant daughter on or about March 5, 2010 through March 7, 2010, while a patient at Southampton Hospital. Causes of action alleging medical malpractice, lack of informed consent, and a derivative claim have been asserted. It is alleged that the defendants negligently departed from the good and accepted standards of obstetrical care during the mother's labor and delivery of the infant plaintiff, causing the infant to suffer right-sided Erb's palsy with injury

to her right brachial plexus, avulsion and/or stretching of the C5-T1 nerve roots, limited range of motion of the right upper extremity and shoulder; Horner's syndrome, torticollis, feelings of embarrassment, weakness and atrophy of the right upper extremity with limited use of the right arm and hand, and surgery on April 6, 2011.

Defendants Southampton Hospital, Kerri Damico, R.N., Amy Hall, R.N., and Carolina Sebastian, R.N. seek summary judgment dismissing the complaint and any cross claims asserted against them on the bases that the care and treatment provided by them to the plaintiff and her infant daughter did not depart from the accepted standards of obstetrical care and did not proximately cause the injuries to the infant plaintiff.

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 (*Friends of Animals v Associated Fur Mfrs.*, 46 NY2d 1065, 416 NYS2d 790 [1979]; *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 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 [1981]).

In support of motion (001), the moving defendants submitted, inter alia, an attorney's affidavit; the affirmation of Victor R. Klein, M.D.; copies of the summons and complaint, the moving defendants' answer and demands, and the plaintiffs' verified bills of particulars; certified medical records from Southampton Hospital; uncertified medical records of defendant Alamia which are not in admissible form pursuant to CPLR 3212 and 4518; and the unsigned but certified transcripts of the examinations before trial of Marisa Boothe dated November 14, 2011 and Carmnetta Booth dated January 22, 2013, which have not been objected to by plaintiff (*Zalot v Zieba*, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); the uncertified and unsigned transcript of the examination before trial of defendant Vito Alamia, M.D. with proof of service pursuant to CPLR 3116, but the exhibits relative thereto have not been provided; and the unsigned and certified transcripts of the examinations before trial with proof of service pursuant to CPLR 3116 of Carolina Sebastian, R.N. and Amy Hall, R.N. It is noted that while the moving defendants also seek dismissal of any cross claims asserted against them, they have not provided a copy of the answers served by their co-defendants.

Marisa Boothe testified about her daughter's medical care and treatment since birth. She testified concerning her prior obstetrical history, and her prior treatment with Dr. Alamia. When she first became aware of the subject pregnancy, she consulted with the Suffolk County Clinic for her prenatal care and treatment, including about six or seven sonograms. She had a sonogram one or two weeks before delivery, and was told that the baby was about seven to seven and one-half pounds. She was advised to go to Southampton Hospital when it came time to deliver her baby, and was given a list of physicians to perform the delivery, but was not advised to see any of the physicians prior to delivery.

The plaintiff continued that when her water broke, she went to Southampton Hospital, however, she had no labor pains. She was seen by a nurse, and then by Dr. Alamia, who examined her, told her she was five centimeters dilated, and that he would deliver once she got to nine centimeters. She stated that she was administered Pitocin because Dr. Alamia told the nurse that she was dilating too slowly. Other than labor pains, she had no complaints. She was placed on the monitor, and the nurse told her the baby's heartbeat was fine. Dr. Alamia checked her a few times, and told her the baby's head was down. No one at any time indicated that they thought that it might be difficult for her to deliver her baby vaginally. When she was taken to the delivery room, Dr. Alamia checked her three times, and said to give her another ten minutes. She could feel the baby's head, then two nurses picked her legs up, and Dr. Alamia and the nurses told her she had to push the baby out. She kept pushing, but the baby would not come out. She testified that Dr. Alamia kept pushing down on her stomach, and it hurt really bad, and he was pulling on the baby's head, "twisting her head like this back and forth," to try to get her out. She stated that he "was just tugging and pulling and tugging and pulling." She stated that Dr. Alamia told her that he thought the baby's shoulder was stuck on her pelvic bone. She gave a big push, and the baby came out. Then, everyone was quiet and no one was saying anything, just doing. She saw the baby was purple and not moving or breathing on her own. She heard the baby cry after about a minute. The plaintiff then testified that she herself then went for surgery to have her placenta removed because it was "stuck."

