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SHORT FORM ORDER

COPY

INDEX No. 11-22440
CAL No. 13-01477MM

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 1-13-14 (#002)
MOTION DATE 12-31-13 (#003 & #004)
MOTION DATE 4-18-14 (#006)
ADJ. DATE 4-18-14
Mot. Seq. # 002 - MotD # 004 -MD
003 - MD # 006 - MG

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ROSEMARY MAHLER, as Administratrix of the Estate of JOSHUA MAHLER and ROSEMARY MAHLER, Individually,

Plaintiff,

- against -

KATHRYN PARKER, M.D., RAHUL PENESAR, M.D., ALMAS ABASSI, M.D., DEVINA PRAKASH, M.D., SHAMEER LAPSIA, M.D., GAGAN SINGH, M.D., CHENG TING LIN, M.D., SETH O. MANKES, M.D., KIMBERLY JOYNER, M.D. and RICHARD JOSEPH SCRIVEN, M.D.,

Defendants.

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RST

Upon the following papers numbered 1 to 54 read on these motions for summary judgment an to discontinue; Notice of Motion/ Order to Show Cause and supporting papers (002) 1-15; (003) 16-21; 22-26; 27-33 (004) 22-26, including CD; (006) 27-33; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 34-37; 38-41; 42-45; Replying Affidavits and supporting papers 46-47; 48-49; 50-52; Other (004) 53- paper copy of defendant Prakash's CD exhibits 53, and 54-Prakash-CD-Exhibits A-I; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by defendants Seth Mankes, M.D. and Kimberly Joyner, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them, is granted as to Seth Mankes, M.D. and the complaint and any cross claims asserted against him are dismissed, and summary judgment dismissing the complaint is denied as to Kimberly Joyner, M.D.; and it is further

ORDERED that motion (003) by defendant Kathryn Parker, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is denied without prejudice to renewal; and it is further

ORDERED that motion (004) by defendant Devina Prakash, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is denied; and it is further

ORDERED that motion (006) by defendant Gagan Singh, M.D., pursuant to CPLR 3217 (b) and General Obligations Law § 15-108 discontinuing this action as asserted against her is granted, the stipulation of discontinuance is so ordered and the complaint is dismissed with prejudice as asserted against Gagan Singh, M.D., and the remaining co-defendants are precluded from seeking contribution and/or indemnification from Gagan Singh, M.D. at the trial of this action.

In this medical malpractice action, Rosemary Mahler, individually and as administratrix of the estate of decedent Joshua Mahler, seeks damages derivatively and on behalf of the decedent for pain and suffering and wrongful death alleged to have been caused by defendants' negligent departures from good and accepted standards of care and treatment. A cause of action for lack of informed consent has also been asserted. Commencing on or about August 14, 2009, the defendants rendered care and treatment to the eighteen year old decedent who was suffering from acute lymphocytic leukemia (ALL), and presented to Stony Brook Hospital emergency department with complaints of right leg pain, dizziness and double vision. It is asserted that the defendants failed to timely diagnose and treat the plaintiff's decedent for gas gangrene (Clostridium Perfringens) in his right thigh, resulting in his death on August 15, 2009 during his admission to Stony Brook University Hospital.

The note of issue and certificate of readiness were filed with this court on August 13, 2013. Pursuant to CPLR 3212, the last day upon which a motion for summary judgment could be made within the 120 days following such filing was on December 11, 3013. In motion (003), defendant Kathryn Parker, M.D. did not serve her motion for summary judgment until December 23, 2013, beyond the statutory 120 days permitted for serving such motion. Counsel for defendant does not mention the untimeliness of the motion and offers no excuse for the failure to timely serve this motion. "Good cause" in CPLR 3212 (a) requires a showing of good cause for the delay in making the motion-a satisfactory explanation for the untimeliness-rather than simply permitting meritorious, non-prejudical filings, however tardy. No excuse at all, or a perfunctory excuse, cannot be "good cause" (*see* ***Brill v City of New York***, 2 NY3d 648, 781

NYS2d 261 [2004]; ***First Union Auto Finance, Inc.***, 16 AD3d 372, 791 NYS2d 596 [2d Dept 2005; ***Tucci v Colella,*** 26 Misc 3d 1234A, 907 NYS2d 441 [Sup Ct, Kings County 2009]). Based upon the failure of counsel to offer any excuse, good cause has not been demonstrated.

Accordingly, motion (003) is denied with prejudice to renewal.

In motion (006), defendant Gagan Singh, M.D. (a/k/a Gagandeep Gill, M.D.), pursuant to CPLR 3217 (b) and General Obligations Law 15-108, has submitted a stipulation discontinuing this action against her with prejudice, signed by counsel for the plaintiff and defendant Singh. Although the stipulation was sent to the co-defendants, they have not signed it, nor has any co-defendant submitted an expert affirmation or affidavit demonstrating liability as to defendant Singh, or a basis for contribution pursuant to Article 14, or for indemnification (*see* ***Dembitzer v Broadwall Management Corp***, 2005 NY Slip Op 50303U, 6 Misc 3d 1035A, 800 NYS2d 345, 2005NY Misc LEXIS 420; citing ***Hanna v Ford Motor Co.***, 252 AD2d 478, 479, 675 NYS2d 125 [2d Dept [1998]), and no defendant has preserved any rights referable to CPLR Articles 14 and 16 or General Obligations Law 15-108 (***Drooker v south Nassau Comm. Hosp***, 175 Misc2d 181 (Sup Ct, Nassau County 1998]).

Accordingly, motion (006) is granted, and the complaint and any cross claims against defendant Gagan Singh, M.D. are dismissed with prejudice, and the co-defendants are precluded from asserting claims for contribution or indemnification as to defendant Singh at the time of trial.

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]).

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 [2nd 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]).

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]).

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]). Uncertified medical records are not in evidence.

In support of motion (002), Seth Mankes, M.D. and Kimberly Joyner, M.D. have submitted, inter alia, an attorney's affirmation; the affirmations of John Pellerito, M.D. and Mark Silberman, M.D.; copies of the summons and complaint, answers served by defendants Scriven, Joyner, Mankes, Parker, Penesar, Abbas and Prakash, Lapsia, Singh and Lin; plaintiff's verified bills of particulars; uncertified medical records which are not in admissible form pursuant to CPLR 3212 and 4518; transcripts of the examinations before trial of Seth Mankes and Kimberly Joyner; and the unsigned but certified transcript of Gagandeep Gill, formerly Gagan Singh.

