Neumann v Silverstein
2020 NY Slip Op 30074(U)
January 2, 2020
Supreme Court, Kings County
Docket Number: 511857/14
Judge: Bernard J. Graham

At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 2d day of January, 2020.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

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REBECCA NEUMANN, AS MOTHER AND NATURAL GUARDIAN OF D.N., AN INFANT, AND REBECCA NEUMANN, INDIVIDUALLY

Plaintiffs,

- against -

Index No. 511857/14

MICHAEL L. SILVERSTEIN, M.D., SAMUEL D. BENDER, M.D. ANDREI REBARBER, M.D., NATHAN S. FOX, M.D., JENNIFER JIMENEZ, CNM, MS, RN, YORLENY SHERRIER, R-PA, CM, MATERNAL FETAL MEDICINE ASSOCIATES, PLLC, THE MOUNT SINAI HOSPITAL, NYU HOSPITALS CENTER, NYU MEDICAL CENTER, NYU LANGONE MEDICAL CENTER AND NYU OB/GYN ASSOCIATES,

Defendants.

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The following papers numbered 1 to 9 read herein:	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-4
Opposing Affidavits (Affirmations)	5-7
Reply Affidavits (Affirmations)	8,9
Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers in this medical malpractice action, defendants Michael L. Silverstein, M.D. (Dr. Silverstein), Samuel D. Bender, M.D. (Dr. Bender), Andrei Rebarber, M.D. (Dr. Rebarber), Nathan S. Fox, M.D. (Dr. Fox), Maternal Fetal Medicine Associates, PLLC, (MFMA), and the Mount Sinai Hospital (Mount Sinai) (collectively the moving defendants) move, pursuant to CPLR 3212, for summary judgment dismissing the complaint

of plaintiff Rebecca Neumann (plaintiff), as Mother and Natural Guardian of D.N., an infant, (infant plaintiff) and Rebecca Neumann, individually as asserted against these defendants.

Background Facts and Procedural History

The instant action arises out of injuries sustained by the infant plaintiff on June 27, 2012 during labor and delivery at Mount Sinai. Plaintiff's first prenatal visit at MFMA occurred on March 7, 2012,where she was seen by defendant Nurse Jennifer Jimenez (Nurse Jimenez). At that time, it was estimated that she was twelve weeks pregnant with an anticipated date of delivery of September 19, 2012. Nurse Jimenez documented that plaintiff had seven prior deliveries and her notes indicate that she was considered to be a high risk patient. Nurse Jimenez performed a physical examination which was unremarkable and a urine specimen was obtained for urinalysis and culturing.[1] Plaintiff was next seen at MFMA on March 13, 2012, where she was examined by Dr. Fox and a nuchal test and ultrasound were performed which revealed no fetal abnormalities. Dr. Fox's notes include the Group B Strep (GBS) results, a plan for cervical length studies and biophysical profile, and a notation that plaintiff's pregnancy was considered high risk.

Plaintiff returned to MFMA on April 17, 2102, and was examined by Dr. Silverstein. He recommended that a fetal anatomy study be performed as soon as possible, and a cervical length study at 20-22 weeks for a prior history of late pre-term delivery. On May 8, 2012, the cervical length study was performed which revealed a normal cervical length of 3.2 cm and the fetal anatomy study revealed no abnormalities. Plaintiff was examined later that day by Dr. Silverstein, and the pregnancy appeared to be progressing without any problems. He

[1]MFMA received the urine culture results on March 9,2012, which revealed a group B streptococcus (GBS) colony count of 9,000.

noted the prior positive GBS results and the plan to treat plaintiff with antibiotics during delivery.

On May 21, 2012, plaintiff contacted MFMA and requested a prescription to treat a severe yeast infection. An appointment was scheduled for her to come in the following day. On May 22, 2012, plaintiff was examined by PA Yorleny Sherrier who prescribed Terazol and Lotrisone creams to treat vaginitis. A urine and bacterial vaginosis (BV) culture were sent for testing. The urine culture was positive for GBS in the range of 10,000-25,000 and the BV culture was positive for BV. A prescription for Clindamycin was thereafter called in to treat the BV.