The plaintiff testified that prior to her discharge, she was told by Dr. Lado, the pediatrician, that her baby was being transferred to Stony Brook Hospital because the baby could not open her right eye due to a birth defect, and because her right arm was not moving due to something with her spine. Dr. Lado told her the baby had Erb's Palsy as a result of a very difficult delivery, and that normally, movement would be regained in about three to six months. The plaintiff testified that she was told that pulling on the baby's head caused the Erb's Palsy. She continued that the baby's head was also cone shaped, which she stated she was told was due to the baby's head being squeezed during delivery. When she saw Dr. Alamia before discharge from the hospital, he told her that he was sorry, but he was just trying to get the baby out to save her life; it was a difficult delivery; and she was tired. After the baby was admitted to Stony Brook, she was told that the baby had Horner's Syndrome, caused by nerve damage to the right eye so that the right eye and pupil are smaller than the left, caused by pulling on the baby's head. Dr. Grossman, an orthopedist, told her that the baby had brachial plexus injury and that he would perform surgery to help by taking a nerve from the infant's calf and putting it in her neck in an attempt to enable the arm to move. The surgery was done on April 5, 2011. Prior to the surgery, the infant did not have any movement in her right arm. Now, she can lift up her hand/arm to a 90 degree angle and move her fingers.

Vito Alamia, M.D. testified to the extent that he practices in the area of obstetrics and gynecology, and is a partner with Hampton Gynecology, a division of Women's Health Professionals. He has been licensed to practice medicine in New York State since 1996, and is board certified in obstetrics and gynecology. He is affiliated with Southampton Hospital. The plaintiff first came under his care on October 3, 2006 at Southampton Hospital, twenty weeks pregnant with a spontaneous abortion and chorioamnionitis. He described her care and treatment. He stated that Suffolk County has an outpatient prenatal center on hospital grounds, and the County provides outpatient services. The County has its own nurse practitioners, and his group covers the nurse practitioners and does periodic visits at the clinic, and performs the inpatient deliveries. On March 5, 2010, he was the obstetrician on call when the plaintiff presented to the emergency room at Southampton Hospital, where she was sent to labor and delivery and triaged there. The intern, Dr. Koke, and the nurse in the labor area each did an evaluation of her, and he saw her thereafter.

Dr. Alamia indicated that the onset of the plaintiff's labor was 9:30 a.m. with rupture of the membranes and contractions every twenty minutes. She was admitted to Southampton Hospital at 10:40 a.m., with cervical dilation three to four centimeters, 80 % effacement, -2 station, and vertex presentation. He described his orders, including Pitocin to make the contractions stronger and to hasten delivery, placement on a fetal heart monitor, and intravenous fluid. He described his Pitocin protocol. He stated that she was full term and he expected a vaginal delivery that day. He continued that because the plaintiff had a body mass index of 34, she was mildly obese. She also had mild anemia, Rh negative, bacterial vaginosis, and increased one-hour Glucola but normal three-hour Glucola, and did not have gestational diabetes. Her ultrasound at 37 weeks and four days gave an estimated fetal weight of 3,172 grams of a single infant, which was appropriate for gestational age. The fetal monitor displayed a baseline fetal heart rate of 150 from 10:46 to 12 noon, and the tracings were reassuring without decelerations. After 12 noon, the fetal heart tracing showed contractions every four to five minutes, and moderate variability in fetal heart accelerations, with no decelerations, level one, indicating no signs of hypoxia.

Dr. Alamia stated that up until 2:30. there was no indication for the use of ultrasound examination. The fetal heart tracings were 130, contractions every three minutes, and the cervix was seven centimeters dilated and 90% effaced, and the fetus was at -1 station. He was satisfied with her progress and anticipated a vaginal delivery within the next several hours. At 4:00 p.m., he reassessed the plaintiff's progress and found that her cervix was nine centimeters dilated and 90% effaced, and the fetus was at -1 station, with fetal heart tracings in the 130s. At 4:45 p.m., the cervix was fully dilated and the fetus at 0 station. He instructed her to start pushing, and remained with her. At 5:05 p.m., the fetal heart baseline raised to 150; at 5:10 it raised to 170. There was moderate variability and variable decelerations from 4:50 to 5:00 p.m., a category two classification. Dr. Alamia stated that a category three classification would indicate that the fetus is undergoing significant signs of possible hypoxia and plans have to be made for delivery.