Dr. Seth Mankes testified to the extent that he is licensed to practice in New York State and is board certified in diagnostic radiology with added qualification, CAQ in neuroradiology for a limited time, as he no longer does neuroradiology. He began his employment at Stony Brook University Hospital as a clinician and faculty member teaching residents in 2003. He worked in the Department of Radiology from 8 to 5. Once or twice a month from 5 to 8 in the evening, he read conventional radiographs in a section assigned for reading emergency room and inpatient studies, plain films, but he stated he did not usually show up until 6 or 6:30 to give the resident opportunity to look at some of the studies before he began a review with the resident. It was the junior resident's responsibility to interpret the conventional radiographs under the supervision of the attending radiologist. In this instance, Cheng Ting Lin was the resident radiologist. He stated that in reviewing the x-ray films, each film is inspected to rule out fractures, primary bone lesions, degenerative changes, and diseases which might involve the bone. The subcutaneous fat and muscles are observed for abnormal densities. There were no fractures or abnormalities seen on the decedent's x-rays of his knee.

Dr. Mankes indicated that a requisition form was received in the radiology department for an x-ray of the decedent's right knee. The x-rays were obtained, and the resident reviewed the images on a computer monitor, took notes, and dictated a preliminary report or draft entered into the PAC system or a Radiology Information System which is separate from PACS. For the purpose of the evening shift, after Dr. Mankes finished his review, he stated he would go home, and then call up the report on his home computer connected to the hospital network, review the drafts, then officially sign off on the reports or make changes that he thought needed to be made. He used the Radiology Information System at home for that, and the PACS to interpret the image in the radiology department with the resident. If the resident provided a preliminary verbal report to the requesting physician, it would be noted in the PACS, and sometimes in the report. Dr. Mankes testified that he would have seen the two reports associated with the two x-ray requests for decedent between 8 and 10 that evening, however, he did not recall interpreting the films. He electronically signed the report at 8:21 p.m., which concluded his review. The image of the right knee encompassed about two inches above and below the knee joint, including the structure of the patella of about four to six inches, totaling eight to ten inches. It was noted that there were two orders for the right knee x-ray, one at 5:20 p.m. and the other at 6:23 p.m. They were standard x-rays.

John Pellerito, M.D. has submitted his affirmation in support of defendants Mankes and Joyner. He affirms that he is licensed to practice medicine in New York State and is board certified in radiology. He set forth his education and training, and the materials and records he reviewed. It is Dr. Pellerito's opinion to a reasonable degree of medical certainty that the radiological care provided by Dr. Mankes to the decedent was in accordance with good and accepted radiological practice; that Dr. Mankes' interpretation of the right knee x-ray was not a substantial factor in the pain and suffering, death or any claim made on behalf of the decedent, Joshua Mahler.

Dr. Pellerito set forth that plaintiff's decedent was a recent high school graduate diagnosed with acute lymphoblastic leukemia (ALL) in July 2009. He was seen and treated at Stony Brook University Hospital for this condition and discharged on August 12, 2009. On August 14, 2009, the decedent presented to Stony Brook University Hospital emergency room at about 4:00 p.m. at which time a right knee x-ray was ordered at the request of the on-call pediatric oncologist, Dr. Prakash. Dr. Pellerito stated that he reviewed these anterior/posterior and oblique x-ray views of the right knee, and that they were adequate and diagnostic. A report was prepared by the resident and signed by Dr. Mankes, and accurately described the status of the right knee and surrounding area on that date, which was determined to be essentially normal. He continued that the x-ray films revealed no evidence of gas suggestive of a gas gangrene circumstance, and that there was nothing in the decedent's record on August 14, 2009 which should have triggered Dr. Mankes to be concerned with the possibility of gas gangrene as the radiology requisition suggested an evaluation relating to knee effusion (swelling) and hemathrosis (blood in the joint). Further, he stated, there was no indication for Dr. Mankes to make any recommendation to the clinical providers as to any other radiology tests, images, or evaluations.

Dr. Pellerito continued that since Dr. Mankes' radiographic care was in accord with good and accepted medical practice, it is his opinion to a reasonable degree of medical certainty that Mankes' limited involvement was not a substantial factor in the claims of pain and suffering and death of Joshua Mahler. He stated that Joshua was admitted to pediatric oncology services, and in the early morning hours of August 15, 2009, a clinical assessment was made suggesting the presence of gas within the left thigh, and an

impression of gas gangrene was made. Dr. Pellerito stated that these circumstances were not related to the interpretation of the right knee x-ray or the ultimate diagnosis or delay in diagnosis.

The plaintiff did not oppose Dr. Mankes' application, and has thus failed to raise factual issues to preclude summary judgment from being granted to Dr. Mankes.

Accordingly, that part of motion (002) by Seth Mankes, M.D. for dismissal of the complaint as asserted against him is granted and the complaint and any cross claims against him are dismissed.

Kimberly Joyner, M.D. testified to the extent that she became licensed to practice medicine in New York State in 2006 and has been board certified in pediatrics since 2007. She completed her residency at Stony Brook University Hospital and became an employee of Stony Brook in 2006 as a pediatric attending physician in the pediatric urgent care setting module, and served as a clinical assistant professor of pediatrics. She moved to the pediatric emergency department immediate care section in 2007. There was transition from immediate to acute care between 2007 and 2009. She supervised Dr. Gagandeep Gill, formerly Gagan Singh, a PGY1 on a pediatric rotation in the pediatric department of the emergency department in 2009.

