Talbi v Saleh

2023 NY Slip Op 34815(U)

March 31, 2023

Supreme Court, Kings County

Docket Number: Index No. 512916/2019

Judge: Pamela L. Fisher

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At an IAS Term, Part 15 194 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 31 day of March 2023.

PRESENT:

HON. PAMELA L. FISHER,
J.S.C.

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FATIMA TALBI, as Parent and Natural Guardian of A.A.H. and infant FATIMA TALBI individually

Plaintiffs,

DECISION/ORDER

- against -

Index No: 512916/2019

IMAN SALEH, M.D. AND WINTHROP UNIVERSITY HOSPITAL

Defendants.

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Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

	Papers Numbered
Notice of Motion/Cross Motion/Order to Show Cause and Affidavits (Affirmations) Annexed	1-5, 6-7
Opposing Affidavits (Affirmations)	8-10, 11
Reply Affidavits (Affirmations)	12-13, 14-15, 16

Upon the foregoing papers in this medical malpractice action, defendant, Winthrop moves in motion sequence 5, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff's complaint against it in its entirety. Defendant, Iman Saleh, M.D., cross moves, in motion sequence6 pursuant to CPLR § 3212, for summary judgment, dismissing the action against it in its entirety. The Court notes that defendant Winthrop University Hospital's motion sequence 5 is granted as unopposed.

Plaintiff commenced this action by filing a summons and complaint on June 11, 2019 (Defendant's Affirmation in Support ¶ 1 motion sequence 6; Summons & Complaint,). Issue was joined by Iman Saleh, M.D. (Dr. Saleh) on or about June 18, 2019 (Defendant's Affirmation in Support ¶ 3, motion sequence 6). Plaintiff served the bills of particulars as to Dr. Saleh on September 4, 2019 (Defendant's Affirmation in Support ¶ 5, motion sequence 6, Verified Bill of Particulars, Exhibit D). On June 29, 2022, plaintiff filed the Note of Issue and on June 29, 2022, the defendant Dr. Saleh thereafter filed the instant motion. In her complaint and bills of particulars, plaintiff alleges that

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defendant departed from good and acceptable medical practice by mismanaging plaintiff-mother's prenatal care and labor and delivery (Complaint; Verified Bill of Particular).

The following facts are not in dispute. On May 18, 2016, plaintiff Fatima Talbi ("plaintiff mother) attended her intake appointment with Dr. Saleh (Defendant's Statement of Uncontested Facts ¶ 13, motion sequence 6). During that appointment, plaintiff mother reported her last menstrual period was March 31, 2016, and a pregnancy test was performed to confirm plaintiff was pregnant. Dr. Saleh's notes document that plaintiff was positive for anemia and reported two prior pregnancies which resulted in miscarriages (*Id.*). On June 2, plaintiff mother, then 8 weeks and 6 days, presented to Dr. Saleh's office for an ultrasound and was advised her estimated due date was January 6, 2017 (*Id. at 14*). On June 15 and July 20, plaintiff mother again presented to Dr. Saleh's office where no complaints or findings were changed (*Id.*). On August 18, plaintiff mother, 19 weeks, and 6 days, presented to Dr. Saleh's office and an ultrasound was performed noting that the single live fetus was in a breech presentation (*Id. at 17*). On September 21, September 23, October 12, October 27 and December 1, plaintiff mother presented to Dr. Saleh's office for scheduled appointments where the fetus continued to be in a breech presentation with appropriate growth and fluid (*Id.*). On December 14, plaintiff mother was found to be Strep B positive (*Id.* at 24). On December 29, plaintiff mother then 38 weeks and 6 days, presented for an ultrasound with the fetus in a breech presentation with appropriate growth and fluid (*Id.*).