Dr. Alamia testified that he had performed approximately 3,500 deliveries and encountered shoulder dystocia in less than a hundred deliveries wherein the head delivers and the shoulder gets impacted behind the pubic symphysis and the body does not follow spontaneously. He stated that the cause of shoulder dystocia is unknown, but can happen with babies greater than 4,500 gm. To deliver when shoulder dystocia is encountered, the McRoberts maneuver is employed, and if that is unsuccessful, suprapubic pressure is applied, and if that is unsuccessful, the Woods maneuver is done. Fetal pelvic disproportion can be a cause for shoulder dystocia where the shoulders are too big for the pelvic outlet. He stated that when he initially examined her, he found she had a gynecoid pelvis, adequate for vaginal delivery. He anticipated a normal sized baby based upon the recent normal ultrasound. Two nurses were present for the delivery, as is the routine.

Dr. Alamia testified that the baby's head delivered spontaneously at 5:13 p.m., but the shoulders did not deliver. Generally, with some maneuvers, the body delivers following the head. He noted the entry into the hospital record by nurse Sebastian indicated that he delivered the head and encountered shoulder dystocia, that he employed the McRoberts procedure, suprapubic pressure was employed two times, and two and a half minutes from delivery of the head, the body delivered. Dr. Alamia testified that prior to the delivery of the head, he had no indication there was shoulder dystopia, but realized it when the shoulder did not follow the head. He testified that he then put gentle traction on the baby's head in the direction of the birth canal, but the shoulders did not move, and he realized the shoulder was stuck behind the pubic symphysis. He did not recall where he placed his hands on the baby's head, or how long he applied traction for, but continued that he put downward traction on the baby's head because the superior shoulder was underneath the pubic symphysis, and

by putting downward traction, the shoulder should slide right underneath the pubic bone and deliver. However, when he did that, the baby's right shoulder did not come out.

Dr. Alamia testified that he then instructed the two nurses to put the plaintiff in the McRoberts position wherein her hips and knees were flexed back towards her shoulders to flatten out the pelvic outlet, changing the angle of the pelvis slightly, to help reduce or relieve the shoulder dystocia. He did not know how long the McRoberts position was held and whether he applied traction again to the baby's head. He then instructed the nurses to apply suprapubic pressure, just over the pubic symphysis in a lateral direction opposite the shoulder. He believed nurse Sebastian applied the pressure while he attempted to turn the baby by placing his hand behind the baby's neck by the baby's shoulder blades, trying to move the shoulder with lateral pressure on the shoulder in the same direction as the nurse was giving suprapubic pressure, to rotate the baby to let the shoulder progress underneath the symphysis pubis. He did not know how long the pressure was applied. He stated he never pressed down on the plaintiff's belly, and at no time did anyone apply fundal pressure, as that could further impact the shoulder and affect damage to the fetus. With the suprapubic pressure, the baby's shoulder moved laterally, and he was able to deliver the posterior shoulder and corkscrew the baby out (Woods screw maneuver) until the baby was completely delivered. With the Woods screw maneuver, the baby's posterior (left) shoulder was turned with his hand in the opposite direction of the shoulder dystocia, and the baby was turned back and forth by the shoulders to get it out. He did not recall if the baby's head turned with this maneuver. The infant's head had been in an ROA position and rotated to an OA position once the shoulder was released, a favorable position for delivery. The plaintiff remained in the McRoberts position until delivery of the baby. Dr. Alamia stated that once the baby was fully delivered, he supported the baby's head and neck, but he never applied traction to the baby's head after he initially first applied gentle traction, and he did not move the head from side to side. He described the delivery as difficult due to the shoulder dystocia, and that it took about two minutes to deliver the baby when the shoulder dystocia was realized.

