[* 1]

SHORT FORM ORDER

COPY

INDEX No. 05-25014
CAL No. 13-01356MM

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

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 1-31-14
ADJ. DATE 3-7-14
Mot. Seq. # 004 - MD

---X

CHRISTINE DUMONT and GAETAN DUMONT, as parents and Natural Guardians of JASON DUMONT, an Infant, CHRISTINE DUMONT, Individually and GAETAN DUMONT, Individually,

Plaintiffs,

- against -

ELI ANKER, M.D., ELI ANKER, M.D., P.C. and GOOD SAMARITAN HOSPITAL and THOMAS K. LEE, M.D.,

Defendants.

---X

PEGALIS & ERICKSON, LLC
Attorney for Plaintiffs
One Hollow Lane, Suite 107
Lake Success, New York 11042

MATTURRO & ASSOCIATES
Attorney for Defendants Anker and Good Samaritan Hospital
1025 Old Country Road, Suite 110
Westbury, New York 11590

PHILLIPS LYTLE LLP
Attorney for Defendant Lee, M.D.
620 Eighth Avenue, 23rd Floor
New York, New York 10018

Upon the following papers numbered 1 to 69 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (004) 1-29; 30-31; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 32-62; 63-64; Replying Affidavits and supporting papers 65-68-no affidavit of service; Other 69 Rely Mem/Law-no affidavit of service; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (008) by defendant Thomas K. Lee, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied.

This medical malpractice action was commenced by Christine Dumont and Gaetan Dumont on behalf of their infant son, Jason Dumont, individually and derivatively, wherein they assert that due to negligent departures from good and accepted medical care and practice, the then ten year old autistic infant plaintiff was caused to suffer an infection, and to lose a portion of his colon and the terminal ileum, following an appendectomy performed on June 9, 2003 by Dr. Eli Anker at Good Samaritan Hospital, and subsequent surgeries by Dr. Thomas Lee on July 4, 2002, and July 22, 2003 at Stony Brook University Hosptial.

Dr. Thomas Lee now seeks summary judgment dismissing the complaint on the bases that he did not depart from the accepted standards of care and treatment and did not proximately cause the injuries

RST

claimed by the plaintiffs. This application is opposed by co-defendant Eli Anker, M.D. and by the plaintiffs.

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]).

In support of this motion for summary judgment dismissing the complaint as asserted against him, defendant Thomas Lee submits, inter alia, an attorney's affirmation; the expert affirmation of Stephen E. Dolgin, M.D. with curriculum vitae; copies of the summons and complaint, amended and supplemental summons and amended complaint, answer served by Dr. Lee; plaintiff's verified bills of particulars; various and partial uncertified printed medical records and medical records contained on CDs which are not in admissible form pursuant to CPLR 3212 and 4518; copies of the signed and certified deposition transcripts of Christine Dumont dated May 17, 2006 and Thomas Lee, M.D. dated April 8, 2013; curriculum vitae of Dr. Lee; unsigned but certified transcripts of the examination before trial of Christine Dupont, Eli Anker, M.D. dated July 28, 2006 and March 22, 2013, with proof of service pursuant to CPLR 3116. The moving defendant has not provided copies of the answers served by co-defendants, as required by CPLR 3212.

The general rule in New York is that an expert cannot base an opinion on facts he did not observe and which were not in evidence, and that the expert testimony is limited to facts in evidence (*see* ***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 uncertified medical records and CD provided by the moving defendants are not in admissible form and are not in evidence. In searching the record, copies of medical records, although not certified, have been provided by Dr. Anker in his opposing papers.

It is determined that even if all the pleadings were provided, as required, and the moving papers were in admissible form and legally sufficient on their face, summary judgment is precluded based upon Dr. Lee's failure to address the issue of proximate cause, and by the factual issues raised in the opposing papers submitted by co-defendant Anker and adopted by plaintiff.

Eli Anker, M.D. testified to the extent that he was a board certified general surgeon as well as a vascular surgeon, but he did not recertify in 2012. 95 % of his patients are adults, but he also treats some

teenagers and children, but no infants. The size of the child is also considered. He had admitting privileges at Good Samaritan Hospital in 2003. He testified that there is a board certification for pediatric surgery, but he did not do a fellowship in pediatric surgery and is not board certified in that area. He performed about 150 appendectomies on children in the past, and employed the cut-off at about age 13 or 14. Jason Dupont became his patient on June 9, 2003, as he was on-call through the emergency room at Good Samaritan Hospital that day. In evaluating possible appendicitis, he looks to how and when the symptoms began, and if there was abdominal pain, nausea, vomiting, anorexia (loss of appetite), or fever. Dr. Anker stated that the longer the symptoms continue, the greater likelihood of a ruptured appendix.

