

Savage v Franco

2014 NY Slip Op 31413(U)

May 21, 2014

Supreme Court, Suffolk County

Docket Number: 99-11088

Judge: Jeffrey Arlen Spinner

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This opinion is uncorrected and not selected for official publication.

ORDERED that motion (015) by defendant, Andrew Wackett, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied; and it is further

ORDERED that motion (016) by defendant, Siddharth Sharma, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied; and it is further

ORDERED that motion (017) by defendants, Leslie M. Quinn, M.D., Stony Brook Children's Service, P.C. and Stony Brook Internists, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied.

In this medical malpractice action, plaintiff Diane Savage, on behalf of her infant son, Victor Savage, alleges that defendants negligently departed from good and accepted standards of medical care in failing to consider, diagnose, and timely and properly treat her infant son, Victor Savage, then four months of age, for meningitis. The infant plaintiff presented to the emergency department at Stony Brook University Hospital on July 22, 1998, where he was initially seen by defendants Siddharth Sharma, M.D., a resident, and Lester Kallus, M.D., an attending physician, for a fever of 105, lethargy and irritability. He was discharged early in the morning on July 23, 1998, only to return to Stony Brook emergency department on July 23, 1998, at 11:19 a.m. The infant again presented with a fever, lethargy, irritability, vomiting, pink stool, a rapid heart rate of 178 and respirations of 42. Andrew Wackett, M.D., who was beginning his second year of residency in the emergency department saw the infant initially. Thereafter, the attending physician in the emergency department, defendant Maria Mortimer, M.D. (Rolon), saw the infant and discharged him unless he could not tolerate fluids. When Dr. Mortimer went off duty, Jeanne M. Alicandro, M.D. was then the attending physician in the emergency room. Defendant Leslie M. Quinn, M.D. was the pediatric attending physician on call for July 23, 1998. The infant was admitted to Stony Brook University Hospital sometime between 5:00 p.m. and 8:45 p.m. It is alleged that the defendants failed to conduct proper and indicated testing, including a lumbar puncture and sepsis work up, failed to make a differential diagnosis to rule out meningitis, and caused delay in the diagnosis and treatment of meningitis in the infant. The infant plaintiff remained hospitalized until August 12, 1998, as he developed seizures and further complications. He underwent bilateral craniotomies and had a subdural drain placed. As a result of the alleged negligent departures from the standards of care, it is alleged that the infant was caused to suffer brain damage, developmental delays, seizure disorder, motor impairment, and cognitive impairment.

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 [2d Dept 1981]).

Unsigned but certified transcripts of examinations before trial may be considered if not objected to (*see Zalot v Zieba*, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]). Unsigned and uncertified copies of transcripts of examinations before trial are not in admissible form (*see Martinez v 123-16 Liberty Ave. Realty Corp.*, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; *McDonald v Maus*, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; *Pina v Flik Intl. Corp.*, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]). An unsigned transcript of an examination before trial of a moving defendant may be considered as adopted as accurate by that moving party (*see Ashif v Won Ok Lee*, 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]).

In support of motion (015), defendant Wackett submitted, inter alia, an attorney's affirmation; the expert affirmation of Gregory Mazarin, M.D.; copies of the summons and complaint, the answer served by Wackett, and plaintiff's verified bill of particulars; signed copies of the examinations before trial of Andrew Wackett dated September 24, 2003 and May 2, 2013, Jeanne Alicandro M.D. dated April 11, 2008, and the unsigned transcript of Maria Mortimer dated October 28, 2003, all of which fail to comport with CPLR 2101 (a) and are barely legible due to improper font size; the unsigned and uncertified copy of the transcripts of the examination before trial of Maria De Los Angeles Rolon (Mortimer), and Diane Savage dated January 23, 2012 which are not in admissible form; the unsigned but certified transcripts of Leslie M. Quinn, M.D. and Diane Savage dated December 13, 2002, March 7, 2003, March 28, 2009 which fail to comport with CPLR 2101 (a); and the illegible and uncertified copy of the infant's Stony Brook Hospital record which is not in admissible form pursuant to CPLR 3212 and 4518 (*Friends of Animals v Associated Fur Mfrs.*, *supra*). 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]), and the uncertified records are not admissible. The moving defendant has failed to provide copies of all the pleadings as required pursuant to CPLR 3212.

In support of motion (016), defendant Sharma has submitted, inter alia, an attorney's affirmation; the expert affirmation of William Meyers, M.D.; a copy of the summons and complaint, his answer, and plaintiff's verified bill of particulars; unsigned and uncertified transcripts of the examinations before trial of Diane Savage which are illegible and fail to comport with CPLR 2101(a); the unsigned but certified transcripts of the examination before trial of defendant Sharma dated August 1, 2003, and Leslie M. Quinn, M.D. dated March 15, 2012 which fail to comport with CPLR 2101(a); the unsigned and uncertified transcript of Lester Kallus, M.D. dated April 13, 2004; affidavit of Leonard Krolov, M.D. dated July 14, 2004; copy of the order dated March 11, 2005 (Oliver, J.) dismissing the action as asserted against Dr. Sharma and the order of the Appellate Division 2nd Department, dated December 12, 2006, reversing the dismissal as to Dr. Sharma; and uncertified medical records which are not in admissible form pursuant to CPLR 3212 and 4518. Defendant Sharma has not provided copies of all the pleadings as required pursuant to CPLR 3212.

In support of motion (017), defendants Quinn, Stony Brook Children' Services, P.C., and Stony Brook Internists, P.C. have submitted, inter alia, an attorney's affirmation; expert affirmation of Bruce Greenwald, M.D.; affidavit of Leslie M. Quinn, M.D.; affidavit of Margaret Parker, M.D. uncertified medical records; a copy of the complaint, answer served by defendant Quinn, Stony Brook Children Services, U.F.P.C., and Stony Brook Children's Services, P.C. and Stony Brook Internists, P.C., defendant Parker, M.D., defendant Nesti, M.D. and plaintiff's verified bill of particulars and bill of particulars for defendant Medzoyan, M.D.; unsigned and uncertified transcripts of the examinations before trial of Maria Mortimer dated October 28, 2003, and April

16, 2013, Jeanne M. Alicandro, M.D. dated May 3, 2013; signed and certified transcripts of the examinations before of Andrew Wackett, M.D. dated September 24, 2003, Leslie Quinn, M.D. dated March 15, 2012, Jeanne M. Alicandro, M.D. dated April 11, 2008; and the unsigned but certified transcript of non-party Alfred Belding, M.D. which is not in admissible form.

In searching the record, legible copies of those aforementioned illegible deposition transcripts have been found and reviewed.

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[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see Derdiarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 221 AD2d 674, 638 NYS2d 700 [2d Dept 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 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 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]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the 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]).