Dr. Alamia testified that the nurse assigned the APGAR score to the infant on a scale of zero to ten: zero being lifeless. The infant's initial score was three. He stated that when the infant was born, her heart rate was greater than a hundred, and he gave positive pressure ventilation for about two minutes until she started breathing spontaneously and became vigor (sic). This, he stated, was due to the baby not getting oxygen through the cord from the time that the head came out until the time the baby was delivered, due to the shoulder dystocia. The baby was also limp with floppy muscle tone at birth. Tactile stimulation was given and the nurses assessed the heartbeat. The baby's color was blue, so oxygen was administered. After two minutes, the APGAR score progressed to nine. Dr. Alamia testified that during the delivery process, the infant suffered no hypoxic event. She weighed 9 pounds 1 ounce (approximately 4,000 grams). He had expected the baby to weight seven and one-half pounds to eight pounds. He did not note that the infant had caput succedaneum, or molding of the head to accommodate moving through the birth canal.

Dr. Alamia testified that he was unaware of the limp right arm or the right eye being shut. He stated that the right eye being shut could indicate nerve damage to the eyelid. Horner's sign can be potential evidence of damage to the cervical nerve roots and can involve a droopy or closed eyelid, which can occur just with delivery and not necessarily with excessive traction. He did not recall having delivered any babies with Horner's sign. He stated that injury to the brachial plexus is one of the potential complications associated with shoulder dystopia, but he did not assess the baby for it after delivery. He continued that there is a relationship between shoulder dystocia and Erb's Palsy due to the impaction of the shoulder or undue forces to the brachial plexus. Erb's Palsy sometimes occurs with stretching of the nerves, and either temporary or permanent damage

to the brachial plexus, or the nerves coming out of the C spine into the neck. Excessive traction on the head or neck can be a cause of Erb's Palsy. Dr. Alamia testified that at delivery, he did not apply excessive traction, only gentle traction. He delivered two other babies with Erb's Palsy. He read an MRI report performed on the infant at Hospital for Special Surgery on July 24, 2010, indicating an impression of pseudomeningocele with avulsed nerve roots at C6/7 and C7/T1, with additional potential small pseudomeningocele at the C5/6 level, compatible with traumatic injury. Dr. Alamia testified that he did not have an opinion as to whether those injuries and findings were caused in the process of the delivery of the child. He also stated that evulsion of the nerve roots following delivery are not evidence of a traumatic delivery, or excessive traction on the head and neck during the course of the delivery. He stated that nerve roots in the cervical and thoracic spine can be evulsed in the normal birth processes.

Dr. Alamia testified that after the delivery of a baby, it takes about two to ten minutes for the placenta to deliver spontaneously, then a bolus of Pitocin is given to prevent postpartum hemorrhage. However, the plaintiff's placenta did not deliver spontaneously, she began bleeding, and was taken to the operating room for a curettage of the retained placenta with ultrasound guidance, under general anesthesia. He did not recall apologizing to the plaintiff at any time.

