Delgado v Parkview Med. and Dental
2019 NY Slip Op 30344(U)
February 5, 2019
Supreme Court, Kings County
Docket Number: 505681/13
Judge: Michelle Weston

At an IAS Term, Part MMESP5 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, located at 320 Jay Street, Borough of Brooklyn, City and State of New York, on the 5th day of February, 2019

P R E S E N T:

HON. MICHELLE WESTON,
Justice.

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VIVIANA DELGADO, as Administrator of the Estate of C----G----B---- a/k/a C----G----, Deceased, and SALOME BLANCO, Individually,

Plaintiffs,

Index No. 505681/13

- against -

DECISION AND ORDER

PARKVIEW MEDICAL AND DENTAL and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (WOODHULL HOSPITAL),

Defendants.

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The following papers numbered and read herein:	NYSEF Doc. No.
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	27 - 47
Opposing Affidavits (Affirmations)	54 - 66
Reply Affidavits (Affirmations)	68 - 69
Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers, in motion sequence number 3, New York City Health and Hospitals Corporation (Woodhull Hospital) (Woodhull or the Hospital) (hereinafter collectively referred to as NYCHHC unless otherwise indicated) moves for an order, pursuant to CPLR 3212, granting it summary judgment dismissing the complaint of Vivian Delgado, as Administrator of the Estate of C----G----B---- a/k/a C----G----, deceased (the

infant or the patient), and Salome Blanco, individually. Ms. Blanco is the infant's mother.

Plaintiffs commenced this action seeking to recover damages for injuries sustained by the infant premised upon claims of medical malpractice, lack of informed consent, wrongful death and negligent infliction of emotional distress.

The infant was born premature at thirty one weeks gestation at Woodhull on March 16, 2012, via emergency cesarean section. He remained at the Hospital until April 14, 2012, when he was discharged. Thereafter the infant was treated for numerous health issues until his death on February 4, 2013 at New York University Medical Center (NYUMC).

Since plaintiffs limit their claim of negligence to NYCHHC's conduct on January 25, 2013, this decision will address only those facts necessary to determine these claims.

On January 24, 2013, Ms. Blanco brought the infant to the office of former co-defendant Francia Holgado-Devera, M.D., with a history of a fever of 101° and a one day bout with diarrhea. Dr. Holgado-Devera diagnosed him as having viral gastroenteritis and prescribed Tylenol and Pedialyte, with instructions to return to the office the next day, or to the emergency room, if the fever persisted and/or the diarrhea became worse.

On January 25, 2013, Ms. Blanco brought the infant to the Woodhull Emergency Department at 2:13 a.m., with complaints of fever and diarrhea for two days, stiffening of the extremities and upward eyeball gaze. His temperature was 103.3°, seizure activity was observed and he was diagnosed with status epilepticus. He was given two separate doses of Ativan to stop the seizures and Acetaminophen to reduce the fever. At 6:00 a.m., the infant

again began seizing and was given a third dose of Ativan, and another at 6:40 a.m.

At or about 8:15 a.m.[1], the infant was admitted to the Special Care Unit (SCU). At or around this same time, the infant received a load dose of Phenobarbital to abort further seizures and an antibiotic. The infant was described as drowsy and unresponsive, with sluggish reactive pupils.

When the infant was examined at 8:28 a.m., he had tachycardia and tachypnea; his blood pressure was 88/51, pulse was 141, temperature was 99.1°, respirations were 56 and oxygen saturation was 99%. The infant continued to be monitored. At 9:17 a.m., a nurse noted that the infant's hands and feet were cool and that there was a change in the assessment of the Glasgow Coma Scale, i.e., he had no motor response. A lumbar puncture to rule out meningitis was attempted three times. At or about this same time, the infant again had self limiting tonic episodes and posturing. At some point thereafter (plaintiff's assert at 9:50 a.m.), the infant became apneic, or in a state of temporary cessation or voluntary suspension of breathing; he was resuscitated with a bag valve mask device, but there was no recovery of spontaneous respirations. Shortly thereafter, the infant's oxygen levels began to de-saturate. Three unsuccessful attempts were made to intubate the infant. The infant was placed on a ventilator.

At 11:30 a.m., the infant's blood pressure was 42/33, his pulse was 118 beats per

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[1] There is some discrepancy as to what time the infant was admitted to the SCU. NYCHHC asserts that the infant was admitted to the SCU at approximately 7:15 a.m., while the plaintiffs aver that the correct time was 8:15 a.m.. Indeed, the parties often disagree about exact times regarding occurrence of some events.

minute, his respirations were 20 and his oxygen saturation remained at 100%. A chest x-ray taken at 11:38 a.m. suggested a right atelectasis, or a lung collapse or infiltrate. The plan was to transfer the infant to NYUMC.

