

**LaRose v St. Charles Hosp. & Rehabilitation
Ctr.**

2007 NY Slip Op 33441(U)

October 17, 2007

Supreme Court, Suffolk County

Docket Number: 0011940/2002

Judge: Robert W. Doyle

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publication.

ORDERED that this motion (003) by defendant, Alan R. Spitzer, M.D., pursuant to CPLR 3212 for summary judgment dismissing plaintiffs' complaint in action #1 under Index No. 11940/02, is denied; and it is further

ORDERED that this motion (004) by defendants Thomas P. Erhart, D.O., and Thomas P. Erhart, D.O., P.C., pursuant to CPLR 3212 for summary judgment dismissing plaintiffs' complaint in action #1 under Index No. 11940/02, is denied; and it is further

ORDERED that this motion (005) by defendant St. Charles Hospital and Rehabilitation Center pursuant to CPLR 3212 for summary judgment dismissing plaintiff's complaint in action #1 under Index No. 11940/02, is denied.

These are two separate actions arising out of the delivery of male twins, the infant plaintiffs, Daniel LaRose and William Rose, who were born prematurely on May 26, 2000 at St. Charles Hospital. The first action was commenced under Index No. 11940/02. The second action was commenced under Index No. 23262/04. Pursuant to an order dated October 18, 2005 (Henry, J.), these two separate actions were joined for all pre-trial purposes and for trial, but were not consolidated as Justice Henry opined that "Joint trial, rather than consolidation, will allow the trial judge to fashion procedures according to fairness." Therefore, separate motions should have been made under the respective Index Numbers. In that separate motions for summary judgment have not been filed for the second action, this court will consider these motions only as they relate to the first named action captioned under Index No. 11940/02.

The amended complaint in this action is premised upon claims sounding in medical malpractice, lack of informed consent, a derivative claim for money damages, and further claim for emotional distress. It is claimed that the infant Daniel suffered neurological damage as a result of the negligence of the obstetrician, the neonatologist and the hospital where the children were born.

Donna LaRose alleges that she has been caused to expend various sums of money and suffer emotional distress due to the negligence of defendants. She claims the infant plaintiff, Daniel LaRose, was caused to sustain perinatal asphyxia causing him to suffer, *inter alia*, intracranial hemorrhage, leukomalacia, periventricular leukomalacia, laryogomalacia, brain damage, mental retardation, cerebral palsy, spasticity and spastic diplegia, cognitive defects, exotropia, ambyopia O.S., severe delays in speech and language development, inability to perform all daily activities of speech and walking, severe delay in achieving milestones, severe impairment of fine motor skills, severe learning impairment, severe perceptual deficits, severe impairment of fine motor skills, respiratory distress, inability to interact with peers, loss of earning capacity, capability and opportunity, necessity for physical therapy, speech therapy and the need for future surgeries to treat the various contractures.

The moving defendants allege there were no departures from the appropriate standards of care and treatment with regard to the care and treatment rendered to plaintiff and the infant plaintiffs and thus seek summary judgment dismissing the complaints.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (*Holton v Sprain Brook Manor Nursing Home*, 253 AD2d 852, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must

establish that defendant's negligence was a substantial factor in producing the alleged injury (*see, Derdarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 221 AD2d 674, 638 NYS2d 700 [1996]) Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see, Fiore v Galang*, 64 NY2d 999, 489 NYS2d 47 [1985]; *Lyons v McCauley*, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

The proponent of a summary judgment motion 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. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (*Sillman v Twentieth Century-Fox Film Corporation*, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (*Winegrad v N.Y.U. Medical Center*, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v N.Y.U. Medical Center, supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; *Zuckerman v City of New York*, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (*Joseph P. Day Realty Corp. v Aeroxon Prods.*, 148 AD2d 499, 538 NYS2d 843 [2nd Dept 1979]) and must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (*Castro v Liberty Bus Co.*, 79 AD2d 1014, 435 NYS2d 340 [2nd Dept 1981]). Summary judgment shall only be granted when there are no issues of material fact and the evidence requires the court to direct a judgment in favor of the movant as a matter of law (*Friends of Animals v Associated Fur Mfrs.*, 46 NY2d 1065, 416 NYS2d 790 [1979]).

Defendant, Alan Spitzer, M.D., in support of motion (003), has submitted an attorney's affirmation; the affirmation of his expert Jonathan M. Davis, M.D.; copies of the supplemental summons and amended verified complaints; the verified answer of Dr. Spitzer; and a copy of plaintiffs' verified bills of particulars.

