Entenza v Proudfit
2022 NY Slip Op 32607(U)
July 28, 2022
Supreme Court, New York County
Docket Number: Index No. 805152/2019
Judge: Judith N. McMahon

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JUDITH MCMAHON** **PART** **30M**

Justice

----------X

YISELLE ENTENZA, YISELLE ENTENZA,

Plaintiff,

- v -

CHRISTINE PROUDFIT, MARA ROSNER, OLIVIA KHOURI, NYU LANGONE MEDICAL CENTER

Defendant.

----------X

INDEX NO.	805152/2019
MOTION DATE	07/26/2022
MOTION SEQ. NO.	001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70

were read on this motion to/for JUDGMENT - SUMMARY.

Upon the foregoing documents, it is ordered that the motion by defendants Christine Proudfit, M.D., Mara Rosner, M.D., Olivia Khouri, M.D., and NYU Langone Hospitals, s/h/a NYU Langone Medical Center, for summary judgment pursuant to CPLR §3212 is granted to the extent that (1) the complaint is severed and dismissed as against the individually named defendants Dr. Proudfit, Dr. Rosner and Dr. Khouri; (2) all claims made by plaintiff-mother Yiselle Entenza relating to prenatal, perinatal and obstetrical care, including the failure to perform an earlier cesarean section are severed and dismissed; (3) the second cause of action for lack of informed consent is severed and dismissed, (4) the fourth cause of action for "spoilation" of evidence is severed and dismissed, and (5) all of plaintiffs' claims concerning extraordinary care are dismissed. The balance of the motion, opposed by plaintiffs, is denied. The only claims remaining in this case are for injuries to the infant and to her mother, derivatively, during the time-period of December 7, 2016, until 7:30 a.m. on December 8, 2016.

This medical malpractice action arises out of the prenatal care of plaintiff, Yiselle Entenza, and the neonatal care and treatment rendered to her infant daughter, S.M.E., who was born on November 13, 2016, at 27 weeks and five days gestation, weighing 740 grams[1]. S.M.E. remained in NYU's NICU for nearly four months and was released home on March 6, 2017. Now five years old, she "is currently in a regular classroom at Washington School in Rutherford, New Jersey" where, with the assistance of a school aide, she performs at grade level (*see* Affirmation of Daniel Adler, M.D.; NYSCEF Doc. No. 56; March 27, 2022 report). S.M.E. suffers from "spastic quadriparesis and language delay" (*id.* at p. 2) and requires the use of crutches to walk, "but the process is slow and takes a lot of effort" (*id.*).

The parties' dispute centers on the cause of periventricular leukomalacia[2] ("PVL"), which all concede resulted in S.M.E.'s quadriplegic cerebral palsy and developmental delays. Plaintiffs argue that a cause of PVL in this case was NYU's negligence during a planned attempt to extubate S.M.E. on December 7, 2016. Specifically, plaintiffs allege that NYU was negligent in failing to heed the signs and symptoms requiring reintubation of the infant well before 7:30 a.m. on December 8th, and that this delay was a proximate cause of PVL which resulted in S.M.E. suffering "global developmental delays, brain damage, mental retardation, central nervous system injury, neurological and cognitive deficits, motor delays, and a brain bleed" all of which will require "speech, language, occupational, feeding and physical therapies as well as special education" (*see*

---

[1] The infant's weight of one pound ten ounces is considered small for her gestational age (*see* Affirmation of plaintiffs' expert, Maureen Sims, M.D.; NYSCEF Doc. No. 57, para 10).

[2] Defendants' expert, Dr. Jacquelyn Evans, describes PVL as follows: "periventricular leukomalacia is injury to the white matter that surrounds the fluid-filled ventricles of the brain. The white matter of the brain transmits information between nerve cells, the spinal cord, and from one part of the brain to the other. Because the periventricular area close to the sides of the lateral ventricles carries the nerves to the motor fibers of the body, injury to this area, including PVL, can cause damage to the nerve pathways that control motor movements" (*see* NYSCEF Doc. Mo. 35, para 3).