Upon arrival at NYUMC, the chief complaint was seizure, hypotension and septic shock. Following a neurological consult, the infant was diagnosed as comatose in the setting of severe, systemic illness with multi-organ failure and no evidence of cerebral function. The infant remained intubated and mechanically ventilated, with no spontaneous movement; he was unresponsive to noxious stimuli. Blood cultures grew Salmonella Heidelberg, a bacterium commonly associated with food borne infections, which causes symptoms including diarrhea, fever and abdominal complaints. A head CT scan revealed diffuse loss of gray-white differentiation, consistent with anoxic/ischemic encephalopathy. On February 4, 2013, the infant was removed from life support and died shortly thereafter.

In support of its motion, NYCHHC alleges that:

> "The gravamen of plaintiffs [sic] complaint . . . as articulated in the Bill of Particulars, is the alleged failure to monitor the patient's reaction to the administration of Acetaminophen. Plaintiff has also asserted a cause of action for lack of informed consent solely regarding the administration of Acetaminophen. In particular, plaintiff alleges a failure to advise the patient's mother of the special risks associated with the administration of Acetaminophen since the patient was diagnosed with liver dysfunction and with disseminated intravascular coagulation (DIC)."

(Affirmation in Support, p 2, para 5) (emphasis in original). As is relevant herein, NYCHHC asserts that Acetaminophen was only administered at Woodhull on January 25, 2013.

NYCHHC further asserts that:

> "In the Verified Bill of Particulars, plaintiff alleges that New York City Health and Hospitals Corporation failed to properly monitor the patient after birth; failed to properly treat fever, diarrhea, rash, low platelet count, and liver problems; failed to properly monitor the reaction to Acetaminophen; failed to diagnose breathing issues and provide oxygen support; failed to refer to the appropriate specialists; and failed to provide Doppler ultrasound equipment."

(Affirmation in Support, p 14, para 52). In support of its motion, NYCHHC relies upon an affirmation from Robert L. Koppel, M.D., who is board certified in Pediatrics, sub-board certified in Neonatal-Perinatal Medicine and certified in Pediatric Advanced Life Support. Dr. Koppel opines that the treatment rendered to the infant was at all times consistent with the existing standards of care and that nothing NYCHHC did, or failed to do, was a proximate cause of any of the infant's injuries or resulting death.

More specifically, Dr. Koppel notes that respiratory depression is a known and accepted risk of Phenobarbital. He opines that the infant was appropriately monitored after Phenobarbital was administered, and positive pressure ventilation was provided via a bag and mask when required. When apnea occurred, the infant was timely intubated; a chest x-ray was performed to confirm the position of the endotracheal tube and the tube was then appropriately re-positioned. Dr. Koppel contends that it is not unusual for physicians to require several attempts to intubate an infant who is actively seizing. Moreover, despite the placement of the endotracheal tube, the infant's carbon dioxide level was normal, which indicates that his acidosis was purely metabolic, without any respiratory component. In other

words, the infant was well ventilated, despite the need for several attempts at intubation, since metabolic acidosis was the result of the infant's hypoperfusion due to septic shock, which was later determined to have been caused by a Salmonella infection, as was confirmed by blood cultures and stool cultures taken. The infant was properly started on an antibiotic.

Dr. Koppel further opines that rectal administration of Acetaminophen was appropriate for the reduction of a fever of 103.3°, as such administration is absorbed quickly, frequently results in rapid temperature reduction and minimizes the risk of vomiting. The administration of Acetaminophen was accordingly not contraindicated and did not cause any injury to the infant or cause his death. Dr. Koppel also asserts that a lumbar puncture was properly performed to rule out meningitis and a head CT scan ruled out intracranial mass or hemorrhage as the cause for the infant's seizures. After intubation, the infant was appropriately transferred to NYUMC for intensive management.

In opposition, plaintiffs rely upon Dr. Grinspan, board certified in Pediatrics and Neurology. Dr. Grinspan asserts that NYCHHC departed from good and accepted practice from 8:15 a.m. to 9:50 a.m. on January 25, 2013 by failing to properly monitor the infant's oxygen saturation, respiratory rate and blood pressure in the SCU. Dr. Grinspan asserts that the lack of oxygen to the brain between the beginning of the apnea, at approximately 9:50 a.m., and the successful intubation at approximately 11:19 a.m., substantially contributed to the irreversible brain injury that was in place by the time of the infant's transfer to NYUMC, as revealed on the MRI taken of his brain on January 31, 2013.