Dr. Spitzer's expert, Jonathan M. Davis, M.D., avers he is duly licensed to practice medicine in New York State and is board certified in pediatrics with a subcertification in neonatal-perinatal medicine. He opines with a reasonable degree of medical certainty that Dr. Alan Spitzer acted appropriately and treated the infant plaintiffs within accepted standards of medical care and that no action or inaction by Dr. Spitzer was the cause of any of the alleged injuries suffered by the infant, Daniel LaRose.

Dr. Davis states that on May 26, 2000, Donna LaRose called Dr. Erhart, her obstetrician, with complaints of cramps and spotting of blood. She was advised to go to St. Charles Hospital to be evaluated. She arrived at 8:57 p.m. Dr. Erhart examined her at 9:20 p.m. and determined she was fully dilated with mild, irregular contractions and staining. William (baby boy A) was delivered shortly thereafter by vaginal delivery and brought into the nursery at 9:50 p.m. Daniel, (baby boy B) was delivered by caesarean section at 9:57 p.m. due to a breech presentation and brought into the nursery at

10:10 p.m. Dr. Davis opines that at all times, the infants were attended to by a senior and very qualified neonatal nurse practitioner. Dr. Davis states that Dr. Spitzer arrived at the hospital within thirty minutes of the delivery and intubated Daniel at 10:15 p.m. This, states Dr. Davis, is within accepted standards.

Dr. Davis further states that the medical records document that the Stonybrook transport team arrived at St. Charles Hospital at 10:25 p.m., within twenty eight minutes of Daniels birth, which Dr. Davis states, indicates Dr. Spitzer called the transport team before the infants were delivered. Dr. Davis opines that Dr. Spitzer timely and appropriately contacted the transport team. Concerning Daniel, Dr. Davis states that Dr. Spitzer was not present at the delivery, but the infant was attended to by a neonatal nurse practitioner from Stony Brook NICU, who appropriately resuscitated Daniel in the delivery room. He was then immediately transferred to the Special Care Nursery where he was intubated and placed on a ventilator at 10:30 p.m. with Dr. Spitzer and the Stony Brook Transport Team in attendance. Saline was administered within thirty minutes of his birth to stabilize his blood pressure.

Dr. Davis also opines within a reasonable degree of medical certainty that both infants had brain damage at the time of birth, which, he states, was caused by a process that began significantly before the infants were born, and that no action or inaction by Dr. Spitzer caused the brain damage or the injuries alleged in this case. Daniel was significantly anemic with a hematocrit level of 36 at birth, and had significant brain damage documented on ultrasound shortly after birth, which, Dr. Davis states, is strong and crucial evidence that the process that caused Daniel to have periventricular leukomalacia began at least one week prior to birth. Dr. Davis states that at birth, the normal hematocrit is between 42% and 64%, and that it takes approximately twelve hours after blood loss for a hematocrit level to drop to the low level of 36, indicating chronic blood loss or significant infection and that this insult or process caused the premature labor and PVL in Daniel's brain. This, he opines, occurred prior to the time of Daniel's birth. Dr. Davis opines that the process of death of brain tissue and the resulting damage that can be seen on ultrasound takes a minimum of one week to develop and at least one week from the process to show up on an ultrasound.

Dr. Davis opines that Daniel suffered from an hypoxic-ischemic insult during the time he was in his mother's uterus, which insult decreased blood flow to the baby's brain. He further stated that approximately 5% of premature babies born at twenty-eight weeks suffer from PVL in the absence of medical negligence. Daniel was born at twenty eight weeks gestation.

In addressing additional claims by plaintiffs, Dr. Davis further opines that it is contraindicated to administer sodium bicarbonate to the infant as it can increase brain damage. Both infants had acceptable blood gases documented in the medical records at birth and were stable. He also opines that dexamethasone, a powerful steroid, should not be administered to the infants as it is known to cause death and cerebral palsy if given too early to premature infants.

Based upon the foregoing, this court determines that defendant Dr. Spitzer has demonstrated prima facie entitlement to summary judgment on the issue of negligence and proximate cause.

Defendant, Thomas Erhart, D.O., in support of motion (004) for summary judgment has submitted, *inter alia*, an attorney's affirmation; the affirmations of his experts David Baker, M.D. and Jonathan M. Davis, M.D.; copies of the summons and verified complaints; copies of the verified answers

of Dr. Ross, St. Charles Hospital, Dr. Spitzer, and Dr. Erhart; copies of plaintiffs' verified bills of particulars and further supplemental verified bills of particulars, amended verified bills of particulars; a copy of the supplemental summons and amended verified complaint; copy of the verified answers of Dr. Erhart and Dr. Spitzer to the amended complaint; copies of various medical records; and a partial, unsigned, unsworn copy of the transcript of the examination before trial of Donna LaRose.