NYSCEF Doc. No. 38, response 4). According to plaintiffs, S.M.E. will suffer from an inability to live independently, a diminished earning capacity, and a continuing loss of enjoyment of life. For its part, NYU argues that PVL is a common complication of extremely premature and low birthweight neonates such as S.M.E., and that no proof exists causally connecting the December 7, 2016 failed extubation to the resulting PVL suffered by the infant.

BACKGROUND

Mrs. Entenza suffered from hypertension throughout her fertility treatments and eventual pregnancy with S.M.E., for which she was twice hospitalized to regulate blood pressure. On November 7, 2016, she was admitted to NYU for a second time, at 26 weeks, 6 days gestation, for suspected intrauterine growth restriction (hereinafter "IUGR")[3] and to rule out superimposed pre-eclampsia[4] (hereinafter "siPEC"). From November 7, 2016, through delivery on November 13, 2016, Mrs. Entenza underwent daily fetal monitoring which confirmed that fetal status was "reassuring" with no signs of "fetal distress" at any time up to and through delivery. While in the hospital, plaintiff's hypertension was treated with 800 mg. of Labetalol along with Hydralazine and oral Nifedipine, administered as needed.

On the morning of November 13, 2016, plaintiff's blood pressure rose significantly above baseline and remained intermittently poorly controlled despite maximal doses of medication. Having now met the criteria for siPEC, the decision was made to deliver S.M.E. by cesarean

---

[3] IUGR is a condition where the fetus "is smaller than it should be at a particular gestational age because it is not growing at a normal rate in utero…a reasonably expected complication of this pregnancy because [plaintiff] had hypertension that pre-existed the pregnancy, which would increase the risk for IUGR" (*see* Expert Affidavit of Jacquelyn Evans, M.D., NYSCEF Doc. No. 35, para 8).

[4] According to defense expert, Dr. Evans, superimposed pre-eclampsia "occurs when a woman with chronic hypertension before pregnancy develops worsening high blood pressure, protein in the urine, or other blood pressure related complications during surgery" (*id.*).

section, and Mrs. Entenza signed the consent for surgical delivery for the third time (*i.e.*, signed consents were previously obtained on October 21 2016 and November 7, 2016).

S.M.E. was born at 11:30 a.m. on November 13, 2016, weighing 740 grams and measuring 13 inches in length. Per the delivery notes, a "tight nuchal cord x 1" was around her neck. S.M.E. had no spontaneous cry at birth, but once she was bulb-suctioned, handed to the pediatrician, placed under a radiant warmer, dried and stimulated, she responded very quickly with an increased heart rate. Spontaneous crying was noted within three minutes, and the infant's Apgar's were 3 at 1 minute, 9 at 5 minutes and 9 at 10 minutes. Her neurological examination was reported to be normal, and S.M.E. was placed on CPAP (continuous positive airway pressure) and transferred to NICU for prematurity.

Upon arrival in the NICU, S.M.E. was switched from CPAP to SiPAP (synchronized inspiratory positive airway pressure), the latter providing bi-level positive nasal pressure ventilation. By November 14, 2016, S.E.M. was intubated and placed on conventional mechanical ventilation through the breathing tube in her trachea. One day later, on November 15, 2016, she was placed on a high frequency oscillatory ventilation (an even higher level of support than "conventional" mechanical ventilation) and started on caffeine to improve respiratory effort and to promote the possibility of a more rapid weaning of ventilatory support.

Eventually S.M.E. transitioned from SIMV (synchronized intermittent mandatory ventilation, a conventional mode of ventilation that is used to synchronize to infant breaths when they begin to breathe on their own) to SiPAP, followed by CPAP, and then to high flow nasal cannula followed, finally, by low flow nasal cannula. On February 6, 2017, S.M.E. was weaned to room air where she remained stable until her discharge, with no subsequent episodes of apnea, bradycardia, or desaturations.

