Short Form Order

SUPREME COURT - STATE OF NEW YORK

I.A.S. PART 7 - SUFFOLK COUNTY

PRESENT:

WILLIAM B. REBOLINI
Justice

Felicity Daly, an infant by her Mother and Natural Guardian, Maxinne Daly,

Plaintiff,

- against -

Paul Ogburn, Jr., M.D., Patricia Dramitinos, M.D., Cecila Avila, M.D., Alan G. Monheit, M.D., University Associates in Obstetrics & Gynecology, University Faculty Practice Corporation, John/Jane Doe, M.D. (First and Last name being fictitious) and Stony Brook University Physicians, University Faculty Practice Corporation,

Defendants.

Index No.: 29423/2011

Attorneys [See Rider Annexed]

Motion Sequence No.: 001; MD
Motion Date: 4/4/14
Submitted: 8/6/14

Motion Sequence No.: 002; MG
Motion Date: 6/20/14
Submitted: 8/6/14

Upon the following papers numbered 1 to 31 read upon these motions for summary judgment: Notice of Motion and supporting papers (001), 1 - 10; (002) 11 - 21; Answering Affidavits and supporting papers, 22 - 27; Replying Affidavits and supporting papers, 28 - 29; 30 - 31; it is

ORDERED that motion (002) by defendants Paul L. Ogburn, Jr. M.D., Cecilia Avila, M.D., Alan G. Monheit, M.D., University Associates in Obstetrics & Gynecology, University Faculty Practice Corporation, Stony Brook University Physicians, and University Faculty Corporation, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied; and it is further

ORDERED that motion (002) by defendant Patricia Dramitinos, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is granted.

In this medical malpractice action, the plaintiff, Maxine Daly, on behalf of her infant daughter, Felicity Daly, seeks damages for injuries allegedly suffered by the infant due to the defendants' alleged negligent departures from good and accepted obstetrical practice. Causes of action sounding in negligence and lack of informed consent have been pleaded. Maxine Daly was pregnant with triplets and suffered a spontaneous reduction of one fetus, and continued with a twin pregnancy. Because this was deemed a high risk pregnancy, she was referred by her fertility specialist to the defendants Paul L. Ogburn, Jr. M.D., Cecilia Avila, M.D., Alan G. Monheit, M.D., University Associates in Obstetrics & Gynecology, University Faculty Practice Corporation, Stony Brook University Physicians, and University Faculty Corporation for obstetrical care and treatment. It is alleged that the defendants negligently failed to diagnose an incompetent cervix which began to shorten and funnel, and that the defendants then failed to timely place a cerclage (suture) on the cervix in an attempt to prolong the pregnancy to permit further fetal maturity. It is further claimed that due to the delay in placing a cerclage, the amnionic sac/membranes within the uterus were caused to prolapse into the vagina, resulting in chorioamnionitis (infection) and premature delivery of the twins by cesarean delivery when twin A's feet presented into the vagina. Twin B, Felicity Daly, is alleged to have suffered severe and serious neurological injury as a result of the defendants' alleged departures from good and accepted obstetrical care and treatment.

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 (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [1981]).

In support of motion (001), defendants submitted, inter alia, an attorney's affidavit, copies of the summons and complaint, defendants' answer and the plaintiff's verified bill of particulars; an uncertified copy of plaintiff's medical records which fail to comport with CPLR 3212 and 4518 (***Friends of Animals v Associated Fur Mfrs***, *supra*); partial copies of unsigned and uncertified transcripts of the examinations before trial of the plaintiff and non-party witness Richard Daly which 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]), and the affirmation of

Adiel Fleischer, M.D. In searching the record, a certified copy of the plaintiff's hospital record has been provided with motion (002).

In support of motion (002), defendant Dramitinos submitted, inter alia, an attorney's affirmation; affidavit of Patricia Dramitinos, M.D.; affirmation of Victor Klein, M.D.; copies of the summons and complaint, defendant's answer, plaintiff's verified and supplemental verified bills of particulars; certified copy of plaintiff's Stony Brook Hospital record; unsigned but certified transcript of the examination before trial of Cecilia Avila, M.D. which is considered, there being no objection (***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was the proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

Cecila Avila, M.D. testified to the extent that she received her license to practice medicine in New York in 1997 and in Connecticut in 2001. She has been employed by Stony Brook University Hospital since July 2004. Her university employment involves education, and the other component of her employment with Stony Brook University Physicians and University Faculty Practice Corporation is for private outpatient care. Included in her duties in 2006, were mainly high risk patients of the faculty practice group and also general obstetrical patients. Patients with twin gestations are considered to be high risk patients, she stated, and at least 10% of her practice involved patients with multiple gestations. In 2006, she worked side-by-side with the residents, who would write the note. She could write an addendum to the note if a significant finding was not contained in the resident's note.