Carolina Sebastian testified to the extent that she is a registered nurse licensed to practice in New York since 1994. She is employed at Peconic Bay Medical Center in labor and delivery three days a week for twelve hour shifts, and has been per diem at Southampton Hospital in labor and delivery since 2001. In 2009, she began part-time at Southampton Hospital, two to three days a week from 7 a.m. to 7:30 p.m. She testified that she has attended in-service education programs involving shoulder dystocia. In a case with shoulder dystocia, the McRoberts position is employed, and she described the same. She also stated that suprapubic pressure is employed by making a fist and applying pressure in the suprapubic area. She was present in the delivery room with the plaintiff during her delivery during the March 5, 2010 admission. She admitted the plaintiff and set forth the care and treatment she provided to the plaintiff, and her observations. When the plaintiff's cervix became fully dilated at 4:35 p.m., she was examined by Dr. Alamia who encouraged the plaintiff to push with contractions. Amy Hall, also a registered nurse, was present in the delivery room. Dr. Alamia was positioned at the foot of the bed, she was on the right, and nurse Hall was to the left. When the head delivered at 5:13 p.m., the body did not follow, so she then first became aware that there was a shoulder dystocia. Dr. Alamia ordered McRoberts, so she and nurse Hall hyperextended the plaintiff's legs while Dr. Alamia told the plaintiff to push with contractions. Dr. Alamia held the infant's head and tried to pull the baby out by applying traction downward. She did not know how many contractions this was done for, but assumed it was one. Dr. Alamia then ordered suprapubic pressure by pushing straight down, which she employed with her right hand while still holding plaintiff's leg in the McRobert's position during a contraction. She did not release pressure until Dr. Alamia told her to stop. During that time, she saw Dr. Alamia pulling down on the baby's head to deliver the baby. She did not characterize the degree of traction used by Dr. Alamia when he was pulling down on the baby's head. The baby was then delivered at 5:16 p.m. She did not recollect if Dr. Alamia used a corkscrew maneuver in delivering the baby, but observed him place his finger inside the birth canal to dislodge the shoulder while the plaintiff was pushing while in the McRoberts position. She testified that no fundal pressure was applied. She did not take care of the infant after she was delivered, and indicated in her nursing note that nurse Hall told her that the baby's arm needed evaluation.

Kerri D'Amico, R.N. testified to the extent that she is employed at Southampton Hospital in OB/GYN as a registered nurse. Her duties and responsibilities are to care for newborns already delivered and to receive

them after delivery, typically in the nursery. Her recollection of the delivery of the infant plaintiff was that she walked into the birthing room to see if anything was needed, and Carolina Sebastian told her there was a shoulder dystocia. Within a few seconds, the baby was out. She saw the plaintiff in the McRoberts position with Dr. Alamia at the foot of the delivery table. The baby was not breathing when she was born, so Dr. Alamia began resuscitation of the baby, using a bulb suction, then positive pressure with an Ambu bag for a couple minutes, assisted by nurses Sebastian and Hall who were listening to the heart rate. She is trained to assess APGAR scores. She noted the baby was pale, which would be a zero on the score. The infant was limp. There was no cry. The score was three at one minute which meant the infant was depressed. She did not attend the infant until after five minutes when the APGAR score was completed. The score was nine at five minutes which meant the infant was doing better. She noticed that the baby's right arm was not moving and there was no finger grip. She brought it to nurse Hall and Dr. Alamia's attention. Nurse Hall said nothing, but Dr. Alamia said he thought he saw it move, and looked at the baby briefly, but did not examine her. She did not notice any abnormalities in the infant's face. At 5:45 p.m., the infant was transported to the nursery. Southampton Hospital did not have a NICU at the time. She stated that the infant fit the definition for larger than gestational age. At some point, Dr. Alamia came into the nursery and she told him that the baby still could not move the right arm.

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 Derdarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 221 AD2d 674, 638 NYS2d 700 [1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see Fiore v Galang*, 64 NY2d 999, 489 NYS2d 47 [1985]; *Lyons v McCauley*, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (*Toomey v Adirondack Surgical Assoc.*, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; *Machac v Anderson*, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

Expert testimony is limited to facts in evidence. (*see also Allen v Uh*, 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; *Marzuillo v Isom*, 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; *Stringile v Rothman*, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; *O'Shea v Sarro*, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; *Hornbrook v Peak Resorts, Inc.*, 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]). The moving defendants' expert, Victor R. Klein, M.D. affirms that he is licensed to practice medicine in New York State and is board certified in obstetrics and gynecology, maternal-fetal medicine, and clinical genetics. He set forth the materials and records which he reviewed, including the records for all subsequent pediatric treatment and the deposition transcripts of all parties involved. It is noted however, that the records of the infant's subsequent treating physicians, and the transcripts of the examinations before trial of Amy Hall, R.N. and Kerri Damico, R.N. have not been provided.