DECEMBER 7, 2016 - DECEMBER 8, 2016

A December 7, 2016 progress note authored at 6:52 a.m. by resident, Dr. Lauren Vrablik (*see* NYSCEF Doc. No. 48, pp. 176-177), states that the infant had transitioned from HFOV (high frequency oscillatory ventilation--a higher level of respiratory support) to SIMV and was tolerating an oxygen concentration of inspired gas. The staff was holding feeds, and S.M.E.'s chest x-ray was improved from the previous day. The plan was "to extubate today" (*id.*).

S.M.E. was extubated at 10:00 a.m.

At 1:28 p.m. the attending neonatologist noted that S.M.E. had tolerated extubation to SiPAP.

By 5:00 p.m. S.M.E. had become bradycardic (*i.e.*, decreased heart rate to 54 beats per minute) with an oxygen saturation of 61%, and color described as dusky[5] (*see* NYSCEF Doc. No. 49, p. 3287). The infant required tactile stimulation to recover from this first recorded bradycardia event which lasted 20 seconds.

At 5:56 p.m. and 6:00 p.m. bradycardia and decreased oxygen saturation was again noted on the flowsheet, and S.M.E. required tactile stimulation to recover. "The first significantly elevated blood pressure, 94/46, was recorded at 6:00 p.m. suggesting that the infant was becoming stressed" (*see* Affirmation of Plaintiff's expert, Maureen Sims, M.D., NYSCEF Doc. No. 57, para 20). Her blood pressure fluctuated throughout the trial extubation.

At 7:00 p.m. bradycardia was still being recorded and the infant was pale, "indicating impaired systemic circulation---a sign in the preterm infant of the potential disturbance of cerebral perfusion" (*id.*, para 21).

---

[5] Dusky skin tone in a premature infant indicates a lack of sufficient oxygen.

At 7:32 p.m. the infant was bradycardiac and her oxygen saturation was 72%. Again, she required tactile stimulation to recover.

At 8:08 p.m. bradycardia of 74 lasting 10 seconds was noted, and the infant required stimulation. Her oxygen saturation was 66 % and she remained dusky. A blood gas drawn at 8:42 p.m. was hypercarbic.

An entry on the flowsheet at 8:30 p.m. states: "infant noted to have multiple brady/desats during handoff" to another nurse.

At 8:50 p.m. neonatology fellow Michelle Vaz, M.D. ordered the infant to be made NPO for "multiple brady/desaturations" (*see* NYSCEF Doc. No. 49, p. 3281). Oxygen concentration was increased to 45 % then to 50% at 9:00 p.m.

At 9:00 p.m. the infant's "pain/agitation score" was elevated and "multimodal measures" were employed to calm her. Tracheal suctioning produced "copious" secretions (*see* NYSCEF Doc. No. 49, p. 3289).

At 12:00 a.m. on December 8, 2016, S.M.E. experienced bradycardia down to 61 beats per minute for 15 seconds, with desaturation to 61%. (According to the records, Dr. Vaz was made aware of this, but no progress note was recorded describing these incidents; *see* NYSCEF Doc. No. 49, p. 3324).

Bradycardia was again noted at 1:35 a.m., and S.M.E. again required suctioning and stimulation.

At 4:54 a.m. the infant was still experiencing bradycardia (63 beats per minute) and desaturation. Her breathing had become shallow, and she required stimulation and supplemental oxygen. S.M.E.'s appearance was again noted to be "dusky." Dr. Vaz was informed, but there are no corresponding progress notes indicating that any change of plan was contemplated. The

progress notes do not reflect to what the NICU team attributed S.M.E.'s recurrent bradycardia and desaturations.

At 6:00 a.m., shallow breathing, bradycardia to 64 beats per minute and desaturation at 82% was noted following the repositioning of the infant (*see* NYSCEF Doc. No. 49, p. 3326).

At 7:30 a.m. reintubation was performed emergently, after a bedside nurse observed the infant with retractions (signaling increased work of breathing) while on 100% oxygen with no improvement after suctioning.