Plaintiff was next seen at MFMA on June 19, 2012, she was examined by Dr. Fox and estimated to be 26 and 6/7 weeks gestation. Dr. Fox documented that plaintiff indicated that she had vague cramping or abdominal pressure the day prior, but that it had resolved. Dr. Fox examined plaintiff and found that there was 50 percent effacement and fingertip dilation, the fetus was in the breech position and the fetal heart rate was 140 beats per minute. Dr. Fox sent plaintiff for a cervical length study which revealed a short cervix of 0.4 cm., with funneling. Dr. Fox prescribed vaginal Progesterone for the short cervix to prevent possible preterm delivery. He also prescribed plaintiff steroids (betamethasone), which were to be injected twice over the course of 24 hours for fetal lung maturity. A glucose challenge test and CBC were ordered and plaintiff was instructed to return to MFMA in one week.

On June 27th, plaintiff had a follow-up cervical length study performed by non-party Dr. Chad Klauser, which revealed that her cervix was dilated 4.9 cm and the fetal membranes were bulging. The fetus was still in a breech position. Dr. Klausner instructed plaintiff to immediately go to Mount Sinai for further evaluation, magnesium sulfate therapy and possible cesarean section. Plaintiff was admitted to Mount Sinai at approximately 10:05

a.m. and found to be in active labor with the fetus in breech footling presentation. Plaintiff complained of painful abdominal cramping that started the day before, and informed PA Lana Marks that vaginal bleeding had begun that morning. Plaintiff indicated that she experienced cramping the previous week and had recently been treated for BV. PA Marks noted that plaintiff had received steroids, and had started on Progesterone for a shortened cervix on June 19th. Plaintiff was placed on external fetal monitoring and blood work was performed, which revealed normal white blood cell count but low hemoglobin and hematocrit.

The maternal fetal medicine attending physician was Dr. Rebarber who ordered: tocolytics (terbutaline) to be administered to plaintiff to minimize her strong contractions; magnesium sulfate for fetal neuroprotection and antibiotics for the GBS. Plaintiff signed an informed consent form at 10:20 a.m. for the possibility of a cesarean section delivery to be performed by Dr. Rebarber. A vaginal examination performed by Dr. Rebarber indicated plaintiff was dilated 4-5 cm and 90 percent effaced with a bulging amniotic sac. Plaintiff's contractions were persisting despite the tocolytics. Ampicillin was administered at 10:55 a.m. for GBS prophylaxis. Plaintiff was taken to an operating room and anaesthesia was started at 11:24 a.m. In addition, one gram (gm) of Anacef was administered to prevent wound infection. Plaintiff's membranes were artificially ruptured at 11:54 a.m. and the infant plaintiff was delivered via cesarean section in the breech position by Dr. Rebarber, assisted by Dr. Bender at 11:55 a.m. The infant plaintiff was intubated and transferred to the NICU due to prematurity. APGAR scores of six and eight at one and five minutes of life, respectively, were recorded. Dr. Bender's operative report indicates that the amniotic fluid was blood tinged and the placenta was found to have an anterior clot consistent with acute placental abruption.

By summons and complaint filed on or about December 15, 2014, plaintiff brought the instant medical malpractice action on her own behalf, and on behalf of her infant against defendants Dr. Silverstein, Dr. Bender, Dr. Rebarber, Dr. Fox, MFMA, Mount Sinai, Jennifer Jimenez CNM, MS, RN, Yorleny Sherrier, R-PA, CM (Jimenez and Sherrier),[2] NYU Hospitals Center, NYU Medical Center, NYU Langone Medical Center and NYU OB/GYN Associates (the NYU defendants).[3] Among other things, the complaint alleged that the individual doctors and nurses were negligent and otherwise departed from good and accepted standards of obstetrical care during the prenatal care and labor and delivery of the infant, and that this departure proximately caused the infant's injuries, including cerebral palsy, hypoxia and mental and cognitive impairments. Plaintiff also alleged a lack of informed consent. After being served with the complaint, the defendants joined issue and served answers. Discovery is now complete and, on or about January 28, 2019, the remaining defendants moved for summary judgment dismissing plaintiffs' claims.