Dr. Klein opined within a reasonable degree of medical certainty that the care and treatment rendered by the moving defendants was entirely in accordance with the standards of good and accepted medical practice and in no way caused or contributed to the injuries claimed in this lawsuit. Dr. Klein set forth that the plaintiff had a total of five pregnancies consisting of three terminations of pregnancy at less than three weeks, one spontaneous abortion at twenty weeks, and the pregnancy at issue resulting in the birth of Carissa Walker on March 5, 2010. Dr. Klein stated that defendant Dr. Alamia had treated the then 26 year old plaintiff relating to the spontaneous abortion in August 2006, which was due to an incompetent cervix. There was a delivery of a non-viable fetus, and Dr. Alamia performed a D&C. The plaintiff was seen initially for the subject pregnancy at the Suffolk County Department of Health Services on September 29, 2009, at which time the pregnancy was confirmed. Her estimated date of confinement was March 8, 2010. She reported a history of cigarette smoking for twelve years, alcohol consumption two times a week, and occasional marijuana use. She also reported a family history of diabetes mellitus, and in December 2009, had an increase in her glucose level at twenty-eight weeks pregnancy. A screening glucose tolerance test was noted to be within normal limits, and remained so thereafter. Dr. Klein continued that according to the prenatal record, the plaintiff's pregnancy was monitored over eleven visits. She was mildly obese with a body mass index of 34, was diagnosed with anemia, and was treated for bacterial vaginosis.

Dr. Klein stated that on February 17, 2010, the fetus had an estimated fetal weight of 3,172 grams which was appropriate for her gestational age of 37 weeks. The plaintiff, who was 5'7", weighed 236 pounds. On March 5, 2010, at age 31, the plaintiff was admitted to Southampton Hospital at 10:22 a.m., after spontaneous rupture of the membranes with clear fluid at 9:30 a.m. At 10:15 a.m., the plaintiff was taken to the labor room where she was cared for by defendant nurse Carolina Sebastian, R.N. She signed a consent form for vaginal delivery or cesarean section by Dr. Alamia. Dr. Alamia ordered Pitocin to augment the plaintiff's labor after reviewing the fetal monitor tracings. The Pitocin was then administered by nursing who titrated the medication in accordance with his order. The plaintiff's cervix was dilated 3-4 centimeters upon admission, and the fetal heart rate was in the 140s with moderate variabilities and no decelerations or accelerations. Contractions were every three to six minutes. The fetus was in a vertex presentation. Dr. Klein continued that Dr. Alamia assessed the adequacy of the plaintiff's pelvis and determined that the pelvis was of normal shape and adequate to deliver vaginally that day, and that the infant would weigh approximately 3,500 gm.

The Pitocin was administered from 12:25 p.m. at 1 milliunit every 20 seconds until contractions were every two to three minutes at 1:35 p.m. At 2:30 p.m., Dr. Alamia examined the plaintiff and found the cervix dilated to 7 centimeters, and the fetus was at -1 station. At 3:35 p.m., the dosage of Pitocin was again increased by Dr. Alamia. At 3:38 p.m., the cervix was dilated to the rim and Dr. Alamia was called in. Upon examination by Dr. Alamia, the cervix was 9 centimeters dilated. At 4:25 p.m., the cervix was fully dilated and the fetus at zero station. The plaintiff was instructed to push, and her legs were placed in stirrups. At 5:13 p.m., Dr. Alamia delivered the infant's head. At that point, shoulder dystopia was encountered, and a McRobert's maneuver and suprapubic pressure were applied for 2 ½ minutes. Nurses Carolina Sebastian and Amy Hall hyperextended the plaintiff's legs above her head while the plaintiff was in McRobert's position, and the plaintiff was instructed to push with contractions, while Dr. Alamia had his hands on the infant's head and neck. This released the shoulder dystocia, and the infant's body was delivered at 5:16 p.m.

Dr. Klein continued that according to Dr. Alamia's notations, the patient pushed for approximately 30 minutes and then delivered the head with difficulty, but the right shoulder was stuck under the symphysis pubis. He continued that the McRoberts maneuver and traction were unsuccessful in delivering the shoulder, and that

the suprapubic pressure by the nurses provided relief of the shoulder dystocia. When the posterior shoulder was released, a cork screw maneuver of the infant was performed by Dr. Alamia. The baby had a decreased heart rate greater than 100, so positive pressure ventilation was given for two minutes, when the infant then developed spontaneous breathing. Dr. Klein stated that the fetus had a normal heart rate throughout. Ten minutes later, the placenta still had not been delivered despite gentle traction on the cord. Copious amounts of blood began pouring out of the vagina. Dr. Alamia then took the plaintiff emergently to the operating room for removal of the placenta under general anesthesia.