On January 4, 2017, plaintiff mother, 39 weeks and 5 days, presented to Dr. Saleh's office where her vital signs were noted as normal, no complaints noted with the fetus in a vertex position with appropriate growth and fluid (*Id.* at 26). In the evening of January 4, Dr. Saleh sent plaintiff mother to Winthrop Hospital for an induction of labor (*Id.*). Upon admission to Labor and Delivery at 10:30PM on January 4, plaintiff mother was placed on fetal monitoring and experienced mild contractions every five to seven minutes lasting from 60-100 seconds (*Id. at 29).* At 10:47PM, plaintiff

mother was 1cm dilated, 70% effaced and at -3 station (*Id.*). At 12:51AM on January 5, 2017, plaintiff mother requested pain medication and nine minutes later, she vomited. At 1:17AM, plaintiff mother was 1.5cm dilated, 80% effaced and the fetal heart rate was 155bpm with moderate variability, positive accelerations, and no decelerations (*Id.*). At 1:40AM, the pain medication Stadol 2mn and antinausea medication Phenergan 12.5mg were started (*Id.* at 33). At 3:16AM, Dr. Saleh determined that plaintiff mother was not making sufficient cervical change and ordered Pitocin augmentation (*Id.* at 34). At 5:13AM, plaintiff mother was started on Pitocin at 2 milliunits per minutes. At 6:14AM, plaintiff mother was 2cm dilated and 80% effaced. At 7:40AM, the anesthetist placed an epidural (*Id. at 37).* At 7:54AM, Pitocin was increased to 4 milliunits, at 8:23AM it was increased to 6 milliunits and at 9:07AM it was increased to 8 milliunits. At 9:38AM, plaintiff mother was 3.5cm dilated and 90% effaced. At 9:40AM, the fetal heart rate was 150 bpm with periods of minimal and moderate variability, positive accelerations, positive non-recurring variability and occasional decelerations with return to baseline with material repositioning (*Id.* at 42). At 10:14AM, Pitocin was increased to 10 and at 10:46AM it was increased to 12. At 10:55AM, Dr. Saleh's office provided Winthrop Hospital with the hard copy of plaintiff mother's Strep B positive test and Penicillin was started (*Id.* at 45).

At 11:07AM, Pitocin was decreased to 8 and at 11:16AM, plaintiff mother was 4.5 cm dilated and 90% effaced. At 11:19AM, Winthrop Hospital staff ruptured plaintiff mother's membranes with a small amount of light meconium without order (*Id.* at 48). At 11:24AM, the fetal heart rate was 150 bpm with moderate variability, positive accelerations and scalp stimulation and positive variable decelerations and Dr. Saleh ordered an amnioinfusion (*Id.*). At 11:36AM, the amnioinfusion was started and at 11:49AM, an amnioinfusion bolus was infused. At 12:22PM, Pitocin was increased to 10 and at 11:11PM it was decreased to 8. At 3PM, plaintiff mother's temperature was 99.6 and she was 7.5 cm dilated and 90% effaced (*Id.* at 54). At 3:03PM, the fetal heart rate was 150 bpm with moderate variability, positive accelerations and no decelerations and at 3:34PM the bpm was up to 155. At

4:20PM, plaintiff mother's temperature was 99.4, she was 8 cm dilated and an epidural bolus was administered. At 4:31PM, Pitocin was decreased to 6. At 5:22PM, plaintiff mother's temperature was 100.0 and the fetal heart tracings revealed tachycardia (*Id.* at 60). At 5:45PM, amnioinfusion was discontinued and plaintiff mother's temperature was 99.7 and the fetal heart rate was 175. At 6:15PM the fetal heart rate was 180, the plaintiff mother's temperature was 101.6 and Tylenol was given. At 6:37PM, plaintiff mother was noted to have a fever and fetal tachycardia and at 7:26PM, Ampicillin and Gentamycin were started for presumed chorioamnionitis (*Id.* at 65). From 7:30PM through and including 8:15PM, plaintiff mother's Pitocin was increased and decreased, vitals were monitored, and the fetal heart rate was noted at 175 bpm.