Summary Judgment Standard

"To prevail on a motion for summary judgment in a medical malpractice action, the defendant must 'make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient's injuries'" (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 826-827 [2016], quoting *Matos v Khan*, 119 AD3d 909, 910 [2014]; *see Kerrins v South Nassau Communities Hosp.*, 148 AD3d 795, 796 [2017]). "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

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[2] Defendants Jimenez and Sherrier's motion for summary judgment dismissing all claims asserted against them was granted on April 11, 2019.

[3] Pursuant to a January 19, 2017 stipulation of discontinuance, the action was discontinued with prejudice as against the NYU defendants.

complaint and bill of particulars" (*Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 726 [2016], citing *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2015]; *see Schwartzberg v Huntington Hosp.*, 163 AD3d 736, 738 [2018] *Bhim v Dourmashkin*, 123 AD3d 862, 865 [2014]; *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 1045 [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 v Halpern*, 73 AD3d 1117, 1118-1119 [2010], quoting *Langan v St. Vincent's Hosp. of N.Y.*, 64 AD3d 632, 633 [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*, 139 AD3d at 826 quoting *Mitchell v Grace Plaza of Great Neck, Inc.*, 115 AD3d 819, 819 [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 [2010], citing *Fileccia v Massapequa Gen. Hosp.*, 99 AD2d 796 [1984], *affd* 63 NY2d 639 [1984]).

Similarly, a plaintiff's expert's affidavit that is conclusory or speculative is insufficient to raise a triable issue of fact in opposition to a defendant's prima facie showing where the expert fails to set forth any basis for his or her opinion and fails to address the specific assertions made by defendant's expert (*see Rivers v Birnbaum*, 102 AD3d 26, 45-46 [2012]; *see generally Senatore v Epstein*, 128 AD3d 794, 795 [2015]; *Bendel v Rajpal*, 101 AD3d 662, 663 [2012]). Further, it is 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 Loaiza v Lam*, 107 AD3d 951, 953 [2013]; *Dandrea v Hertz*, 23 AD3d 332, 333 [2005]).

Finally, "[i]n a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (*Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 [2005], quoting *Holton v Sprain Brook Manor Nursing Home*, 253 AD2d 852, 852 [1998], *lv denied* 92 NY2d 818 [1999])."A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury" (*Semel v Guzman*, 84 AD3d 1054, 1055-1056 [2011], quoting *Goldberg v Horowitz*, 73 AD3d 691, 694 [2010], quoting *Alicea v Ligouri*, 54 AD3d 784, 786 [2008]).

Defendants' Motion

In support of their motion for summary judgment, the moving defendants rely on the expert affirmation of Dr. Annette Perez-Dellboy (Dr. Perez-Dellboy), a New York state-licensed physician, Board certified in Obstetrics and Gynecology and Maternal Fetal Medicine. Dr. Perez-Dellboy opines that none of the moving defendants departed from the accepted standards of medical care in their treatment of plaintiff during her prenatal visits to MFMA, or during her hospitalization at Mount Sinai, and that none of their actions or omissions were the proximate cause of the infant plaintiff's alleged injuries. Dr. Perez-Dellboy opines that the infant-plaintiff's premature birth could not have been prevented by the defendants, and was not the result of improper care. Specifically, she opines that the

failure to offer plaintiff prophylactic interventions such as cerclage, pessary, tocolytics and Progesterone earlier was not negligent. Dr. Perez-Dellboy opines that the standard of care in 2012, regarding the use of cerclage, was to offer this when a mother had a history of preterm delivery at, or prior to 34 weeks gestation, and a short cervix measuring 2.5 cm or less. She opines that plaintiff did not meet this criteria, noting that she did not have a history of preterm delivery, and that the records indicate that plaintiff's seven prior children were all delivered between 37 and 41 weeks gestation. Dr. Perez-Dellboy acknowledges that plaintiff had a history of preterm labor managed with tocolytics but contends that this is not an indication for a cerclage, and that only prior preterm delivery would be an indication.