The infant plaintiff was examined by pediatrician Dr. David Lado on March 5, 2010, who noted the infant weighed 9 pounds 1 ounce at birth, and that she had decreased tone of the right arm and hand, as well as positive caput and moulding of her head. She had decreased tone on the right extension and clavicle with smooth pronation. Reflexes were noted to be asymmetric Moro and negative grip on the right side. APGAR scores were 3 and 9 at 1 and 5 minutes respectively. Nurse Howard documented at 7:40 p.m. that the infant had a left arm with good range of motion, but the right arm remained flaccid. Dr. Lado then spoke to the infant's father. On March 6, 2010, the infant's right arm remained without movement, and she had a 2/6 systolic murmur and potential Horner's Syndrome in that there was a positive right myosis and positive ptosis. The infant was then transferred to NICU at Stony Brook Hospital at 1:00 a.m. that day.

Dr. Klein opined that many of the allegations asserted against the hospital and nurses pertain to functions which are the responsibility of the physician. Sonograms were properly performed and interpreted as per the responsibility of the physician. The hospital records indicated the plaintiff underwent rapid triage upon admission, and appropriate history, physical and indicated diagnostic testing were obtained. It was Dr. Alamia's decision to permit the plaintiff to deliver vaginally or by cesarean section. He performed the first internal examination upon the plaintiff's admission to the hospital, found the fetus was in a vertex presentation and was of average size, ordered Pitocin and how it was to be administered, and formulated the plan and prognosis. The nursing staff monitored the plaintiff at appropriate intervals and properly conveyed findings to Dr. Alamia. Dr. Klein set forth that the records and testimony do not support that the infant was experiencing fetal distress, and that the infant's cord blood was normal. He stated that in reviewing the fetal monitor strips, he found no periods of "significant decelerations which would be cause for concern as to the wellbeing of the infant", and the strips show good variability of the fetal heart rate with no "significant episodes of fetal bradycardia."

Dr. Klein continued that the plaintiff's second stage of labor began at 4:25 p.m. and that there was no prolonged labor as the second stage ended at 5:16 p.m. with the delivery. The infant's head was delivered at 5:13 p.m., and the nursing staff appropriately responded to the shoulder dystocia by following Dr. Alamia's orders. The McRoberts Maneuver was employed by Dr. Alamia after delivery of the head. Dr. Klein stated that no fundal pressure was used during the delivery, and that suprapubic pressure was employed by nurse Sebastian in the direction and duration directed by Dr. Alamia, after the head was delivered. Such application of suprapubic pressure was not contraindicated and was entirely in accordance with the standard of care for managing shoulder dystocia. After delivery of the infant, the Southampton Hospital nurses, Damico, Hall and Sebastian, appropriately and timely diagnosed the child's flaccid upper right extremity and appropriately responded by having the infant evaluated by the pediatrician, Dr. Lado, who transferred the infant to Stony Brook Hospital Medical Center for further evaluation. It is Dr. Klein's opinion that there was no treatment which the infant required that she did not receive for the Erb's Palsy, and there is nothing about the neonatal care at Southampton Hospital which in any way caused or contributed to the damages claimed. Informed

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consent was the responsibility of Dr. Alamia who was to inform the plaintiff of the risks, benefits, or alternatives of the medical procedures provided, including the delivery and the D&C post delivery.

Based upon the foregoing, the moving defendants have established prima facie entitlement to summary judgment dismissing the complaint and any cross claims asserted against them on the issues of informed consent, liability, proximate cause, and vicarious liability.