A physician owes a patient three basic duties of care: (1) the duty to possess the same knowledge and skill that is possessed by an average member of the medical profession in the locality where the physician practices; (2) the duty to use reasonable care and diligence in the exercise of his or her professional knowledge and skill; and (3) the duty to use best judgment applying his or her knowledge and exercising his or her skill (*see Nestorowich v Ricotta*, 97 NY2d 393, 740 NYS2d 668 [2002]; *Pike v Honsinger*, 155 NY 201, 49 NE 760 [1898]). However, a resident or medical intern who assists a physician and performs a medical procedure or implements a treatment plan, and who does not exercise any independent medical judgment, cannot be held liable for malpractice if the supervising physician's directions do not so greatly deviate from normal practice that the intern or resident should be held liable for failing to intervene (*Soto v Andaz*, 8 AD3d 470, 471, 779 NYS2d 104 [2d Dept 2004]; *see Bellafiore v Ricotta*, 83 AD3d 632, 920 NYS2d 373 [2d Dept 2011]; *Cham v*

St. Mary's Hosp. of Brooklyn, 72 AD3d 1003, 901 NYS2d 65 [2d Dept 2010]; *Costello v Kirmani*, 54 AD3d 656, 863 NYS2d 262 [2d Dept 2008]; *Muniz v Katlowitz*, 49 AD3d 511, 856 NYS2d 120 [2d Dept 2008]).
MOTION (015) *

Motion (015) has been brought by defendant Andrew Wackett, M.D. for summary judgment dismissing the complaint as asserted against him.

Andrew Wackett, M.D. testified to the extent that he became licensed to practice medicine in New York State in 1998, and has been employed with Stony Brook University Hospital as an attending physician in the emergency department, treating both adults and children. He became board certified in emergency medicine in 2001. On July 22, 1998, he was just beginning his second year residency in emergency medicine at Stony Brook University Hospital. Dr. Wackett testified that he was not involved in the care and treatment of the infant during his visit to the emergency room on July 22, 1998, but he was involved on the July 23, 1998 visit. He did not remember the infant, but noted his written entry in the hospital record.

Dr. Wackett stated that when he first saw the four and a half month old infant at 12:00 noon, on July 23, 1998, the infant was irritable but consolable, and lethargic, signs of possible meningitis. He noted that the infant had febrile illness, and considered a very large differential of all possible things that can cause the fever, mostly things that are infectious, either bacterial or viral. He did not believe the infant looked toxic. His plan was to obtain a CBC, blood culture, urinalysis, chemistry, Motrin for the fever, administration of intravenous fluids, and then reassess. He thought the likelihood of the infant having meningitis was low. After the labs came back, he did not order any further tests or evaluations. Dr. Mortimer ordered Tylenol at 2:25 p.m., which was given at 2:45 p.m. He wrote an order for a normal saline bolus of 180 cc. At 6:40 p.m., he noted "revitalized patient- able to tolerate second bolus." He noted the infant vomited once after receiving the first fluid bolus and oral fluid. He did not know who told him to order the two intravenous fluid boluses, but he could have ordered them without the attending having told him to do so.

Dr. Wackett testified that signs and symptoms of meningitis in an infant his age would be fever, alteration in mental status, lethargy, bulging fontanelle, rigid neck, sometimes vomiting and anorexia, and increased intracranial pressure. A lumbar puncture with analysis of the spinal fluid is used to diagnose meningitis. The spinal fluid is observed for cloudiness, and the white blood cell count and differential are evaluated for elevation in the fluid, which is also cultured. A CBC can be suggestive of meningitis wherein there is an elevated white blood cell count and shift to the left, with a predominance of neutrophils and a percentage of bands which may indicate a bacterial infection.

Dr. Wackett did not know if there was a discussion concerning a lumbar puncture, but the attending would have had to order it; he could not. When asked who gave the order to admit the infant to pediatrics, he responded, "[m]e, as directed by my attending physician," whom he thought was Dr. Alicandro, and that the order was given at about 5:00 p.m. He saw no note from Dr. Alicandro in the hospital record. He thought the pediatric residents saw the infant at about 5:00 p.m., and that the pediatric residents do not come to see the patient unless the patient has already been admitted. Dr. Wackett testified that once he was ordered to admit the infant, he would have called the primary care physician and the pediatric residents, but he did not recall much of the discussion. He stated that the calls would have been made before 5:00 p.m. He wrote the note to admit the infant to Dr. Quinn, the attending physician covering pediatrics. The clerk called bed control at 8:01 p.m. to alert that a pediatric bed is going to be occupied, but the infant was still in the emergency room at that time. Dr.

Wackett testified that the infant was admitted at 8:45 p.m., which typically meant that the nurse's call report is done, and that the nursing information is being transferred from the emergency department to pediatrics. A pediatric admission note was written at 9:30 p.m., and a senior pediatric admission note at 10:00 p.m., but he did not know if the infant was already in pediatrics when those notes were written. His discharge diagnosis upon transfer was hyperglycemia. He did not know what his differential diagnosis was.

Maria Mortimer, M.D. testified to the extent that she became licensed to practice medicine in New York State in 1997, and was an employee of Stony Brook University Hospital. She completed her residency in emergency medicine June 30, 1998 at Stony Brook University Hospital. She saw the infant plaintiff on July 23, 1997, as a private attending physician in the emergency department at Stony Brook Hospital. She started work at 8:00 a.m. and went off duty at approximately 4:00 p.m. She testified that prior to leaving work for the day, she signed off to Jeanne Alicandro, M.D., the emergency room attending physician coming on duty. Mortimer testified that she told Dr. Alicandro that she suspected the infant had gastroenteritis because he had been vomiting, had some loose stool, and appeared dehydrated. She stated that she told Dr. Alicandro that "if the kid vomited, the kid was to be admitted; if the kid was tolerating p.o., then the kid could be discharged." She stated that Dr. Alicandro agreed, and that Dr. Alicandro suggested that she would admit the child anyway. Mortimer continued that she told Alicandro that it was up to her. She did not discuss with Dr. Alicandro the possibility that the infant might have meningitis or that a spinal tap should be done. Dr. Mortimer stated that on July 24, 1998, she learned from Dr. Alicandro that the infant had meningitis, and that Dr. Alicandro did not consider the possibility of meningitis. She stated that Dr. Alicandro had decided to admit the infant to the hospital, and had the pediatricians examine him in the emergency room.

Dr. Mortimer continued that Andrew Wackett was the resident working in the emergency department on July 23, 1998, and that he was caring for the infant. There were no pediatric residents assigned to the emergency room at the time. She had no recollection if Dr. Wackett spoke with the infant's attending pediatrician. She learned the infant had been seen in the emergency room on July 22, 1998, and was discharged home about 2:00 a.m. on July 23, 1998, after being hydrated. She stated that Dr. Wackett reported the lab reports to her from the prior visit, including a negative blood culture, and that he felt the infant could be discharged home. She stated that just because the blood culture was negative at twelve hours did not mean the infant did not have sepsis. She indicated that she examined the infant around 2:25 p.m. for about ten minutes, then wrote her note, and gave an order for Tylenol, as the infant still had a fever.