Dr. Avila described the first trimester of pregnancy as up to 13 weeks. The second trimester is from 13 weeks to 26 weeks. The third trimester is from 26 weeks until term delivery between 37 and 41 weeks. She testified that she diagnosed incompetent cervix and has performed cerclage in her practice. She described funneling in the cervix as a sonographic finding wherein the cervix opens progressively inside out, as the internal os opens progressively and reaches the external os, or may stop before the external os. The fetal membranes can funnel through. She testified that she knew since 1997 that patients with funneling have a greater incidence of preterm deliveries than

patients who do not have funneling. She stated that the date is unclear whether there is also an increased incident of preterm rupture of the membranes. Transabdominal ultrasounds can suspect funneling, but transvaginal ultrasounds are more accurate in determining if the internal os on the cervix is opening.

Dr. Avila testified that on a typical sonogram day, she would review about 40 to 50 sonograms. Once the sonographer obtained the images taken while performing real time video, she would review them on the computer screen while the patient is in the room, and would see the patient right away for something unusual. Otherwise, she would generate a report and a note on the encounter sheet. The images document the number of fetuses and the location of the placenta. Concerning the plaintiff, a transvaginal cervical length was requested. She continued that when a patient has three fetuses, and more than two or three weeks have elapsed since the last imaging, the fetuses would be measured, and the cervical length would be obtained transabdominally. If the cervical length appears normal, there would not be a transvaginal sonogram requested. She testified that she looks at the images and generates her own comments and report. She stated that she does not read the comments which may have been entered by a sonographer, but does not delete the sonographer's comments.

Dr. Avila testified that on October 10, 2006, she did an interpretation of the plaintiff's sonogram and found the cervix was normal, so it would have been unlikely that she would have seen the plaintiff. At 14 to 15 weeks gestation, a cervical length above 35 mm would be perfectly normal, even 3 cm (30 mm). She considered a cervical length below 2.8 cm (28 mm) as shortened. At 25 to 28 cm she would be worried about the short length and would bring the patient back in one to two weeks for another cervical length measurement. Her interpretation was "Fetal growth. Dichorionic diamnionic twins (spontaneous reduction from triplets to twins). Transvaginal cervical length.... On transvaginal cervical length, the cervix appeared closed and 4.1 cm long." Dr. Avila testified that the sonographer used a caliper on each end of the cervix, then the computer measured and generated the length. Dr. Avila indicated that a sonogram done on October 27, 2006 interpreted the plaintiff's cervix to be 40 mm, which she stated was normal. Dr. Avila testified that a sonogram of November 17, 2006, was interpreted by Dr. Paul Ogburn, who found the cervix was 18 mm shortened, and funneled. When she saw the plaintiff on November 26, 2006, the standard of care would have been for her to review that sonogram of November 17, 2006. However, she continued, it was important to know that the cervical length was stable. She would not make an intervention on what happened in earlier sonograms, and that her intervention would take into account the more recent sonogram.

Dr. Avila testified that on November 26, 2006, the plaintiff had a portable transvaginal sonogram which was done in her presence in labor and delivery by Dr. Dramitinos. She measured the cervix at 1.6 to 1.84 on the two readings. These measurements, she stated, would have been in the expected range of variation. She stated that it was a short cervix and there was funneling, but she did not measure the amount of funneling. She stated that she could have admitted the plaintiff to the hospital on bed rest, but did not feel it was indicated. She stated that she needed to treat the plaintiff for an infection before evaluating her for cerclage, as any infection in the vagina can be

introduced into the cerclage and sepsis can be produced in the baby. She stated that there was a positive white discharge adherent to walls, which is more consistent with a yeast infection, whereas a bacterial infection is more yellowish. Another note on that date indicated the discharge was a whitish-yellow, which possibly could indicate bacterial infection, normal, or anything, she stated. She continued that any infection is a contraindication for doing a cerclage. Dr. Avila stated that the note of November 26, 2006 indicated that the plaintiff was 21+ week, there were twins, and the plaintiff had a shortened cervix with a yeast infection, for which she discharged the plaintiff with strict precaution for bed rest. Dr. Avila stated that cervical shortening itself is related to premature delivery. She was unaware that the note indicated the plaintiff was complaining of leukorrhea or discharge on November 17, 2006. She did not take a culture of the discharge, but did order a urinalysis, urine culture and sensitivity, and beta strep culture.

