

<b>E.A. v New York &amp; Presbyt. Hosp.</b>
2019 NY Slip Op 31825(U)
June 7, 2019
Supreme Court, Kings County
Docket Number: 500351/2014
Judge: Ellen M. Spodek
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At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 7<sup>th</sup> day of June 2019

PRESENT:

HON. ELLEN M. SPODEK, Justice

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E. A., an Infant by his Mother and Natural Guardian ARISALDA CAPELLAN and ARISALDA CAPELLAN Individually,

Plaintiffs,

DECISION AND ORDER

-against-

Index No. 500351/2014

*MS #7*

THE NEW YORK AND PRESBYTERIAN HOSPITAL,

Defendant.

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Papers

Numbered

Notice of Motion and Affirmation .....	<u>1</u>
Affirmation in Opposition .....	<u>2</u>
Reply Affirmation .....	<u>3</u>

Defendant THE NEW YORK AND PRESBYTERIAN HOSPITAL ("NYPH"), moves for an order granting summary judgment as a matter of law and dismissing the plaintiff's claims in their entirety, and any such other and further relief as this court may deem just, proper, and equitable under the circumstances. Plaintiff opposes the motion.

Plaintiff Arisalda Capellan presented to Woodhull Medical Center ("Woodhull") on April 3, 2011. An ultrasound was performed showing positive intrauterine pregnancy and positive fetal heart rates for two fetuses (Twin A and Twin B). Woodhull provided prenatal care until May 18, 2011. On May 18, 2011, an obstetrics ultrasound was performed, and the measurements of Twin A and Twin B were inconsistent. The care rendered at Woodhull is not at issue in this case.

On May 20, 2011, the plaintiff presented to NYPH for an evaluation of her Monochorionic diamniotic ("MCDA") twin pregnancy complicated by Twin-to-Twin Transfusion Syndrome ("TTTS"). A sonogram was performed, and the findings satisfied a diagnosis of early-onset Stage III TTTS. Dr. Russel Miller discussed with the plaintiff the various risks if the TTTS is left untreated. Dr. Miller also discussed the options available to the plaintiff, which are intended to maximize the outcomes for both fetuses, and each option's respective risks and benefits. Ultimately, the plaintiff decided to proceed with the pregnancy and undergo Selective Laser Photocoagulation ("SLP"). The consultation was performed with a Spanish interpreter.

On May 21, 2011, plaintiff was admitted to NYPH to undergo SLP by Dr. Lynn Simpson. The plaintiff was told that the loss of one or both fetuses could occur despite this procedure, but without the SLP the risk of loss of the entire pregnancy was greater than 80-85%. Plaintiff consented to the SLP and Dr. Simpson performed the procedure. At the end of the procedure, the abnormalities were seen, photocoagulated, and both twins had normal heart rates. A post-operative ultrasound

showed two viable fetuses with normalization of fluid in both sacs. The plaintiff was discharged home that evening.

On May 26, 2011, at 20 weeks pregnant, the plaintiff had a follow up appointment with Dr. Simpson. Dr. Simpson planned to treat the pregnancy as monoamniotic twins with inpatient management at 24-26 weeks and delivery by 32 weeks. On June 24, 2011, Dr. Miller reviewed the sonographic findings and discussed his concerns with the plaintiff. Dr. Miller was concerned that Twin B may demise or suffer in-utero injury and as a result, there was potential for Twin A to die or suffer neurological injury due to the demise of Twin B. Dr. Miller recommended intervention at 26-28 weeks and the plaintiff decided to pursue a course of expectancy until 28 weeks. At 25 weeks, a sonogram was performed and the amniotic fluid appeared to be normal. However, Dr. Christina Farkouh assessed the patient and discussed the various options. There were poor findings for Twin B, but if delivery were to occur at that point there would be a very high risk of mortality or moderate to severe neurodevelopment issues to Twin A. Plaintiff decided to continue the current treatment to optimize the outcome for Twin A.

On July 8, 2011, (26 weeks) the plaintiff was examined by Dr. Miller who decided to aggressively intervene in order to save both fetuses if possible. Plaintiff was transferred and admitted to labor and delivery. Dr. Devine did not proceed with delivery because both fetuses were very active and it was difficult to monitor them individually with a sonogram. On July 9, 2011, Dr. Jessica Buck examined the plaintiff and noted that the plan was to deliver if there was deterioration in the tracings or

biophysical profile. On July 10, 2011, Dr. Perez-Delboy performed an ultrasound and confirmed that the plaintiff was aware that preterm delivery at 26 weeks would likely result in damage to the fetuses, including possible neonatal death, cerebral palsy, mental retardation, seizures, blindness, respiratory distress syndrome, and chronic lung disease. On July 11, 2011, Twin A showed a normal preliminary biophysical profile (8/8) with normal Doppler studies but Twin B's monitoring showed intermittent fetal distress. On July 12, 2011, plaintiff was transferred to the antepartum unit.

Until the morning of July 14, 2011, both twins had moderate variability and positive accelerations. At 8:20 pm, a nurse noted that it appeared that the same baby was being traced despite placing the transducers in different areas of the abdomen. These results were reviewed by Dr. Buck and the nurse at 10:00pm and 10:30pm. An ultra sound was performed and confirmed the death of Twin B. Dr. Buck then informed the plaintiff, through an interpreter, of the death of Twin B and that she would be transferred to labor and delivery for monitoring of Twin A. At 2:42 am on July 15, 2011, a bedside scan showed that Twin A had a biophysical profile of 6/8 with -2 for breathing. Dr. Smok indicated to the plaintiff the risks of birth at this premature stage in gestation but after Twin A showed a biophysical profile of 4/8 with -2 for breathing, no flexion extension, and minimal positive movement noted over 30 minutes at 6:17am, plaintiff requested delivery.