She further opines that the failure to offer plaintiff a pessary was not a departure from accepted standards of care as it is not something given prophylactically to prevent preterm labor. She further opines that Dr. Fox timely and appropriately prescribed Progesterone on June 19, 2012 ,when plaintiff's cervix was found to be short. She opines that the standard of care in 2012 was to offer Progesterone only to pregnant women with a history of prior preterm delivery. However, she acknowledges that at that time it was also appropriate to prescribe it when a short cervical length of less than 1.5 cm was found. In this regard, she notes that on May 8, 2012, plaintiff's cervix length was measured and found to be normal at 3.2 cm and, thus, Progesterone was not indicated at that time, and the failure to prescribe it was not a departure. She further opines that the standard of care at that time did not call for routine cervical length assessments unless there were other signs of preterm labor, which were not present when plaintiff presented on May 8, 2012.

Dr. Perez-Dellboy opines that it was appropriate for Dr. Fox to order a cervical length study on June 19, 2012, when plaintiff complained of abdominal cramping. She further opines that when the study revealed a short cervix measuring 0.4 cm, it was appropriate to

prescribe Progesterone and steroids, as this was the standard of care for management of possible preterm labor and delivery in the context of a short cervix in 2012. With regard to the records indicating fingertip cervical dilation on that date, she opines that this is a common finding in pregnant women in the third trimester, and more particularly, in a woman similar to plaintiff with a history of seven prior vaginal deliveries. Dr. Perez-Dellboy avers that such finding is not evidence of preterm labor, but is consistent with a short cervix. Dr. Perez-Dellboy further opines that it was appropriate to schedule plaintiff to return in one week for a further assessment, and that it was not a departure from the standard of care to not admit plaintiff to the hospital on that date. In this regard, she opines that the infant-plaintiff's preterm birth would not have been avoided if plaintiff had been admitted to the hospital on June 19, 2012, and administered tocolytics, as these do not prevent preterm labor and delivery but rather are used to decrease contractions in order to administer steroids to aid in fetal lung maturity. She opines that since plaintiff was not in labor on June 19, 2012, it is not likely that tocolytics would have been administered.

Dr. Perez-Dellboy opines that it was appropriate to send plaintiff to Mount Sinai when she was evaluated at MFMA on June 26, 2012 and found to have advanced cervical dilation with bulging fetal membranes on the morning of June 27, 2012. She further opines that plaintiff went into labor (on June 26th or the morning of June 27th), due to acute placental abruption and acute infection, and that no intervention prior to this time could have prevented the preterm labor and delivery of the infant.

Dr. Perez-Dellboy opines that the management of plaintiff's labor and delivery by Drs. Rebarber and Bender and the Mount Sinai staff was at all times appropriate, noting that she presented to the hospital at 10:05 a.m. with abdominal cramping, significant vaginal bleeding and was 4-5 cm. dilated. Thus, she opines it was appropriate to administer tocolytics

(Terbutaline) in an attempt to decrease plaintiff's strong contractions and to timely administer antibiotics[4] due to plaintiff's GBS colonization, and magnesium sulfate[5], which is administered in an attempt to prevent cerebral palsy in preterm fetuses. Dr. Perez-Dellboy further opines that it was not a departure to fail to administer additional steroids on June 27, 2012, as plaintiff informed Dr. Rebarber that she had already completed a course of steroids prior to her hospital admission. Therefore, she opines there was nothing else the doctors or staff could have done to prevent the infant plaintiff's preterm birth, which was via cesarean section at 11:55 a.m.. Dr. Perez-Dellboy notes that the amniotic fluid was blood tinged and a clot was identified which is indicative of an acute placental abruption. She further points to the placental pathology report which reveals that the placenta evidenced focal early acute chorioamnionitis which is evidence of an acute placental infection that developed less than 24 hours prior to delivery. Moreover, she notes that the cord blood gas results were normal and demonstrate that the infant plaintiff did not develop a hypoxic brain injury from prolonged asphyxia during labor and delivery.

The moving defendants also submit an affidavit from Dr. Jesus Jaile-Marti, a physician duly licensed to practice medicine in New York State and Board certified in Pediatrics and Neonatal-Perinatal Medicine. Dr. Jaile-Marti opines, to a reasonable degree of medical certainty, that no act or omission by the Mount Sinai staff caused or contributed to the infant plaintiff's alleged injuries, and that the care and treatment rendered was at all times appropriate and consistent with good and accepted standards of medical practice. Specifically, he opines that the infant was properly oxygenated at birth as evidenced by the

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[4]The records indicate that 2 gm of Ampicillin was administered at 10:55 a.m.