Dr. Avila testified that at the November 26, 2006 visit, the plaintiff was complaining of vaginal pressure without contractions. She opined, however, that the weight of the twin gestation does not cause shortening of the cervix. She did not feel that the pressure on the cervix from forces of gravity, and the weight of the babies and the placenta, would necessarily be relieved by having the plaintiff lie horizontally, but it possibly could. Complaints of pressure are normal prior to 24 or 25 weeks gestation before the uterus becomes an intra-abdominal organ. Bedrest for a patient with shortened cervix, she stated, could sometimes be ordered, and she sometimes did order it for high risk obstetrical patients. Some physicians used cerclage for a shortened cervix with twin gestations.

Dr. Avila indicated that the plaintiff had a history of human papillomavirus (HPV), a prior termination of pregnancy, and a bicornate (heart-shaped) uterus which would place the plaintiff at an increased risk for premature delivery as there is decreased available capacity in the uterus for the fetuses. Dr. Avila stated that the plaintiff also had depression which placed her at an increased risk for premature delivery. In addition, the plaintiff had bleeding in her first and second trimester which placed her at risk for premature rupture of the membranes.

Dr. Avila continued that a cerclage is done to improve single pregnancies with shortening and an asymptomatic cervix, but has not been proved to improve outcomes in twin pregnancies. When asked if a patient with a shortened cervix and multiple gestations should have cerclage when the cervix is at 1.5 cm or greater, Dr. Avila testified that the data is less clear. She would discuss cerclage with the patient and advise that there is no certainty that the outcome is improved.

Dr. Avila stated that in 2006, Drs. Quirk, Buckley, Ogburn, and Monheit were all part of the faculty practice. On December 4, 2006, Dr. Quirk transferred the plaintiff from his office to the hospital by ambulance. The plaintiff was seen by Dr. Avila whose note stated that the resident's note was reviewed and she incorporated the plan of care as outlined by Dr. Ogburn and Dr. Quirk. The note indicated the plaintiff was at 22 and 1/7 weeks pregnant, with a spontaneous reduction from triplets to twins at 13 weeks. She was admitted for a funneled cervix and contractions every three to ten minutes. The cervix was 1 cm dilated and 100% effaced. The twins' sizes were appropriate for their gestational age. The plaintiff was noted to be at very high risk for extreme premature

delivery, so she was to be assessed for possible cerclage in the morning by Dr. Quirk. Indomethacin was given to help treat premature labor and delivery. It was her opinion that cerclage could be effective for the plaintiff. She stated that this situation was a storm that was started by the patient's decision to put three embryos in a bicornate uterus, so it started a cascade of events. She noted that the resident did not indicate any signs or symptoms of infection or discharge. She anticipated that the plaintiff would have completed the medication prescribed for the vaginal discharge on the last visit.

Defendants Paul L. Ogburn, Jr. M.D., Cecilia Avila, M.D., Alan G. Monheit, M.D., University Associates in Obstetrics & Gynecology, University Faculty Practice Corporation, Stony Brook University Physicians, and University Faculty Corporation submitted the affirmation of Adiel Fleischer, M.D., a physician licensed to practice medicine in New York State who is board certified in obstetrics, gynecology, and maternal fetal medicine. He did not set forth his education and training, but indicated that he has many years experience in his specialty, including patients with multiple fetuses who are high risk. Dr. Fleisher indicated that he reviewed the pertinent medical records, but did not indicate with any specificity what records were reviewed. He also reviewed all the deposition testimony, however, none of those depositions transcripts have been provided, and are not in evidence. Dr. Fleischer stated that it is his opinion within a reasonable degree of medical certainty that the aforementioned defendants treated Ms. Daly in full conformance with the applicable standard of care and that none of the treatment they provided, or allegedly failed to provide, was a proximate cause of any of the injuries alleged.

Dr. Fleisher set forth that Ms. Daly, who had a history of polycystic ovarian syndrome, received care from Dr. Kenisberg, a fertility specialist, and successfully became pregnant with triplets. Dr. Kenisberg treated the plaintiff for the first several weeks of this pregnancy, then referred Ms. Daly to the defendants for obstetrical management. Although Dr. Fleisher does not provide a date, he stated that at the end of the 12th week of gestation, the plaintiff spontaneously miscarried one fetus. Her pregnancy continued, however, and on November 17, 2006, at nine weeks and five days gestation, a sonogram revealed a significant shortening of the cervix to 18 mm (1.8 cm). Significant shortening, he stated, is less than 2.5 cm in the second trimester, and is an indication that a premature delivery is likely. At the beginning of the 22nd week of the plaintiff's pregnancy, a sonogram revealed that she had no remaining functional cervix, so she subsequently underwent a cerclage, a surgical procedure wherein a stitch is placed in the cervix to prevent it from opening prematurely and to prolong the pregnancy. Dr. Fleisher opined that earlier placement of the cerclage would not have prolonged the pregnancy because the plaintiff delivered her twins prematurely due to early cervical shortening and funneling, which cerclage does not prevent or treat. He added that cerclage placement does not alter the risks of prematurity associated with a shortened cervical length in twin gestations, citing to certain medical articles which have not been provided.

