Medrano v Carugno
2015 NY Slip Op 30186(U)
January 9, 2015
Supreme Court, Bronx County
Docket Number: 300585/11
Judge: Stanley B. Green
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[* 1] FILED Jan 20 2015 Bronx County Clerk

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M
---X
PATRICIA MEDRANO, as Administratrix of the Estate of
ANTHONY FERNANDEZ, Deceased,

INDEX No. 300585/11

Plaintiff(s),

- against-

JOSE CARUGNO MD., MARIA BAUTISTA MD,
JOHN ILAGAN MD, ST BARNABAS HOSPITAL
and ST BARNABAS OB/GYN PC,

Defendant(s)

DECISION

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HON. STANLEY GREEN:

The motion by St. Barnabas Hospital (SBH) for summary judgment dismissing the complaint and the cross-motion for summary judgment by Maria L. Bautista M.D. s/h/a Maria Bautista, M.D. are hereby consolidated for decision with the motion for summary judgment by John Ilagan, M.D. Upon consolidation: (1) the motion by SBH is granted only to the extent that all claims against it for direct negligence and for vicarious liability based on the alleged malpractice of Dr. Carugno and Dr. Ilagan, M.D. are dismissed; (2) the motion by Maria L. Bautista, M.D. is denied; and (3) upon a search of the record, the motion by John Ilagan, M.D. is granted. (The cross-motion by Jose Carugno, M.D and St. Barnabas OB/GYN was previously granted, without opposition, by order of this court dated May 22, 2014).

Plaintiff claims that defendants failed to properly manage plaintiff mother's labor and delivery, failed to perform a timely cesarean section and negligently managed the infant from the time of his birth and as a result, the infant expired 14 hours after his birth.

Decedent's mother presented to the Emergency Department of SBH on June 28, 2010 at 24.6 weeks gestation with premature rupture of membranes. She was admitted to labor and delivery with fetal monitoring and bed rest in place. A biophysical profile (a prenatal ultrasound evaluation of fetal well-being) performed on June 29, 2010 revealed a score of 4 out of 8, with breathing and gross movement noted. No significant events event were noted through 1:53 on June 30, 2010, when the fetal heart rate decreased to 70 with a slow recovery. At that time, Dr. Ihemaguba evaluated plaintiff and ordered the administration of oxygen. Plaintiff's cervix remained closed and, occasionally, variable decelerations were documented. The plan was to continue monitoring plaintiff and, if the tracing worsened, to perform a cesarean section.

At approximately 3:00 p.m. on June 30th, Dr. Ilagan, a Maternal Fetal Medicine attending physician (who was employed by Montefiore Medical Center, but worked at SBH as a consultant for high risk obstetrics cases), was assigned to perform a BPP. Based on the BPP score of zero out of eight, Dr. Ilagan recommended that a Cesarean section be performed as soon as plaintiff arrived downstairs from the ultrasound unit. However, approximately one hour later, Dr. Ilagan was informed by Dr. Suri (non-party attending physician) that plaintiff had been fed. At Dr. Ilagan's request, Dr. Suri evaluated the fetal tracing and reported moderate variability. In light of the risk of aspiration of gastric contents, Dr. Ilagan advised Dr. Suri that they could wait for six to eight hours after the meal to perform the cesarean section to allow for gastric emptying, but, if the fetal heart tracing became non-reassuring prior thereto, they should be ready to perform a delivery by cesarean section, regardless of the risk (EBT, p. 104-105, 100). That was Dr. Ilagan's only involvement in this case.