A Caesarian section was performed at 6:15am on July 15, 2011 by Dr. Vink with the supervision of Dr. Smok. The infant (Twin A) was born on July 15, 2011.

Twin B was stillborn. Twin A was taken to the transitional nurse and was discharged home on October 15, 2011.

Defendant submits the expert affirmations of Dr. Anthony Johnson, maternal fetal medicine specialist, and Dr. Robert Koppel, M.D., a neonatology specialist, in support of their motion for summary judgment. Dr. Johnson opines that the sonograms and fetal monitoring were timely performed and appropriately interpreted throughout the plaintiff's pregnancy. Dr. Johnson also opined that the SLP procedure was timely and appropriately performed within the standard of care at all times. Dr. Johnson further affirmed, in support of Dr. Smok's testimony, that laser photocoagulation is not always effective and not guaranteed. Dr. Johnson opined that the statuses of the fetuses did not indicate the need for early delivery, rather it would create a high risk of mortality or severe neurodevelopmental injuries to both premature fetuses.

Additionally, Dr. Johnson opined that immediate delivery of Twin A following the demise of Twin B was not required by the standard of care nor would it have changed the neonatal/infant outcomes. Dr. Johnson, in support of Dr. Smok's testimony, stated that delivery became appropriate on July 15, 2011 when the plaintiff desired to deliver and the biophysical profile had changed. Dr. Johnson affirmed that an earlier delivery was within the standard of care at all times. Dr. Johnson also opined that Twin A's injuries were not proximately caused by any action or inaction of NYPH. Dr. Johnson states that the injuries to the Twin A were a risk of a TTTS pregnancy which plaintiff was made aware of from the beginning of treatment.

Dr. Koppel reviewed the records and testimony and opined that the infant plaintiff's claims against NYPH lack medical merit as the infant's treatment from birth to discharge was within the standard of care at all times.

Plaintiff opposed the motion for summary judgment, and submitted expert affirmations of Bruce L. Halbridge, M.D., an obstetrician; Carolyn S. Crawford, M.D., a neonatologist with long experience attending preterm deliveries; and Stephen J. Thompson M.D., a pediatric neurologist. Plaintiff's experts base their opinions on the mother and child's hospital records and determine that the failure to deliver the infant promptly at the time of the intrauterine fetal demise of Twin B was a departure from good and accepted obstetrical care, and that departure resulted in the injury to Twin A. Dr. Halbridge opines that the NYPH staff departed from good and accepted practice when they chose a "wait and see" approach following the demise of Twin B. Dr. Halbridge affirms that the potential complications from a preterm birth can be treated in the NICU and are far less likely than the likelihood of harm to the surviving twin following an intrauterine fetal demise in a TTTS pregnancy. Dr. Crawford opined that it was a departure in care to delay the delivery of Twin A until finding evidence of deterioration through diminished biophysical profile scores. Dr. Crawford further states that the in utero blood loss proximately caused the infant's brain injury.

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. *Brinkley v. Nassau*

*Health Care Corp.*, 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v. Streiter*, 83 A.D.3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden then shifts to the plaintiff to submit evidentiary facts or material to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v. Prospect Hosp.*, 68 NY.2d 320, 324 (1986); *Fritz v. Burman*, 107 A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. City of New York*, 99 A.D.3d 673, 675 (2d Dept. 2012).

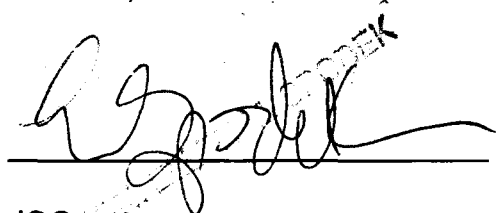
The Court finds that NYPH has failed in part to sustain its burden for summary judgment. After reviewing the papers, it is clear that there are issues of fact regarding the care administered by defendant following the death of Twin B. "Summary judgment may not be awarded in medical malpractice actions where the parties adduce conflicting opinions of medical experts." *McKenzie v. Clarke*, 77 A.D.3d 637, 683 (2d Dept. 2010); see *Adjetey v. New York City Health & Hosps. Corp.*, 63 A.D.3d 865 (2d Dept. 2009). In the present case, there are conflicting expert opinions regarding the plaintiff mother's care at NYPH after the demise of Twin B, until the delivery of Twin A. Dr. Johnson stated that there was no departure from the standards of care by NYPH because delivery was delayed due to the high risks associated with premature birth and the inherent risks of a TTTS pregnancy. Additionally, Dr. Johnson stated that the injuries sustained by the Twin A were an ever-present risk of the pregnancy and were not caused by the NYPH staff. Dr. Halbridge and Dr. Crawford stated the NYPH staff deviated from the standard of care because following the demise of Twin B, the risk of damage to Twin A was higher than the risks associated

with premature birth. Additionally, Dr. Crawford stated that Twin A's injuries were a direct result of the blood loss experienced in utero.

The plaintiffs failed to dispute defendant's argument that the claims regarding informed consent of the plaintiff, employment and supervision of the hospital staff, and the treatment and care of Twin A after delivery lacked merit. Therefore, defendant's motion for summary judgment dismissing the claims concerning the informed consent of the plaintiff, employment and supervision of the hospital staff, and the treatment and care of Twin A after delivery are granted. The remainder of the motion for summary judgment is denied.

This constitutes the decision and order of the Court.

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KINGS COUNTY CLERK  
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