Dr. Joyner testified that the decedent presented to the emergency department on August 14, 2009, and had been diagnosed with ALL about three weeks prior in the oncology hematology department at Stony Brook, and was discharged August 12, 2009 from the hospital. He presented with right lower leg extremity pain that began that day at home, and which progressed in nature and intensity. When the father called the pediatric hematology oncology nurse practitioner on call prior to presenting to the emergency department, it was recommended that Joshua be given pain medication, Oxycodone, to see if the pain would improve. It did not. Joshua then presented at Stony Brook University Hospital emergency room, very uncomfortable, pointing to pain in his right lower extremity, specifically his mid thigh to knee on the right extremity. He had no fever, no vomiting or diarrhea, no trauma, and no weakness or sensory loss. Joyner and Dr. Singh took a history and examined Joshua, obtained preliminary labs, provided Morphine for pain intravenously. She recommended that Dr. Singh call the oncologist hematologist on call, Dr. Prakash, whose instructions they followed. Dr. Joyner stated that she left work at 6 p.m., having reported off to her colleague. The decision was made to admit Joshua.

Dr. Joyner testified that Joshua advised that he had pain in his right lower extremity, but she could not remember the severity or type of pain. Dr. Joyner continued that Joshua had tenderness to palpation from his mid thigh to his knee on his right extremity. There was no swelling, redness or other discoloration or warmth. He had sensation, but limited range of motion of the knee and entire lower extremity from the pain. If he had swelling, she testified, it would indicate to look for something else, as swelling is found with local congestion or inflammation, and helps to weed out the main and different conditions in the differential diagnosis. Dr. Joyner testified that Joshua had decreased range of motion in his right hip and knee due to significant pain. She recall him grabbing his leg between his knee and his hip from the pain. He also had purpurea of his bilateral lower extremities from his shin to his ankles. Dr. Joyner testified that these purpuric lesions are evident in many different processes, including issues with platelets caused by destruction or lack of production; congenital issues such as infections; acquired infections; drugs; viruses; trauma; or anaphylactic reaction. Her plan was to get basic labs, place an intravenous, provide pain medication as his pain was 10/10, and contact the on-call hematology oncology attending, Dr. Prakash.

Dr. Joyner testified that she felt it was a perplexing physical examination and that the cause of decedent's pain was not clear. She did not note any differential diagnoses, but did consider bone pain associated with ALL, from the side effect of the medication he was taking at home, or from chemotherapy. Dr. Joyner stated that she did not feel any radiographic studies would offer help in deciding the cause of Joshua's pain. Dr. Prakash requested an x-ray of the right knee, and a right lower venous Doppler, coagulation study, and admission. Dr. Joyner testified that that was the first time she gave consideration to having an x-ray done. There was concern Joshua may have a blood clot in his leg. She left work at about 6 p.m. after writing the order to admit Joshua and reporting to Dr. Christopher Carleo, an emergency department attending. On August 15, 2009, she learned from Dr. Singh that Joshua had died from an infection.

Dr. Gagan Singh (Dr. Gagandeep Gill) testified that Dr. Joyner informed her of Joshua's passing. She also spoke to Dr. Lapsia who advised her he was present for the code which was called for Joshua, and that he was upset about the situation. Dr. Singh also spoke with Dr. Kathryn Parker after Joshua's death and they consoled each other. Dr. Singh testified that she was an intern rotating through the pediatric emergency room on August 14, 2009, and had completed about 10 or 14 days of a 4 month rotation. She was the first physician to see Joshua in the emergency room and was supervised by Dr. Joyner, her attending physician. She testified that when she first saw Joshua with his father, she noted Joshua was in a significant amount of pain, holding his right lower extremity over his thigh area. Joshua's level of pain and history of ALL was out of her comfort level, she stated, so, she went to Dr. Joyner and spoke to her about Joshua. Dr. Joyner then saw Joshua, supervised her examination of him, and performed her own examination. Joshua described the pain as 10/10 and crushing. He stated he could not bear weight on his leg due to the pain in his right thigh. She noted that Joshua could not cooperate with the examination due to acute distress. She also noted bilateral purpurea or vascular rash on both of his lower legs. Upon completion of the exam, she called hematology/oncology and spoke with Dr. Prakash, the attending covering pediatric hematology/oncology, and took her orders, including pain medication, labs, peripheral intravenous, diagnostic imaging consisting of venous duplex and right knee x-ray, and accepting Joshua onto her service for admission to Stony Brook Hospital. Joshua was transferred out of the emergency room into the hospital at approximately 8:10 p.m. on August 14, 2009. Just before the transfer, Joshua passed bloody urine, of which she advised Dr. Carleo. She also made Dr. Kathryn Parker aware that a urinalysis and culture were ordered.

Mark Silberman, M.D. affirmed that he is licensed to practice medicine in New York and is board certified in internal medicine, pulmonary medicine, critical care medicine, and emergency medicine. He set forth his education, training, and work experience, and the records and materials which he reviewed. His affirmation is submitted on behalf of defendant Kimberly Joyner, M.D. It is Dr. Silverman's opinion within a reasonable degree of medical certainty that defendant Joyner acted in accord with good and accepted standards of emergency medicine practice, and that her care and treatment was not a substantial factor with regard to the allegations of pain, suffering, and the death of Joshua Mahler. On August 15, 2009, Dr. Joyner learned from Dr. Singh that Joshua had died from an infection. Dr. Joyner did not recall if she considered infection in her differential. She did not consider gas gangrene.

Dr. Silberman stated that the decedent was diagnosed with ALL in July 2009. He had been treated for this condition by the pediatric oncologists at Stony Brook University Hospital as an in-patient, and was discharged on August 12, 2009. On August 14, 2009, the decedent presented to the emergency room at

Stony Brook with complaints of increasing pain in his right leg, centered in the upper portion of his right leg from just below the hip down to the knee. The triage note indicated the decedent had pain in the right lower extremity since the morning, becoming progressively worse. Approximately 45 minutes after the decedent was admitted to the emergency room, he was evaluated by Gagan Singh, M.D., a resident, and then by Kimberly Joyner, M.D., the attending emergency room physician. Dr. Silberman stated that Dr. Singh noted the decedent could not move his right lower extremity, was unable to flex his right knee, had tenderness on the posterior aspect from the knee to the upper right thigh, but that he had normal sensation bilaterally. Dr. Silberman stated that Dr. Joyner noted the decedent had right lower extremity pain beginning today, without fever or trauma, and pain to the right upper thigh to knee, with superficial tenderness upon palpation of the right thigh/knee, and limited range of motion due to the pain. She stated that Joshua appeared non-toxic. Dr. Prakash, the pediatric oncologist on call was contacted, various diagnostic studies were ordered, and a plan was formulated and instituted. Joshua was admitted to the inpatient pediatric floor about 8 p.m.