Dr. Mortimer continued that infants are at higher risk for meningitis than the normal population, and that meningitis is the "worst case scenario in a kid with a fever." When meningitis is suspected, a lumbar puncture test would be done to obtain the spinal fluid. She could have done the lumbar puncture or supervised Dr. Wackett in doing one, but looked for another source of the infection first. When she reviewed the blood tests, she was reassured by the differential which, she stated, was more indicative of a viral infection rather than a bacterial infection as the lymphocytes were within the high normal range. But, because she did not like the bandemia, she still considered bacterial infection as well. She continued that fever, dehydration, irritability with inability to console, lethargy, floppiness, and not being responsive to noxious stimuli, could be signs and symptoms of meningitis. She was told by Dr. Wackett that the infant was lethargic, irritable but consolable, and that he had an increased respiratory and heart rate. She told Dr. Wackett that she did not feel a spinal tap was indicated. She stated that the infant's fontanelles were neither bulging nor sunken.

Dr. Mortimer testified, that, with hindsight, it appeared that the infant had meningitis when she saw him in the emergency room. He was sick and sleeping, but not toxic. She considered a viral illness and dehydration, but stated he did not seem dehydrated. A heparin lock for intravenous fluid was placed at 3:00 p.m. She thought the infant already had intravenous fluid when she saw him at 2:25 p.m., but testified that a heparin lock is needed for the IV, so it appeared the infant did not receive any fluid before 3:00 p.m., which was when the heparin lock was placed. The infant vomited one time after a fluid challenge with Pedialyte given orally. She only saw the infant one time in the emergency room. Had she known the infant's glucose level was elevated, she would have called the pediatrician. She later testified that she learned from Dr. Wackett, and noted, that the infant's glucose was in the 200s the evening before, but she did not recall if she asked what his current level was. She did not see any pediatricians examining the infant prior to her leaving at about 4:00 p.m., but indicated that the pediatric evaluation was done at 5:00 p.m.

At her deposition on April 16, 2013, Maria De Los Angeles Rolon, M.D. (Mortimer) testified to the extent that her diagnosis for the infant at the time was gastroenteritis. She did consider hyperglycemia as part of her diagnosis, but later testified that Dr. Wackett made the diagnosis of hyperglycemia. She signed over care of the infant to Dr. Jeanne Alicandro by discussing the plan for the infant before she left. By the time she left, she had not written the order for the p.o. challenge. She did not formulate a plan with respect to the hyperglycemia. Prior to leaving, she did not contact anyone in the pediatrics department, and could not remember if she instructed any of her residents to do so. She then testified that she wouldn't have instructed anyone to contact pediatrics. She testified that Dr. Wackett wrote on the record that the infant was to be admitted to Quinn, pediatrics, and 11N, with the final diagnosis of hyperglycemia. She added that pediatric, endocrinology, and infectious disease consultants were available, but she did not order any consults. She stated that once the admission is put in to the clerk, the patient is admitted. She could not tell when the infant was admitted.

Jeannie Alicandro, M.D. testified to the extent that she has been licensed to practice medicine in New York State and is board certified in emergency medicine. With regard to the infant plaintiff being a patient in the emergency room at Stony Brook University Hospital on July 23, 1998, she recalled having had one conversation with Dr. Mortimer. Dr. Alicandro stated that she wrote no note in the emergency room record, which indicated that she did not examine the infant. She stated that she had no recollection of who admitted the patient to pediatrics, but stated that the chart indicated that Dr. Mortimer did, but it did not indicate a time. She did not know what time the pediatric attending was contacted, but stated that the record indicated the infant was admitted to Quinn who was advised as to the infant's disposition, and that Dr. Mortimer signed it. She stated the ER attending or ER resident would discuss the patient with the pediatric attending to transfer care over, and the pediatric attending would have to accept that admission. The pediatric residents would then come to the emergency room to examine the patient, and write the orders in the hospital chart, and admit the patient. The pediatric residents would be then communicating with the pediatric attending. Thereafter, the patient is brought to pediatrics.

Dr. Alicandro testified that when the pediatric residents saw the infant at 5:00 p.m., they would not have seen the infant for any reason other than admission. They would have spoken to the emergency room resident to obtain history, condition, course and anything related. At 8:01 p.m. a call was made by nursing to obtain a bed. At 8:45 p.m., a report was called by nursing, typically done when the patient was being transferred to the floor. The infant's admitting diagnosis was hyperglycemia. Dr. Alicandro testified that based upon the chart, she was not involved in admitting the infant to the hospital and if the infant was in the care of pediatrics, his care would have been transferred by Dr. Mortimer to pediatric care, and not to her.

Dr. Wackett submitted the affirmation of Gregory I. Mazarin, M.D., in support of his motion. Dr. Mazarin affirmed that he is a physician licensed to practice medicine in New York State and is board certified in emergency medicine. He set forth his education, training, and work experience, as well as familiarity with the standards of practice in the field of emergency medicine. He stated that based upon his years of study in emergency medicine, his knowledge of resident training, and his experience, it is his opinion to a reasonable degree of medical certainty that Dr. Mortimer's plan to administer a p.o. challenge to the infant, and then admit or discharge him accordingly, did not deviate from normal medical practice to imply that Dr. Wackett should have intervened. Dr. Mazarin stated that at all times Dr. Wackett conformed to accepted standards of medical care for a second year resident, and did not depart from any appropriate standards of care and did not cause any injury to the infant.

Dr. Mazarin stated that Dr. Wackett, a second year resident in emergency medicine, obtained the infant's initial history and physical examination, followed by the examination of the attending emergency room physician, Dr. Mortimer, a typical practice in a teaching hospital such as Stony Brook University Hospital. Dr. Mazarin continued that Dr. Wackett presented the case to Dr. Mortimer, who was ultimately responsible for the infant's evaluation and plan of care, and that Dr. Wackett did not depart from the standard of care. He continued that Dr. Mortimer performed an independent physical examination of the infant so as to make the correct diagnosis, allowing for the teaching element to be met. Entries were made within the medical record reflecting the examinations. Dr. Mazarin stated that it is always the attending who makes the final decisions regarding medical management of a patient. He continued that the standard of practice as a second year resident was that Dr. Wackett was to write the history, report physical examination findings in the chart and to the attending physician, follow the assigned patient, obtain pertinent laboratory data, make that data available for the attending physician, and generally assist the attendings, who were Dr. Mortimer and Dr. Alicandro. He stated that Dr. Wackett followed the standard of care.

Dr. Marzarin set forth the infant's history and presentation to the emergency room, commencing July 23, 1998, noting a two day history of fevers to 105 with pinkish stool, and presentation to the emergency room the previous evening with fever. Dr. Mazarin set forth the tests which were done, and that the blood tests, urinalysis, blood cultures and chest x-ray were negative. The infant had decreased oral intake and no vomiting or diarrhea, rash, or upper respiratory tract infections. He had increased respiratory rate and lethargy. Upon examination, Dr. Wackett noted his findings, including clear tympanic membranes, among other things. Dr. Wackett then assessed the infant with febrile illness, and his plan was to obtain a complete blood count, blood culture, urinalysis, and chemistry, administer Motrin, start intravenous fluids, and to reassess the infant thereafter. Dr. Mazarin set forth the test results were normal. He indicated that when Dr. Mortimer examined the infant, he was not irritable during her examination. Dr. Mortimer agreed with Dr. Wackett's plan and, as per her custom and practice, would have reviewed test results, and the prior night's chart. Dr. Marzarin indicated that Dr. Mortimer went off duty at 4:00 p.m. and signed off to Dr. Alicandro, who agreed with the plan formulated by Dr. Wackett, to which Dr. Mortimer had also agreed. Dr. Mazarin stated that Dr. Mortimer testified that when she left, the infant had not yet been admitted. Dr. Mazarin noted that Dr. Alicandro testified that typically the attending would direct the resident to admit a patient.