Dr. Fleisher stated that, at the plaintiff's last visit with Dr. Monheit on December 28, 2006, the cerclage remained intact and her cervix remained closed. However, later that day, the plaintiff presented to the hospital with abdominal pain. She was having contractions and her cervix was

dilated 4-5 cm, with the cerclage intact. Tocolytic agents were given to arrest contractions, and betamethasone (steroid) was given to enhance maturity of the fetal lungs. Examination also revealed the membranes had prolapsed beyond the cervix into the vagina, so antibiotics were started to prevent choramnionitis (infection/inflammation of the amniotic membranes). However, choramnionitis was later confirmed when the placenta was sent to pathology following delivery. Dr. Fleischer added that cerclage is not intended to prevent membrane prolapse. He stated that when the amniotic membranes prolapse into the vagina, this is a clear sign of cervical insufficiency known as cervical incompetence, wherein the mother is physically unable to retain the pregnancy and the cervix is incapable of maintaining its integrity. The prolapsed membranes lead to the plaintiff developing choramnionitis. On December 31, 2006, the plaintiff developed a fever, a clear indication of infection, which required delivery of the twins, despite their extreme prematurity.

Dr. Fleisher continued that despite the care and treatment started, there is no known effective method of preventing premature delivery. Bed rest is ineffective in preventing cervical shortening, and the premature labor was due to cervical shortening. Dr. Fleisher stated that there is no known treatment or intervention to prevent or forestall cervical shortening. He added that from about the 13th or 14th week of this pregnancy, the plaintiff had placed herself on self-imposed bed rest. He also stated that bed rest does not prolong a pregnancy involving twins. Dr. Fleisher also opined that bed rest would have placed the plaintiff at risk for deep vein thrombosis and would have been inappropriate. He added that the plaintiff was morbidly obese before she became pregnant. She gained more weight, which immobilized her to the point that she could not get out of bed at all. Dr. Fleisher stated that hospitalization for continual fetal monitoring and administration of tocolytics prior to the 24th week of gestation is not the standard of care, because, prior to the 24th week, the fetus is not viable as it is immature and incapable of living outside the womb. Non-reassuring fetal monitor results would lead to a cesarean section which is not performed prior to the 24th week of gestation due to the lack of fetal viability. The plaintiff reached the 24th week of gestation on December 17, 2006, therefore, fetal monitoring prior to his point would not have been warranted.

Dr. Fleisher stated that the administration of tocolytic agents was neither appropriate nor warranted before December 28, 2006, as they are used for the purpose of arresting uterine contractions to control premature labor, and would have provided no benefit. He continued that the plaintiff did not satisfy the criteria for tocolytic agents until December 28, 2006. The use of tocolytic agents prior to December 28, 2006, would have subjected the plaintiff to pulmonary edema, arrhythmia, and hypotension. Fetal risks included heart rate irregularities and renal failure.

It is determined that the moving defendants have not demonstrated prima facie entitlement to summary dismissal of the complaint. Dr. Fleischer's opinions are conclusory, and he does not set forth the standard of care or the criteria for cerclage placement and treatment of a patient with a shortened and funneled cervix. While he opined that there is no effective method of preventing premature delivery, he has not set forth the standard of care for prolonging the pregnancy to enhance fetal maturity, and how the defendants comported with those standards. In any event, even if the

defendants demonstrated prima facie entitlement to summary judgment dismissing the complaint, plaintiff has raised factual issues which preclude summary judgment from being granted.

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]). Here, the plaintiff has opposed the applications by submitting a redacted expert affirmation and an unredacted affirmation to the court for *in camera* inspection, as required (***Marano v Mercy Hospital***, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]).