Dr. Anker testified that Jason Dupont was an autistic child, whose symptoms of abdominal pain, nausea, vomiting, fever, and anorexia began two days prior to admission. He diagnosed the child as having an acute abdomen from appendicitis, requiring surgical removal of his appendix. Jason weighed 100 pounds and was 5 feet tall. He stated that he has treated adult patients the same size. He did not feel that there was any difference between the presentation of Jason Dupont in 2003 from any adult patient with the same symptoms in terms of the operative procedure he anticipated performing on the child. With the child's presentation, there were no alternatives to surgery that he considered, and he did not think the child's appendix had yet ruptured. A ruptured appendix could present risks with anesthesia, infection, need for a secondary surgery, poor wound healing, and the potential for doing poorly postoperatively.

Dr. Anker testified that the anesthesiologist, Dr. Domingo, was present during the surgery. Upon initial exploration, Dr. Anker stated that he found an omental mass which appeared to be inflamed, which is not usually encountered with an appendectomy. He dissected away the omental mass surrounding the appendix, but he did not know if he had to cut it away from the appendix. Generally, he does not cut away the omental mass off the appendix itself. This enabled him to visualize the appendix. He further indicated that the presence of the inflamed omental mass suggested that the inflamed appendix had been there longer than rather than shorter. Further exploration revealed a peritoneal collection of fluid which he drained and sent for culture. He stated that a peritoneal collection of fluid can frequently be found in the absence of a ruptured appendix. The appendix was in a retrocecal position, which is less common that a non-retrocecal position. Because of the retrocecal position of the appendix, he then performed a retroperitoneal exploration, sharply and bluntly (with scissors and fingers), by going around the lateral side of the cecum. The appendix was inflamed, so it made it more difficult to dissect the appendix in the retrocecal position. He removed the appendix, which he stated had not ruptured, using multiple clamps. He swabbed the stump of the appendix with Betadine, then performed a copious amount of irrigation to wash out any material and potential bacteria.

Dr. Anker testified that the culture report of the fluid found in the peritoneum was E. coli, a bacteria most commonly associated with appendicitis. He believed the source of the E. coli was the appendicitis due to the inflammatory process which permitted the bacteria to leak out, and not due to a ruptured or perforated appendix in this case. He placed Jason on an antibiotic, Mefoxin, to which the bacteria was sensitive. There were no infectious disease physicians at Good Samaritan Hospital who saw pediatric patients. Postoperatively, Jason continued to vomit intermittently. He did not believe Jason had an abdominal infection at the time, so he discharged him home on the antibiotic Ampicillin. The pathology report from this June 9, 2003 admission indicated acute suppurative (consistent with severe infection) appendicitis with marked periappendicitis (inflammatory changes around the appendix). He noted that the report of the preoperative x-ray of the abdomen on June 9, 2003 indicated that there was a small area of

focal small bowel dilation, inflammation in the area, and that focal small bowel ileus is not excluded. Clinical correlation was suggested. Dr. Anker testified that this is consistent with appendicitis, and that there was no ruptured or perforated appendix as there was no free air demonstrated on the x-ray.

The infant plaintiff was readmitted to the Good Samaritan Hospital on June 15, 2003 through June 20, 2003 with a wound discharge for one day of whitish, followed by a yellow, foul smelling discharge. He had a fever of 102.7, and a white blood cell count of about 20,000. He saw the child on June 16, 2003 and thought he had a wound infection, which he treated with drainage and local care, and antibiotics, with improvement. He did not feel it was necessary for a ten year old to have a CT scan of the abdomen due to the radiation. The culture came back positive for E. coli and beta strep. After discharge, the child had home wound care to flush the area until it healed over. On June 26, 2003, when he saw Jason in his office, the child's abdomen was soft, the wound was healing , and there was minimal drainage. On July 2, 2003, the infant's mother called his office to advise he still had a low grade fever. Antibiotics were changed from Ampicillin to Amoxicillin. Subsequently, the child was admitted to Stony Brook Hospital.