Dr. Silberman stated that Dr. Joyner's shift ended at 6 p.m., prior to Joshua's admission to the hospital, and his care was turned over to Dr. Carleo. No changes in the decedent's condition were noted in the record between 5 and 6 p.m. Dr. Silberman continued that after midnight into the early morning hours of August 15, 2009, Joshua was diagnosed with gas gangrene of the right thigh, secondary to a Clostridium Perfringens bacteria. It is Dr. Silverman's opinion that Dr. Joyner acted in accordance with the good and accepted emergency medicine practice within the time frame of the decedent's arrival to the emergency room through the transfer of his care to Dr. Carleo. He continued that Joshua was promptly triaged, and timely seen and evaluated by Dr. Joyner, who performed an appropriate history and physical, and observed the right leg for any abnormalities. He continued that Dr. Joyner's progress note does not memorialize any evidence of gas within the right thigh, and that she found no signs whatsoever of infection upon examination due to the absence of warms and redness in the right lower extremity. He opined that if there was a presence of gas within the soft tissues of the right thigh, crepitus (grating) on palpation of the leg would be identified, and crepitus was not identified in Joshua's right leg, so a clinical diagnosis of gas gangrene could not be made.

Dr. Silberman continued that Dr. Joyner appropriately ordered blood tests to further evaluate Joshua's medical and metabolic status, that the oncology attending be contacted, and she obtained an x-ray of the right knee. However, Dr. Joyner was not available to review the results of that x-ray, as she had turned over care of the decedent to Dr. Carleo. Dr. Silberman stated that there was no indication for Dr. Joyner to order an x-ray of Joshua's right thigh or hip, despite the "mere fact" that Joshua had pain from just below the hip to the knee. There was no traumatic event and no crepitus to suggest the need. Dr. Silberman continued that it was clear that Joshua was ill, given his history of chemotherapy from ALL and right leg pain, but it was not possible during the short time Dr. Joyner treated Joshua for her to make a diagnosis of gas gangrene, because he had no fever, redness, increased warmth, or crepitus. Dr. Silberman stated that the explosive nature of the infection and Joshua's rapid demise was due to his severely compromised state as a result of his acute leukemia and the absence of white blood cells in his bloodstream, expected after chemotherapy. Joshua had non-specific limb pain so that Dr. Joyner could not have diagnosed gas gangrene. Thus, stated Dr. Silberman, Dr. Joyner's care and treatment was not a substantial factor in the events which followed. The subsequent treating medical providers were responsible for review and evaluation of the various test results and evaluation of Joshua's evolving condition.

The plaintiff has submitted the affirmation of her expert physician, William M. Lipsky, M.D.[1] who is licensed to practice medicine in New York and is board eligible in internal medicine and a diplomat of the American Board of Disability Analysis. He set forth his education and training and work experience, and the records and materials which he reviewed. He set forth Joshua Mahler's course of care and treatment upon admission to the emergency room at Stony Brook University Hospital and his admission into the hospital. Dr. Lipsky stated that Joshua was diagnosed with gas gangrene infection, a condition most often caused by bacteria, Clostridium Perfringens, the organism cultured from Joshua. He continued that, as the bacteria grows inside the body, it makes gas and harmful substances known as toxins that damage body tissues, cells and blood vessels. Dr. Lipsky stated that gas gangrene is a clinical emergency, develops suddenly, and usually occurs at the site of a trauma or recent surgical wound, or, as in this case, the site of an intramuscular injection. He stated that it causes very painful swelling, severe pain consistent with the complaints made by Joshua upon his presentation to the emergency room, which raises a red flag to the clinician who must be diligent in determining the cause. If the condition is not treated, the patient can develop shock, with decreased blood pressure, kidney failure, coma, and death, which is what occurred in Joshua's case. Cultures must be taken, along with x-rays, CT scan or MRI of the affected areas which may show gas in the tissue, and this is what occurred when the x-ray of Joshua's abdomen revealed gas, albeit too late to save Joshua. Once gas gangrene is diagnosed, surgery must be performed emergently to remove dead, damaged, and infected tissue, and in some cases, surgical removal (amputation) of an arm or leg to control the spread of the infection.

Dr. Lipsky continued that when Joshua presented to the emergency room with pain in his right thigh on a scale of 10/10, his complaint was out of proportion to the findings on physical examination, as documented by Dr. Singh and Dr. Joyner. Dr. Lipsky opined within a reasonable degree of medical certainty that this degree of out-of-proportion pain was the hallmark clinical sign of gas gangrene, and an x-ray of the right thigh would have revealed lucence in the tissue consistent with air in the tissue, which would have prompted immediate surgical and antibiotic intervention. When the "hematuria" (blood in the urine) was first noted, a stat urinalysis should have been done, not two hours later as in this case. When it was done, the test revealed a few red blood cells, and the color of the urine was no doubt due to a breakdown of muscle tissue secondary to the early stages of gas gangrene. Such a finding on the urinalysis would have indicated tissue destruction and the need for a stat x-ray of the right thigh.

Dr. Lipsky opined within a reasonable degree of medical certainty that it was a departure from good and accepted practices by Dr. Joyner to fail to order a CT or plain x-ray series of Joshua's right thigh on a stat basis at the time of the initial evaluation at 4:45 p.m. on August 14, 2009, as Joshua's complaints and history were a red flag to Dr. Joyner. Dr. Joyner had a duty to be diligent in determining the cause of Joshua's severe thigh pain which had started earlier in the day, steadily increasing in intensity despite the administration of oxycontin and acetaminophen. Dr. Lipsky stated that Dr. Joyner testified she did not consider recommending or ordering any radiographic studies, which was a departure from the standard of care, especially in light of her testimony that Joshua's clinical picture was unclear. She failed to consider that Joshua's severe pain may have been caused by a deep infection or abscess. A CT scan or plain x-ray of the thigh should have been ordered stat by Dr. Joyner when she saw Joshua at 4:45 p.m., and the failure to do so was a substantial factor in the death of Joshua, as it would have revealed subcutaneous air involving

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[1]Dr. Lipsky is identified by name in counsel's affirmation.

the right thigh, and diagnosis of gas gangrene would have been made at that time. Dr. Lipsky continued that his opinion is based upon the deterioration of Joshua's condition between the time of presentment to the emergency room at 4:32 p.m. and 3:30 a.m. when the diagnosis of gas gangrene was made, and upon the basis of the x-ray done at 1:17 a.m.