Dr. Jonathan Davis sets forth in his affirmation that he is board certified in pediatrics with a subcertification in neonatal-perinatal medicine. This affirmation does not comment on the standard of care of an obstetrician during labor and delivery and the perinatal-neonatal period and therefore does not address the issues of whether or not Dr. Erhart departed from accepted medical practice during his care and treatment of Mrs. LaRose and delivery of the infants.

Dr. Erhart has also submitted the affirmation of his expert, David A. Baker, M.D., who is licensed to practice medicine in the State of New York and is certified in obstetrics and gynecology and maternal and fetal medicine. It is Dr. Baker's opinion based upon a reasonable degree of medical certainty that Dr. Erhart did not depart from good and accepted medical practices in his care and treatment of Mrs. LaRose. Dr. Baker states Dr. Erhart treated plaintiff mother as a high risk pregnancy, she was seen at proper intervals and had obstetrical sonograms, blood tests and evaluations appropriate to a high risk pregnancy.

Dr. Baker states Mrs. LaRose was first seen by Dr. Erhart on January 11, 2000. She was 37 years old, married and pregnant for the fifth time, having had three children via normal spontaneous vaginal delivery and one abortion. She reported her menstrual history as irregular with her last menses on September 26, 1999. A history was taken and physical examination was consistent with fourteen weeks gestation. Pre-natal studies were taken and she was referred for a sonogram which was performed on January 19, 2000 and revealed live twins consistent with a gestational age of ten weeks. Her estimated date of confinement was August 16, 2000.

She was again seen by Dr. Erhart on February 8, 2000. An amniocentesis was ordered and performed on March 7, 2000, revealing both fetuses were male with normal chromosomal complements. Alpha fetoproteins were within normal limits. A third prenatal visit was on March 13, 2000 wherein it was determined Mrs. LaRose's weight gain was progressing normally. Fetal anatomic surveys revealed concordant growth of the twins with no anatomic abnormalities.

Fetal heartbeats were auscultated on April 7, 2000, maternal blood pressure was normal, and maternal urine was negative for glucose and albumin.

The last prenatal visit of May 5, 2000 revealed a normal blood pressure. Her urine was negative for glucose and albumin. Both fetal heartbeats were heard. A sonogram was performed on May 25, 2000 and revealed the estimated gestational ages of the twins at twenty eight weeks, one day, and twenty eight weeks, four days. The cervix was long and closed and revealed no funneling. Dr. Davis opines there was nothing suggestive in this sonogram that Mrs. LaRose would go into preterm labor.

The day after the sonogram, on May 26, 2000, Ms. LaRose testified she went into labor at some point after 1 p.m. The hospital record at St. Charles Hospital indicates she reported contraction began at 7 p.m. She called Dr. Erhart and told him the contractions were going to her back and she was spotting

blood. She stated she was advised by Dr. Erhart to go to St. Charles Hospital which was about ten minutes from her home. She arrived there about an hour or so from the time she spoke with Dr. Erhart. Upon arrival, blood work was taken, and at 9:08 p.m., Terbutaline, a tocolytic agent used to stop uterine contractions, was administered per Dr. Erhart's phone order. Dr. Erhart arrived at the hospital and examined Mrs. LaRose at 9:20 p.m. at which time he found her cervix was fully dilated. Dr. Davis opines that there was nothing that could be done at this point to prolong the pregnancy. A sonogram performed in the delivery room revealed William was in a vertex presentation and Daniel was in a transverse lie. Mrs. LaRose's white blood cell count was elevated to 20,200 with a differential indicative of an infection.

In addressing various assertions by plaintiffs, Dr. Baker opines that it was not a departure from accepted medical practice for Dr. Erhart to use external monitoring of the fetuses prior to delivery as rupture of the membranes could introduce infection. Additionally, the external tracings did not indicate fetal distress of any kind. Dr. Erhart appropriately determined to allow a vaginal delivery, opines Dr. Baker. Dr. Baker further stated Magnesium Sulfate or Terbutaline would not be effective in arresting labor as Mrs. LaRose was fully dilated. He also opined that Dexamethasone can be administered to the mother to enhance the development of lung maturity in a fetus where it is anticipated that delivery can be delayed for at least forty eight hours. However, no benefit is demonstrated where delivery is imminent, as was the case herein. Dr. Baker opines Surfactant is a substance which cannot be administered prior to an infant's birth and must be administered after birth by instillation through the endotracheal tube by the neonatologist, not by an obstetrician.