[5]The record indicated that magnesium sulfate was administered at 10:30 a.m. and Dr. Perez-Dellboy notes that it needs to be administered at least thirty minutes prior to delivery.

normal cord blood gas results, and was timely intubated and admitted to the Neonatal Intensive Care Unit (NICU) following birth. Dr. Jaile-Marti notes that the NICU records indicate that the infant was admitted to the NICU for prematurity and to rule out GBS sepsis. The NICU records further indicate that high frequency jet ventilation was administered due to respiratory distress related to the prematurity, not labor related hypoxia, which was indicated and appropriate. Dr. Jaile-Marti opines that the infants's intra ventricular hemorrhages were secondary to his significant prematurity and that it is well established that premature infants are at a significant risk for developing intra ventricular hemorrhage as the blood vessels in their brains are very immature and fragile leading to ruptures especially where breathing difficulty related to underdeveloped lung function exists. He further opines that the infant was appropriately weaned off the ventilator to room air in early August 2012.

Based upon the foregoing, the court finds that the moving defendants have set forth a prima facie case in favor of dismissal, and have demonstrated that there was no departure from accepted standards of medical practice by any of these defendants that proximately caused plaintiffs' injuries (*Stiso v Berlin,* 176 AD3d 888 [2019]; *Aliosha v Ostad,* 153 AD3d 591, 593 [2017]; *Senatore v Epstein,* 128 AD3d 794, 796 [2015]). Thus, the burden shifts to plaintiffs to raise a triable issue of fact.

Plaintiffs oppose defendants' motion arguing that material issues of fact exist regarding the care and treatment plaintiffs' received while under the care of the moving defendants. Specifically, plaintiffs argue that MFMA's failure to classify the pregnancy as high risk was a departure from the applicable standard of care, and that Dr. Fox departed from the standard of care in failing to diagnose and treat plaintiff's preterm labor on June 19, 2012. In support of these contentions, plaintiffs submit an affidavit from Dr. Gary Brickner, a physician duly licensed to practice medicine in New Jersey and board certified in obstetrics

and gynecology. Dr. Brickner states that he reviewed all relevant medical records and deposition testimony. He opines, to a reasonable degree of medical certainty, that when plaintiff presented to MFMA on March 7, 2012, she was at high risk for preterm labor due to her eight prior pregnancies and the fact that she had experienced preterm labor during three prior pregnancies, which were brought to term through tocolytic interventions. Specifically, Dr. Brickner opines that plaintiff should have had transvaginal ultrasounds every two weeks and a cerclage should have been performed if cervical shortening was observed. He notes that for high risk women with a cervical length less than 25mm before 24 weeks, a cerclage reduced the preterm rate by 30 percent versus no cerclage. With regard to plaintiff, he opines that he does "not believe there was a rapid and sudden cervical change related to a purported acute placental abruption because plaintiff reports being highly symptomatic prior to bleeding"(Brickner aff at ¶10).

Dr. Brickner further opines that progesterone should have been administered between 16 and 20 weeks, citing the October 2012 American College of Obstetrics and Gynecology (ACOG) Practice Bulletin, which documented that high risk patients who were administered progesterone between 16 and 20 weeks had a 40-50 percent reduction in preterm labor in comparison to those who received no treatment. He opines that the failure of MFMA to perform serial cervical exams and prescribe prophylactic progesterone deprived plaintiff of a significant opportunity to bring the infant plaintiff to term.

He further contends that since plaintiff's prior preterm labors were treated with tocolytic interventions, it was incumbent on MFMA to assume that, but for those tocolytic interventions, those pregnancies would have resulted in preterm births. Dr. Brickner disagrees with Dr. Perez-Dellboy's position that since studies show that tocolytics typically do not prolong labor for more than 48-72 hours, the administration of this intervention was

not responsible for extending plaintiff's prior preterm labors. He notes that in plaintiff's case, this intervention extended three of her prior preterm labors for three weeks or more. Thus, Dr. Brickner opines that had plaintiff had the aforementioned interventions the likelihood of her pregnancy reaching term would have been greatly improved.