Dr. Lipsky stated that defendant's expert, Dr. Silberman, opined that there was no indication for Dr. Joyner to order a plain x-ray of the right hip and/or thigh given the lack of trauma and crepitus upon examination, and no reasonable basis for Dr. Joyner to suspect the presence of gas gangrene. Dr. Lipsky disagrees with Dr. Silverman's opinion given that Joshua's complaints of pain were inconsistent with his clinical picture and history. Lipsky opined that a deep infection or abscess should have been considered by Dr. Joyner. Dr. Lipsky continued that Dr. Joyner failed to consider such differential diagnosis, which represents a departure from the standard of care. While Dr. Silberman opined that the diagnosis of gas gangrene was not possible during the short period of time that Dr. Joyner was caring for Joshua, Dr. Lipsky disagreed and opined that had radiographic studies been performed at the time of Dr. Joyner's initial evaluation of Joshua, the diagnosis would have been made, resulting in timely intervention which would have saved Joshua's life. While Dr. Silberman opined that Dr. Joyner's care and treatment of Joshua was not a substantial factor in the pain and suffering and death of Joshua, it is Dr. Lipsky's opinion that the failure of Dr. Joyner to order appropriate radiological studies caused in a delay in the diagnosis and treatment of Joshua's condition and resulted in his death. By the time the diagnosis was made at about 3:30 a.m. on August 15, 2009, it was too late to reverse the course of the disease.

Dr. Silverman's reply affirmation serves only to raise further factual issues. Based upon the foregoing, the plaintiff has raised factual issues which preclude summary judgment from being granted to Kimberly Joyner, M.D.

Accordingly, that part of motion (002) by Kimberly Joyner, M.D. for summary judgment dismissing the complaint as asserted against her is denied.

In support of motion (004), Devina Prakash, M.D. has submitted, inter alia, an attorney's affirmation; multiple exhibits contained on a CD which is not in admissible form, but which exhibits have been provided in paper form as requested, and contain copies of hospital/medical records which are not certified, and copies of the deposition transcripts contained on the CD; and the CD with exhibits A-I; and the affirmation of Bruce Frederick Farber, M.D.

Dr. Prakash testified to the extent that she is licensed to practice medicine in New York State and is board certified in pediatrics and pediatric hematology/oncology. She assumed call as the pediatric hematology/oncology attending on Friday, August 14, 2009 at 5:00 p.m. until 8 a.m. Monday morning. On weekends, there is a pediatric hematology senior resident in pediatrics who takes care of all the patients on the general pediatric floor as well as the pediatric hematology/oncology floor. Joshua had not been her patient, and the first she learned of him was when Dr. Gagan Singh called her between 5:00 and 5:30 p.m. on August 14, 2009. She was not sure where she was at the time, but she could have been driving home. She was contacted because of the underlying problem of acute leukemia, although he presented with pain in his thigh. Dr. Prakash testified that she was familiar with the protocol Joshua had received as he was day 17 of induction chemotherapy. She was aware he received Asparaginase, one dose by intramuscular injection into his thigh, on about day four or five of the induction, and that Asparaginase has a fairly

reasonable risk of causing a clot to develop. So her first concern was that he may have developed a clot in his leg, as the timing was consistent. She testified that she told Dr. Singh that she wanted a Doppler of the leg done immediately to rule out a clot, to start Joshua on pain medication, and to admit him due to the amount of pain he was having. Dr. Prakash testified that Dr. Singh ordered the Doppler at 6:15 p.m., which study would be read by the vascular radiologist. Joshua went for the exam about 6:35 p.m. and returned to the emergency room at 8:00 p.m. She ordered no other consults. She further testified that she gives recommendations which may or many not be implemented by the emergency room physicians based on their agreement. She did not indicate a differential diagnosis to Dr. Singh. Dr. Prakash testified that she made the decision that going to the hospital to evaluate Joshua was not warranted.

Dr. Prakash testified Dr. Parker, the senior resident, was advised that the DVT was negative. Dr. Parker called her at home and reported the result to her about 9:15 to 9:30 p.m. She stated that Dr. Parker did not advise her what tests had been done. Joshua had been admitted to the floor about 9 p.m., was seen by Dr. Parker who advised her that Joshua's vital signs were stable, that he looked okay, and still had tenderness in his thigh. Dr. Prakash was then concerned that Joshua might have cellulitis in his thigh because the Asparaginase had been given intramuscularly into that thigh, and an infection might have developed from a small hematoma which can be the nitus for infection. She did not consider anything else in her differential. A blood culture and CRP were ordered, and antibiotics were started. Since nothing had changed, she determined that it was not necessary for her to go to the hospital to evaluate him. She testified that patients who are neutropenic and immunocompromised may not show a lot of erythema or redness at the site of infection. The antibiotic was given at 11 p.m. Dr. Prakash testified that she did not order an x-ray of Joshua's thigh, but someone did. She continued that an x-ray of the thigh would not have assisted in either ruling in or out cellulitis, but it would be helpful with gas gangrene. Dr. Prakash testified that it would take hours for crepitus in the tissue to develop; that it is rapidly evolving; and it produces a toxin which causes hemolysis, or breakdown of the blood. The patient then presents with jaundice, blood in the urine, pain, and crepitus which is the most prominent clinical finding. She continued that crepitus appears very late in the infectious process. When there is jaundice and blood in the urine, it is very late, and they go into septic shock from the toxins.