William (twin A) was born via spontaneous vaginal delivery at 9:38 p.m. with Apgar scores of 6 at one minute and 8 at five minutes. Dr. Baker sets forth it was then anticipated that Daniel (twin B) would drop to a vertex presentation, or less likely, a breech, but this did not happen, and Dr. Erhart appropriately attempted a version under ultrasound to permit delivery, although it was unsuccessful. An attempted breech extraction was then made, but Dr. Erhart was able to grab only one foot and could not bring the second foot down to accomplish the delivery. He states the fetal heart rate remained in the 130's throughout both procedures. A primary cesarean delivery under general anesthesia was then performed at 9:55 p.m., wherein Dr. Erhart was assisted by another attending obstetrician immediately available, with the assistance of the labor and delivery nurses.

Dr. Baker states the pathology report of the twins' placenta revealed acute inflammatory changes. It is Dr. Baker's opinion that this pathological finding, together with the mother's elevated white blood cell count and left shift in the white blood cell differential count suggests that Mrs. LaRose's pre-term labor was related to infection. He also opines that although plaintiffs claim Mrs. LaRose should have been directed to Stony Brook Hospital, there was nothing needed from an obstetrical point of view which was not readily available at St. Charles Hospital as all necessary personnel and equipment were readily available for care of the twins at St. Charles Hospital Special Care Nursery.

Daniel was delivered at 9:57 p.m. with Apgar scores of 3 at one minute and 7 at five minutes. Dr. Baker opines that Daniel's one minute Apgar score was somewhat lower than his twin's due to the general anesthesia administered to Mrs. LaRose, and bases this opinion on the Apgar score rising to 7 at five minutes. He further opines that an infant sustaining an asphyxia and/or an hypoxic/anoxic event during the course of labor and delivery would not rebound in this manner and would remain

depressed for a significant period of time.

Defendant Erhart has also submitted the hospital record for Daniel (exhibit AA) wherein it is noted the Discharge Summary indicates Daniel was noted to be gasping at birth, had a heart rate of approximately 80 beats a minute, and was noted to be profoundly bruised at the time of delivery. Upon arrival to the Special Care Nursery, Daniel required immediate intubation, ventilation and placement of umbilical, arterial and venous catheters. His initial arterial saturation was 80-82% which could not be raised until he received a volume push of 20 cc/kg of normal saline. When placed on the respirator, he was noted to be nonresponsive to any stimuli whatsoever. Examination of Daniel's head revealed a fontanel that increased in size with widening sutures during his two hour stay at St. Charles Hospital. The initial impression set forth in this note written by Dr. Spitzer is that the child has "severe immaturity with a precipitous presentation, difficult delivery requiring cesarean section, mild respiratory distress, hypovolemia secondary to bruising, possible central nervous system injury and intraventricular hemorrhage." In the Neonatal Attending note, Dr. Spitzer indicated that this was a difficult delivery, R/O CNS trauma. The NNP Transfer note indicates Daniel's head was bruised with no molding. There was bruising of all extremities presumed secondary to a difficult extraction. The infant's trunk was bruised as well. There was no movement of the extremities noted.

These foregoing notes are inconsistent with Dr. Baker's opinion that "an infant sustaining an asphyxia and/or an hypoxic/anoxic event during the course of labor and delivery would not rebound in this manner and would remain depressed for a significant period of time." The medical records do not indicate the infant rebounded upon delivery. Although Dr. Baker opines the infant's heart rate remained at 130's throughout the procedures and delivery, it is documented as being in the 80's at birth. In that the infant needed immediate intubation, ventilation, and was not responsive to any stimuli, there are factual issues raised in the moving papers concerning Dr. Baker's opinion that the infant rebounded, and what is documented in the medical records. Also, Dr. Spitzer's note which considers that there was hypovolemia secondary to bruising, possible central nervous system injury and intraventricular hemorrhage also raises factual issues concerning Dr. Baker's opinion that Daniel did not suffer asphyxia and/or an hypoxic/anoxic event during the course of labor and delivery. In his neonatal attending note, Dr. Spitzer indicated that this was a difficult delivery, R/O CNS trauma. The existence of these critical, triable, factual issues presented in the moving papers preclude summary judgment.

Accordingly, it is determined that defendant Erhart has not demonstrated prima facie entitlement to summary judgment and motion (004) is therefore denied.

Motion (005) by defendant St. Charles Hospital for summary judgment is supported by an attorney's affirmation; copies of the summons and complaint, verified answer of St. Charles, supplemental summons and complaint, amended verified complaint, verified answer of St. Charles Hospital to the amended complaint; copies of various medical records; unsigned copies of the transcripts of the examinations before trial of Tamara Ferrara, Anne Salice, Ambra Piccone, R.N.; and the affirmations of Dr. Joel Cooper, M.D. and Terri A. Cavaliere, RNC, MS, NNP.