Dr. Grinspan further opines that NYCHHC negligently monitored and responded to the infant's tachycardia and tachypnea indicators of early stage septic shock, which ultimately resulted in his death at NYUMC.

Based upon the infant's condition, Dr. Grinspan is of the opinion that there are two interventions required by good and accepted pediatric practice that should have occurred in the time between admission to the Woodhull SCU between 8:15 a.m. and 9:50 a.m. on January 25, 2013. He asserts that first, the infant should have been assessed for ongoing tachycardia, tachypnea, cool extremities and a change in the level of responsiveness. All four can be early symptoms of shock and require urgent intervention. Interventions should also have included the administration of additional fluids. Dr. Grinspan alleges that the need for intubated respiratory support was of particular importance, given a child with ongoing seizures and unstable vital signs, particularly after being treated with Ativan and Phenobarbital, which are sedating and can cause further respiratory suppression.

Dr. Grinspan also contends that the infant should have been connected to an electroencephalogram, or an EEG, for continuous monitoring, since subclinical seizures, or electrical seizures, even after medications have successfully controlled clinical seizures was possible; he explains that these subclinical seizures can lead to brain injury. Dr. Grinspan contends that had the infant been found to have subclinical seizures, the clinical team would have had the option to administer additional anti-seizure medication.

Dr. Grinspan further notes that by 9:50 a.m., the infant had become apneic and his

oxygen saturations dropped to the 30-40% range; oxygen was then given by mask, cardiopulmonary resuscitation commenced and the infant responded with saturation 100%. However, the infant again desaturated to 40-50%, blood pressure to 60/50; CPR was restarted and normal saline was given. Dr. Grinspan contends that this indicates that the infant continued to display tachypnea and tachycardia, along with abnormally cool extremities, all of which were early warning signs of clinical instability, or shock.

In reply, NYCHHC alleges that since its motion was submitted, this court issued a decision, order and judgment dated May 30, 2017 dismissing this case as to Dr. Holgado-Devera, based upon the strength of the expert affirmation of Dr. Koppel submitted by NYCHHC in support of its motion; plaintiffs did not oppose that motion. NYCHHC thus contends that the court has necessarily determined that no issues of fact exist in this case as to the alleged impropriety in administering Acetaminophen to the infant, that an informed consent was not required for the administration of Acetaminophen and that the infant was properly monitored for Acetaminophen toxicity. NYCHHC concludes that since plaintiffs had a full and fair opportunity to litigate those issues in Dr. Holgado-Devera's motion, but failed to do so, it should be granted partial summary judgment on these issues pursuant to the doctrine of collateral estoppel.

On the merits, NYCHHC contends that plaintiffs did not submit any expert opinion that rebutted Dr. Koppel's contention that the infant was properly given Acetaminophen, that he did not suffer any toxicity as a result thereof, that he was properly monitored for any

adverse reaction to Acetaminophen and that the care that he received during treatment at Woodhull was proper. NYCHHC accordingly argues that these claims must be deemed abandoned and dismissed.

NYCHHC further contends that instead of opposing Dr. Koppel's showing of propriety in the care of the infant, plaintiffs instead raise an entirely new claim not articulated in the bill of particulars, i.e., that NYCHHC did not properly treat respiratory depression that arose secondary to the proper administration of Ativan and Phenobarbital to treat ongoing seizure activity during a presentation to Woodhull's Emergency Department. Because plaintiffs did not assert this claim in the bill of particulars, NYCHHC asserts that it should not be entertained in opposition to defendant's prima facie showing. Further, even if the court does entertain these allegations, NYCHHC avers that they are not sufficiently grounded in proof to raise a triable issue of fact.

The court declines to grant NYCHHC summary judgment dismissing plaintiffs' complaint on the ground of collateral estoppel.

> "The equitable doctrine of collateral estoppel is 'intended to reduce litigation and conserve the resources of the court and litigants and it is based upon the general notion that it is not fair to permit a party to relitigate an issue that has already been decided against it' (*Kaufman v Lilly & Co.*, 65 NY2d 449, 455 [1985]). It 'is grounded on concepts of fairness and should not be rigidly or mechanically applied' (*D'Arata v New York Cent. Mut. Fire Ins. Co.*, 76 NY2d 659, 664 [1990]). Its essential ingredients are: '[f]irst, the identical issue necessarily must have been decided in the prior action and be decisive of the present action, and second, the party to be precluded from relitigating the issue must have had a full and fair opportunity to contest the

> prior determination' (*Kaufman v Lilly & Co.*, *supra*, at 455, citing *Gilberg v Barbieri*, 53 NY2d 285, 291 [1981]). Significantly, '[t]he party seeking the benefit of collateral estoppel has the burden of demonstrating the identity of the issues in the present litigation and the prior determination, whereas the party attempting to defeat its application has the burden of establishing the absence of a full and fair opportunity to litigate the issue in the prior action' (*Kaufman v Lilly & Co.*, *supra*, 65 NY2d, at 456).