Dr. Carugno, an attending physician at SBH, first saw plaintiff on June 30, 2010, at

approximately 5:30-6:00 p.m., when Dr. Suri signed out plaintiff to him. His first note, at 7:23 p.m., indicates that plaintiff's delivery was delayed because she had eaten and that as long as the tracing was reassuring, they could wait to allow for gastric emptying. Dr. Carugno's only other note in the chart, at 1:45 a.m. on July 1, 2010, indicates that secondary to multiple emergencies of other patients on the floor, the cesarean section was delayed, but plaintiff was continuously monitored and they were going to proceed with the cesarean section. At 1: 50 a.m., plaintiff was taken to the operating room and the infant was delivered at 2:33 a.m. with APGARS of 6 and 8. Plaintiff mother's placenta was positive only for acute chorio-amnionitis and chorionic plate vasculitis. The infant had no infection.

Dr. Bautista (an attending pediatrician employed by NY Bronx Pediatric Medicine, P.C.), was present at the time of delivery. She immediately intubated the infant due to labored respirations and transported him to the Neonatal Intensive Care Unit (NICU). In the NICU, the infant received Survanta (a surfactant) for treatment for Respiratory Distress Syndrome (RDS), caffeine and full respiratory support through a ventilator. A chest x-ray at 4:23 a.m. was significant for bilateral infiltrates and RDS, along with proper placement of endotracheal tube. The chest film was done prior to the Surfactant administration. The infant's blood gases improved at 8:00 a.m., when Dr. Bautista signed off to Dr. Lezcano, the Director of the NICU.

In the NICU, the infant's RDS improved briefly, but then he developed a pneumothorax (collapsed lung) which was corrected with a right sided chest tube at approximately 11:19 a.m. A subsequent chest x-ray revealed a 95% resolution of the pneumothorax. Subsequently, the infant's RDS became more pronounced and at 2:30 p.m., Dr. Leczano changed the vent settings to the maximum of 100. An echocardiogram was also performed and it was significant for

Patent Ductus Arteriosis (PDA). The infant became bradycardic at 3:35 p.m. Epinephrine and Sodium Bicarbonate were given, but the infant was pronounced dead at 4:35pm after aggressive resuscitation efforts were deemed unsuccessful.

SBH seeks dismissal of the complaint on the grounds that: (1)its staff involved in plaintiff's care followed all attending physicians' orders, exercised no medical judgment and were not negligent; (2) the care and treatment provided by the named attending physicians was appropriate in all respects and did not require any member of the nursing or resident staff to intercede or countermand such instructions; (3) SBH cannot be held vicariously liable for treatment provided by attending physicians whom plaintiff has failed to sue or for whom the Statute of Limitations has expired; and (4) SBH cannot be held vicariously liable for the actions of attending physicians under the circumstances of this case.

In support of the motion, SBH submits the affirmation of Dr. Denise Guidetti, who is Board Certified Obstetrics and Gynecology. Dr. Guidetti opines that plaintiff received appropriate pre-partum management, that the treatment decisions by the attending physicians were appropriate and reasonable exercises of their medical judgment and no decision made by any member of the attending staff, including Dr. Carugno's decision regarding the delivery, played any role in the infant's outcome. Dr. Guidetti opines that Dr. Ilagan's recommendation to perform a Cesarean section when he obtained a BPP of 0/8 was proper and that "to the extent that the fetal heart tracings remained appropriate for gestational age, a delay to accommodate the fact that a meal had been taken at approximately 12 noon was an appropriate exercise of judgment."

As to the further delay of the delivery to 1:30 a.m., Dr. Guidetti opines that although an earlier delivery had been planned and would have been appropriate, the later delivery did not

have an effect on the infant's presentation at delivery or cause any injury to the infant because the fetal heart strips never became compromised so as to require an emergent or stat cesarean section.