Dr. Joel Cooper, M.D. sets forth in his affirmation that he is a physician licensed to practice medicine in the State of New York and is board certified in Obstetrics and Gynecology. He sets forth

opinions expressed within a reasonable degree of obstetrical certainty that St. Charles Hospital, by way of its staff, did not depart from good and accepted standards of obstetrical care and treatment of plaintiffs, that all the care and treatment was appropriate, and that none of the allegations made by plaintiffs in their bills of particulars have any merit concerning the care and treatment rendered to plaintiffs by St. Charles Hospital.

Dr. Cooper states St. Charles received Mrs. LaRose at her physician's directive and timely and appropriately carried out all his orders. The staff had no authority to override Dr. Erhart's orders. Mrs. LaRose's staining was due to rupture of tiny blood vessels as the cervix softened and dilated and was not medically significant. St. Charles had no duty to assign another obstetrician to Mrs. LaRose. The staff was in contact with Dr. Erhart and appropriately apprised him of contractions and fetal heart rate.

He further states that nurse Piccone applied a twin external fetal monitor with separate belts to obtain tracings of the fetal heart activity. Although the tracings were not continuous due to the movement of the fetuses, amniotic fluid, and artifacts which appeared on the tracings. He also states nurse Piccone obtained good fetal heart rates of 140 bpm for each fetus, and was able to monitor the individual fetal heartbeats as they flashed on the monitor as US1 and US2, well within standards of good and accepted medical practice.

Dr. Cooper states St. Charles Hospital had no duty to transfer Ms. LaRose to Stony Brook prior to her deliveries, and it would have been more hazardous to risk delivery of premature twins in an ambulance on the roadside. Dr. Cooper further opines St. Charles had no duty to insert an internal monitor in the absence of an order by her attending obstetrician, and because twin B was in a high transverse lie, it would have been impossible to insert an internal monitor. Upon arrival, Dr. Erhart did not see any signs of fetal distress and offered no criticism of the nursing care by nurse Piccone who properly recorded the history and findings, properly evaluated Ms. LaRose, properly reported to her physician, and properly carried out his orders. St. Charles timely set up for a twin delivery either vaginally or by caesarean.

Appropriate surgical nurses and anesthesiologist were present as was a second obstetrician to assist in delivery. St. Charles timely notified the neonatologist, Alan Spitzer, M.D. of the impending births. Dr. Spitzer timely arrived at the hospital within thirty minutes, along with the transport team. A neonatal nurse practitioner and a nurse from the Special Care Nursery were present in the delivery rooms for delivery of both infants who were immediately resuscitated in the delivery room and timely transferred to the Special Care Nursery.

It is Dr. Cooper's opinion that there were no omissions or commissions on the part of nurse Piccone or other staff members at St. Charles which were the proximate cause of any of the alleged injuries to the infant plaintiffs.

Terri A. Cavaliere, licensed to practice in the state of New York as a registered nurse and neonatal nurse practitioner, has submitted an affirmation on behalf of St. Charles Hospital. This purported affirmation subscribed by a nurse does not constitute competent evidence (*see*, CPLR 2106). While certain persons are authorized to make an affirmation without appearing before a notary, nurses are not among them (CPLR 2106; *Doumanis v Conzo*, 265 AD2d 296, 696 NYS2d 201 [2nd Dept

[1999]).

Despite the inadmissibility of the affirmation of Terri A. Cavaliere, it is determined that defendant St. Charles Hospital has demonstrated prima facie entitlement to summary judgment.

Plaintiffs, in opposing these motions, have submitted, *inter alia*, copies of the pleadings; various medical records of plaintiffs; copies of the transcripts of the examinations before trial of Donna LaRose, Ambra Piccone, R.N., Thomas P. Erhart, D.O., Alan Spitzer, M.D., Anne Salice; and the affirmations of their obstetrical and pediatric experts.¹

Plaintiff's obstetrical expert is licensed to practice medicine in New York State and is board certified in obstetrics and gynecology, and opines with a reasonable degree of medical certainty that Thomas P. Erhart, D.O. and the hospital staff at St. Charles Hospital and Rehabilitation Center departed from good and accepted practice in the management of the labor and delivery of both Daniel and William LaRose, and that as a result of these departures, both William and Daniel LaRose suffered permanent brain damage.