With regard to the care and treatment rendered by Dr. Fox, Dr. Brickner opines that the standard of care required plaintiff to be admitted to the hospital on June 19, 2012, to rule out preterm labor when she presented with complaints of abdominal pressure and a cervical ultrasound revealing a cervical length of 0.4 cm., internal cervical dilation as well as fingertip dilation. He further opines that she was in preterm labor on that date based on her symptoms. Dr. Brickner states that he disagrees with Dr. Perez Dellboy's opinion that due to acute placental abruption, the events that occurred on June 27th are unrelated to plaintiff's June 19, 2012 presentation. In this regard, he notes that the placenta pathologist (Dr. Reznick) inspected the subject pathology slides and determined that the placental abruption occurred due to an infection that was present for approximately 48-72 hours. Dr Brickner contends that had plaintiff been admitted for a preterm labor work up on June 19th, antibiotics would have been administered prophylactically, and it is more likely than not that the infection and related placenta abruption would have been prevented. Finally, he opines that had plaintiff been properly treated and diagnosed on June 19, 2012, the pregnancy would have been extended 2-3 weeks, as tocolytics would have been administered, which resulted in the extension of some of her prior preterm labors for more than three weeks.

In further support of their opposition, plaintiffs submit an affirmation from licensed physician Dr. Sandra Reznik, the Director of Perinatal Pathology at Montefiore Medical Center/Albert Einstein College of Medicine. Dr. Reznik affirms that she reviewed the medical records related to the birth of the infant plaintiff and performed an inspection of the

pathology slides which revealed the presence of a bacterial infection, which had been present for 48-72 hours prior to the birth. She opines that placental abruption can occur as a result of infection. Dr. Reznik opines that the abruption here occurred within a few hours of the birth and could have been prevented with appropriate treatment on June 19, 2012.

Plaintiffs also submit the affidavit of Dr. Susan Miller, Board Certified in Pediatric Neonatal-Perinatal Medicine, licensed to practice in the State of South Carolina.[6] Dr. Miller reviewed all of the pertinent documents and opines that the infant plaintiff's birth at 28 2/7 weeks was a substantial factor in the grade 3 intra ventricular hemorrhage with peri ventricular leukomalacia and diagnosis of cerebral palsy. She opines that he would have suffered less complications related to prematurity if he had been born at a later gestational age.

In reply, the defendants point out that plaintiffs' experts fail to rebut or even address any of the defendants' experts' opinions regarding the appropriateness of the treatment rendered by Drs. Rebarber, Bender, Silverstein and Mount Sinai. The defendants also note that plaintiffs' experts fail to rebut several of the defense experts opinions in regard to Dr. Fox and MFMA. Specifically, they contend that they fail to rebut: Dr. Perez-Dellboy's opinion that it was not a departure from the standard of care to not offer plaintiff a pessary, nor to administer additional steroids on June 27, 2012, as the steroids administered on June 19, 2012 were sufficient to promote fetal lung maturity. In addition they fail to rebut the opinion that the moving defendants appropriately managed plaintiff's GBS infection and appropriately treated her vaginosis.

Defendants argue that Dr. Brickner's opinion that plaintiff was at high risk for preterm birth is disingenuous and directly contradicted by the ACOG guidelines which states that

[6] Dr. Miller had been licensed in the State of New York from 2005-2014.

"[o]ne of the strongest clinical risk factors for preterm birth is a prior preterm birth."[7] Thus, defendants argue that the criteria used in the ACOG guidelines is whether a pregnant woman previously delivered a child preterm, not whether there was suspicion for preterm labor and tocolytics were administered. Defendants note that although the guidelines discuss the relevance of prior pregnancies and the use of tocolytics, such prior use is not a criteria for consideration when determining whether a patient is at risk for preterm birth. Defendants further note that even if plaintiff had been considered high risk, serial cervical ultrasounds were not the standard of care as the ACOG Committee Opinion, in effect in 2012, stated that serial cervical length measurements were not recommended and that the indications for such screening was if the mother had a history of prior preterm delivery, or an identified short cervix during this pregnancy. Here, defendants point out plaintiff did not have a history of preterm delivery, and that her cervical length was measured on May 8, 2012 when she was 20 6/7 weeks pregnant, and was found to be completely normal.[8] At her next visit on June 19, 2012, cervical length screening was performed at which point her cervix was found to be short, when she was 26 6/7 weeks pregnant. Thus, defendants argue that Dr. Brickner's conclusion that plaintiff's cervix would have been found to be short if additional cervical ultrasounds were performed prior to 24 weeks gestation is improper hindsight reasoning and should be rejected.