S.M.E.'s RADIOGRAPHIC INJURIES

A December 12, 2016 head ultrasound (comparison studies of November 13, 2016, November 16, 2016 and November 22, 2016 were all "normal") found "interval development of subtle abnormal increased echogenicity in the subependymal regions bilaterally which may represent small bilateral grade 1 germinal matrix hemorrhages".

A January 9, 2017 follow up ultrasound revealed "interval development of biparietal periventricular leukomalacia (PVL) bilaterally, right greater than left".

An MRI performed on February 23, 2017 confirmed "mild to moderate late-stage periventricular leukomalacia characterized by multiple T2 hyperintense, T1 hypointense cystic lesions along the lateral ventricular periventricular white matter of the frontal and parietal lobes. There is associated colpocephalic dilation of the lateral ventricular atria". The impression was reported as "mild to moderate late-stage periventricular leukomalacia with associated volume loss and colpocephalic dilation of the ventricular atria" (*see* NYSCEF Doc. No. 48, p. 640-641).

MOTION FOR SUMMARY JUDGMENT

Defendant doctors Proudfit (attending, maternal-fetal medicine), Rosner (attending, maternal-fetal medicine) and Khoury (resident, maternal-fetal medicine), and the defendant NYU move for summary judgment. The three individually named physicians were part of the delivery team but played no role in the care and treatment of S.M.E. once she was born. In support of the motion, the named doctors rely, in part, upon the affidavit of maternal-fetal medicine expert, Errol Norwitz, M.D., (*see* NYSCEF Doc. No. 34), who sets forth that the prenatal and perinatal treatment of plaintiff-mother as rendered by Drs. Proudfit, Rosner and Khouri was in accordance with the accepted standard of care.[6]

Plaintiffs submit no opposition to Dr. Norwitz' affidavit. Accordingly, as previously indicated, that branch of defendants' motion to dismiss plaintiffs' complaint as against Christine Proudfit, M.D., Mara Rosner, M.D. and Olivia Khouri, M.D. is granted, and the complaint is severed and dismissed as to the individually named defendant doctors.

Plaintiffs do, however, oppose that branch of the motion for summary judgment in favor of NYU.

In support of its motion, NYU relies upon, *inter alia*, the affirmation of Jacquelyn Evans, M.D., who is board certified in pediatrics with a subspecialty in neonatal-perinatal medicine (*see* NYSCEF Doc. No. 35). Dr. Evans explains that PVL is common in very premature low birthweight babies, that it is usually not seen on head ultrasound until six weeks after birth, and that, "while there are no physical signs of PVL initially, as the infant grows the damaged nerve

---

[6] To the extent relevant regarding PVL, Dr. Norwitz opines "to a reasonable degree of medical certainty that the infant's claimed injuries are due to prematurity, not any negligence, acts or omissions by the defendants, and that the defendants' treatment plan to prolong the pregnancy and increase the gestational age (thus making the baby less premature at birth) was at all times in accordance with the accepted standards of care" (*see* NYSCEF Doc. No. 34, para 40).

cells can result in muscles that are tight, spastic, or resistant to movement in addition to being weak" (*see* NYSCEF Doc. No.35, para. 34). According to Dr. Evans, the incidence of PVL is inversely related to gestational age at birth, and the best prevention of the condition is the prevention of a preterm birth. The doctor goes on to inform that "[t]he periventricular area of the brain is very vulnerable to injury in premature babies because this area is located in a 'watershed area' where blood flow is more at risk to be suboptimal." She opines that because of the varied initiating factors for PVL (*i.e.,* the lack of many autonomic blood vessel regulatory mechanisms in the brain in older people that protect their brains from normal and abnormal fluctuations in blood pressure), the injury "*usually* occurs absent any negligence," (emphasis supplied) and that even though the injury may have occurred remotely, "it is often **presumed** that the injury causing PVL occurs during delivery or in the early days postnatally when a baby has systemic illness such as respiratory distress syndrome or need for mechanical ventilation, due to the unavoidable fluctuations in blood pressure that occur during this time, that would not seriously impact the brain of a more mature baby" (*id.,* at para 36; emphasis supplied). Dr. Evans concludes "to a reasonable degree of medical certainty that S.M.E.'s claimed injuries are due to extreme prematurity and low birth weight, not to any negligence or acts or omissions by the defendants" (*id.,* para 47), and that "the care rendered to infant-plaintiff by defendants was within accepted standards of medical care at all times and did not cause or contribute to the injuries allegedly sustained…but rather were a result of extreme prematurity and extremely low birth weight" (*id.*, para 51).