At 9PM, Dr. Saleh documented in the hospital chart that plaintiff mother was fully dilated, and the fetal heart rate was Category 1. Pitocin was increased to 12, the baseline fetal heart rate was 165 with moderate variability and Dr. Saleh noted the fetal heart tracings were reassuring (*Id.* at 73). At 9:19PM, Pitocin was increased to 14 and at 10:24PM, plaintiff mother was instructed and urged to push. Plaintiff mother pushed for the next hour and 40 minutes and fetal heart tracings were reassuring as measured between contractions (*Id.* at 75). At 11:48PM, pediatrics arrived at bedside and on January 6, 2017, at 12:02AM, plaintiff mother delivered the infant plaintiff via a normal spontaneous vaginal delivery. Notes indicated Dr. Saleh performed the delivery with right medial laceration episiotomy. The umbilical cord was noted to be wrapped loosely around the infant plaintiff's neck and was reduced by Dr. Saleh and the episiotomy was repaired without complication (*Id.* at 77). At birth, infant plaintiff weighed 6 lbs and 10 oz, Apgar's were 2 at 1 minutes, 6 at 5 minutes and 8 at 10 minutes. At 5 minutes, oxygen was administered via nasal CPAP and continued through 10 minutes until infant plaintiff demonstrated good cry, some flexion of extremities, cough/sneeze/pull away reflex and pink body (*Id.* at 79). At 12:35AM, infant plaintiff was transferred to the NICU for further management where placental pathology revealed mature placenta, low weight for gestational age with acute

chorioamnionitis and chronic plate vasculitis and two vessel cord. Infant plaintiff was weaned from CPAP to room air shortly after admission and he received three days of Ampicillin and Gentamicin for presumed sepsis (*Id.* at 80). On January 12, 2017, infant plaintiff was discharged home to plaintiff mother's care (*Id.*). Infant plaintiff was noted as demonstrating normal physical development since birth but has delayed speech and expressive language development and symptoms suggestive of mild to moderate autism spectrum disorder (*Id.* at 81).

In support of its motion for summary judgment, defendant submits an expert affidavit from Gil Farkash, M.D., a physician board certified in obstetrics and gynecology, contending that Dr. Saleh did not deviate from the standard of care during the treatment of the plaintiffs, and that they did not proximately cause their injuries (Farkash Expert Affidavit ¶¶ 2, 5, annexed as Exhibit B to defendant's motion papers, motion sequence 6). Dr. Farkash's opinion is based on review of the bills of particulars, deposition transcripts, and medical records, as well as her own training and experience (*Id.* at ¶¶ 3). Dr. Farkash's opines that Dr. Saleh managed the plaintiff mother's prenatal care, her elective induction of labor and her delivery in accordance with the standard of care (*Id.*). She further opines that plaintiff mother's prenatal course was entirely benign and without complication as she gained the appropriate amount of weight, did not develop gestational diabetes, diagnosable infection, or significant pregnancy complications. Dr. Farkash states that Dr. Saleh timely and appropriately performed and monitored the plaintiff mother's prenatal care and that there is no evidence that Dr. Saleh failed to diagnose or treat intrauterine infection during the prenatal period or that Dr. Saleh should have recommended a c-section delivery (*Id.* at 5). Dr. Farkash further opined that Dr. Saleh acted in accordance with the standard of care in monitoring and adjusting the plaintiff mother's labor and that the intervention was timely administered. Dr. Farkash contends that the recurring variable decelerations that had occurred did not necessitate a cesarean-section delivery given that the fetal heart tracings improved in response to the amnioinfusion and only further demonstrate Dr. Saleh acted appropriately and timely (*Id.* at 10).

Dr. Farkash opined that as plaintiff mother made steady cervical change but then developed a fever concurrent with fetal tachycardia, Dr. Saleh timely intervened, diagnosing chorioamnionitis and administering Tylenol for the fever and IV Ampicillin and Gentamycin for presumed intrauterine infection. Dr. Farkash contends that the fetal tachycardia was due to maternal fever and not evidence of neonatal hypoxia.