Dr. Prakash continued that she received a telephone call from Dr. Parker about 2:30 a.m. and she arrived at the hospital about 3:00 a.m. She testified that Dr. Parker advised her over the phone that Joshua's status changed, his blood pressure was dropping for which she gave fluid boluses, and his jaundice was worsening. She testified that Dr. Parker did not report to her earlier that Joshua had jaundice. When she learned of the jaundice, she thought there was something else going on and that she should evaluate him herself. She testified that the drop in blood pressure and the development of jaundice should have been reported to her immediately. She stated that Joshua was clearly going into septic shock, if he wasn't there already, but that did not explain the jaundice. She thought it might be TTP (thrombotic thrombocytopenia purpurea). Dr. Penesar, the pediatric intensivist attending physician in PICU, advised her when she arrived that he had everything under control, and that Joshua was going into septic shock. She spoke to Joshua's mother who told her that Joshua had swelling in his thigh in the emergency room; that he had been jaundiced since the evening; and that she told someone in the emergency room that his urine was red. Dr. Prakash then saw Joshua. When she placed her hand on his thigh, she felt crepitus, and saw it was swollen. That was when she made the diagnosis of gas gangrene. They looked at an x-ray of Joshua's abdomen, which inadvertently included part of his thigh, and the gas could be seen on the x-ray. She spoke with the Sharon Nachman, M.D., the infectious disease attending, and to Dr. Scriven from surgery. Although

Joshua had been transferred to PICU and the service of Dr. Pensear at 3:00 a.m., she stayed through the morning because he was so sick.

Dr. Prakash testified that Dr. Scriven performed fasciotomy surgery on Joshua's right thigh at the bedside to prevent compartmental syndrome. Ultimately, Joshua was never transferred to the operating room to remove the necrotic muscle tissue in his thigh because he was not stable enough. Joshua had been intubated and medicated, so he did not regain consciousness. His pupils were fixed and dilated after the first code, indicating he had potentially already suffered brain hypoxia and brain damage. His hemoglobin dropped to 3 grams, and they are willing to tolerate only 8 grams, so they pushed blood with a syringe. Dr. Prakash stated that this happened due to the hemolysis from the gas gangrene. The toxins produced by gas gangrene cannot be removed surgically. Penicillin and Clindamycin were ordered at 3:30 a.m., but were not administered until 4:37 and 4:53 a.m. because they had to keep calling pharmacy to get it. Joshua coded a second time and was pronounced dead on the morning of August 15, 2009.

Dr. Prakash also testified she later learned that when Joshua was admitted to the floor, he was noted to be dusky and cool to touch. Dr. Prakash testified that Dr. Parker did not tell her that, and she also learned that there was some clamping down which would suggest that he was already starting to go into septic shock at the time he arrived on the floor. Dr. Parker did not advise her that Joshua was having difficulty urinating. The saline boluses were given by Dr. Parker at 21:55 hours, 22:59, 1:06 a.m. and 1:59 a.m., however, Dr. Parker did not notify her until 2:30 a.m. Because there was evidence at 10:00 p.m. of hypotension, Dr. Prakash testified that Joshua was already going into septic shock. Blood work values could not be determined because the blood was hemolyzing as part of the toxemia. Because Joshua developed abdominal pain during the night, Dr. Prakash stated that the gas gangrene may have started to go up to his abdominal wall, but she had not been made aware that he developed abdominal pain. She was not aware the abdominal x-ray had been taken until 3:20 a.m.

Kathryn Parker, M.D. testified that she started her intern year with pediatrics in 2008, and in August 2009, was in her second year of that program. Her residency completed on June 30, 2011. She was not invited back for a fourth year. At the time of her deposition on June 3, 2011, she was not licensed to practice medicine in New York State. On August 14, 2009, her shift in pediatrics hematology/oncology and general medical started at 6:00 p.m. and continued to 7:00 a.m. the following morning. Dr. Prakash was the attending physician for Joshua Mahler on the pediatric unit, who decided to admit him prior to 6:00 p.m. Joshua was admitted to pediatrics at 9:00 p.m. on August 14, 2009. Dr. Stern, the out-going intern reported to her at 7:00 p.m. that the ultrasound was pending, and that Joshua's leg x-ray was negative. When she first saw Joshua, he appeared sallow, slightly jaundiced, a little diaphoretic, and complaining of pain in his right leg in the area of the quadriceps, on a scale of 10/10. She felt the skin in the area of the quadriceps appeared tenser or tighter than the normal, and he had tenderness of the inner thigh. His mucous membranes were dry. She noted he was cold to touch and had petechiae on his lower extremities. He was complaining of abdominal pain and appeared dazed. His heart rate was elevated to 133-139, and respirations were elevated to 24.

Dr. Parker testified that she telephoned Dr. Prakash after she examined Joshua, and reported her findings to Dr. Prakash, and that she would have advised her of Joshua's abdominal pain and jaundice. Based upon her telephone conversation with Dr. Prakash, she believed the jaundice was caused by Joshua's bilirubin being elevated, relating to his diagnosis of ALL. Dr. Prakash advised her to call regarding the

results of the ultrasound, and in the morning to obtain a white count, chemistry, and urine analysis. Dr. Prakash suggested that her differential diagnosis was DVT, the possibility of cellulitis, with Vincristine as the cause. There was no discussion with Dr. Prakash concerning a consult with infectious disease. Dr. Parker stated it was up to the attending to order any consults. Dr. Parker continued that she called Dr. Prakash just prior to 9:49 p.m. to advise her that the Doppler exam was negative for DVT, so Dr. Prakash ordered an antibiotic as the diagnosis of cellulitis seemed more likely, and Joshua was neutropenic.

At her continued deposition, Dr. Parker testified that although Joshua complained of abdominal pain upon admission to pediatrics, she felt it was due to constipation. After 11:00 p.m., Joshua complained of nausea and increasing abdominal pain. He was medicated with Morphine for abdominal pain, and given Benadryl for nausea. When she examined him, his pain was on the right lower side of his abdomen and over his bladder area, which she felt was a change in his clinical condition, so, at about 12:00 midnight, she spoke with Dr. Prakash who recommended an abdominal x-ray and to administer fluids as he had not urinated. She then administered one liter bolus of fluid stat at about 1:00 a.m. per instructions. About 1:05 a.m., Joshua's respiratory rate increased, and she thought he might be anxious. It is noted that pages 316 through 422 of Dr. Parker's testimony, concerning the events which transpired after 1:05 a.m. until the time of Joshua's death, have not been provided to this court, leaving this court to speculate as to the content of the testimony and why those pages were not provided.