Plaintiff's expert affirms that he/she is licensed to practice medicine in New York State and is board certified in obstetrics and gynecology, which he has practiced for 40 years. He set forth the bases for his qualifications to proffer expert opinion in this action with respect to the care and treatment rendered to the plaintiff, and the effect that the care had on the infant plaintiff, Felicity Daly. He set forth the records and materials he reviewed and rendered his opinion within a reasonable degree of medical certainty. Plaintiff's expert stated that Dr. Fleisher set forth that the cerclage was not utilized and was not the standard of care; that a cerclage is not efficacious in prolonging pregnancy in twin pregnancy; that bed rest is not efficacious, and strict bed rest is not the standard of care; that nothing could have been done to prolong the pregnancy; that the cerclage was intact at the time of the December 28, 2006 hospitalization; that the prolapse of the membranes that led to chorioamnionitis and the need for delivery on December 31, 2006 was inevitable; and that nothing that the defendants did or failed to do contributed to that occurrence. Plaintiff's expert disagrees with Dr. Fleisher on these issues.

Plaintiff's expert stated that Dr. Ogburn testified that there are cerclages done early in the second trimester whereby the plaintiff is able to last without delivering until term; that there are twin gestations where a patient has cervical shortening and funneling at mid second trimester and the pregnancy is able to continue to term with cerclage; and that he has extended the pregnancy of a patient by doing cerclage. He continued that Dr. Ogburn testified that the success of cerclage is linked to the point in the pregnancy when the cerclage is placed, and that it can have higher rate of success if it is done earlier, perhaps when it is not necessary as it helps to prevent premature deliveries. Plaintiff's expert stated that while Dr. Fleischer opined that bed rest and cerclage would not have altered the outcome for this plaintiff, Dr. Monheit testified that if a patient has twin gestation and is between 25 and 26 weeks gestation, as a general statement, if you can extend the pregnancy, that will improve the prognosis for the fetuses. Dr. Monheit also admitted that for a patient between 25 and 26 weeks, extending the pregnancy by a week will allow for more maturity of the fetuses and better prognosis.

Plaintiff's expert stated that Dr. Ogburn testified patients are admitted for complete bedrest and observation so that the patient can be positioned in a particular way whereby gravity helps

prevent further shortening by taking the pressure off the cervix. Plaintiff's expert stated that Dr. Monheit testified that one of the treatments for a patient who is high risk for premature labor is to put the patient on strict bedrest, and sometimes admit to the hospital to remove the forces of gravity from the cervix, with hope to improve the chances of extending the pregnancy. Plaintiff's expert stated that Dr. Fleischer's implication that the level of bedrest which the plaintiff herself instituted was the same as strict or complete bedrest is inaccurate and misleading, as evidenced by the plaintiff thereafter being ordered to then have absolute bed rest, clearly indicating change in the level and manner. He continued that on December 4, 2006, Dr. Ogburn wrote that the plaintiff would be transferred for absolute bed rest and called an ambulance to transport her to the hospital to avoid pressure on the cervix. These facts, stated plaintiff's expert, clearly contradict the entire basis for Dr. Fleischer's opinions as to the standard of care and the efficacy of cerclage and bed rest. He continued that the standard of care is not as Dr. Fleischer stated: that nothing need be done because nothing would have resulted in a term delivery. Indeed, that the defendants utilized some of the very methods which Dr. Fleischer stated were not the standard of care and did not provide an efficacious benefit created a contradiction that Dr. Fleischer does not explain. Plaintiff's expert stated that the two modalities, bedrest and cerclage, have been, and continue to be, employed pursuant to the standard of care. Plaintiff's expert continued that the studies referenced by Dr. Fleischer do not mean that physicians are permitted to do nothing in the face of an incompetent cervix in a twin pregnancy, nor does it establish that the standard of care was to do nothing to treat and address cervical incompetence. It does not mean that had the defendant properly followed the standard of care that the outcome for the plaintiff would have been the same.

Plaintiff's expert stated that the average gestational age at the time of delivery for a single fetus is 38.6 weeks. By comparison, twin pregnancies occasionally progress to 40 weeks, but the average gestational age for twins is 35 weeks. Thus, by definition, plaintiff's expert stated, we expect a twin gestation to be premature, rendering Dr. Fleischer's statement misleading that the one practice or another, combined, will not prevent premature delivery. Plaintiff's expert stated that the issue is not whether any practice would have gotten the plaintiff's pregnancy to 38.6 weeks, or to 35 weeks, but, rather, if the proper standard of care had been timely and properly initiated, in all likelihood, it would have prevented the birth on December 31, 2006, near the very brink of viability. Plaintiff's expert opined that had the proper practice in terms of timely and appropriate bedrest and timely cerclage been followed, the pregnancy would have proceeded past that time. With every passing day, there would have been significantly decreased chances of suffering the devastating injuries the infant sustained, or at least minimized injuries. At a minimum, he opined, the infant sustained a loss of chance as a result of the defendants' departures from accepted standards of care. He continued that there is a distinct and significant difference between whether or not the placement of cerclage will allow a patient to carry to term and whether cerclage prolongs a pregnancy, even if it is not to term. Extending the length of gestation by even a few days, or weeks, is meaningful in the difference between relative health and devastation to the infant. Plaintiff's expert stated that as to the issue of whether or not cerclage or bedrest are utilized and efficacious in prolonging pregnancies, the defendants themselves acknowledge by words and actions that bed rest is an