Dr. Lee testified to the extent that he is a physician licensed to practice medicine in New York. In 2003, he was, and is presently, employed by Stony Brook Surgical Associates, which is the full-time practice for Stony Brook Medicine, the full-time faculty plan. He stated that Jason was admitted to Stony Brook Hospital on July 4, 2003 upon transfer from Southside Hospital. He reviewed the transfer record from Southside Hospital, and ascertained the child had a fever, rapid heart rate with tachycardia, some shortness of breath, rapid breathing, and abdominal pain with nausea, vomiting, and a mass in the right lower quadrant of the abdomen with drainage from his surgical wound from the appendectomy. He reviewed the CT scan from Southside Hospital which revealed a mass that was both a combination of a phlegmon (organized infection), as well as micro or small pockets of abscess in his abdomen. The mass was five centimeters. The child's white blood cell count was 16,000. He was aware that the child had been receiving antibiotics for about two weeks, and was concerned about not addressing the source of the infection directly. He determined that surgery was the best therapeutic option at that time.

Dr. Lee stated that he performed an exploratory laparotomy, on July 4, 2003, to explore the area of the abscess, and the neighboring appendectomy site. The preoperative diagnosis was abdomen abscess after appendectomy of June 9, 2003, and bedside exploration of the wound (incision). Dr. Lee testified that he encountered adhesions and an omental mass (layer of fatty tissue which often migrates to an area of infection) in the retrocecal area, a hole where the appendix stump was taken, and a hole in the cecum. He removed a portion of the omentum and found no other infected material within the abdomen, just in the mass. With regard to the hole in the cecum, he could not tell whether it created the omental mass or was part of the process. He did not know the amount of omentum removed, but cultured the purulent fluid contained within. The culture grew E. coli, anaerobic streptococcus constellates, and moderate bacteroides fragilis, all consistent with gastrointestinal tract bacteria. The pinhole at the presumed base of the previous existing appendix was also noted, which he repaired. He observed the entire cecum and noted it to be in healthy condition. A drain was inserted. The infant remained hospitalized until July 15, 2003, on intravenous antibiotics. The CT scan taken on July 10, 2003 indicated a fluid collection in the pelvis around the cecum, with a wall thickening of the cecum in the ascending colon with stranding and surrounding fat, so the child was discharged home with a PICC line to continue intravenous antibiotics. He did not opt for more aggressive surgery at this point as an ileocecal resection can have some of the consequences he saw in the follow-up visit with frequent bowel movements and concern for vitamin

deficiency. He testified that this was within the standard of care. He felt he could then manage Jason's infection postoperatively with antibiotics. In hindsight, however, it was not sufficient to eradicate the abdominal infection that he encountered on July 4, 2003.

Jason had a second admission on July 22, 2003 due to fever and vomiting after an outpatient CT scan which could not be completed as he was having bloody streaked vomiting while drinking. It did, however, show that there was interval resolution of the previously noted focal fluid collection in the cul-de-sac, interval development of multiple rim enhancing fluid collection in the right lower quadrant, some of which were surrounded by bowel loops in the left upper quadrant, markedly increased inflammatory changes in stranding in the right lower quadrant and anterior left upper quadrant, indicating that the infection was still not under control. On July 23, 2003, Jason was taken back to surgery for an open exploratory surgery, after eighteen days of antibiotic therapy.

Dr. Lee testified that this time, he encountered an abscess cavity adjacent and adherent to the ascending colon (which immediately follows the cecum), a new finding compared to July 4, 2003. He also documented a separate abscess in the ileocolic mesentery, in close proximity but separate from the aforementioned abscess, also a new finding. He also noted a new omental mass or abscess, and a perforation in the ascending colon, which was different from the perforation encountered on July 4, 2003. His impression was that it bore a relationship to the July 4, 2003 surgery as it was an ongoing infection which required more surgical debridement and drainage that was not adequately treated by the initial surgery and antibiotics. Dr. Lee continued that it is a standard risk in dealing with operations involving intra-abdominal infection. Dr. Lee also found an ischemic section of bowel involving the mesentery, wherein the blood supply was compromised either in terms or arterial flow or venous drainage, so he removed that section of bowel due to the questionable viability of the intestine ranging from the ileum to the ascending colon after drainage of the abscess. He stated that given the involvement of infection, it would be best treated to remove that section of the intestine. He removed ten centimeters of the terminal ileum and the entire ascending colon due to the blood supply distribution where the abscess had set, affecting the blood supply, as he did not want to jeopardize the anastomosis or hook-up of the bowel.