Plaintiff's obstetrical expert states that Dr. Erhart, a non-board certified obstetrician, had an obligation to monitor the pregnancy by evaluating Ms. LaRose every three weeks and obtaining a consultation by a perinatologist. Instead, Dr. Erhart saw Ms. LaRose on a monthly basis and never obtained a proper consultation with a perinatologist, departing from good and accepted medical practice as he did not recognize her as a high risk. If he did obtain a consult of Ms. LaRose's contractions in April, 2000, it would have lead to complete bed rest and possible early admission to the hospital to avoid premature labor. This would have avoided hypoxic damage each twin experienced as a result of being born prematurely resulting in brain damage.

Plaintiff's obstetrical expert states Ms. LaRose testified at her deposition that it was at the third visit she began to experience mild contractions in the nature of pressure being pushed down on the babies. On the fourth visit, she apprised Dr. Erhart that her contractions were getting a little deeper, heavier and more frequent and pressure was now becoming constant, remaining the same until May 25, 2000. Disagreeing with Dr. Baker, plaintiff's expert opines that proper standards dictated that once Dr. Erhart was told in April 2000 that her contraction pattern had increased since March, he had an obligation to ensure this mother would not experience pre-term labor.

Again disagreeing with Dr. Baker, plaintiffs' expert opines that once Dr. Erhart was informed by Ms. LaRose on May 26, 2000 that she was experiencing contractions and spotting blood, he should have known this was an ominous sign that she was experiencing premature labor, and because she was carrying twins with a distinct possibility of premature delivery, the standard of care dictated that he instruct her to go to Stony Brook University Medical Center with a level III Nursery equipped to deal with low birth weight infants and critical conditions to avoid further brain damage. This failure was a departure from accepted practice by Dr. Erhart.

¹ The Court has conducted an in-camera inspection of the original unredacted affirmations and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted experts' names. In addition, the Court has returned the unredacted affirmations to plaintiff's attorney.

Plaintiff's obstetrical expert states that Ms. LaRose was not evaluated by any physician or nurse for her first 43 minutes at St. Charles Hospital, and that nurse Piccone testified Dr. Erhart never instructed her to do a vaginal exam, nor did he instruct her to call another obstetrician to evaluate Ms. LaRose. Disagreeing with Dr. Baker, plaintiffs' expert opines that good practice dictated that if another obstetrician evaluated the mother during that 43 minute delay, a sonogram would have been performed revealing the presentation of each twin, followed by a vaginal examination revealing the station and dilation of the cervix, and in considering twin B was in a transverse lie, an immediate C-section would have been ordered avoiding significant injury to the twins.

Plaintiffs' obstetrical expert also disagrees with Dr. Baker's assessment that it was proper standard to administer a tocolytic such as Terbutaline without knowing the dilation of the cervix and the station. Doing so, he opines, without having someone clinically examine her prior to its administration was a departure, and if she were examined it would have been learned that baby B was in a transverse lie requiring immediate C-section.

Plaintiffs' expert further disagrees with Dr. Baker's opinion on the issue of infection as it is well known in the obstetrical field that during labor, the white blood count may go as high as 25,000 physiologically. It is plaintiffs' expert's opinion that there was no infection and that it played no role in the events in question.

Plaintiffs' expert further opines that it was a departure from good practice by Dr. Erhart not to perform an immediate C-section upon finding twin B was in a transverse position, as doing so would have avoided the hypoxic brain damage suffered by twin A and avoided the hypoxic/traumatic brain damage suffered by twin B (Daniel). Attempting an external version of an infant with such a low birth weight put the infant at risk for a prolapsed cord if the membranes ruptured during the attempt and also put the infant at risk for significant trauma in attempting to turn the infant. Twin B (Daniel) suffered significant bruising all over his head and body, which was a significant factor in causing his hypoxic/ischemic brain damage, and which could have been avoided by not attempting external version.

Plaintiff's expert further opines that after this failed attempt at version, Dr. Erhart further departed from accepted standards by attempting a breech delivery instead of immediately performing a stat C-section to avoid further trauma and not as devastating hypoxic/ischemic brain damage. This attempted breech delivery caused further trauma to the infant as demonstrated by his bruising. Plaintiffs' expert further opines that this severe bruising, documented in the neonatal notes at St. Charles and Stony Brook, was a significant factor in causing Daniel's devastating brain damage attributable to the external version, internal podalic version and external version and extraction.

Again disagreeing with Dr. Baker who claims the extensive bruising and trauma suffered by Daniel was due to a constriction ring and/or uterine contraction, plaintiffs' expert states there was no evidence of an obstructed labor and certainly no evidence of Bandl's ring, and it would be medically impossible for even a constriction ring to cause the amount of bruising and trauma this battered infant suffered.