Dr. Farkash opines that to a reasonable degree of medical certainty, maternal chorioamnionitis and fetal tachycardia are not indications, alone, for caesarean section, particularly in a woman that is 7.8 cm dilated and making adequate progress toward delivery (*Id. at 11).* Dr. Farkash further contends that the fetal heart tracings were reassuring from the time amnioinfusion began through administration of IV antibiotics and there was no reason to stop Pitocin because there were no signs of fetal distress. Dr. Farkash opines that the baseline fetal heart rate continued to decrease with resolution of plaintiff mother's fever and the four to five hours of self-resolving fetal tachycardia without prolonged or recurring variable decelerations was not indication for c-section and is not evidence of untreated hypoxia or fetal distress (*Id.* at 12). Dr. Farkash opines that the hour and 40 minutes of steady pushing were appropriate as the fetal heart tracings continued to be reassuring as measured between contractions and that one hour and 40 minutes is not a prolonged or unreasonable period to push, particularly for a 34-year-old woman delivering her first child (*Id.* at 13). Dr. Farkash opines that Dr. Saleh appropriately requested that the NICU team be at bedside prior to delivery and that at no point was there any indication that a c-section delivery was needed. Dr. Farkash contends that the fact the infant plaintiff was born with low Apgar at two and five minutes, needed oxygen and was admitted to the NICU are not evidence of neonatal hypoxia nor are they proof that Dr. Saleh should have delivered the infant via c-section. Dr. Farkash states that such claims are based on hindsight reasoning and are inconsistent with the standard of care leading to unnecessary c-sections, increased maternal complications from surgery and need for future c-section deliveries (*Id. at 17).*

In further support of its motion for summary judgment, defendant submits an expert affidavit from Michelle Ehrlich, M.D., a physician board certified in pediatrics and neurology with a specialty in child neurology, contending that the infant plaintiff did not suffer intrauterine hypoxic insult leading to hypoxic ischemic encephalopathy ("HIE") (Ehrlich Expert Affidavit ¶¶ 2, 5, annexed as Exhibit C to defendant's motion papers, motion sequence 6). Dr. Ehrlich's opinion is based on review of the bills of particulars, deposition transcripts, and medical records, as well as her own training and experience (*Id.* at ¶¶ 4). Dr. Ehrlich's opines that the infant plaintiff underwent serial physical exams during the birth hospitalization which did not reveal evidence of HIE. She states that the infant's physical exam was grossly normal and neurologic exam revealed normal muscle tone, normal activity and mental status, normal Moro reflex, normal suck reflex, and normal grasp reflex (*Id. at 5).* Dr. Ehrlich opines that the discharge neurologic exam was consistent with the admission exam and all radiographic examinations were normal and showed no evidence of HIE or structural abnormality. Dr. Ehrlich contends that to a reasonable degree of medical certainty the infant plaintiff's developmental neurologic dysfunction was not cause by HIE (*Id.).* Dr. Ehrlich states that although chorioamnionitis is considered a risk factor for neurologic dysfunction, the medical community has not adopted the theory that chorioamnionitis is a direct cause of developmental delays such as are alleged in this case (*Id. at 6).*

In opposition to defendant's motion for summary judgment, plaintiff submits an expert affidavit from Jeffrey C. Hammer, M.D., a retired physician who was board certified in obstetrics and gynecology until his retirement in December 2017, (Dr. Hammer's Expert Affirmation ¶ 2, motion sequence 6). Dr. Hammer opines that Dr. Saleh departed from good and accepted obstetrical practice on January 5, 2017, hours before infant plaintiff's delivery at 12:04AM on January 6, 2017, by failing to deliver the infant by cesarean section, which was indicated by maternal fever, chorioamnionitis and non-reassuring fetal heart rate patterns, specifically tachycardia and loss of heart rate variability in the setting of an exceptionally slow first stage of labor (*Id.* at ¶ 8). Dr. Hammer's opinion is based on

review of the bills of particulars, medical records, deposition transcripts, and defendants' expert affidavits (*Id.*). Dr. Hammer contends that Dr. Saleh deviated from the standard of care by allowing the plaintiff mother's labor to continue when her condition and fetal status required cesarean section to be ordered no later than 7:40PM on January 5, 2017, and delivery to follow within a half hour thereafter (*Id.* at 9). Dr. Hammer states that he specifies 7:40PM because by that point the plaintiff mother had only one cm cervical change over four hours, from 7.5 cm to 8.5 cm and fetal heart rate variability was minimal for a 20-minute period. Dr. Hammer contends that by 7:40PM it was obvious that the plaintiff mother, in the 40th week of her pregnancy, second stage labor was not imminent, despite continued Pitocin infusion. Dr. Hammer further contends that the fact that over a four plus hour period there had only been a one cm increase in cervical dilation, there was no way to reasonably anticipate that spontaneous delivery would ensue promptly (*Id.* at 11).