Dr. Mazarin continued that Dr. Wackett recalled that Dr. Alicandro gave him the order to admit the infant, and that if an attending gave him the order to admit, he would make calls to make it happen. He stated that Dr. Wackett recalled speaking to a pediatric resident and pediatric attending about the admission, and that it was possible he spoke to Dr. Leslie M. Quinn. Dr. Mazarin stated that Dr. Quinn testified that on July 23, 1998,

she was the on-call pediatric attending physician, and as such, if she were notified by the emergency department, she would have to agree to accept the admission. She also testified that she was called about the infant "somewhere about 8:00 p.m.. Sometime before 10:00 p.m., the infant went to the pediatric floor.

Dr. Mazarin stated that, as a resident, Dr. Wackett would require approval from the attending to perform a spinal tap, and that in the emergency room, that authority would have been the emergency room attending. He stated that no such order was given by an emergency room attending. Dr. Mazarin opined that the record and the deposition testimony do not evidence any change in the infant's condition while he was in the emergency department on July 23, 1998, that would have warranted Dr. Wackett to disagree with Dr. Mortimer's original assessment and plan and consider performing a lumbar puncture on the infant. He continued that it was the attending physician's responsibility to act and/or to plan for the management of the patient, and it was Dr. Wackett's duty to follow the directives and orders of the attending emergency room physicians. Dr. Mazarin stated that there is no evidence that Dr. Wackett failed to timely follow any of the attending physician's orders or directives, and also did not fail to arrange for a timely admission of the infant to the pediatric department. He further opined that diagnosing meningitis in an infant such as Victor is a highly sophisticated item of medical knowledge and not one that anyone would expect a resident physician to know.

Based upon the foregoing, it is determined that Dr. Wackett has not demonstrated prima facie entitlement to summary judgment dismissing the complaint. While Dr. Mazarin has set forth the standard of care for Dr. Wackett as a resident, he has not set forth the standard of care for the emergency room attending physicians, Dr. Mortimer and Alicandro, to establish that the supervising physician's directions did not so greatly deviate from normal practice such that the intern or resident should be held liable for failing to intervene. This would apply to the decision to admit the infant and to perform the lumbar puncture. Dr. Mazarin does not indicate the standard of care for determining when a lumbar puncture should be performed, whether a differential diagnosis should have been considered and either ruled in or ruled out by either Dr. Wackett or the emergency room attending. The testimonies conflict concerning whether Dr. Mortimer or Dr. Alicandro gave the order to admit, when it was given, and to whom Dr. Wackett spoke, and at what time the attending Dr. Quinn was notified by him, if at all. Additionally, as will be discussed, plaintiff's experts have raised factual issues which preclude summary judgment from being granted to Dr. Wackett.

MOTION (016)

In motion (016), defendant, Siddharth Sharma, M.D., seeks summary judgment dismissing the complaint as asserted against him on the basis that during his care and treatment of the infant plaintiff, he did not exercise any independent medical judgment; he was under the direct supervision of the attending physician, Dr. Kallus; and his care and treatment of the infant was not the proximate cause of the plaintiff's claimed injuries. This motion has been filed after the completion of discovery and is considered.

Siddharth Sharma, M.D. testified to the extent that he is board certified in emergency medicine since 2001. He first became licensed in New York State in 1999, having completed a three year residency in emergency medicine at Stony Brook University Hospital. On July 22, 1998, after 8:00 p.m., as a second year resident, he saw the infant plaintiff in the emergency room at Stony Brook University Hospital, and signed him out at 2:00 a.m. on July 23, 1998. Dr. Lester Kallus, the attending physician, discharged the infant at approximately 2:20 a.m.

Dr. Sharma continued that after the infant presented to the emergency department, he was seen by the triage nurse at about 7:40 p.m., where an axillary temperature of 103 was obtained. He stated that an axillary temperature is less reliable than a rectal temperature, and may be one to two degrees lower. A rectal temperature taken at 8:10 p.m. was 105.7. He saw the infant and wrote his note at about 8:15 p.m., indicating the infant had a rectal temperature of 105.5 at home, with vomiting since noon. Motrin was given at 8:30 p.m. At 11:45 p.m., the infant's rectal temperature was 98.4, and his heart and respiratory rates were elevated to 190 and 42, respectively, which Dr. Sharma felt was due to the fever. The infant's mother informed him that Dr. Franco, their pediatrician, had seen the infant earlier that day, and diagnosed the child with an ear infection for which Ampicillin and Tylenol were prescribed. He vomited twice and had nothing to drink since 10:00 a.m. that day. The infant's mother also reported that he seemed lethargic. Dr. Sharma testified that the infant was smiling, looking around, and was not listless, so he did not feel he looked lethargic. He did not recall seeing the nurse's note which indicated the infant seemed lethargic. He felt that clinically, he could not see suggesting a lumbar puncture at that point. His differential diagnoses after examining the infant were possible bacterial infection, occult bacteremia, pneumonia, a urinary tract infection, meningitis, or viral infection. Ear examination was negative. He ordered a blood culture, CBC, Chem 7, urinalysis, and chest x-ray to help further evaluate the infant. He discussed his findings with Dr. Kallus, but did not remember if they discussed whether or not a lumbar puncture should be done.

Dr. Sharma testified that lumbar punctures or spinal taps could be done in the emergency room in 1998, on any age patient, including four and five month old babies, and pediatric consults could be obtained. There were no consults called for the infant that night and a lumbar puncture was not performed. He stated that the attending physician would determine if a lumbar puncture would be done, and the resident would perform the procedure, assisted by the attending, if assistance were needed. Dr. Sharma testified that meningitis in a four month old can present with fever, change in mental state, a stiff neck, enlarged fontanelle, poor feeding, and sometimes vomiting. With meningitis, the concern or problem is swelling of the brain which may be manifested by some fontanelle fulness when the child is raised, but not when lying flat. He discussed diagnosing and treatment for meningitis.

Dr. Sharma testified about the results of the laboratory studies obtained, and indicated that he did not consider the neutrophil level to be indicative of a bacterial infection and no bands were reported on the differential. The Chem 7 revealed an elevated glucose level of 231, however, its significance was unclear, given the infant's blood tests as a whole, and his physical examination. A finger stick blood sugar was 129, just slightly elevated. He then had a discussion with Dr. Kallus who thought the child looked well and that no obvious source of infection had been found. Dr. Kallus deemed it safe for the infant to go home and to follow up with his primary doctor. He had already been started on an antibiotic, was to be observed, given Tylenol or Ibuprofen for fever, and to return if there was persistent vomiting or difficulty tolerating oral feedings. Dr. Sharma stated that Dr. Kallus did not believe a spinal tap was necessary at this time.