Defendants further point out that Dr. Brickner's opinions regarding the indications for cerclage are based upon pure speculation inasmuch as he states that if cervical shortening

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[7]American College of Obstetrics and Gynecology Practice Bulletin Number 130, October 2012.

[8] The MFMA records indicate that plaintiff was scheduled to return in four and eight weeks and an appointment was scheduled for June 5, 2012, but there is no indication in the record why this appointment did not take place.

was observed during serial cervical length studies prior to 24 weeks, plaintiff would have been a candidate for cerclage. Moreover, defendants argue that Dr. Brickner's opinion is insufficient to establish a question of fact as he fails to address Dr. Perez Dellboy's opinion that neither a cerclage nor the administering or Progesterone would have prevented the infant plaintiff's delivery as it was secondary to acute placental abruption.

Finally, defendants point out that plaintiffs raise the allegation regarding the need for antibiotics and/or the defendants failure to prevent an infection, resulting in placental abruption, for the first time in the affidavit of Dr. Brickner and the affirmation of Dr. Reznik. Defendants argue that this is prejudicial as defendants were not on notice of these allegations and, thus, Dr. Perez-Dellboy did not opine regarding these theories. In reply, defendants submit an affirmation from Dr. Bender, addressing theses allegations. However, the court need not consider Dr. Bender's affirmation as it declines "to consider the alternative theory of liability raised by the plaintiffs' expert for the first time in opposition to the defendants' motion" (*Garcia v Richer*, 132 AD3d 809, 810 [2015]; *see Anonymous v Gleason*, 175 AD3d 614, 617 [2019]; *Palka v Village of Ossining*, 120 AD3d 641, 643 [2014] holding that ["[a] plaintiff cannot, for the first time in opposition to a motion for summary judgment, raise a new or materially different theory of recovery against a party from those pleaded in the complaint and the bill of particulars"]; *Kelley v Kingsbrook Jewish Med. Ctr.*, 100 AD3d 600 [2012]; *Dolan v Halpern*, 73 AD3d 1117, 1119 [2010]; *Langan v St. Vincent's Hosp. of N.Y.*, 64 AD3d 632, 633 [2009]). However, the court notes if it were to consider it, Dr. Bender affirms that he was the doctor that would have performed a preterm labor evaluation of plaintiff had she been admitted to Mount Sinai on June 19, 2012. He affirms that he would not have administered antibiotics on that date as there were no signs of infection, no evidence of preterm labor and her membranes were intact. He avers that Dr. Brickner's contention that

antibiotics are given prophylactically to prevent preterm labor is inconsistent with the standard of care, as well as the ACOG and Mount Sinai practice guidelines. Therefore, to the extent that plaintiffs' experts opine that any of these new theories were the proximate cause of the infant plaintiff's injuries, the court finds this to be conclusory and not supported by the medical record (*see Swanson v Raju*, 95 AD3d 1105 [2012]).

Here, the court notes that plaintiffs' experts fail to rebut or even address any of the defendants' experts' opinions regarding the appropriateness of the treatment rendered by Drs. Rebarber, Bender, Silverstein and Mount Sinai. Moreover, with regard to the claims asserted against Mount Sinai, a hospital may not be held liable for the acts of a physician who was not its employee, such as an independent physician retained by the patient; and the affiliation of a doctor with a hospital alone is insufficient to impute the doctor's alleged negligent conduct to the hospital (*see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]; *Bleiler v Bodnar*, 65 NY2d 65, 72 [1985]; *Seiden v Sonstein*, 127 AD3d 1158,1160 [2015]; *Zhuzhingo v Milligan*, 121 AD3d 1103 [2014]). Accordingly, that branch of defendants' motion seeking dismissal of all claims asserted against Drs. Rebarber, Bender and Silverstein, as well as those claims asserted against Mount Sinai, is granted and said claims are dismissed.