Plaintiffs' expert further opines that the nursing staff of St. Charles Hospital departed from

good practice as it relates to the management of the labor and delivery of Donna LaRose on May 26, 2000. The first fetal monitor strip is at 8:37 p.m. Dr. Erhart presented at the bed side at 9:20 p.m., during which period of time, no physician examined Ms. LaRose. Plaintiffs' expert, disagreeing with defendants' expert Dr. Cooper, opines it was a departure by nurse Piccone not to have another obstetrician examine Ms. LaRose. Good standards dictated that nurse Piccone should have spoken to Dr. Erhart to get permission to have another obstetrician examine her, or have the supervisor call Dr. Erhart to come to the hospital immediately or have another physician examine her. Proper examination would have led to discovery of the transverse lie which would have led to an immediate C-section.

Plaintiffs' expert further opines it was a departure from good practice by St. Charles and nurse Piccone not to do an ultrasound upon admission at 8:37 p.m. to determine the presentation of the fetuses, thus revealing the transverse lie, followed by vaginal examination and immediate C-section. This failure was a significant factor in causing the twins to suffer significant brain damage.

Plaintiff has also submitted the affirmation of their pediatric expert who is licensed to practice medicine in the State of New York and who is board certified in pediatrics with a subspecialty in neonatology. It is plaintiffs' pediatric expert's opinion that Dr. Alan Spitzer and the nursing staff St. Charles Hospital departed from good and accepted practice in the management of immediate neonatal care of both Daniel and William LaRose, and as a result of these departures, both William and Daniel LaRose suffered permanent brain damage.

Plaintiffs' pediatric expert states that nurse Piccone testified Ms. LaRose was having contractions every one to one and a half minutes from 8:37 to 9:00 p.m. on May 26, 2000, and that there was so much artifact and loss of information on the fetal heart rate tracings that she did not know if the tracing in the 90's range was for a twin or for the mother. Looking at the tracings between 120-150, she stated the tracings did not provide sufficient information for fetal heart management. She did not recall if she tried to speak to any doctor prior to the arrival of Dr. Erhart. When Dr. Erhart arrived, it was the first Ms. LaRose was seen by a physician since her arrival to the hospital. Upon examination by Dr. Erhart at 9:20 p.m., she was noted to be fully dilated and at +2 presentation and membranes were intact. She gave a history of mild, irregular contractions with pink staining since 7 p.m. She was then formally admitted to St. Charles in anticipation of delivery. Dr. Erhart indicated the fetal hearts were stable with accelerations times 2, with contractions every three to four minutes. At 9:30 she was transferred to the OR for vaginal delivery, but there is no fetal monitor strip available for Mrs. LaRose following her transfer to the DR/OR. A sonogram was done in the delivery room.

After twin A was born, Dr. Erhart attempted version of twin B to a cephalic position with sonogram but this was unsuccessful. Membranes were ruptured and he attempted a vaginal breech extraction without anesthesia, but encountered a single footling and was unable to bring the second foot down. After the internal podalic version and extraction attempt, Dr. Erhart then decided to do a caesarean delivery stat and noted the fetal heart rate to be 130's by sonogram/external monitor. Dr. Erhart testified that from the time he arrived at the hospital until the C-section, there was no indication of fetal distress of either baby. Daniel was born at 9:57 with the cord around his body. Dr. Erhart testified he did not see any bruising on the baby after it was delivered.

Dr. Spitzer entered a Neonatal Attending Note in the St. Charles record which indicated "... the baby was noted to be gasping at birth and had a heart rate of approximately 80. Apgars were 3 and 7. The baby was noted to be extremely bruised." At his deposition, Dr. Spitzer testified he saw both babies to make an assessment as to who needed the attention the most. Baby B (Daniel) had the very difficult delivery and baby A needed respiratory support to a lesser level than Daniel. Daniel was intubated twice to get a better fit of the endotracheal tube and to provide optimal gas exchange. Anne Salice testified that the documented Oxygen Saturations at 10:10 p.m. and 10:30 p.m. were in the 80's. Plaintiffs' pediatric expert states Daniel remained hypoxic until he was given 20 cc/kg of normal saline at 10:40 p.m. as initial attempts to ventilate could not produce an oxygen saturation level greater than 82-83%. Soon after, Daniel again became hypoxic with oxygen saturation levels in the 70-80% range, however, an additional amount of normal saline was not given until just prior to transfer at 11:20 p.m.

Daniel's physical exam note indicated a "Very bruised infant on a ventilator. Completely non-responsive. HEENT: Fontanel increased in size over the two hours in the nursery and felt full with wide sutures. Extremities: Full ROM, Bruised completely. Neuro: Non-responsive to any stimuli." Plaintiffs' expert stated that Dr. Spitzer testified as to what significance it had for him that he wrote that the fontanel was increasing in size over the two hours in the nursery, and that he responded that the baby was bruised..... "...one of the worries we always have with a premature baby is that they have an intraventricular hemorrhage, and very often one of the early signs of that is a fullness of the fontanel."