Dr. Hammer opines that delivery was the only way that fetal exposure to a hazardous intrauterine environment, characterized by intra-amniotic infection (chorioamnionitis) and evidence of diminished fetal oxygen reserve could be relived. Dr. Hammer disagrees with Dr. Farkash's opinion that there was no indication for a c-section delivery at any point. He states that while chorioamnionitis alone is not necessarily itself an indication for c-section, here there was a maternal fever documents at 3PM, 4:20PM, 5:22PM, 5:56PM and 6:24PM, and more than three hours of fetal tachycardia as well as minimal fetal heart rate variability for a 20-minute period commencing at 7:20PM (*Id.* at 14). Dr. Hammer contends that the fetal tachycardia was not "self-limiting" after five hours and that while the fetal heart rate did slow to the upper range of normal, the fetal heart tracings were non-reassuring and tachycardic. Dr. Hammer states he disagrees with Dr. Farkash's claim that the infant's Apgar score and initial need for oxygen are not evidence of fetal hypoxia (*Id.*). He contends that while these observations are not conclusive evidence of fetal hypoxia, they are more likely than not evidence of

fetal decompensation due to the combined effect of hypoxic stress and exposure to intra-amniotic infection, which are synergistic in their deleterious effect on fetal well-being (*Id.* at 17).

Dr. Hammer contends that Dr. Saleh could not have reasonably expected the plaintiff mother to deliver spontaneously within a tolerable period in the presence of maternal fever and fetal tachycardia uninterrupted for three hours and since the mother's active first stage of labor was exceedingly slow despite more than 12 hours of continued Pitocin induction. Dr. Hammer opines that Dr. Saleh departed from accepted practice by failing to obtain the patient's consent for a c-section no later than 7:40PM and then proceeding to deliver the infant plaintiff within at most one-half hour thereafter (*Id.* at 19). Dr. Hammer opines that these departures, directly and proximately resulted in some four- and one-half additional hours of needless exposure to hypoxic insult and intra-amniotic infection, which the standard of care is designed to prevent. Dr. Hammer further opines that this exposure has the capacity to cause injury to the infant plaintiff (*Id.* at 21).

In further opposition to defendant's motion for summary judgment, plaintiff submits an expert affidavit from Stephen J. Thompson, M.D., a physician board certified in pediatrics and neurology with a special qualification in child neurology, (Dr. Thompson's Expert Affirmation ¶ 2, motion sequence 6). Dr. Thompson conducted a neurological examination of the infant plaintiff via Zoom after obtaining a history and observing the infant plaintiff. Dr. Thompson opines that the infant plaintiff exhibits signs of brain injury, specifically a profound speech and language disorder, that is consistent with the obstetric records. Dr. Thompson contends that intrauterine exposure to the chemical products of chorioamnionitis, combined with hypoxic-ischemic stress has unpredictable consequences (*Id.* at 14). Dr. Thompson opines that in the absence of any other explanatory contributing facts, the intrauterine environment to which the infant plaintiff was exposed during the hours before birth was more likely than not, a substantial contributing factor to his profound speech disorder, which is a feature of a permanent brain injury (*Id.* at 16).