Further, the court finds that Dr. Brickner's affidavit was conclusory and speculative, and failed to address the specific assertions of defendants' experts, and thus plaintiffs have failed to raise an issue of fact regarding whether any act or omission on the part of any defendants proximately caused the injuries alleged herein (see *Gullo v Bellhaven Ctr. for Geriatric & Rehabilitative Care, Inc.*, 157 AD3d 773, 774-775 [2018]; *Brinkley v Nassau Health Care Corp.*, 120 AD3d 1287, 1289-1290 [2014]; *Shashi v South Nassau Communities Hosp.*, 104 AD3d 838, 839 [2013]). Specifically, the plaintiffs' experts did not address important elements set forth by the defendants' expert regarding causation (*Sukhraj*

v New York City Health & Hosps. Corp., 106 AD3d 809, 810 [2013]; *see Swanson*, 95 AD3d at 1106-1107; *see also Rivers v Birnbaum*, 102 AD3d 26, 43 [2012]; *Bendel v Rajpal*, 101 AD3d 662, 664 [2012]).

Moreover, the court notes that the mere fact that the plaintiffs' expert may have chosen a different course of treatment, this, "without more, 'represents, at most, a difference of opinion among [medical providers], which is not sufficient to sustain a prima facie case of malpractice'" (*Ibguy v State of New York*, 261 AD2d 510, 510 [1999], lv denied 93 NY2d 816 [1999], quoting *Darren v Safier*, 207 AD2d 473, 474 [1994]; *see Park v Kovachevich*, 116 AD3d 182, 190 [2014]). Here, the record reveals that plaintiff suffered an acute placental abruption on June 26-27, 2012, due to an infection that, based upon the opinion of plaintiffs' own expert, Dr. Reznick, developed on June 23, 2012. Thus, the decisions to not perform serial cervical ultrasounds, to not prescribe Progesterone earlier and/or not to perform a cerclage cannot be said to be the proximate cause of the injuries sustained by the infant plaintiff due to his premature birth. Based upon the foregoing, that branch of the defendants' motion seeking summary judgment dismissing plaintiffs' claims alleging medical malpractice is granted and said claims are hereby dismissed.

Turning to that branch of the motion seeking dismissal of the lack of informed consent claim, defendants note that the record indicates that plaintiff signed an informed consent form on June 27, 2012, while at Mount Sinai prior to the cesarean section delivery of the infant plaintiff. They argue that it cannot be reasonably inferred that Mount Sinai knew or should have known whether private attending physicians Drs. Rebarber and Bender were acting without plaintiff's consent.

To succeed on a lack of informed consent cause of action, a plaintiff must demonstrate

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient

> of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"(*Khosrova v Westermann*, 109 AD3d 965, 966 [2013] [citation and internal quotation marks omitted]).

Here, neither plaintiffs, nor their experts, address this claim and have failed to demonstrate that plaintiff would not have undergone the caesarean section delivery of the infant plaintiff had she been fully informed of any risks, and that any lack of informed consent was a proximate cause of the injuries alleged (*see Wright v Morning Star Ambulette Servs., Inc.*, 170 AD3d 1249, 1252 [2019]; *Spiegel v Beth Israel Med. Center-Kings Hwy. Div.*, 149 AD3d 1127, 1130 [2017]; *Raucci v Shinbrot*, 127 AD3d 839, 843 [2015]; *Bhim v Dourmashkin*, 123 AD3d 862 [2014]; *Deutsch v Chaglassian*, 71 AD3d 718, 719-720 [2010]; *Rebozo v Wilen*, 41 AD3d 457, 459 [2007]). Thus, plaintiffs have failed to raise any triable issue of fact as to a lack of informed consent claim and said claim is hereby dismissed (*see Bezerman v Bailine*, 95 AD3d 1153, 1154 [2012]).

Accordingly, defendants' motion to dismiss plaintiffs' lack of informed consent claim is granted and said claim is hereby dismissed as asserted against all defendants.

The foregoing constitutes the decision, order and judgment of the court.

ENTER,

J. S. C.

KINGS COUNTY CLERK
FILED
2020 JAN -9 AM 8:12

HON. BERNARD J. GRAHAM

Nancy T. Sunshine
NANCY T. SUNSHINE
Clerk