Dr. Lester Kallus, testified to the extent that he was licensed to practice medicine in New York State in 1977 or 1978 and is board certified in emergency medicine, and was board certified in family practice, but did not recertify in that area. He started working as an attending physician at Stony Brook Hospital emergency department in 1981. On July 22, 1998, he saw Victor Savage in the emergency department and discharged him at about 2:00 a.m. on July 23, 1998. He learned thereafter from the child's mother that the infant had been admitted to the hospital with meningitis. He later discussed the matter with Dr. Sharma, and remembered their conversation about how good the child looked prior to discharge because he was smiling, looking around, and

interacting in his mother's arms. Dr. Kallus continued that when the infant was discharged, he had the benefit of the laboratory results, and felt the child would do well with good follow-up with his physician, the administration of fluids, and instructions to return if the infant appeared lethargic or had difficulty with fluid intake.

Dr. Kallus testified that he examined the infant and reviewed the chart either before or after seeing him. He had a discussion with Dr. Sharma who presented the history and findings after examining the infant. Dr. Kallus testified that he considered bacterial meningitis to be a more serious infection with the goal to diagnose and start treatment as soon as possible. Bacterial infection is the main concern of every patient with a fever. He observes and evaluates the child, evaluates the blood test results, looks for other causes of fever if the blood work and lab work is good, and if the child looks good without a fever, he is satisfied that a more serious cause of infection is less likely. He is then less likely to pursue a lumbar puncture, hospitalization and repeated blood cultures. Dr. Kallus testified that in 1998, lumbar puncture was the gold standard for diagnosing bacterial meningitis. Either the resident or the emergency room attending could perform the lumbar puncture, but the resident could not do so without prior discussion with the attending. He added that the microbiology department, which tests the spinal fluid, closed at midnight and did not reopen until 7 or 8 a.m. the following morning. He continued that the emergency room attending decides if admission is necessary, and may present findings over the phone to the attending physician. He stated that there is no practice for a pediatric consult in the emergency department, and he did not obtain a consult.

Dr. Kallus testified that some forms of bacterial meningitis in a baby that go untreated for even six hours can potentially have catastrophic effects on the baby, and in some babies, can cause permanent brain damage or even death. In deciding whether to do a lumbar puncture, a risk analysis is done to see if the benefits outweigh the risks. Dr. Kallus stated that infection, introduction of meningitis, pain, and bleeding are likely risks of the spinal tap. He continued that based upon the history, physical exam, and tests done in the emergency room on the night of July 22 into the early morning of July 23, 1998, he could not rule out the presence of bacterial meningitis in the infant, as one can never rule it out: one can only look at probabilities. He continued that every child with a fever is a child that may have bacterial meningitis, and to prove a child does not have meningitis is saying that every child with a fever requires a lumbar puncture. Dr. Kallus did not feel a lumbar puncture was indicated.

Dr. Sharma has also submitted the affirmation of William Myers, M.D. in support of his application for summary judgment. Dr. Meyers affirmed that he is licensed to practice pediatric medicine in New York State, and that he is board certified in pediatric medicine. Dr. Meyers has not set forth his education and training or work experience upon which he bases his qualifications to appear as an expert in this matter. He has, however, indicated the materials and records which he reviewed and upon which he bases his expert opinion, in part, although he does not identify such materials and records specifically.

It is Dr. Meyer's opinion to a reasonable degree of medical probability that there were no departures from the standard of care by Dr. Sharma during the July 22, 1998 emergency visit. He continued that Dr. Sharma's history, physical exam, assessment, plan, and orders were all within the standard of care for a four month-old infant presenting with the infant's signs and symptoms. Dr. Sharma, a second year resident at the time, monitored the infant in the emergency room for over six hours, and the infant was noted to be stable. Dr. Meyer described the examination performed by Dr. Sharma, the findings he documented, and the results of his

work-up and observations, which he stated did not suggest that the infant was suffering from bacterial meningitis or any other medical condition that required further work-up that evening.

Dr. Meyers stated that, specifically, a lumbar puncture was not indicated in the emergency room on July 22-23, 1998, based upon the clinical presentation and observation of an active, alert infant with the testing results obtained. Consultations with other specialists were not indicated as there were no signs or evidence of a primary neurologic illness. Admission to the hospital for further evaluation was not warranted based upon the infant's test results and his presentation over the six hour period. Dr. Meyers also opined that Dr. Sharma did not contribute to or cause the injuries the infant is alleged to have suffered.

Based upon the foregoing, it is determined that Dr. Sharma has not demonstrated prima facie entitlement to summary judgment dismissing the complaint. While Dr. Meyers set forth that he did not feel a lumbar puncture was indicated at the time the infant was seen by Dr. Sharma, he does not indicate the standard of care for Dr. Sharma as a resident, and he has not set forth the standard of care for determining whether or not a lumbar puncture should be conducted. Dr. Meyers has not set forth the standard of care for the emergency room attending physician, Dr. Kallus, to establish whether the supervising physician's directions did not so greatly deviate from normal practice that Dr. Sharma, as a resident, should not be held liable for failing to intervene. Additionally, as will be discussed, plaintiff's experts have raised factual issues which preclude summary judgment from being granted to Dr. Sharma.

MOTION (017)

In motion (017), defendants, Leslie M. Quinn, M.D., Stony Brook Children's Service, P.C. and Stony Brook Internists, seek summary judgment dismissing the complaint as asserted against them on the bases that they did not depart from the accepted standards of pediatric care and treatment and did not contribute to or proximately cause the injuries sustained by the infant plaintiff.

Jeannie Alicandro, M.D. testified to the extent that she had a conversation with her former supervisor at Stony Brook, Dr. Mark Henry, who advised her that when the patient is admitted to pediatrics, that the pediatricians are in charge. The ER attending or ER resident would discuss the patient with the pediatric attending to transfer care, and the pediatric attending would have to accept that admission. The pediatric residents would come to the emergency room to admit the patient, examine the patient, and write the orders in the hospital chart. The pediatric residents would be then communicating with the pediatric attending. Thereafter, the patient is brought to pediatrics.

Dr. Alicandro stated that the pediatric residents saw the infant at 5:00 p.m., and they would not have seen the infant for any reason other than admission. They would have spoken to the emergency room resident to obtain history, condition, course, and anything related. At 8:01 p.m. a call was made by nursing to obtain a bed. At 8:45 p.m., report was called, which, she stated, typically meant the patient was being transferred. She did not know what time the pediatric attending was contacted, but stated that the record indicated an admission to Dr. Quinn on the infant's disposition, and that Dr. Mortimer, whose shift ended at 4:00 p.m., signed it. The infant's admitting diagnosis, she stated, was hyperglycemia. Dr. Alicandro testified that based upon the chart, she was not involved in admitting the infant to the hospital. She continued that if the infant was in the care of pediatrics, his care would have been transferred by Dr. Mortimer to pediatric care, and not to her. Had the patient been signed out to her at 4:00 p.m., she would have evaluated the patient. When the pediatric residents

are seeing the patient in the emergency room, that means the patient is already admitted. When a call is made to the pediatric attending, the pediatric residents would be sent to the emergency room to write the admitting orders. When asked if there was anything in the emergency room record that indicated that it was not true that Dr. Quinn, per her testimony, was not contacted until 8:00 p.m., Dr. Alicandro stated that the nurses's noted that pediatric residents were in the infant's room at 5:00 p.m.