In reply, defendant reiterates that Dr. Saleh did not deviate from the standard of care during their treatment of the plaintiff, and that she did not proximately cause her injuries (Reply Affirmation ¶ 3, motion sequence 6). Defendant maintains that plaintiffs' expert opinions are insufficient to raise a triable issue of fact, as it is speculative, conclusory, and unsupported by any evidentiary foundation (*Id.* at ¶ 4). Defendant argues that Dr. Hammer failed to explain how much cervical change was expected during the period at issue and what a "tolerable period" to wait for a spontaneous delivery would have been under the circumstances. Defendant further argues that Dr. Hammer failed to acknowledge that the fetal tachycardia was caused by and directly related to plaintiff mother's fever and that Dr. Farkash established that the maternal fever and the fetus's tachycardia were due to the same condition, chorioamnionitis, which was properly and timely diagnosed and appropriately treated with Tylenol, antibiotics and amnioinfusion (*Id.* at 6). Defendant contends that Dr. Hammer did not refute that Dr. Saleh timely diagnosed and properly treated plaintiff mother's fever and that the maternal fever and tachycardia are not separate conditions and therefore Dr. Hammer's attempt to utilize both to support his conclusion that an emergency c-section was warranted is unsupported by the evidence (*Id.* at 7). Defendant contends that even if plaintiff was able to establish a question of fact as to whether the infant should have been delivered via c-section a few hours earlier, plaintiff has failed to show that the alleged malpractice was a proximate cause of the alleged injury as there is no evidence that the infant suffered HIE (*Id.* at 11).

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant "deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v. Streiter*, 83 AD3d 18, 23 [2d. Dept. 2011]). On a motion for summary judgment, defendant must "make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*lulo v. Staten Is. Univ. Hosp.*, 106 AD3d 696, 697 [2d. Dept. 2013]). To "sustain this burden, the defendant

must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars" (*Anonymous v. Gleason*, 175 AD3d 614, 617 [2d. Dept. 2019]; *Bendel v. Rajpal*, 101 AD3d 662, 663 [2d. Dept. 2012]). Once the defendant meets its burden, the burden then shifts to the plaintiff to "raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing" (*Stukas*, 83 AD3d at 24). If the defendant "makes only a prima facie showing that he or she did not deviate or depart from accepted medical practice, the plaintiff, in order to defeat summary judgment, need only raise a triable issue of fact as to the alleged deviation or departure, and need not address the issue of proximate cause" (*Hayden v. Gordon*, 91 AD3d 819, 821 [2d. Dept. 2012]). Conclusory allegations that are "unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat defendant physician's summary judgment motion" (*Deutsch v. Chaglassian*, 71 AD3d 718, 719 [2d. Dept. 2010]). Further, a plaintiff cannot defeat a motion for summary judgment by "rais[ing] a new or materially different theory of" "liability" "for the first time in opposition to a motion for summary judgment" that was not "pleaded in the complaint or bills of particulars" (*Gleason*, 175 AD3d at 617; *Cox v. Herzog*, 192 AD3d 757, 759 [2d. Dept. 2021]; *Abalola v. Flower Hosp.*, 44 AD3d 522, 522 [1st Dept. 2007]). Where the parties have submitted conflicting expert reports, summary judgment should not be granted; "[s]uch credibility issues can only be resolved by a jury" (*Deutsch*, 71 AD3d at 719).

Here, defendant, Dr. Saleh, met her prima facie burden on summary judgment. Defendant's experts affirmed that Dr. Saleh did not deviate from the standard of care during care and treatment of the plaintiff mother and that she did not proximately cause injuries to the infant plaintiff. They opined that Dr. Saleh properly assessed the plaintiff mother's labor progression and the fetal monitoring and provided appropriate intervention. The defendant's experts further opined that there was no evidence that the infant plaintiff suffered from HIE and that if infant plaintiff did have HIE, it is not indicative of

the infant plaintiff's neurological conditions. Defendant's experts established that Dr. Saleh properly managed plaintiff mother's labor and delivery, timely and properly treated her chorioamnionitis and associated fetal tachycardia, and helped her to deliver the infant normally, spontaneously, vaginally, and without the need for extensive surgery. The expert's opinions constitute competent evidence, in that it is based on the bills of particulars, medical records, and deposition transcripts, as well as their own training and experience.