Bruce Farber, M.D. affirmed that he is licensed to practice medicine in New York State and is board certified in infectious disease. He set forth his education and training and current work experience. He set forth the materials and records which he reviewed. It is Dr. Farber's opinion to a reasonable degree of medical certainty that at no time did Dr. Prakash depart from good and accepted standards of medical practice, and there is nothing which she did or did not do which was causally related to the injuries complained of or the death of the plaintiff.

It is Dr. Farber's opinion that when Joshua entered Stony Brook Hospital on August 14, 2009, he already had a life threatening infection in his body and it was too late to change his outcome as he was already immunosuppressed, at an increased risk for spontaneous infection, and neutropenic (had decreased number of white blood cells that eat bacteria) due to induction chemotherapy treatment for ALL. Dr. Farber stated that Joshua was severely neutropenic upon entering the emergency department and blood was drawn for testing. Dr. Farber does not indicate what Joshua's neutrophil count was and the normal value. Dr. Farber continued that when the Clostsridoum Perfringens gets into tissue, it causes rapid and progressive destruction with the formation of gas. Joshua had pain in his upper right thigh where he had an injection of Asparaginase as part of his chemotherapy, which is known to cause clots which can be very painful in a blood vessel. He stated that the normal signs of infection in the soft tissues, fascia, or muscle, such as redness of the skin, warmth and fever were not evident in this case.

While Dr. Farber indicates that Joshua's mother telephoned Stony Brook University Hospital at 11:00 a.m. on August 14, 2009 due to pain in his right thigh, Dr. Farber does not indicate to whom the mother spoke, and whether or not it was the attending on call, Dr. Prakash. However, Oxycodone was prescribed. He continued that Joshua's clinical presentation to the emergency department was not suspicious for infection and he did not meet the criteria for sepsis. He stated that the diagnosis of DVT (deep vein thrombosis) by Dr. Prakash, was not only logical, but mostly based upon the lack of signs of infection and the history of an injection of Asparaginase, however, he does not state the basis for this

opinion. He then noted that the ultrasound ruled out DVT at 10:00 p.m., at which time Dr. Prakash considered the most likely cause of his pain as infection. He stated that Dr. Prakash ordered the appropriate tests to identify the type of infection and started Joshua on an empiric broad spectrum antibiotic commonly used in neutropenic patients. He does not indicate whether anyone ever checked Joshua's thigh for crepitus. Dr. Farber does not indicate when Dr. Prakash came to see and examine Joshua. Dr. Farber then opined that Joshua had signs of organ failure while he was in the emergency room evidenced by blood in his urine, which he stated was indicative of hemolysis by the organism, renal failure, and bone marrow failure. It is noted that Dr. Lipsky opined that the color of the urine noted at 6:00 p.m. on August 14, 2009, and the presence of "few blood cells" in the urine, were due to a breakdown of muscle tissue secondary to the early stages of gas gangrene. Thus, Dr. Farber's affirmation raises factual issues whether the urine color was due to a breakdown of muscle tissue secondary to the early stages of gas gangrene, or was indicative of hemolysis by the organism, renal failure and bone marrow failure.

Dr. Farber stated that once Clostridium Perfringens enters an immunosuppressed individual, it is normally too late to successfully treat it as the organism causes rapid and progressive organ failure, and it is one of the most fulminant causes of fatal infection in humans. While Dr. Farber opined that the only possible treatment for gas gangrene caused by Clostridium Perfringens is to perform radical debridement of the affected areas from the tissue surgically, he does not address the passage of time between 3:00 a.m when gas gangrene was diagnosed, and the failure to perform debridement until 6:30 a.m. at the bedside. He continued that there is nothing that Dr. Prakash could have done which could have changed the outcome. He stated that she came to the hospital as soon as she was informed of the situation, however, Dr. Farber does not indicate what situation he is talking about. He does not opine whether the standard of care required Dr. Prakash to go to the hospital earlier, or whether it was not necessary for her to attend to Joshua until 3:00 a.m. He continued that starting antibiotics sooner would not have mattered.

Dr. Farber does not address the issue of the increasing pain in Joshua's right thigh, limitation of movement of the leg, and the presence of bilateral purpurea of the lower extremities, and whether or not these were signs of infection, or what their significance was. Dr. Farber opined that Joshua had dizziness, light headedness, and blurriness of vision, but stated conclusively that it was due to the pain medication. Dr. Farber does not set forth the standard of care for treating a patient with neutropenia and how Dr. Prakash comported with such standard of care. Dr. Farber does not address the issue of whether infectious disease was, or should have been consulted at 10:00 p.m. when DVT was ruled out, or sooner. Dr. Farber's final opinion is that, based on "the patient's clinical presentation in the emergency room," Dr. Prakash did not depart from the standards of care. However, this raises factual issue, as Dr. Farber has not set forth the standard of care or how Dr. Prakash comported with the standard of care. It is noted that Dr. Prakash testified that she was not aware that Joshua was jaundiced until 2:30 a.m. on August 15, 2009. However, Dr. Parker testified that she advised Dr. Prakash that Joshua was jaundiced after her examination of Joshua prior to 10:00 p.m., and per her conversation with Dr. Prakash, it was thought the elevated bilirubin to be due to the ALL diagnosis. Thereafter, she spoke with Dr. Prakash about three times before Joshua was transferred to PICU at 3:00 a.m.

The foregoing factual issues preclude summary judgment and it is further determined that the plaintiff's expert Dr. Lipsky has raised factual issues which preclude summary judgment from being granted to Dr. Prakash.

Dr. Lipsky stated that when Joshua arrived in the pediatric hematology/oncology department at approximately 9:00 p.m. on August 14, 2009, he appeared dusky, yellowish, and his extremities were cool to touch. He reported difficulty urinating. Blood had been reported in his urine at 6:00 p.m. in the emergency room. Dr. Lilpsky stated that Dr. Parker, the resident, saw the decedent within five minutes of his arrival to the floor. She found his inner thigh was tender to touch, and the skin around his right quadriceps was tense, which she felt was consistent with an inflammatory process. She noted Joshua began to complain of abdominal pain, and that the preliminary ultrasound report was negative for DVT. She contacted Dr. Prakash, advised her of her findings, and it was Dr. Prakash's differential diagnosis of DVT, cellulitis, and concern for Vincristine chemotherapy as a cause. There was no discussion concerning an infectious disease consult, or additional radiographic studies. Dr. Lipsky stated that Dr. Prakash ordered a broad spectrum antibiotic, Cefepime, as she was concerned the pain was due to the intramuscular injection of Asparaginase into his thigh, which could lead to cellulitis, and that patients on chemotherapy are immunosuppressed.