In opposition, plaintiffs submit the affirmations of two physicians, Daniel Adler, M.D., the pediatric neurologist who examined the infant on March 23, 2022 (*see* NYSCEF Doc. No. 56), and Maureen Sims, M.D., who is board certified in pediatrics and neonatal perinatal medicine (*see* NYSCEF Doc. No. 57).

Dr. Adler describes S.M.E.'s neurological disabilities as "permanent" and, to the extent relevant, refers to "records from the newborn intensive care unit which indicate that S.M.E. was doing well despite the complicated pregnancy and then suffered complications in the newborn intensive care unit which resulted in brain injury" (*see* NYSCEF Doc. No. 56. p. 3).

For her part, Dr. Sims opines that NYU departed from "good and accepted practice in the provision of respiratory support from December 7 to December 8, 2016, during which time the infant's cardiopulmonary status deteriorated, resulting in permanent brain injury, specifically periventricular leukomalacia (PVL) that became apparent on HUS [head ultrasound] one month later and was confirmed as bilateral cystic PVL by MRI on February 23, 2017, when SME was three months old (two weeks before her discharge home on March 7, 2017)" (*see* NYSCEF Doc. No. 57, para 7). Dr. Sims opines that S.M.E. should have been reintubated at or shortly after 5:00 p.m. on December 7, 2016, and that this failure is a departure from the accepted standard of care and is a substantial contributing cause of PVL and its sequelae as described in Dr. Adler's neurological report.

Dr. Sims states that NYU and its NICU team were negligent in: (1) "failing to reintubate the infant with reasonable promptness after her respiratory status had clearly deteriorated between 5:00 p.m. and 6:00 p.m. (on December 7, 2016) and she was no longer safely tolerating the trial extubation after several hours, as her reserves to maintain respiratory efficiency deteriorated": (2) "failing to assess what caused the infant to suddenly desaturate at 5:00 p.m. and become bradycardic and dusky over one hour"; (3) failing to make a "thorough assessment between the hours of 5:00 pm to 7:00 pm on December 7, 2016 of why the infant by that point had appeared to no longer safely tolerate the extubation trial"; (4) "wrongly assuming that the desaturations and bradycardias were merely secondary to the occasional desaturations or bradycardias in preterm

babies' experience, without factoring the infant's duskiness followed by pallor at 7:00 p.m. as indicative that blood flow to the skin had become affected as the body centralizes its circulation to prioritize the heart, brain and adrenal organs"; (5) failing to "appreciate the continual pattern of deterioration, since the desaturations and bradycardia with clinically evident color changes of paleness were not recognized as a pattern which would eventually lead this vulnerable newborn to irrevocable damage to her brain by compromising her cerebral blood flow," and (6) failing to appreciate S.M.E.'S hypertensive response.

Dr. Sims was "astonished" at the fact that no evaluation or plans for intervention were documented at 4:54 a.m., when the infant demonstrated bradycardia, desaturation, and shallow breathing: "These departures from accepted practice were a substantial contributing cause of the infant's PVL because bradycardia and oxygen desaturations of the extent to which this infant was exposed result in poor systemic organ perfusions (pumping blood through the body) and intermittent hypoxia, and in extremely low birth weight extremely premature infants, interferes with cerebral perfusion pressure and deprives the brain white matter of adequate blood flow. The immature brain cells of the white matter, adjacent to the lateral ventricles (thus the word periventricular) are exquisitely sensitive to hypoxic-ischemic stress, and without an adequate constant supply of highly oxygenated blood fall victim to different pathways of cell death, such as excitotoxicity and apoptosis" (*see* NYSCEF Doc. No. 57, para 43-49).