Dr. Leslie Quinn set forth in her affidavit that she is board certified in pediatrics and child abuse pediatrics. She averred that she was the on-call attending pediatrician for Stony Brook University Hospital's pediatric unit on July 23, 1998, and received a telephone call at home at approximately 8:00 p.m. from an emergency department resident about Victor Savage. Prior to that call, she did not care for or treat the infant in any way. She continued that the resident gave her some information concerning why he wanted to admit the infant. Although the infant was stable, he had hyperglycemia. Someone from pediatric endocrinology had been consulted, and they wanted the infant admitted. She was also advised of the infant's history of vomiting, fever, irritability, and that this was the second emergency room visit in two days. Dr. Quinn stated that she did not direct the pediatric residents to see the infant at 5:00 p.m., she did not know why they appeared in the emergency room, and that she had no responsibility to supervise them. She did not know if anyone in pediatrics was contacted regarding admitting the infant prior to her being called at 8:00 p.m. on July 23, 1998. Dr. Quinn stated that although she received the telephone call from the emergency room at 8:00 p.m., the infant was not admitted to her service until he actually arrived on the pediatric unit on the floor that night.

Dr. Quinn continued that she was concerned about the possibility of an infection and that the infant needed to have a work-up completed to fully evaluate him. She felt it was necessary that a spinal tap be done to rule out the possibility of meningitis infection, and advised the senior pediatric resident to admit the infant to the general pediatric unit, and to complete the work-up for infection by doing the spinal tap. Antibiotic treatment was also discussed and was to be started if the spinal tap look abnormal. She stated that the infant was admitted after 8:45 p.m. but before 10:00 p.m. when the senior resident timed a note in the records. The spinal tap was performed at about 11:00 p.m. She was advised by the senior resident that the spinal fluid was cloudy, an indication that there could be an infection. Antibiotics were ordered "stat" at 11:50 p.m., and administered 11 minutes thereafter. She saw the infant the following morning at about 9:00 a.m. on July 24, 1998, requested an infectious disease consult, and transfer of the infant to PICU (pediatric intensive care unit). Thereafter, she had no further involvement with the infant's care and treatment.

At her examination before trial, Dr. Quinn testified that she is licensed to practice medicine in New York State. In July 1998, she was employed by the State University of New York at Stony Brook, in the Department of Pediatrics, and was paid by the State University of New York. She was not affiliated with any professional corporations. She then testified that part of her salary comes from Stony Brook Children's Services, P.C., which is within the department of pediatrics. In 1998, as an attending physician on service in the pediatric floor, a patient would come to her either by admission through the emergency room, transfer from another hospital, or sometimes directly from one of the outpatient offices. Usually, she is contacted by either the emergency room attending or resident about an admission. She continued that the infant would not come under her care until he arrived on the pediatric floor.

Dr. Quinn testified that because of the high blood sugar, fevers, and vomiting, she had concerns of sepsis or infection rather than diabetes, which is why she asked the senior pediatric resident to do the spinal tap. She stated that sepsis would usually mean an infection, and meningitis is one type of an infection. She also

testified that the emergency room had also contacted endocrinology who advised to admit the child to general pediatrics and that they would see the child the following day. She thought it was possible that she spoke with the senior resident at 8:30 or 9:00 p.m., but was not really sure of the time. She did not consider an infectious disease consult at the time. She did not stress that the spinal tap had to be done in any specific amount of time, but stressed the importance of moving forward in an orderly fashion. Dr. Quinn continued that she was notified by the senior resident that the tap was cloudy, which indicated bacterial, viral, fungal, or parasitic infection, and that the resident was ordering antibiotics.

Dr. Quinn stated that it was her responsibility to supervise the pediatric medical students, residents, and chief resident of pediatrics. She read into the record her note from July 24, 1998, including examinations and findings, laboratory tests, and order to transfer the infant to PICU, due to continued irritability and gram negative rods recorded on the blood culture. She noted the infant's anterior fontanelle to be full, but not bulging, when it was palpated with the infant in a sitting position. Dr. Quinn testified that usually she assumes the care of the patient when the patient comes to the floor and gets admitted. If there is some concern or issue specifically expressed by an emergency room physician that she were needed in the emergency room, to do something or to assess something, she would certainly go to the emergency room. Dr. Quinn testified that on July 24, 1998, at 9:00 a.m., she countersigned the senior resident's note written by Dr. Bockova, on July 23, 1998 at 10:00 p.m.

Defendant Quinn has submitted the expert affirmation of Bruce Michael Greenwald, M.D. who affirms that he is a physician licensed to practice medicine in New York State and is board certified in pediatrics and pediatric critical care medicine. He set forth his education and training. He indicated that he bases his opinions on his clinical experience and professional education as well as pertinent medical records, although he does not identify those records he reviewed. He also reviewed the affidavit of Dr. Quinn dated November 21, 2013, and pleadings and depositions in this action as well as those from an earlier related matter. It is Dr. Greenwald's opinion to a reasonable degree of medical certainty that the care and treatment rendered by defendant Dr. Quinn to the infant, Victor Savage, was at all times reasonable, that she did not depart from good and accepted standards of medical practice, and she was not the proximate cause of either the child's bacterial meningitis or the sequelae of the condition.

Dr. Greenwald stated that bacterial meningitis is an infection of the covering of the brain which can extend into the brain itself. Signs and symptoms of bacterial meningitis can include high fever, irritability, inactivity, vomiting, and poor feeding, as well as elevated blood glucose levels associated with bacterial sepsis. If meningitis is suspected, a sepsis work-up, including lumbar puncture (spinal tap) is appropriate. He continued that permanent neurologic injury is common as a result of bacterial meningitis and can include significant cognitive and motor deficits as well as impairment of hearing and sight, and can lead to death.

Dr. Greenwald opined that Dr. Quinn was the first attending physician to suspect the possibility that the infant had meningitis and to formulate a plan of care accordingly, and directed that the infant undergo a sepsis work-up, including a spinal tap, which he opined was carried out in a timely way. The spinal tap confirmed the diagnosis of bacterial meningitis. Appropriate antibiotic therapy was timely instituted, after which the care of the infant was transferred from Dr. Quinn to Dr. Nesti, an intensivist in the PICU, and to other specialists as well.

Dr. Greenwald stated that the pediatric residents saw the infant plaintiff at about 5:00 p.m. He continued that Dr. Quinn denied sending the pediatric residents to see the child and did not learn about him, and did not become involved in the care of the infant, until about 8:00 p.m. on July 23, 1998. The infant was eventually admitted to PICU at 10:00 p.m. Dr. Greenwald stated that there is no evidence that Dr. Quinn agreed that the infant would be under her care as the accepting physician prior to his admission into the hospital. Dr. Quinn suspected the possibility of meningitis and ordered the pediatric house staff to perform a sepsis work-up, including a spinal tap, which was performed at 11:00 p.m. and revealed meningitis, caused by *Haemophiles influenza*. Dr. Greenwald stated that there was no need for Dr. Quinn to go to the hospital that evening to see the infant as antibiotics were ordered stat at 11:50 p.m. Dr. Quinn did finally see the infant at 9:00 a.m. on July 24, 1998, and requested a pediatric infectious disease consult and transfer of the infant into PICU.