appropriate treatment for alleviating pressure on the cervix and extending a twin pregnancy, and that cerclage can prolong a twin pregnancy with a shortened cervix.

The plaintiff's expert opined that it is a departure from the standard of care not to institute an appropriate level of bedrest, cerclage, or other means, including appropriate monitoring. He continued that absolute bedrest and cerclage, although ordered, were ordered later than that required by the standard of care. That the plaintiff developed chorioamnionitis, and had to be delivered, is inextricably intertwined with the defendants' failure to properly treat the patient. Chorioamnionitis developed, he opined, as a result of the membranes prolapsing and becoming exposed. This, he stated, was due to the cerclage tearing. The more cervical tissue available to suture, the better the chances of the cerclage being successful. Here, cerclage was delayed to the point of being done on an emergency basis, permitting the continuum and progression of cervical incompetence. Waiting to perform a cerclage until it becomes an emergency is a departure from the standard of care, and contributes to the decreased chance of success of the cerclage, stated plaintiff's expert. Although Dr. Fleisher set forth that the cerclage was intact at the time of the December 28, 2006 hospital presentation, such statement is contradicted by the hospital record, stated plaintiff's expert. The cerclage tore due to the extremely short length of the cervix by the time the defendants finally placed the suture, and due to the weight that was placed on the cervix and cerclage by the twin pregnancy, which would have been lessened had the defendants followed the appropriate standards of care. Thus, he stated, the significantly shortened cervical length and the increased pressure are causally related to the defendants' failures to follow the accepted and required standards of care. The longer the infant is permitted to mature and the pregnancy to progress, the less risk there is of permanent neurological damage to the infant.

The plaintiff's expert stated that the plaintiff had a history of colposcopy, cone biopsy, dilation and curettage, and a bicornate uterus, which is a congenital abnormality. These are all risk factors for cervical insufficiency, or incompetent cervix wherein the cervic shortens and thins. While patients will not have intervention for this condition until a sonographically established 24 mm shortening, this is not the standard of care for a patient such as the plaintiff with the aforementioned historical factors. General statements of the standard of care do not apply to someone with these historical factors, and the plaintiff would have benefitted significantly from timely placement of cerclage and the institution of bed rest. Plaintiff's expert continued that contrary to Dr. Fleischer's opinion, a physician's obligation to institute complete, strict bedrest for a patient's well-being is not fulfilled by the fact that a patient may institute their own version of bedrest, as modified bedrest does not meet the standard of care in a pregnancy such as at issue. He added that complete bedrest is not precluded by concerns for deep vein thrombosis.

The plaintiff's expert opined that, because of the plaintiff's historical factors, 24 mm in cervical length is not the trigger used. The decrease in cervical length from 41 to 40 mm from October 10, 2006 to October 27, 2006, with the plaintiff's history, required weekly sonograms to determine if this decrease is heralding the early process of shortening of the cervix in this high risk patient, so that early intervention can be effectuated. Dr. Monheit saw the plaintiff on October 30,

2006, but did not record the cervical length and there is no documentation in the plaintiff's chart to demonstrate Dr. Monheit gave this any consideration. The standard of care required that he take the sonogram result of October 27, 2006 into consideration in arriving at his plan for the management of the plaintiff, however, he instructed the plaintiff to return in two to three weeks. The plaintiff's expert stated, that in violation of good and accepted obstetric practice, the plaintiff was then not given another sonogram for three weeks. Thereafter, on November 17, 2006, the cervix was 18 mm shortened with funneling. Despite this very significant and ominous finding in a high risk patient, Dr. Ogburn did not take any action and instructed the plaintiff to return in two weeks. The plaintiff's expert opined that Dr. Ogburn departed from the standard of care as he failed to place the plaintiff on strict bed rest in a hospital setting, perform an appropriate and thorough evaluation, and place a cerclage.