Dr. Lipsky stated that Dr. Parker was aware from about 11:00 p.m. that Joshua's heart and respiratory rate continued to increase. By 12:01 a.m. on August 15, 2009, Joshua was still complaining of abdominal pain and nausea, and was unable to urinate. He was medicated with Morphine. At 2:15 a.m., Joshua's heart rate was 140, respirations 40, blood pressure was 106/46, he had to work harder to breathe, his level of consciousness decreased, his extremities were cold to touch, capillary refill was greater than 3 seconds, and peripheral pulses could not be obtained. At 3:00 a.m., the rapid response team was called and Joshua was transferred to PICU at 3:30 a.m. Dr. Rani Panesar, the PACU attending noted that the abdominal x-ray, interpreted initially as having no free air, in hindsight, showed free air in the right upper thigh. Joshua had the petechial rash on his chest and legs, his right leg/thigh was palpated with crepitus, and the diagnosis of gas gangrene was considered. Surgery consult was called. The inadvertent x-ray view of the tibia and fibula (accidently performed too low) show air dissecting into facial planes in the thigh. Surgery recommended a CT of the leg and that Joshua be taken to the operating room for debridement stat. However, Joshua's blood pressure went too low, and he developed tachycardia. Joshua coded with pulseless electrical activity (arrest), and CPR was commenced at 5:40 a.m. until 6:16 a.m., at which time he was noted to be comatose. Dr. Lipsky continued that Dr. Panesar noted that Dr. Scriven, the surgeon, decided Joshua was too unstable to be taken to the operating room and performed an emergency fasciotomy at the bedside at which time, non-viable tissue was visualized, however, no debridement was done as it was decided to take Joshua to the operating room later. A wound culture revealed Clostridium Perfringens. Thereafter, Joshua coded again. At 8:05 a.m., he was noted to have no heart sounds and no pulse. Resuscitation was performed, however, Joshua was pronounced dead at 10:00 a.m. by Dr. Panesar.

Dr. Lipsky opined that Dr. Prakash departed from good and accepted practices by failing to order or recommend a CT scan or plain x-ray series of Joshua's right thigh stat, specifically of the area Joshua was complaining of upon admission when he was seen by Dr. Singh. Dr. Lipsky stated that Dr. Prakash's initial diagnosis of DVT was too limited, and she failed to consider that the extreme thigh pain could have also been caused by an infection beneath the surface or an abscess, in light of his history of Asparaginase injection in the right thigh. Dr. Prakash was aware of the injection, and she did not consider deep infection or abscess secondary to the injection in her differential. Such consideration would have warranted the performance of radiological studies of the thigh, and the failure to consider infection in the differential and order radiological studies was a departure from the standard of care. Dr. Lipsky continued that when Dr. Parker advised Dr. Prakash that DVT was ruled out by the ultrasound at 7:30 p.m., Dr. Prakash departed

from the standard of care by not ordering radiological studies, and instead ordering Cefepime for a presumed cellulitis when there was no clinical evidence of cellulitis. She further departed from the standard of care by not including deep infection or abscess in her differential upon learning the ultrasound ruled out DVT.

Dr. Lipsky opined that had a plain x-ray or a CT scan of Joshua's thigh been ordered by Dr. Prakash at 5:04 p.m. when she spoke with Dr. Singh, or at 9:00 p.m. after she spoke with Dr. Parker, the study would have revealed subcutaneous air involving the right thigh and the diagnosis of gas gangrene would have been made at that time. Dr. Lipsky stated that he based this opinion on the deterioration of Joshua's clinical condition between the time of presentment to the emergency room at 4:32 p.m. and 3:00 a.m. the following morning when the diagnosis of gas gangrene was made, as well as upon the results of the abdominal x-ray performed at 1:17 a.m. Had the diagnosis been made in a timely manner, it is Dr. Lipsky's opinion that emergent surgical intervention to remove the infected tissue with appropriate antibiotic administration would have saved Joshua's life. Dr. Lipsky opined that he disagreed with Dr. Farber's statement that "when this patient entered Stony Brook University Hospital on August 14, 2009, he already had a life threatening infection in his body and it was already too late to change his outcome." Dr. Lipsky opined that appropriate surgical intervention and antibiotic treatment implemented on or before approximately 10:00 p.m., would have altered the course of the disease. Had the gas gangrene been diagnosed earlier, emergent surgery would have been performed stat to remove the infected tissue, coupled with appropriate antibiotic treatment, and saved Joshua's life.

Dr. Lipsky also disagrees with Dr. Farber, stating that while the clinical presentation to the emergency room did not meet the classic criteria for sepsis, his presentation with severe pain should have alerted Dr. Prakash to the possibility of deep infection, which Joshua had. Dr. Lipsky also disagreed with Dr. Farber on the basis that an injection is more likely to have caused a complication of deep infection rather than DVT. Dr. Prakash's too narrow differential should have considered infection, and it was a departure from the standard of care not to have considered infection. While Dr. Farber opined that once Clostridium Perfringens has entered an immunosuppressed individual, it is normally too late to successfully treat it, Dr. Lipsky opined that if the diagnosis is timely made, it is more likely than not that the patient will not succumb to the infection regardless of the patient being immunosuppressed. Dr. Lipsky also opined that Joshua did not have signs of organ failure in the emergency room, however, the failure of Dr. Prakash, Dr. Joyner, and Dr. Parker to timely diagnose gas gangrene, did in fact lead to organ failure, sepsis, and Joshua's death.

Based upon the foregoing, the factual issues raised by plaintiff's expert, Dr. Lipsky, precludes summary judgment from being granted to Dr. Prakash.

Accordingly, motion (004) by Devina Prakash for summary judgment is denied.

Dated: 6-19-14

Hon. Denise F. Molia
A.J.S.C.

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