Based upon the foregoing, it is determined that Dr. Quinn has not established prima facie entitlement to summary judgment dismissing the complaint. Dr. Greenwald did not set forth the standard of care, and stated in a conclusory manner that the care provided by Dr. Quinn was reasonable and appropriate, consistent with good medical practice, and did not cause or contribute to the meningitis or sequelae that resulted therefrom.

In opposing these motions by defendants, the plaintiff has submitted the unredacted, signed affirmations of her expert physicians, as required pursuant to *Marano v Mercy Hospital*, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998], and thus plaintiff's physician's affidavits are in admissible evidentiary form, have been considered, and returned to plaintiff's counsel. The affirmations have been submitted in opposition the motions submitted by Andrew Wackett, M.D., Siddharth Sharma, M.D., and Leslie M. Quinn, M.D.

Plaintiff has submitted the affidavit of her first expert who is duly licensed to practice medicine in New Jersey and is board certified in internal medicine, emergency room medicine, and infectious diseases. This expert averred to having practiced said specialties for over 40 years, and stated he is fully familiar with the evaluation, diagnosis, and treatment of newborns, infants, and young children with infections in the emergency room setting. He stated that he is also familiar with the standards as they existed in 1998 that pertain to the evaluation, work-up, diagnosis, and treatment of such patients on an in-patient basis, including pediatric patients; and the standards of accepted medical practice, as they related to residents in 1998. He indicated that he is familiar with the standards of care relative to the work up of patients for infectious diseases, such as meningitis and sepsis, including pediatric patients. He set forth the materials and records reviewed, including the opinions of plaintiff's emergency room and pediatric experts.

Plaintiff's first expert stated that the effects of untreated meningitis can be devastating to a patient, and thus it was incumbent upon the health care providers to follow accepted standards of care so as to prevent these consequences to the patient. Rapid recognition, proper evaluation and treatment of signs and symptoms of a progressive infectious disease process is required to provide for the safety of the infant. The progression of the serious conditions of sepsis and/or meningitis can be arrested, and the devastating effects eradicated, with timely institution of appropriate antibiotic treatment. In 1998, spinal taps were being performed regularly in the emergency room setting, as well as on patients admitted to units such as the pediatric floor, for the purpose of culturing the fluid obtained, and observing if the fluid is cloudy, which is presumptive of meningitis. Plaintiff's first expert stated that in 1998, in a four and a half month old infant with signs of lethargy, vomiting, irritability, and fever of 105 with continuing elevations, the physician is obligated to include in his/her differential diagnosis, the very real possibility that these signs and symptoms were the result of an infectious process.

Careful consideration and planning was required to ensure that the infectious process is not permitted to progress to a more serious infectious process, such as sepsis and/or meningitis.

As to Dr. Wackett and Dr. Quinn, plaintiff's first expert stated that, pursuant to the standard of care, Dr. Wackett, was required, as a resident, at a minimum, to be aware of the fact that the signs and symptoms presented by the infant could represent a very serious condition that required immediate and aggressive action directed at identifying the cause of the infant's condition, given the potential gravity of the situation. Further, stated plaintiff's first expert, Dr. Wackett was required to act immediately on the orders from an attending without delay, as any delay in orders can, and in this case did, result in a delay of an appropriate work-up and treatment. Intravenous fluids were ordered, however, the heparin lock was not inserted until 3:00 p.m., and thus the infant was not being hydrated prior to that time despite being in the emergency room since 11:19 a.m.

Plaintiff's first expert continued that, in 1998, once Dr. Quinn was contacted about the patient (the time of which is in dispute) she was required to immediately rule out meningitis and sepsis, through a lumbar puncture and administration of intravenous fluids and antibiotics. The failure to immediately institute this work-up was a departure from the standard of care. Such delays were the departure from the standard of care, and substantial contributing factors in causing injury to the infant. He continued that this standard of care is to prevent the serious consequences a patient may suffer should a potential infectious disease be left brewing and untreated. The plaintiff's first expert noted that the 5:00 p.m. emergency room record notes that the pediatric residents were in to see the infant. However, Dr. Quinn testified that she was not contacted until 8:00 p.m. and that she had no responsibility for the infant until he reached the pediatric floor sometime between 8:45 and 10:00 p.m. Thus, the expert stated, at a minimum, twelve hours passed from when the infant first presented to the emergency room until antibiotic treatment was instituted. The delays in the work-up and treatment of the infant were substantial contributing factors in causing injury to the infant, and resulted in the loss of chance by the infant for recovery without permanent brain injury.

The plaintiff's first expert noted the conflicting testimonies among Dr. Mortimer, Dr. Wackett, and Dr. Alicandro concerning with respect to when the child was to be admitted, when the child was actually admitted, who was responsible for the child after the decision to admit was made, when fluids were administered intravenously, and when Dr. Quinn was notified about the infant. He stated that if Dr. Alicandro's testimony is correct, then Dr. Wackett delayed four hours to call for admission, a departure from the standard of care. If Dr. Mortimer's testimony was correct concerning when the p.o. challenge was administered, and when the child vomited, and the failure of Dr. Wackett to document the time, it is impossible to tell how much time passed between the time of the failed p.o. challenge and the call to Dr. Quinn. If Dr. Wackett's testimony is believed, that Dr. Quinn was contacted at 5:00 p.m., and any delay in the admission, work-up and treatment of the child would be Dr. Quinn's delay, a departure from the standard of care. Then, if Dr. Quinn's testimony is believed, there was a significant delay from her being contacted and the performance of the lumbar puncture hours later, which should have been ordered stat by her. Thus, the factual issues cited by plaintiff first expert with regard to the disputed testimonies preclude summary judgment.

It is further noted that in opposing Dr. Quinn's motion, Dr. Alicandro submitted the expert affirmation of Dr. Andrew Sama, M.D., a physician licensed to practice medicine in New York State, who is board certified in internal medicine, emergency medicine, and pediatric emergency medicine, and whose practice is limited to emergency medicine. Dr. Sama stated that other than receiving intravenous fluids and vomiting once during the period after 5:00 p.m. on July 23, 1998, there is no documentation that the infant's condition changed or

deteriorated significantly before he was physically transferred to the pediatric unit. He also opined that clinical responsibility for an emergency room patient who has been admitted is transferred from the emergency room physician to the attending physician who is admitting the patient, when the emergency room physician notifies the admitting service and physicians from that service agree to admit the patient. This is so even if the patient has to remain physically present in the emergency room while a hospital bed is freed and prepared for the patient, whether it be unavailable for several hours or several days. This raises factual issues concerning with Dr. Quinn's opinion of when the care of the infant transferred to her. It is further noted that no one has submitted the hospital policy, if one exists, concerning who has responsibility for a patient when a transfer of care is being made relating to the admission process.