(*Juan C. v Cortines*, 89 NY2d 659, 667 [1997]; *see generally Wilson v Dantas*, 29 NY3d 1051, 1062 [2017]; *David v State of NY*, 157 AD3d 764, 765 [2d Dept 2018], *lv denied* 31 NY3d 912 [2018]). Herein, NYCHHC fails to make a showing that the claims of negligence against Dr. Holgado-Devera are identical to the claims asserted against it. The court does find, however, that plaintiffs expert does not address NYCHHC motion regarding the allegedly improper administration of Tylenol and/or the lack of informed consent pertaining thereto. Thus, summary judgment dismissing these claims as against NYCHHC is granted.

The court agrees with NYCHHC's general assertion that a plaintiff cannot properly assert an alternative theory of liability for the first time in opposition to a motion for summary judgment (*see e.g. Dolan v Halpern*, 73 AD3d 1117, 1119 [2d Dept 2010]; *Abalola v Flower Hosp.*, 44 AD3d 522, 522 [1st Dept 2007] [plaintiffs' physician expert improperly raised, for the first time in opposition to the summary judgment motion, a new theory of liability regarding the treatment of plaintiff's decedent that had not been set forth in the complaint or bills of particulars]).

Herein, as part of the bill of particulars, plaintiffs assert that NYCHHC failed to check

the vital signs and blood pressure of the infant on his arrival to hospital; failed to diagnose breathing issues; failed to provide oxygen support, resulting in brain death; and failed to have Doppler ultrasound equipment available. These are precisely the claims discussed in detail by Dr. Grinspan in his affirmation. Accordingly, the assertion by NYCHHC that plaintiffs are now seeking to amend their bill of particulars in opposition to their motion for summary judgment is belied by a reading of the bill of particulars.

A defendant demonstrates a "prima facie entitlement to judgment as a matter of law by establishing, through the deposition testimony, medical records, and the affirmation of their expert, that there was no departure from good and accepted medical practice, and, in any event, that any alleged departure was not a proximate cause of the [decedent's] injuries" (*Lahara v Auteri*, 97 AD3d 799, 799 [2d Dept 2012], citing *Garrett v University Assoc. in Obstetrics & Gynecology, P.C.*, 95 AD3d 823 [2d Dept 2012]; *Lau v Wan*, 93 AD3d 763 [2d Dept 2012]; *Brady v Westchester County Healthcare.*, 78 AD3d 1097 [2d Dept 2010]). "In order to sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (*Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 726 [2d Dept 2016], citing *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *Bhim v Dourmashkin*, 123 AD3d 862 [2d Dept 2014]; *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 1045 [2d Dept 2010]).

"'In opposition, a plaintiff then must submit material or evidentiary facts to rebut the defendant's prima facie showing that he or she was not negligent in treating the plaintiff'"

(*Dolan*, 73 AD3d at 1118, quoting *Langan v St. Vincent's Hosp.*, 64 AD3d 632, 632-633 [2d Dept 2009] [internal quotation marks and citations omitted]). "[P]laintiff need only raise a triable issue of fact regarding 'the element or elements on which the defendant has made its prima facie showing'" (*McCarthy v Northern Westchester Hosp,*, 139 AD3d 825, 826-827 [2d Dept 2016], quoting *Mitchell v Grace Plaza*, 115 AD3d 819, 819 [2d Dept 2014]). Further, "general allegations of medical malpractice that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a malpractice defendant's motion for summary dismissal" (*Melendez v Parkchester Med. Servs., P.C.*, 76 AD3d 927, 927-928 [1st Dept 2010], citing *Fileccia v Massapequa Gen. Hosp.*, 99 AD2d 796 [2d Dept 1984], *affd* 63 NY2d 639 [1984]).