SBH also submits the affirmation of Dr. Andrew M. Steele, who is Board Certified in Pediatrics and Neonatal-Prenatal Medicine. Dr. Steele opines that the infant was properly intubated in the delivery room and transferred to the NICU, where surfactant was administered and full respiratory support was given for treatment of RDS. Dr. Steele opines that all of the treatment in the NICU was appropriate. He also opines that the ventilation setting chosen by Dr. Bautista was appropriate and the ventilator settings were appropriately changed throughout the infant's life to accommodate his changing respiratory picture and his severe RDS. He explains that RDS at birth is the product of prematurity and lungs that are not fully developed and that the presence of pneumothorax was the product of RDS, an appreciated complication that was managed appropriately

Drs. Bautista and Dr. Ilagan seek dismissal of the claims against them on the ground that the expert affirmations submitted in support of SBH's motion show that the care and treatment they rendered to plaintiff and the infant was at all times within the standard of care and no act or omission by them was the proximate cause of the claimed injuries. They adopt and rely upon the evidence submitted in support of SBH's motion, including the expert affirmations of Dr. Guidetti and Dr. Steele.

Dr. Ilagan acknowledges that his motion was filed more than 120 days after the filing of the note of issue, but contends that there is good cause to extend the time in which to file the motion because there was confusion among the parties as to the date that plaintiff filed the Note

of Issue. In the alternative, Dr. Ilagan asks that if SBH's timely motion is granted, that based upon the absence of departures and cause as to him, the court search the record and dismiss all claims against him.

Plaintiff contends that the delay in delivery of the infant after she had been admitted to SBH for 48 hours with pre-term, premature rupture of membranes and chorioamnionitis, was a substantial contributing factor in causing the infant's death. Plaintiff also contends that Dr. Bautista and other members of the NICU staff departed from good and accepted standards of practice by: (1) failing to reduce the ventilator inspiratory pressure after the administration of surfactant; (2) failing to change the ventilation mode from conventional to "HFOV" (high frequency oscillating ventilation) after the pneumothorax was appreciated; and (3) by failing to administer dobutamine to increase the infant's cardiac output in order to effectively treat acidosis, apnea, bradycardia and oxygen desaturation, and that these departures were substantial contributing factors in causing the infant's death.

In opposition to defendants' motions, plaintiff submits the affidavit of Bruce Hallbridge, M.D., a Board Certified Obstetrician and Gynecologist and the affidavit of Carolyn Crawford, M.D., who is board certified in pediatrics and neonatal-perinatal medicine.

Dr. Hallbridge opines that Dr. Ilagan's initial recommendation for a prompt cesarean section was correct, but the decision by SBH staff to delay the cesarean delivery to allow time for gastric emptying, to which Dr. Ilagan assented, was a departure and that the standard of care was to deliver the infant as soon as possible and not to wait several hours for the mother to completely digest her meal. Dr. Hallbridge opines that the cumulative effect of "prolonged exposure to an unfavorable intrauterine environment and hypoxia-ischemia" (evidenced by

nonreassuring fetal status measured by the BPP), was a substantial contributing factor to the infant's death on his first day of life and that "had the infant been delivered by C section within a reasonably short period of time from when the BPP was completed on June 30, 2010, he would have "had a much better response to the respiratory support and other treatment" he did receive during his 14 hours of life.

Dr. Crawford disagrees with Dr. Steele's opinion that the pneumothorax was an unavoidable consequence of extreme prematurity. She opines that although the infant's respiratory distress may have been an unavoidable consequence of birth at 25 weeks gestational age (because the lungs are not fully developed and thus, not sufficiently compliant at that gestational age), respiratory distress can be treated without causing pneumothorax.

Dr. Crawford notes that while Dr. Steele's' affirmation indicates that pneumothorax occurs when mechanical forces in the lung cause a tear, this implies that these mechanical forces are an entirely natural process, "merely because pneumothorax is a relatively common complication of prematurity." It is her opinion that pneumothorax results from baro-and/or volutrauma of the immature lung when excessive ventilation pressures or tidal volumes are employed during positive pressure ventilation. Dr. Crawford opines that Dr. Bautista, Dr. Lezcano and the SBH NICU staff departed from accepted neonatology practice by failing to reduce the peak inspiratory pressure (PIP) delivered by the ventilator at any time after the infant received exogenous surfactant between 4:45 and 6:00 a.m. She notes that the NICU flowsheet reflects that the PIP was at all times 18cmH20. She opines that the standard of care is to reduce the PIP after the administration of surfactant through the endotracheal tube and that failure to do so can result in rupture of alveoli after their surface tension has been reduced by the surfactant