The plaintiff's second expert is a pediatrician licensed to practice medicine in New York State, who is board certified in pediatrics, with 15 years experience in the specialty. His affirmation pertains to other defendants, and not to the moving defendants in motions (015), (016) and (017). However, he set forth the standard of care for an infant presenting with those signs and symptoms presented by the infant plaintiff, and those standards of care comport with the standards set forth by plaintiff's first expert.

As to defendant Dr. Sharma, plaintiff's first expert opined that Dr. Sharma departed from accepted standards of care, as related to residents in 1998, and that those departures were substantial contributing factors in causing injury to the infant. He continued that in 1998, when a patient is under the care and treatment of a physician and reports signs and symptoms and /or complaints, that physician is required to formulate a differential diagnosis, the process whereby a list is made of the processes or diseases with the same or similar symptoms to those from which this patient is suffering by a systematic comparison, and contrasting of the clinical findings, and then ruling in or ruling out each condition or disease process. Such process may include consultation by a specialist in one or more fields of medicine. The most serious potential cause of a patient's condition are ruled in or ruled out first to minimize or avoid the most serious consequences facing a patient.

The plaintiff's third expert is a physician licensed to practice medicine in New York State who is board certified in internal medicine and emergency medicine, with over 15 years experience in said specialties. He affirmed that as an emergency room physician, he is familiar with the evaluation, diagnosis, and treatment of newborns, infants and young children with infections in the emergency room setting, and additionally works with and trains residents in the emergency room setting. He affirms he is fully familiar with the standards of accepted medical practice pertaining to patient and emergency care, as well as the standard of care applicable to residents in 1998. He opines with reference to Siddharth Sharma, M.D. and Lester Kallus, M.D.

The plaintiff's third expert set forth that any physician, including a resident, who undertakes the performance of an independent evaluation of a patient must include in such evaluation, a physical examination; the elicitation, recording and reporting of a complete history; the formulation of an appropriate differential diagnosis; the consideration of the need for any diagnostic testing, and where appropriate, initiation of steps necessary to complete a diagnostic work-up and render treatment. He continued that a resident in the emergency room setting who performs an evaluation of a patient has an independent duty to record and report all of a patient's reported signs and symptoms, as well as those symptoms observed in the emergency room itself. Recording and reporting all of a patient's signs and symptoms were required pursuant to good and accepted practice in 1998.

Accepted standards of medical care in 1998 required a physician to take immediate and aggressive action when presented with an infant four to five months of age with a history of vomiting, observations by the parent of lethargy and irritability, and a history of 105 fever. Such signs and symptoms should have raised significant concerns that the patient was suffering from an infectious disease process, whether meningitis, septicemia, or even a very bad localized infection, such as an ear infection. Irrespective of whether the disease process was meningitis, or some other infection, prompt treatment with intravenous antibiotics was required under this infant's circumstances. Plaintiff's third expert stated that it was a departure from accepted standards of medical practice to treat the infant plaintiff as a child with merely an ear infection, based upon the history of vomiting, significant fevers, lethargy and irritability, which clearly required more specific care and treatment, including a complete septic work-up, intravenous antibiotics, and intravenous hydration, immediately. This was the standard of care whether the infant had a progressing ear infection or some simultaneously occurring process. This is so to prevent the very serious consequences should a potential infectious disease process be left brewing and untreated.

It is well established, continued plaintiff's third expert, agreeing with plaintiff's expert pediatrician, that when a patient is under the care and treatment of a physician and reports signs, symptoms and/or complaints, the physician is required to formulate a differential diagnosis, pursuant to the standard of care. The physician is further required to take steps to ensure that the most serious potential cause of a patient's condition is ruled in or out first, to avoid or minimize the most serious disease process and /or illness responsible for the patient's condition. Here, the defendant was obligated to include an infectious process in the differential diagnosis, and then plan so as not permit the infectious process from progressing to a more serious infectious process such as sepsis and/or meningitis.

The plaintiff's third expert stated that a normal white blood cell count does not rule out meningitis in a four to five month old infant, and the diagnosis of meningitis is usually made by culturing bacteria from a sample of spinal fluid obtained by performing a spinal tap. Bacterial meningitis, he continued, can be treated with a number of effective antibiotics, and it is important that treatment be started early so as to eliminate and/or minimize injury, as per the standard of care in 1998. The absence of ominous signs of neck rigidity and bulging fontanelle do not rule out the presence of meningeal infection. He set forth the infant's history and presentation to the emergency room on July 22, 1998, where he remained for approximately six hours, and stated that Dr. Sharma failed to note the significant history of irritability and orange colored discharge in the infant's diaper, or diarrhea in the emergency room. Dr. Sharma, he stated, noted that the infant appeared less active to the mother, but he did not report this lethargy to Dr. Kallus. There was no observation of the infant's mental/neurological status following the 8:15 p.m. examination of the infant, or prior to his discharge. Motrin was administered at 8:30 p.m., but while Motrin reduces fever and inflammation, it eliminates the utility of diagnostic signs in detecting underlying conditions.

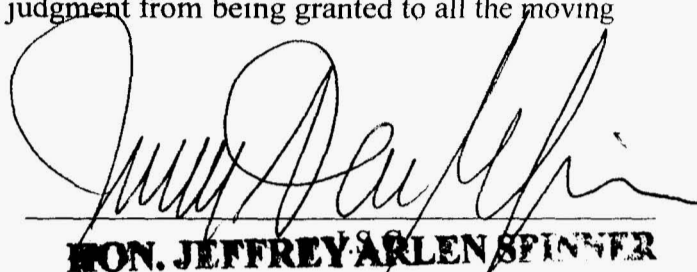
The plaintiff's third expert stated that none of the laboratory values obtained by Dr. Sharma and Dr. Kallus ruled out an infectious disease process, and he set forth the basis for such opinion. The infant's presentation in the emergency room gave rise to serious concerns which should have caused Dr. Sharma and Dr. Kallus to realize the infant was suffering from an infectious process which was not being effectively treated, especially in light of his being unable to hold down oral antibiotics and fluids. He opined that Dr. Sharma and Dr. Kallus both departed from the accepted standards of care on July 22, 1998 into the early morning hours of July 23, 1999. Dr. Sharma departed from the standard of care by failing to timely and accurately record a proper medical history and to timely report to the attending physician; failing to arrive at an appropriate differential

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diagnosis; failing to timely and properly re-examine the infant prior to discharge; failing to immediately admit the infant to the pediatric service; failing to order a complete sepsis work-up; failing to properly consider the infant's signs and symptoms; failing to consider that the infant was not being treated with antibiotics as he was unable to keep antibiotics down due to the vomiting; and failing to administer intravenous antibiotics and intravenous hydration. He continued that when the infant was admitted to Stony Brook Hospital the following day, he developed seizures, and underwent bilateral craniotomies and placement of a subdural drain, as a result of the failure to timely and properly diagnose and treat the infant for meningitis. Consequently, the infant has suffered brain damage, developmental delays, seizure disorders, and motor and cognitive impairment.

Based upon the foregoing, it is determined that the multiple factual and credibility issues raised by the conflicting testimonies, set forth above, preclude summary judgment from being granted to all the moving defendants.

Dated: May 21, 2014


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