The plaintiff's expert continued that, on November 26, 2006, when the plaintiff presented to the labor and delivery triage with complaints of vaginal discharge, she was evaluated by Dr. Avila, with the assistance of Dr. Dramitinos as a resident. A sonogram revealed the cervical length of 1.63-1.84 and closed, however, Dr. Avila diagnosed a yeast infection and discharged the plaintiff. The plaintiff's expert opined that instead, the plaintiff should have been placed on strict bed rest, cultured, and been provided with blood work, given prophylactic antibiotics, and had a cerclage placed immediately. Thus, he stated, Dr. Avila departed from the standard of care in failing to order that necessary treatment. It was then not until December 4, 2006, that Dr. Ogburn found the plaintiff's cervix was no longer with functional length, funneling, and slightly open, and admitted the plaintiff by ambulance to the hospital for absolute bed rest, at 22 weeks and 2 days gestation. Dr. Buckley admitted the plaintiff, and the assessment and plan was to admit to antepartum for strict bedrest, possible rescue cerclage, and antibiotic administration. After discussion with Dr. Quirk, the plan was also to include administration of Indocin/Carafate to attempt to decrease fluid, and to consider rescue cerclage. Two days later, a repeat ultrasound revealed a cervix with funneling, 1 cm dilated, and 3 cm in length. On December 7, 2006, the cervix was 1 cm dilated, soft, 2.5 cm in length, with no funneling, and the cerclage was placed. The plaintiff was discharged on December 8, 2007, but Dr. Quirk did not ensure that the important instruction of strict bedrest was transmitted, so the plaintiff was sent home with instructions for modified bedrest, placing her at increased risk for cerclage failure.

On December 14, 2006, the plaintiff was seen by Dr. Monheit at 23 weeks 5 days gestation. The cervix was 1.5 cm in length. She was discharged home on modified bedrest, which plaintiff's expert stated was a departure from the standard of care as strict bed rest was required. On December 22, 2006, a repeat sonogram report revealed the cervix was 9 mm with funneling. The suture was intact. On December 28, 2006, the plaintiff was seen by Dr. Monheit at 25 weeks and 4 days, and reported pelvic pressure and increasing cramps. However, Dr. Monheit reported no new symptoms and did not change the plan or order a repeat sonogram. The plaintiff's expert opined that the pelvic pressure and increasing cramps could be clues of impending preterm labor. She was told to return in two weeks. However, on the night of December 28, 2006, she presented to the labor and delivery triage at Stony Brook University Hospital with complaints of lower abdominal crampy pain with

radiating tightness across her entire abdomen since 5:30 a.m. It stopped after 2-3 hours, but then resumed at 7 p.m., with increasing intensity every 8 to 10 minutes. A pelvic exam revealed a cerclage suture, visible and bulging amniotic sac, and the cervix dilated to 1 cm. Vaginal exam then found the cervix 4-5 cm dilated with 89% effacement. No tension was found on the cerclage and there was discussion concerning whether it had torn. Plaintiff's expert stated that, contrary to Dr. Fleischer's assertions, the assessment and plan noted that it was most likely that the cerclage had already torn and that there would be limited vaginal exams. The history and physical record of December 29, 2006, determined after evaluation, that the stitch was no longer intact. This, stated plaintiff's expert, was the cause of the amniotic membranes protruding into the vagina. He continued that had the cerclage been timely inserted before the cervix became significantly shorter, and had the plaintiff been maintained on strict bedrest, the membranes would not have protruded, and chorioamnionitis could have been prevented.

The plaintiff's expert stated that antibiotics were given. Magnesium sulfate was provided for tocolysis and decreased contractions. Betamethasone was given twice, 24 hours apart, to aid with fetal lung maturity. On December 31, 2006, the plaintiff experienced chest heaviness. The amniotic membranes descended further into the vagina, and the fetal feet of twin A were in the vagina. The plan was cesarean section secondary to chorioamnionitis which developed due to the prolapsed membranes as a result of the dilated cervix and tear of the cerclage. The plaintiff's expert opined that the chorioamnionitis would not have occurred had the defendants followed the standard of care in treating the plaintiff. The infant, Felicity Daley, suffered severe and permanent injuries, including brain damage, as a result of being born at the gestational age she was at delivery. Plaintiff's expert opined that these injuries were proximately caused by the failure of the defendants to properly treat the risk of cervical incompetence.

Based upon the foregoing, it is determined that the plaintiff raised multiple material factual issues concerning the standards of care, the defendants' alleged departures from those standards of care, as well as proximate cause between those alleged departures and the neurological injuries sustained by the infant plaintiff, Felicity Daly.

Accordingly, motion (001) is denied in its entirety.