(which is the immediate objective of the treatment) when exposed to the same inspiratory pressure as was given before surfactant treatment. She notes that after the surfactant treatment, which commenced at 4:45 a.m., the infant's oxygen saturations were good until 10:00 a.m., when SpO2 decreased to 83% and at 11:00 a.m. when SpO2 was 81% and a chest x-ray at about 11:19 a.m. revealed a right sided tension pneumothorax. She opines that the infant was subjected to excessive synchronized intermittent mandatory ventilation (SIMV) pressure after the lungs were "softened" and rendered more prone to air leak following surfactant administration.

Dr. Crawford notes that the pneumothorax was appropriately treated with a chest tube to evacuate air from the pleural space, but the infant never fully recovered from the pneumothorax. She opines that the pneumothorax and pneumomediastinum, both of which tend to put external pressure on the heart and lungs and reduce venous return to the heart, were substantial contributing factors to the infant's cardiorespiratory failure and death within about five hours.

Dr. Crawford also opines that it was also a departure to fail to switch the infant from the conventional mode of ventilation to high frequency oscillating ventilation (HFOV) after the pneumothorax was identified and that this was a further substantial contributing factor in the infant's continued oxygen desaturations and cardiorespiratory failures. She explains that HFOV delivers breaths at a faster rate, with lower pressure, and is a more efficient method of providing adequate respiratory support (particularly in the presence of respiratory acidemia) to a severely premature infant. It also has the added advantage of avoiding continuing barotrauma to immature lungs.

Dr. Crawford opines that a third departure was Dr. Lezcano's failure to administer dobutamine or another inotropic agent after the pneumothorax was identified, and as the infant

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developed acidosis, apnea and bradycardia and worsening desaturations from about 2:00 p.m. until his death two and a half hours later. She explains that Dobutamine is standard treatment to increase cardiac output through stimulating cardiac muscle contractility and to raise systemic blood pressure. She opines that it was a departure to withhold dobutamine when blood gas results at 2:00 p.m. revealed respiratory acidosis and as oxygen saturations were in the 60's over the next two hours and bradycardia developed, all of which were contributing factors to the infant's cardiorespiratory collapse and death.

On a motion for summary judgment, it is the burden of the summary judgment proponent to demonstrate, prima facie, that he is entitled to judgment as a matter of law with evidence sufficient to eliminate any material issue of fact; failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers (Alvarez v. Prospect Hosp., 68 NY2d 320; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851). The burden then shifts to the party opposing the motion to demonstrate by evidentiary proof in admissible form that a triable issue of fact exists (Zuckerman v. City of New York, 49 NY2d 557). A court's task is issue finding rather than issue determination (Sillman v. Twentieth Century-Fox Film Corp., 3 NY2d 395) and the court must view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference and ascertaining whether there exists any triable issue of fact (Boyce v. Vazquez, 249 AD2d 724).

With respect to the motion by SBH, generally a hospital cannot be held vicariously liable for the acts of private attending physicians (Hill v. St. Claire's Hosp., 67 NY2d 72) and is shielded from liability when its employees follow the orders of the attending physician, unless the staff knows that the doctor's orders are so clearly contraindicated by normal practice that

ordinary prudence requires inquiry into the correctness of the orders (Fiorentino v. Wenger, 19 NY2d 407; (Filippone v. St. Vincent's Hospital and Medical Center, 253 AD2d 616). However, where, as here, a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician, the hospital may be held vicariously liable for the negligent performance of those services by the doctors and staff it hired and furnished to the patient (Mduba v. Benedictine, 52 AD2d 450). Therefore, if it is determined that an attending physician assigned by SBH to treat plaintiff was negligent, then SBH may be held vicariously liable for that physician's negligence.