In reply, NYU maintains that Dr. Sims' opinions are unsupported by the evidence, without foundation in the medical record, and speculative and conclusory, because she overlooked notes establishing that the infant was evaluated, that appropriate interventions were performed, and that all episodes of bradycardia and desaturations were brief and resolved with treatment. Defendants argue that by admittedly basing her review solely on the hospital records (and not upon the

additional medical records and deposition of Dr. Lauren Vrablik, the resident who reintubated S.M.E. on December 8, 2016), Dr. Sims' conclusion that S.M.E. required reintubation due to poor systemic organ perfusion and intermittent hypoxia is incorrect, because the records detail that during the relevant time that she was not hypoxic, and that the oxygen saturation was adequate. Moreover, NYU maintains that plaintiffs have failed to demonstrate proximate causation because plaintiffs' expert's statements as to causation are without reference to specific facts and are contradicted by the medical records.

APPLICABLE LAW

The standards for summary judgment are well settled. The proponent "must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; [*internal citations omitted*]). The motion must be supported by evidence in admissible form (*see Zuckerman v. City of New York*, 49 NY2d 557, 562 [1980]), and the facts must be viewed in the light most favorable to the nonmoving party (*see Vega v. Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). "In determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on the issues of credibility" (*Garcia v. J.D. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept. 1992]).

Once the movant has met his or her burden on the motion, the nonmoving party must establish the existence of a material issue of fact (*see Vega v. Restani Constr. Corp.*, 18 NY3d 449 at 503). A movant's failure to make a *prima facie* showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]; [*internal citations omitted*]). It has been held that merely "pointing to gaps in an opponent's

evidence is insufficient to demonstrate a movant's entitlement to summary judgment" (*Koulermos v. A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept. 2016]).

"The drastic remedy of summary judgment, which deprives a party of his day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*DeParis v. Women's Natl. Republican Club, Inc.*, 148 AD3d 401 [1st Dept. 2017]; [*internal citations omitted*]). "It is not the court's function on a motion for summary judgment to assess credibility" (*Ferrante v. American Lung Assn.*, 90 NY2d 623, 631 [1997]).

To sustain a cause of action for medical malpractice, the plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of the claimed injury. A medical provider moving for summary judgment, therefore, must make a *prima facie* showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15 [1st Dept. 2009]; [*internal citations omitted*]), or by establishing that the plaintiff was not injured by such treatment (*see* generally *Stukas v. Streiter*, 83 AD3d 18 [2d Dept. 2011]).

To satisfy the burden on the motion, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and the opinion should specify "in what way" the plaintiff's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v. Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept. 2010]). Once a defendant has made such a showing, the burden shifts to the plaintiff to "submit evidentiary facts or materials to rebut the *prima facie* showing by the

defendant" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]), but only as to those elements on which the defendant met the burden (*see Gillespie v. New York Hosp. Queens,* 96 AD3d 901 [2d Dept. 2012]). Accordingly, a plaintiff must produce expert testimony regarding the specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*Alvarez v. Prospect Hosp.*, 68 NY2d at 325). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to defeat summary judgment (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v. New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]). The plaintiff's expert must address the specific assertions of the defendant's expert with respect to negligence and causation (*see Foster-Sturrup v. Long*, 95 AD3d 726, 728-729 [1st Dept. 2012]).

Where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. "Resolution of issues of credibility of expert witnesses and the accuracy of their testimony are matters within the province of the jury" (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 25; *see also Cruz v. St. Barnabas Hospital*, 50 AD3d 382 [1st Dept. 2008]).

This Court finds that defendant NYU has established its entitlement to judgment as a matter of law by submitting the affirmation of its expert, Dr. Evans, who opined that defendant made all appropriate and timely decisions during the December 7, 2016 planned attempt to extubate S.M.E. and that PVL was a proximate result of the infant's extreme prematurity and extremely low weight at birth.