It is the opinion of plaintiffs' pediatric expert that Daniel was the product of both a premature and traumatic delivery process and was gasping for air at birth. He was noted by both Dr. Spitzer and the staff at St. Charles to be severely bruised and battered. His oxygen saturation levels of 80-82% revealed he was an hypoxic infant, and when he recovered, his levels dropped again, but it was not until 11:20 p.m. at the time of transfer that a second bolus of saline was administered. He states it is clear that at the time of his delivery, Daniel experienced significant brain injury from his prematurity and the traumatic delivery he experienced as evidenced by his Apgar scores, oxygen saturation levels, his significant anemia and respiratory capacity, all caused by hypoxic/ischemic damage suffered around the time of birth. The significant anemia was caused by the traumatic delivery he experienced at the hands of Dr. Erhart and the staff at St. Charles Hospital due to bruising of his head and body.

Plaintiffs' pediatric expert disagrees with Dr. Davis' argument that evidence of chronic bleeding was the reason for premature labor, and that this position by Dr. Davis is medically unsound because Daniel suffered anemia and "hypovolemia secondary to bruising," as stated by Dr. Spitzer in his note. Dr. Spitzer further testified that "with bruising we know that there is small loss of blood into the skin of the baby. The loss of blood that gives in this purplish discoloration is associated with a reduction of the baby's blood volume. In a premature infant, the blood volume is too low to start and so even that amount of blood loss into the skin can result in what we would term hypovolemia." Plaintiffs' expert concurs with a reasonable degree of medical certainty with this assessment of Dr. Spitzer. Plaintiff's expert opines that Dr. Spitzer and the hospital staff had an obligation to properly monitor Daniel's oxygen saturation levels and ensure they remained normal. By allowing the levels to slip back to the low 80's and then delay in providing proper support, was a grave departure from good practice, further compounding Daniel's hypoxic/ischemic damage and causing further brain damage.

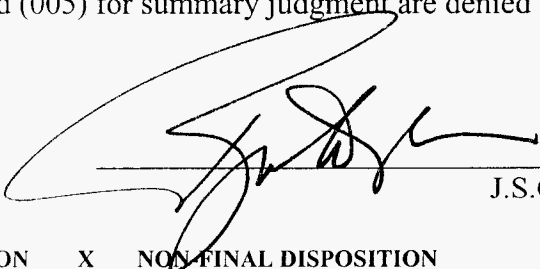
Plaintiffs' expert also disagrees with Dr. Davis and nurse Cavalier that on May 27, 2000 the head ultrasound of Deniel demonstrated PVL. He states that the first head ultrasound of Daniel at Stony Brook on May 27, 2000, demonstrated suspicion for changes of periventricular leukomalacia and demonstrated "increased echogenicity in the periventricular region." He states that both experts for defendants are medically mistaken to argue that reading diagnoses PVL as the diagnosis was never made although a suspicion was raised.

A second ultrasound on May 30, 2000 also documented increase in echogenicity in the periventricular location, but again never diagnosed PVL. The June 8, 2000 ultrasound does diagnose PVL. It is plaintiff's expert's opinion to a reasonable degree of medical certainty that this initial increased density in the periventricular region was edema (swelling) which is secondary to the insults Daniel experienced from prematurity and to the traumatic delivery he experienced. He further opines that it is well known and accepted in the medical community to find this increased density within the first few days of life after experiencing an insult around the time of birth. He further stated that Daniel suffered his insults around the time of birth and immediately following birth, as evidenced by his PVL (brain damage) which evolved within the accepted 1-3 week period.

Based upon the foregoing, it is determined by this court that plaintiffs have raised material, triable issues of fact precluding summary judgment to defendants Dr. Alan Spitzer, Thomas Erhart, D.O. and St. Charles Hospital and Rehabilitation Center. In determining a motion for summary judgment, the court's function is not to resolve issues of fact or to determine matters of credibility but rather to determine whether issues of fact exist precluding summary judgment (*see, Roth v Barreto*, 289 AD2d 557, 735 NYS2d 197 [2001]; *O'Neill v Fishkill*, 134 AD2d 487, 521 NYS2d 272 [1987]).

Accordingly, motions (003), (004) and (005) for summary judgment are denied

Dated: JUL 17 2006



J.S.C.

 FINAL DISPOSITION X NON-FINAL DISPOSITION