Here, the affirmations of Drs. Guidetti and Steele establish, prima facie, that the care and treatment rendered to plaintiff and the infant by Drs. Bautista, Carugno and Ilagan and SBH staff was at all times within good and accepted standards of medical practice, that no claimed act or omission by them proximately caused the claimed injuries, and that "no decision made by any member of the attending staff ... played any role in the baby's outcome." Thus, the burden shifted to plaintiff to present competent evidence sufficient to raise a material issue of fact to defeat the motions (Zuckerman, supra).

While Dr. Hallbridge opines that it was a departure for Dr. Ilagan to agree to delay the cesarean delivery for eight hours because plaintiff had eaten lunch, he fails to explain how the delay, attributable to Dr. Ilagan, from approximately 4 p.m. until 8 p.m. was a substantial factor in causing injury to the infant when, according to Dr. Carugno's note, the cesarean section was delayed another six hours "secondary to other emergencies." The fact that Dr. Hallbridge does not address the additional delay in performing the surgery while plaintiff was under the care of Dr. Carugno and that plaintiff did not oppose Dr. Carugno's motion for summary judgment

renders Dr. Hallbridge's opinion conclusory and speculative and insufficient to raise a material issue of fact as to Dr. Ilagan's negligence. Accordingly, SBH is entitled to dismissal of all claims for vicarious liability arising out of Dr. Ilagan's care and treatment of plaintiff and, upon a search of the record, all claims and cross-claims against Dr. Ilagan are dismissed.

As to the motion by Dr. Bautista, while Dr. Steele opines that the care and treatment rendered by Dr. Bautista and the NICU staff was at all times proper and did not cause the claimed injuries, Dr. Crawford's opinion raises triable issues of fact as to whether Dr. Bautista and Dr. Lezcano departed from accepted neonatology practice by failing to reduce the peak inspiratory pressure (PIP) delivered by the ventilator at any time after the infant received exogenous surfactant between 4:45 a.m. to 6:00 a.m. and as to whether failure to switch the infant from the conventional mode of ventilation to high frequency oscillating ventilation (HFOV) after pneumothorax was identified were substantial contributing factors in causing the infant's death. Accordingly, Dr. Bautista's motion for summary judgment must be denied and SBH may be held vicariously liable for her negligence, if any.

As to SBH NICU staff, however, the testimony of the attending physicians and the affirmations of Drs. Guidetti and Steele show that SBH staff properly followed all of the orders of the attending physicians and no evidence has been submitted to the contrary. Accordingly, SBH is entitled to summary judgment dismissing all direct claims against it based on the acts of its staff, including nurses and residents.

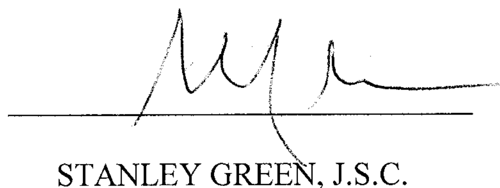
As to SBH's contention that it cannot be held vicariously liable for the alleged negligence of unnamed attending physicians who treated plaintiffs, such as Dr. Leczano, because the claims against them are barred by the statute of limitations, the failure to commence a timely direct

action against the unnamed attending physicians does not compel dismissal of plaintiff's vicarious liability claims against SBH for their alleged negligence because plaintiff's action against SBH was timely commenced within the 2 ½ year statute of limitations period and the unnamed attending physicians are not necessary parties to an action seeking to hold SBH vicariously liable for their alleged negligence on principles of respondeat superior (Shapiro v. Good Samaritan, 55 AD3d 821). SBH had full knowledge of the role of Leczano and he was deposed on September 16, 2003. Thus, there can be no claim of surprise or prejudice to SBH regarding the claim of vicarious liability for Leczano.

Movants shall serve a copy of this order with notice of entry on the Clerk of the Court who shall enter judgment dismissing the complaint and all cross-claims against Dr. Ilagan.

This constitutes the decision and order of the court.

Dated: January 9, 2015



STANLEY GREEN, J.S.C.