Dr. Lee also testified that he removed more of the omentum on July 23, 2003, but he did not remember the amount. Jason was discharged home on August 14, 2003, and was seen for an office visit on August 28, 2003. On September 4, 2003, he wrote a note to Jason's pediatrician advising that Jason had finally recovered from his appendicitis. He saw Jason again on January 20, 2004, and followed with another letter to his pediatrician that there had been a chronic appendiceal abscess. He testified that he was trying to convey the information that the infectious process went back to the initial appendicitis and appendectomy. Dr. Lee testified that due to the lack of an ileocecal valve (which he removed during the bowel resection), food content within the small intestines is seen in the colon, and causes further frequency of bowel movements. He recommended referral to a pediatric gastroenterologist.

When asked, Dr. Lee stated that he did not have a detailed chance to evaluate whether or not, before Jason became his patient, if the infection had been appropriately treated. When asked if Jason had septicemia on July 4, 2003, he stated he was concerned about it, but that he did not believe he had a true sepsis. He continued that he had all the warning signs for septicemia. He then testified that he believed Jason had sepsis at that time. He stated the child also had localized peritonitis in the right lower quadrant. He did not consider calling in an infectious disease consult because, as a pediatric surgeon, he is defined as

an expert and handles intra-abdominal infection. He stated he does not operate on all patients who have abdominal infections, and administers intravenous antibiotics to start. He did not consider percutaneous drainage, and set forth his reasons. Dr. Lee also testified that normally, omentum may cover the appendiceal stump after an appendectomy, but did not know if that was the case. Prior to the surgery he performed on July 4, 2003, there was intraperitoneal free air noted on the CT scan, which he stated was irrelevant as all perforated stumps do not leak air. He did not have an opinion for the cause of the pinhole in the appendiceal stump. He noted that he removed multiple hemoclips during the surgery of July 23, 2003. He did not see a clip on the appendiceal stump. When he first saw Jason, he considered consulting with an interventional radiologist, but ruled it out. Dr. Lee testified that where there is a leakage of bacteria from the appendix intraluminally (through the wall) to the peritoneum, it is a perforated appendix. He stated that perforation and rupture are synonymous.

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 [1999]). 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***, 224 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], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***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]).

Dr. Lee submitted the affirmation and curriculum vitae of his expert, Stephen E. Dolgin, M.D., who affirms that he is a pediatric surgeon licenced to practice medicine in New York State, and is board certified in surgery, with a special qualification in pediatric surgery. Dr. Dolgin set forth the materials and records which he reviewed. He opined within a reasonable degree of medical certainty that Dr. Lee's choice of treatment options, including surgery and antibiotics for Jason's significant abdominal infection, is assessed against the standards relevant to pediatric patients, as Jason was a child under the care of Dr. Lee.

Dr. Dolgin stated the Dr. Lee's decision to perform an exploratory laparotomy on Jason on July 4, 2003 was appropriate and not a departure from good and accepted pediatric surgical practice. Interventional radiology could not have effectively treated Jason's infection because it was phlegmonous and not a substantial collection of fluid. Given the history of failed antibiotic therapy and his presentation at Southside Hospital, and then at Stony Brook Hospital, Dr. Lee's decision to perform surgery on July 4, 2003, and his conduct of this surgical procedure were reasonable and appropriate. Percutaneous drainage

by interventional radiology was not within the standard of care as the phlegmon was not drainable. While antibiotic therapy can avoid operating in a chronically infected area, the disadvantage is that this approach may fail and can lead to multiple serious complications, such as fungal infection, resistant bacterial infections, or ongoing increasingly refractory intraabdominal sepsis. He stated that during the surgery, Dr. Lee performed a partial omentectomy which would not leave an abscess cavity that would have been appropriate for placement of an intraperitoneal drain, thus, Dr. Lee did not place an intraperitoneal drain in the July 4, 2003 surgery. Administration of intravenous antibiotics via the PICC line upon discharge was reasonable and not a departure from the standard of care.