In opposition, plaintiff produced affidavits a retired obstetrician and a pediatric neurologist who attest to departures from accepted standards of medical practice, and that these departures were a producing cause of the infant plaintiff's neurological conditions/injuries. Plaintiff's expert opinion fails to raise a triable issue of fact as to the causes of action for medical malpractice, as they are conclusory, speculative, and do not "address specific assertions" of defendants' expert (*See Tsitrin v. New York Community Hosp.*, 154 AD3d 994, 996 [2d. Dept. 2017]; *Foster-Sturrup v. Long*, 95 AD3d 726, 728-29 [1st Dept. 2012]; *Abalola v. Flower Hosp.*, 44 AD3d 522, 522 [1st Dept. 2007]). The Court notes that plaintiff's expert, Dr. Hammer has been retired from medicine since 2017 and has not delivered a baby since 2013 and that his opinion is based on his review of the records but also on a review of current literature in the fields of obstetrics and gynecology. Plaintiff's expert states that the defendant departed from accepted standards by not performing an emergency c-section, on or around 7:40PM on January 5, 2017, because given the circumstances surrounding the progression of labor, defendant could not have reasonably expected plaintiff to deliver spontaneously within a tolerable period, these opinions are speculative conclusions that fail to rebut defendant's experts. Specifically, Dr. Hammer failed to explain how much cervical change was expected during the period at issue and what a "tolerable period" to wait for a spontaneous delivery would have been under the circumstances. Additionally, plaintiff's experts fail to address defendant's contentions that the fetal tachycardia was caused by and directly related to plaintiff mother's fever. Defendant's expert Dr. Farkash opines that

the fever and fetal tachycardia were due to the same condition, chorioamnionitis, which was properly and timely diagnosed and treated. Here, Dr. Hammer did not refute Dr. Farkash's opinion that defendant timely diagnosed and properly treated plaintiff. Dr. Hammer's only support for his claim that defendant should have ordered an emergency c-section was the slow progression of plaintiff's labor and delivery and an approximately 20-minute period of minimal fetal heart rate variability. Dr. Hammer did not digest or appreciate the Category II or III tracings or that the fetal heart rate returned to normal after proper treatment of chorioamnionitis. Plaintiff's experts attempted to raise a contrary opinion that the infant plaintiff's central depression at birth (scoring Apgar points only for heart rate, but emerging limp, pale, apneic and without reflex response) was "more likely than not evidence of fetal decompensation" caused by combined exposure to hypoxic stress and an infected intrauterine environment but fail to show any evidence that the infant suffered hypoxic insult in utero. Specifically, Dr. Thompson claimed that the infant suffered profound speech impairment because of the alleged malpractice and without any medical basis, made the assertion that there is a link between chorioamnionitis and hypoxic-ischemic stress and profound speech disorder. Plaintiff's experts generally opine that the intrauterine environment was negatively impacted by chorioamnionitis, and that this environment would be bad for a fetus but fail to refute defendant's contentions that the fetus did not suffer a hypoxic insult and without proof of hypoxia, plaintiff cannot establish proximate cause. Therefore, Dr. Thompson and Dr. Hammer's opinions are speculative, conclusory, and insufficient to rebut defendant's prima facie entitlement to judgment as a matter of law (see *Callistro v Bebbington, M.D.*, 94 A.D.3d 408 [1st Dept. 2012] ("summary judgment affirmations were insufficient to create triable issues of fact as to whether failure to perform c-section caused infant child to sustain hypoxic event responsible for child's cognitive delays.") *Wally G. ex rel. Yoselin T. v New York City Health and Hospitals Corporation*, 120 A.D.3d 1082 [1st Dept 2014])).

ORDERED that defendant Winthrop's motion for summary judgment is granted as unopposed and the defendant Winthrop Hospital is dismissed from this action; and it is further

ORDERED that defendant Dr. Saleh's motion for summary judgment is granted.

This constitutes the decision and order of the Court.

ENTER:_

Hon. Pamela L. Fisher
J.S.C.

Hon. Pamela L. Fisher J.S.C.