As is also relevant here, it has been held that "[t]o defeat summary judgment, the expert's opinion 'must demonstrate "the requisite nexus between the malpractice allegedly committed" and the harm suffered'" (*Anyie B. v Bronx Lebanon Hosp.*, 128 AD3d 1, 3 [1st Dept 2015)], quoting *Dallas-Stephenson v Waisman*, 39 AD3d 303, 307 [1st Dept 2007], quoting *Ferrara v South Shore Orthopedic Assoc.*, 178 AD2d 364, 366 [1st Dept 1991]). Stated simply, a plaintiff's expert must address the issue of causation (*see generally Ducasse v NYCHHC*, 148 AD3d 434, 436 [1st Dept 2017]; *Steinberg v Lenox Hill Hosp.*, 148 AD3d 612, 613 [1st Dept 2017]).

It is also well settled that summary judgment may not be awarded in a medical malpractice action where the parties offer conflicting expert opinions, which present a

credibility question requiring a jury's resolution (*see e.g. Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]; *Dandrea v Hertz*, 23 AD3d 332, 333 [2d Dept 2005]).

Turning to the merits, the court finds that NYCHHC made a prima facie showing, based upon the affirmation of Dr. Koppel, that Woodhull did not depart from accepted standards of care in treating the infant in administering Ativan, Phenibarbital and/or Cerftiaxone (*see generally Sukhraj*, 106 AD3d at 810). Plaintiffs, however, present sufficient evidence to raise issues of fact that warrant denial of the motion.

Briefly stated, NYCHHC contends that the infant died as a result of septic shock from a Salmonella infection that caused his organs, including his brain, to shut down. Plaintiffs' expert contends that the infant died because he was not properly monitored, respirated and hydrated while at Woodhull on January 25, 2013, and was accordingly unable to fight the infection. Thus, these differences in the opinions of the experts cannot be resolved on the papers now before the court and must instead be resolved by the trier of fact (*see e.g. Loaiza*, 107 AD3d at 953; *Dandrea*, 23 AD3d at 333.

Plaintiffs contend that NYCHHC was negligent in failing to obtain informed consent. NYCHHC argues that plaintiffs make no reference to a specified procedure or treatment which was performed by Woodhull that required an informed consent. Moreover, an informed consent was obtained on January 25, 2013 for the performance of a lumbar puncture to confirm meningitis. Dr. Koppel further asserts that an informed consent was not required for any of the other procedures performed on the infant and in any event, informed

consent would not have affected the patient's treatment and/or ultimate outcome.

Public Health Law § 2805-d(1) provides that the claim for:

> "[L]ack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical . . . practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation."

(*see generally Dyckes v Stabile*, 153 AD3d 783, 784-785 [2d Dept 2017], quoting *Kleinman v North Shore Univ. Hosp.*, 148 AD3d 693, 694 [2d Dept 2017] [internal quotation marks omitted]). "'Lack of informed consent is a distinct cause of action requiring proof of facts not contemplated by an action based merely on allegations of negligence'" (*Figueroa-Burgos v Bieniewicz*, 135 AD3d 810, 811 [2d Dept 2016], quoting *Jolly v Russell*, 203 AD2d 527, 528 [2d Dept 1994]). Further, "'[t]o state a cause of action for lack of informed consent, plaintiff must allege that the wrong complained of arose out of some affirmative violation of plaintiff's physical integrity'" (*Smith v Fields*, 268 AD2d 579, 580 [2d Dept 2000], quoting *Iazzetta v Vicenzi*, 200 AD2d 209, 212-213 [3d Dept1994], *lv dismissed* 85 NY2d 857 [1975]).

Plaintiffs' claim for lack of informed consent is not predicated upon an affirmative violation of the infant's physical integrity, but is instead based upon NYCHHC's alleged failure to provide appropriate treatment to the infant. Since a claim of failure to timely treat a patient or to advise him or her of the seriousness of his or her condition cannot serve as the

basis for a claim of lack of informed consent, this claim must be dismissed (*see e.g. Flanagan v Catskill Regional Med. Ctr.*, 65 AD3d 563, 566-567 [2d Dept 2009]; *Schel v Roth*, 242 AD2d 697, 698 [2d Dept 1997]; *Iazzetta*; 200 AD2d at 212-213).

Accordingly, the motion by NYCHHC is granted only to the extent of dismissing all claims predicated upon the administration of Tylenol, all treatment provided to the infant between the date of his birth and his admission to the Woodhull Emergency Department on January 25, 2013 and the claim of lack of informed consent. The remaining claims are severed and shall continue. All other relief requested is denied.

The defendant is directed to serve a copy of this decision and order on the plaintiff.

The foregoing constitutes the order and decision this court.

E N T E R,

Michelle Weston

J. S. C.

Hon. Michelle Weston

KINGS COUNTY CLERK
FILED
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