To rebut a prima facie showing of entitlement to an order granting summary judgment by a defendant, the 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 defendant's 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 [2d Dept 2004]; *Domaradzki v Glen Cove OB/GYN Assocs.*, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997])

The plaintiff has submitted an attorney's affirmation wherein counsel states that the plaintiff has executed stipulations of discontinuance as to the defendant nurses. Counsel for defendants sets forth in his reply that executed stipulations have not been provided by the plaintiff as of yet. Counsel for the plaintiff asserts that to the extent that the defendants' motion seeks dismissal of plaintiff's claims as to the defendants' motion, that the motion should be denied as moot. However, counsel for the plaintiff has not submitted copies of the signed stipulations of discontinuance to this court with the opposing papers. The plaintiff has not submitted an expert affirmation in opposition to defendants' motion, thus, it is determined as a matter of law that summary judgment be granted to the moving defendants as the plaintiff has raised no factual issue concerning liability of the defendant nurses or vicarious liability of Southampton Hospital with regard to the defendant nurses which it employs.

Accordingly, motion (001) is granted and summary judgment is granted to defendant Kerri D'Amico, R.N., Amy Hall, R.N., and Carolina Sebastian, R.N., and to Southampton Hospital for any vicarious liability as to these defendants.

A hospital or other medical facility is liable for the negligence or malpractice of its employees, however, that rule does not apply when the treatment is provided by an independent physician, as when the physician is retained by the patient himself, unless the hospital knows that the patient is unaware of the dangers and novelty of the medical procedure proposed to be performed (*Birdell Hill v St. Clare's Hospital*, 67 NY2d 72, 499 NYS2d 904 [1986]). A hospital generally cannot be held liable, other than derivatively, for another's malpractice. Thus, where there is no vicarious liability, the plaintiff must establish that the hospital, through its own agents, was guilty of malpractice or other tort concurring in causing the harm (*Fiortino v Wenger*, 19 NY2d 401, 280 NYS2d 373 [1967]; *Belak-Redi v Bollengier*, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; *Welch v Scheinfeld*, 21 AD3d 802, 801 NYS2d 277 [1st Dept 2005]).

It is noted that the moving defendants did not seek summary judgment with regard to any vicarious liability which may be attributable to Southampton Hospital for any alleged acts or omissions by defendant Vito Alamia, M.D.. The expert affirmation of Dr. Klein addresses only the actions of the defendant nurses and Southampton Hospital on the issue of vicarious liability as it relates to those nurses, and not as to Dr. Alamia. Counsel for plaintiff argues that there are factual issues as it relates to Southampton Hospital's vicarious liability for Dr. Alamia. However, that issue has not been raised in motion (001) and is not properly before this

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court by way of a cross motion by plaintiff. Even if it were, the plaintiff has not submitted admissible evidence in support of such argument.

The plaintiff has submitted a redacted expert affirmation, but has not provided an unredacted copy of said affirmation to this court for review. A redacted version of an expert affidavit lacks evidentiary value (*Marano v Mercy Hospital*, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). “A party may successfully oppose a summary judgment motion without disclosing the names of the party’s expert witnesses. In opposition to such a motion the party defending against a summary judgment motion may serve the movant with a redacted copy of its expert’s affirmation as long as an unredacted original is provided to the court for its in camera inspection” (*Marano v Mercy Hospital, supra*). This procedure preserves the confidentiality of the name of plaintiff’s medical expert while also preserving plaintiff’s obligation in opposing defendant’s motion, in that by submitting a redacted affirmation and by offering the original to the court for in camera inspection, plaintiff has opposed the motion by evidence in admissible form (*Rubenstein v Columbia Presbyterian Medical Center*, 139 Misc.2d 349, 527 NYS2d 680 [NY County 1988]). A copy of the affidavit with the expert’s name and signature have not been provided to this court under separate cover. Accordingly, plaintiff’s expert affidavit is not in admissible form and is insufficient to raise a triable issues of fact as to any defendant’s alleged malpractice (*Rose v Horton Medical Center*, 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]). Thus, plaintiff has failed to raise a factual issue to establish liability, vicarious or individual, or that any act or omission by the moving defendants proximately caused plaintiff’s claimed injuries, or that informed consent was not provided by the moving defendants.

Dated: March 26, 2014



J.S.C.

\_\_\_\_\_ FINAL DISPOSITION  X  NON-FINAL DISPOSITION