While a private physician may be held vicariously liable for conduct of a resident physician where the resident is under the direct supervision and control of the private physician at the time of the conduct; the key is whether the resident exercises independent medical judgment (***Freeman v Mercy Medical Center***, 2008 NY Slip Op 31337U; 2008 Misc Lexis 10141 [Sup Ct, Nassau County]). A resident who assists a doctor during a medical procedure, and who does not exercise independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene (***Muniz v Katiowitz***, 49 AD3d 511, 856 NYS2d 120 [2d Dept 2008]).

Turning to motion (002), Patricia Dramitinos, M.D. seeks summary dismissal of the complaint on the bases that in October and November 2006, she was a post graduate year-four level resident at Stony Brook University Hospital and worked directly under the supervision of an attending OB/GYN physician during her assignment to labor and delivery. In particular, on November 26, 2006, she became involved in the care and treatment of Maxine Daly, to the limited extent of documenting the history as presented by the plaintiff; findings based upon the sterile speculum exam; observing and assisting in the performance of a transvaginal ultrasound under the direct supervision and guidance of her supervising attending physician, Cecilia Avila, M.D., who was present throughout the speculum exam and ultrasound.

Dr. Dramitinos avers she did not exercise any independent medical judgment as to whether to discharge the patient home, admit her, or make any decisions for the plan of treatment of Maxine Daly. She avers she was never consulted concerning the plan of treatment for the plaintiff, diagnostic testing, monitoring of contractions, and timing or performance of cerclage. She concluded that at all times she was continually and directly supervised by Dr. Avila.

Dr. Avila testified that as an attending, she supervised Dr. Dramitinos, a resident working on the labor and delivery floor. If Dr. Dramitinos were taking care of the plaintiff, she would have been supervising. It is required that she be present to supervise and participate in a transvaginal ultrasound being performed by the resident.

Dr. Dramitinos has also provided the affirmation of Victor R. Klein, M.D. who affirms that he is a physician licensed to practice medicine in New York State and is board certified in medical genetics, obstetrics and gynecology, and maternal fetal medicine. He set forth his education and training, work experience, and the records and materials which he reviewed. Dr. Klein opined to a reasonable degree of medical certainty that Dr. Dramitinos bears no liability for the care and treatment she provided to the plaintiff. Dr. Klein stated that the only procedures performed during Maxine Daly's labor and delivery room visit of November 26, 2006, were a sterile speculum exam and a transvaginal ultrasound. Dr. Dramitinos was then a PGY-4 level resident studying obstetrics and gynecology, who at the time she examined Ms. Daly, was continually under the supervision of her attending physician, Dr. Avila.

Dr. Klein set forth the care and treatment provided by Dr. Dramitinos, and affirmed that the medical management of a patient remains the responsibility of the attending physician. This, he continued, included the assessment, plan of treatment, and discharge home, as determined by Dr. Avila. While Dr. Klein opined that on November 26, 2006, it was not a negligent departure from accepted standards of obstetrical care for the attending physician to not have performed a cerclage, he does not set forth the standard of care or basis for such opinion. Dr. Klein continued that Dr. Dramitinos, as a resident, did not have the right to make independent determinations with respect to the timing of fetal/uterine monitoring, the timing and administration of tocolytic agents, the discharge of patients, or the timing of a cerclage placement. It would have been inappropriate for her to have done so, and she did not exercise any independent medical judgment.

Dr. Klein concluded that the care and treatment by Dr. Avila did not so greatly deviate from normal practice that Dr. Dramitinos should have intervened. While this opinion not supported with a basis for Dr. Klein's opinion, the plaintiff has not opposed this application and has not raised factual issues to preclude summary judgment from being granted to Dr. Dramitinos, who has established prima facie entitlement to summary dismissal of the complaint as asserted against her. Plaintiff has not raised a factual issues concerning any departures from the standard of care concerning Dr. Dramitinos documenting the history as presented by the plaintiff; her performance and findings based upon the sterile speculum exam; or in her observing and assisting in the performance of a transvaginal ultrasound under the direct supervision and guidance of Dr. Avila. It has been demonstrated that she did not exercise independent medical judgment and did not take part in the plan and assessment of Ms. Daly, or in discharging home on November 26, 2006.

Accordingly, motion (002) is granted and the complaint as asserted against Patricia Dramitinos, M.D. is dismissed.

Dated: September 12, 2014

William B. Rebolini

HON. WILLIAM B. REBOLINI, J.S.C.

_____ **FINAL DISPOSITION** ___X___ **NON-FINAL DISPOSITION**

RIDER

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