Dr. Dolgin continued that when the child returned to Stony Brook Hospital on July 22, 2003, CT imaging indicated that there was an ongoing infection, and therefore, interventional radiology was not a reasonable option due to the small, multiple, diffuse fluid collections. The decision not to wait to see if further antibiotic therapy would work was reasonable and not a departure under the circumstances, since a course of intravenous antibiotics had already failed. Delay in surgery would have only led to a worsening of the child's condition. Thus, concludes Dr. Dolgin, Dr. Lee's decision to perform further surgery on the child on July 23, 2003, and to remove a portion of his bowel was also reasonable and appropriate and not a departure from good and accepted pediatric surgical practice. Dr. Dolgin stated that the ileo-cecal resection was appropriate and ultimately curative, and that when appendicitis becomes this complicated, such operation is often the way to solve the ongoing infection.

Dr. Dolgin did not offer any opinion with regard to proximate cause, nor did he opine that the care and treatment rendered by Dr. Lee did not proximately cause any of the alleged injuries to the infant plaintiff, or that there were no omissions from the standards of care and treatment. Thus, even if the moving papers were sufficient on their face, summary judgment is precluded.

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]).

Defendant Eli Anker, M.D. opposed the motion by Dr. Lee and submitted the affirmation of his expert, David Raphael Dorfman, M.D., who affirmed that he is a physician licensed to practice medicine in New York State and is board certified in diagnostic radiology with added qualifications in vascular and interventional radiology. Dr. Dorfman set forth his education and training, and his work experience, as well as the materials and records which he reviewed. It is Dr. Dorfman's opinion that Dr. Lee departed from good and accepted standards of care in that he decided to perform surgery on the infant without first obtaining consultation with infectious disease and interventional radiology prior to performing surgery on July 4, 2003. It is noted that plaintiffs also oppose Dr. Lee's motion for summary judgment on the basis of Dr. Dorfman's affirmation and expert opinion.

Dr. Dorfman stated that a consult with an interventional radiologist to assess the possibility of peructaneous drainage on July 4, 2003 should have been attempted prior to surgery, and that there was no reason not to treat with antibiotics first. The child's white count was 16,200, which was elevated but not as

high as when the child had a white count of 20,000 and Dr. Anker performed a simple drainage. His temperature was 100.4, which was not life threatening and did not require emergent surgery. Dr. Dorfman stated that Dr. Lee indicated in his initial admission note of July 4, 2003, that the CT showed a single abdominal abscess, and therefore, he should have considered a consult with an interventional radiologist regarding a per cutaneous drainage and antibiotic therapy to avoid surgery. Dr. Dorfman opined that surgery was done less than two hours after the child was admitted on July 4, 2003, without the consideration of antibiotic therapy.

Dr. Dorfman opined that the surgery on July 4, 2003 should have been the last choice, as the potential success of the operation is affected because the tissue is healing and is much weaker; knowing that there is an infection in the area to be operated will lead to a decreased success in the surgery and increase possible complications; there are routine complications of surgery which are greater than medical therapy and possible per cutaneous drainage; and the child was not so sick that medical therapy could not have been attempted, as based on the record. Dr. Dorfman continued that the child had not failed antibiotic therapy on all available antibiotics because he had not been treated with a broad spectrum intravenous antibiotic. On July 3, 2003, the child had been off antibiotics for three days. He indicated that although the mother had called Dr. Anker's office for a refill of the Ampicillin, the prescription was not refilled.

Dr. Dorfman stated the operative report from July 4, 2003 describes only a single purulent collection which was removed in total, and which could have been drained percutaneously. He stated that there is no description of a collection associated with the pinhole described, which Dr. Lee stated in his deposition was sealed by the overlying omentum. Dr. Dorfman concluded that the decision to perform surgery less than two hours from the child's admission without first obtaining the infectious disease consultation and interventional radiology consultation for possible percutaneous abscess drainage and antibiotic therapy was a departure from the standard of care.

Based upon the foregoing, it is determined that Dr. Anker has raised triable factual issues which preclude summary judgment on the issue of whether or not the infant should have had an infectious disease consult, administration of a broad spectrum intravenous antibiotic, and an interventional radiology consult with possible percutaneous drainage of the single purulent collection, prior to surgical intervention on July 4, 2003 by Dr. Lee; and also on the issues of whether or not Dr. Lee departed from the standard of care and treatment, and whether or not he proximately caused any of the injuries sustained by the infant plaintiff.

Accordingly, motion (004) by Thomas Lee, M.D. for summary judgment dismissing the complaint as asserted against him is denied.

Hon. Denise F. Molia

Dated: 5-21-14

A.J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**