In opposition plaintiff has successfully raised a triable issue of fact to defeat summary judgment through the unequivocal opinion of Dr. Sims, who opined that based on S.M.E.'s signs and symptoms, she required reintubation at 5:00 p.m. on December 7th---or at the very latest by midnight on December 8th---and that NYU's failure to reintubate her was a departure from accepted practice and "in [her] opinion a substantial contributing cause of the infant's PVL, later seen on ultrasound and MRI" (*see* NYSCEF Doc. No. 57, para 45). While evidence of injury alone does not mean that the defendant was negligent (*see Landau v. Rappaport*, 306 AD2d 446 [1st Dept. 2003]) here, Dr. Sims' affirmation in which she (1) contrasts S.M.E.'s ongoing symptoms with the actions taken by the NICU staff, (2) compares the prolonged attempt to extubate with the abnormal radiological findings that appeared after December 8, 2016 and (3) opines that NYU's failure to change course and reintubate S.M.E. between the hours of 5:00 p.m. and 7:30 a.m. on December 8, 2016 was a proximate cause of PVL, sufficiently raises a question of fact as to NYU's negligence.

There is no question in this case that S.M.E. was assessed and evaluated during the critical time-period, as reflected in the flowchart and hospital records. The question successfully raised by plaintiffs is whether NYU departed from accepted practice by failing reintubate S.M.E. *before* it became an emergency, and whether this failure was a proximate cause of PVL. Any alleged inconsistencies in Dr. Sims' opinion, as argued by defendants, will go to the weight of the opinion as determined by the finders of fact.

As previously indicated, plaintiffs did not address or specifically oppose dismissal of the complaint as against the: (1) individually named doctors, (2) claims by plaintiff-mother Yiselle Entenza relating to prenatal, perinatal and obstetrical care including the failure to perform an earlier cesarean section, (3) second cause of action for lack of informed consent, (4) fourth cause

of action for spoilation of evidence, or (5) plaintiffs' claims concerning extraordinary care. Having met its burden on the motion, summary judgment must be awarded to defendants severing and dismissing the complaint against Drs. Proudfit, Rosner and Khouri, and severing and dismissing the second and fourth causes of action together with any allegations of extraordinary care and medical malpractice other than those associated with the attempt to extubate S.M.E. which was commenced on December 7, 2016 and abandoned at 7:30 a.m. on December 8, 2016.

Accordingly, it is

ORDERED that the motion for summary judgment by defendants Christine Proudfit, M.D., Mara Rosner, M.D., Olivia Khouri, M.D. and NYU Langone Hospitals s/h/a NYU Langone Medical Center is granted; and it is further

ORDERED that the second cause of action for lack of informed consent is severed and dismissed; and it is further

ORDERED that the fourth cause of action for spoilation of evidence is severed and dismissed; and it is further

ORDERED that all claims made by plaintiff, Yiselle Entenza, relating to prenatal, perinatal and obstetrical malpractice are severed and dismissed; and it is further

ORDERED that all claims made by plaintiffs concerning extraordinary care are severed and dismissed; and it is further

ORDERED that the balance of the motion is denied; and it is further

ORDERED that the parties appear for a pre-trial conference via Microsoft Teams on **September 21, 2022 at 9:30 a.m.**; and it is further

ORDERED that the Clerk of the Court enter judgment dismissing the complaint against defendants Christine Proudfit, M.D., Mara Rosner, M.D. and Olivia Khouri, M.D.; and it is further

ORDERED that the Clerk of the Court enter judgment severing and dismissing plaintiffs' Second Cause of Action and Fourth Cause of Action from the Complaint.

7/28/2022
DATE

JUDITH McMAHON, JSC
Hon. Judith N. McMahon
J.S.C.

CHECK ONE:		CASE DISPOSED			x	NON-FINAL DISPOSITION	
		GRANTED		DENIED	x	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE