

**Golub v Good Samaritan Hosp. Med. Ctr.**

2010 NY Slip Op 31603(U)

June 22, 2010

Supreme Court, Suffolk County

Docket Number: 07-7214

Judge: Patrick A. Sweeney

Republished from New York State Unified Court System's E-Courts Service.  
Search E-Courts (<http://www.nycourts.gov/ecourts>) for any additional information on this case.

This opinion is uncorrected and not selected for official publication.

INDEX No. 07-7214  
CAL. No. 09-01277-MM  
6-22-10

SUPREME COURT - STATE OF NEW YORK  
I.A.S. PART 29 - SUFFOLK COUNTY

PRESENT:

Hon. PATRICK A. SWEENEY  
Justice of the Supreme Court

MOTION DATE 10-29-09  
ADJ. DATE 2-25-10  
Mot. Seq. # 003 - MD  
# 004 - MD

-----X		PEGALIS & ERICKSON, LLC
CATHERINE GOLUB and TIMOTHY GOLUB,	:	Attorneys for Plaintiffs
As Administrators of the Estate of JOHN	:	1 Hollow Lane, Suite 107
TIMOTHY GOLUB, deceased, and CATHERINE	:	Lake Success, New York 11042
GOLUB, individually,	:	
	:	FUMUSO, KELLY, DeVERNA, SNYDER, et al.
Plaintiffs,	:	Attorneys for Defendant Good Samaritan Hospital
	:	110 Marcus Boulevard, Suite 500
- against -	:	Hauppauge, New York 11788
	:	
GOOD SAMARITAN HOSPITAL MEDICAL	:	SHAUB, AHMUTY, CITRIN & SPRATT, LLP
CENTER, SOUTH BAY OB/GYN, P.C.,	:	Attorneys for Defendants South Bay OB/GYN,
PETER ADAM JUDGE, M.D., and MARIA E.	:	Judge & Lockhart
LOCKHART, M.D.,	:	1983 Marcus Avenue
	:	Lake Success, New York 11042-1056
Defendants.	:	
-----X		

Upon the following papers numbered 1 to 87; read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 18; 19 - 41; Notice of Cross Motion and supporting papers; Answering Affidavits and supporting papers 42 - 57; 58 - 60; Replying Affidavits and supporting papers 61 - 72; 73 - 87; Other Memorandum of Law; (and after hearing counsel in support and opposed to the motion) it is,

ORDERED that the motion by defendants South Bay OB/GYN, P.C., s/h/a South Bay OBGYN, P.C., Peter Adam Judge, M.D., and Maria E. Lockhart, M.D. is denied; and it is further

ORDERED that the motion by defendant Good Samaritan Hospital Medical Center is denied.

Defendants South Bay OB/GYN, P.C., s/h/a South Bay OB/GYN, P.C., Peter Adam Judge, M.D., and Maria E. Lockhart, M.D. ("South Bay," "Judge," "Lockhart," and, collectively, "defendants") move for an order dismissing claims asserted by plaintiffs Catherine Golub and Timothy Golub, as administrators of the estate of John Timothy Golub, deceased ("decedent" or "infant" or "baby" and, collectively, "plaintiffs"), and Catherine Golub, individually ("Golub"). Defendants provide copies of the pleadings, copies of deposition transcripts, medical records, a birth certificate, and affidavits by

Golub v Good Samaritan  
Index No. 07-7214  
Page No. 2

Robert Scanlon, M.D. ("Scanlon"), and Warren Rosenfeld, M.D. ("Rosenfeld"). Defendant Good Samaritan Hospital Medical Center ("Good Samaritan") also moves for summary judgment dismissing plaintiffs' complaints and provides copies of the pleadings, copies of deposition transcripts, medical records and copies of affidavits by Scanlon and Rosenfeld. Plaintiffs have submitted an affirmation in opposition and provide physicians' affirmations, copies of the pleadings, and a document titled "Catherine Golub, Brief Summary of Pregnancy and Labor." Plaintiffs also submitted a supplemental affirmation in opposition and a memorandum of law. Defendants have, respectively, replied.

By decision of this court dated December 17, 2007, separate actions brought, respectively, by Catherine Golub and Timothy Golub, as administrators of the estate of John Timothy Golub, deceased, against Good Samaritan Hospital Medical Center, South Bay OB/GYN, P.C., Judge and Lockhart and Catherine Golub, individually, against the same defendants, have been consolidated. By their amended complaint, as to the first cause action, the administrators of the infant's estate assert a claim for conscious pain and suffering and personal injury by the infant leading to his demise against Good Samaritan, South Bay, Judge and Lockhart. The second cause of action alleges a claim for wrongful death against the same defendants by the administrators of the infant's estate. The third cause of action alleges lack of informed consent. The action by Golub, individually, alleges a cause of action against the same defendants for "severe and significant emotional distress, injuries and damages as a result of inappropriate and negligent medical care and treatment rendered to her and her infant at the time of his birth."

The following chronology has been gleaned from the various submissions before the court. Golub gave birth to decedent on June 8, 2005 at Good Samaritan. Decedent died on June 12, 2005 at the Schneider Children's Hospital Division of Long Island Jewish Medical Center. Golub received prenatal care at South Bay where she was seen by Judge. Her first prenatal visit occurred on October 14, 2004 at which time she was given an estimated due date of May 29, 2005. Her weight on her first visit was 134 pounds and her blood pressure was 100/60. She reported a pre-pregnancy weight of 128 pounds. An ultrasound performed that day revealed that the size of the fetus was consistent with the anticipated due date. Subsequent sonograms indicated that the fetus's size was larger than its gestational age. Golub was seen by Judge on visits which occurred on May 12, May 17, May 25, June 1 and June 8, 2005. On Golub's May 12 visit she weighed 190 pounds and was 37 weeks, four days pregnant. A medical assistant noted edema of the hands and feet. On June 1, at 40 weeks, three days, Golub weighed 195 pounds and analysis of her urine revealed trace protein. An ultrasound showed fetal well being and a non-stress test was reactive. During the course of her pregnancy Golub noted spotting of her vision which she reported to Judge. She also complained, on June 6, of shivering and called the office to report the symptom but felt better later in the day. Golub was advised by the receptionist to call back if she felt unwell. On the evening of June 7, Golub felt less movement than usual. She later detected fetal movement and felt that her stomach was hard and tight at about 7:00 p.m. Golub felt cramping when she awoke the following morning and when she got out of bed between 8:00 a.m. and 8:30 a.m. she noted vaginal bleeding. She then called South Bay and went to the office at about 9:00 a.m. At that time Golub was examined by Judge and placed on a fetal monitor. She was found to be experiencing contractions and presented with a bloody show. She was further found to be one to two centimeters dilated and urine analysis revealed protein. Golub was determined to be 41 weeks and three days pregnant. She was directed to go to Good Samaritan Hospital. Upon arrival at the hospital, Golub was

Golub v Good Samaritan

Index No. 07-7214

Page No. 3

examined by nurse Nancy Cecere ("Cecere") and was placed on a fetal monitor at 11:20 a.m. She was moved to a labor room at 11:53 a.m. During that time Golub was experiencing contractions every two to three minutes. The infant's heart rate was ranged between the 140s and 150s. Golub's pulse was 85 and her blood pressure was 136/84. At 1:00 p.m. Lockhart examined Golub and found her blood pressure to be 140/90 with contractions every two to three minutes lasting between 60 and 90 seconds. The fetal heartbeat was in the 130s and Golub was three centimeters dilated. According to Lockhart's plan of care, Golub was to receive an epidural followed by a rupture of her membranes and the application of an internal fetal monitor. Lockhart next saw Golub at 2:00 p.m. at which point the fetal heart rate decreased to 60 beats. Upon rupture of the membranes, thick meconium was observed and an emergency C-section was directed. Golub was taken to the operating room at 2:05 p.m. and the baby was delivered at 2:15 p.m. Neonatologist Branda Shrivasta ("Shrivasta") M.D. from Good Samaritan was present at delivery. The infant was born severely depressed. He had an Apgar score of zero for the first 10 minutes of life. His heart rate was not palpable initially. A heart rate was detected at 2:30 p.m. At 15 minutes after delivery, the Apgar score was three. The infant was transferred to the neonatal intensive care unit and was determined to be severely anemic and hypotensive. He was treated with transfusions and Dopamine. He was diagnosed with meconium aspiration, severe acidosis, hypotension and severe perinatal depression. The infant was thereafter transferred to Schneider Children's Hospital where he was diagnosed with meconium aspiration syndrome, metabolic acidosis, persistent pulmonary hypertension, seizure activity, hypoxic ischemic encephalopathy and anemia. The baby's condition did not improve and on June 12, 2005 treatment was withdrawn and he was pronounced dead at 4:00 p.m.

Plaintiffs and defendants have submitted expert reports. Those respective analyses follow.

By his report, on behalf of defendants, Scanlon, upon review of the medical records from South Bay, Good Samaritan, the various deposition transcripts, and the pleadings, rendered an opinion based upon his education, training and experience, within a reasonable degree of medical certainty, that the care rendered to Golub and her infant son was within the standard of care. Specifically, Scanlon found that Golub's prenatal course was benign through the June 1 office visit. He found, according to the records, that at that time there were no signs of labor. Golub's cervix was fingertip dilated. Scanlon did note the urinalysis finding of trace protein. He also noted that on that visit an ultrasound revealed the estimated fetal weight to be 9 pounds, 5 ounces. A biophysical profile resulted in an 8/8 score. Scanlon noted that a non-stress test was determined to be reactive. Golub was directed to return for an office visit in one week. According to Scanlon, when seen by Judge on June 8, Golub indicated she felt decreased fetal movement the evening before. Scanlon noted that Golub "did not call the doctors' office, their service, or go to the hospital." He also noted that Golub experienced a "bloody show" on June 8. Upon the visit, Golub was observed to be between one and two centimeters dilated and "a fetal heart was heard." Decreased fetal movement was detected and a fetal heart monitoring strip showed "decreased beat-to-beat variability. [Plaintiff's] blood pressure was 140/80 and she had 1+ protein in her urine." She was then advised to go to the hospital. Scanlon opined that it was appropriate and within the standard of care for Judge to send Golub to the hospital "for further fetal surveillance." Scanlon noted that Lockhart was covering for South Bay on June 8 and was advised by Judge of the findings of his examination. Scanlon noted that Judge had no further contact with Golub on that day. After admission, Golub was seen by Lockhart. According to Scanlon, Lockhart's plan of treatment was an epidural, an artificial rupture of membranes and fetal surveillance. Lockhart's notes indicated that

Golub v Good Samaritan

Index No. 07-7214

Page No. 4

“plaintiff presented complaining of no fetal movement since 7:00 p.m. on June 7, 2005 with questionable rupture of membranes and vaginal bleeding.” Lockhart made other notations concerning the status of the fetus and Golub. Scanlon opined, based upon the medical records, that the care and treatment rendered to Golub by Lockhart and the staff at Good Samaritan was within the standard of care. Further, Scanlon stated that “[i]t is also my opinion within a reasonable degree of medical certainty that although the tracing was not reactive, it did not require an emergent cesarean section at the time Dr. Lockhart examined the plaintiff. It was appropriate for Dr. Lockhart to conduct fetal surveillance and allow the plaintiff to labor.” Scanlon opined that Lockhart’s plan to review the fetal heart monitor tracing after placement of the epidural was appropriate. Scanlon also opined, within a reasonable degree of medical certainty, that “there did not appear to be fetal distress at the time the tracing was reviewed at 1:00 p.m., even though the tracing was non-reactive.” According to the records, plaintiff arose to go to the restroom at 1:49 p.m. and, at 2:00 p.m., Lockhart was advised by a nurse that “there had been a prolonged deceleration. The records note that the fetal heart rate went down to 60.” A sonogram was requested to confirm the deceleration and upon its completion Lockhart called for an emergent cesarean section. A neonatologist from Good Samaritan was present for the delivery at 2:15 p.m. Scanlon noted “that the baby’s hematocrit came back at 20, which is very low. A Kleihauer-Betke stain revealed that there was a significant amount of fetal blood in the mother.” Scanlon opined, “within a reasonable degree of medical certainty, that the infant herein suffered a fetomaternal hemorrhage.” He also opined “within a reasonable degree of medical certainty that the most common etiologies of this type of hemorrhage were not present, including placental abruption, abnormal placenta, uterine rupture, advanced maternal age, severe hypertension or elicit [sic] drug use.” Scanlon concluded by opining “that there was no way to predict or prevent the fetomaternal hemorrhage and that none of the injuries or subsequent death of the infant was caused by any departure from good and accepted medical practice” on the part of defendants.

Rosenfeld also provided an affidavit on behalf of defendants. He is board certified in pediatrics and neonatal perinatal medicine. He too reviewed the records from South Bay, Good Samaritan and Long Island Jewish Children’s Hospital, as well as the pleadings, affidavits and transcripts of various deposition testimony. Based on that review, Rosenfeld opined that the standard of care rendered to Golub and her child were within the standard of care. In part, Rosenfeld’s affidavit mirrors Scanlon’s. Rosenfeld, however, also notes the following: “it is important to note that the infant was not ‘stillborn’ or dead at the time of birth. A fetal death means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. In this case, the fetus had a heart beat while in utero during the plaintiff’s labor and also after birth, although not immediately palpable. It is my opinion within a reasonable degree of medical certainty that the fetomaternal hemorrhage occurred at least 12 hours before the plaintiff presented to the office on June 8, 2005 and 16-18 hours before birth causing a significant brain injury and other organ damage, resulting in the fetus to be born in a severely depressed state. Significantly, no death certificate was issued by Good Samaritan Hospital Medical Center and the infant was, in fact, taken to the neo-natal intensive care unit at Good Samaritan Hospital Medical Center and later transferred to Long Island Jewish Medical Center for a brain cooling study.” Rosenfeld opined that the bleeding experienced by Golub was the result of a fetomaternal hemorrhage which occurred more than 12 hours before she presented to South Bay on June 8. He further opined that “the severity of

Golub v Good Samaritan  
Index No. 07-7214  
Page No. 5

the fetomaternal hemorrhage prevented the infant from sustaining any conscious pain or suffering from the time of his birth until his death on June 12, 2005.” Finally, Rosenfeld concluded, “within a reasonable degree of medical certainty that there was no way to predict or prevent the fetomaternal hemorrhage and that none of the injuries or subsequent death of the infant was caused by any departure from good and accepted medical practice.”

Defendants, by their respective motions, argue, among other things, that pursuant to *Sheppard-Mobley v King*, 4 NY3d 627 (2005) a patient cannot recover damages in medical malpractice actions for emotional harm based upon an infant’s physical injury, where the infant was allegedly injured in utero, but carried to term and born alive. Inasmuch as the infant here was issued a birth certificate, defendants claim, any assertion that Golub is entitled to damages must be dismissed because she was not injured and, therefore, any claim of malpractice belongs solely to the infant. It is also claimed that any assertion that the infant could not withstand labor based upon the information available to her doctor at the time she visited his office on June 8 is based upon a retrospective view of events and, therefore, conclusory and insufficient to raise an issue of fact. It is contended that the actions taken by Judge in examining Golub and sending her to labor and delivery for further fetal surveillance were appropriate. It is also contended that Lockhart’s efforts to formulate a plan to have Golub receive an epidural and thereafter undergo rupture of her membranes was also appropriate. It is argued that, as Scanlon affirmed, a non-reactive tracing does not require an emergency cesarean section and that Lockhart’s plan to determine that method of delivery based upon the progress of delivery fell within the standard of care. Upon observing a significant decrease in fetal heart rate, according to defendants, Lockhart appropriately determined an emergent cesarean was necessary. It is contended that the efforts undertaken to revive the infant were within the standard of care and were not the proximate cause of the infant’s injuries.

Defendant Good Samaritan, by its motion, also relies upon affidavits by Rosenfeld and Scanlon. It contends that the actions by Cecere and Lockhart were appropriate and within the standard of care. Good Samaritan also points to *Cook v Reisner*, 295 AD2d 466 (2002) in support of its position that it cannot be held liable when its employees followed the direction of the private attending physician. Good Samaritan also asks, if this court determines that denial of summary judgment is warranted, there should nonetheless be a dismissal of Golub’s claims for emotional damage as a matter of law also citing *Sheppard-Mobley v King*, supra.

Plaintiffs have submitted an affidavit by a physician with board certification in obstetrics and gynecology. The physician reviewed the court documents and defendants’ physicians’ affidavits as well as a chronology of events penned by Golub. Based upon his review, the physician opined that “all of the defendants herein departed from accepted standards of care, and that these departures from accepted standards of care were direct contributing causes of the decedent’s severe perinatal depression, massive hemorrhage and ultimately his death.” He found that Judge departed from the standard of obstetrical care “in failing to closely monitor this pregnancy when Mrs. Golub reached term.” He opined that “the degree of error associated with ultrasounds performed at [40 weeks gestation] and the weight could be off as much as 10%. The abdominal circumference was consistent with a macrosomic fetus. Urine revealed trace protein. While Mrs. Golub was not yet hypertensive, she had experienced some elevation in her blood pressure from her original baseline of 100/60, and considering this with the trace protein, in

Golub v Good Samaritan

Index No. 07-7214

Page No. 6

a post-date patient, accepted standards of care required that she be seen on a twice weekly basis.” He also found that Judge should have evaluated Golub for a possible induction on June 1. The physician opined that on that date a full assessment was required and that the lack of documentation from that date indicates that such assessment was not performed. He found that given the fact that she was post-term, with a “very large fetus, and had excessive edema, rising blood pressure, and trace protein in her urine, Mrs. Golub may have been inducible on that date, and if she was, induction and delivery was indicated. If she was not inducible on that day, accepted standards of care required that she be evaluated for possible induction within several days. At the very least, the mother and fetus needed to be evaluated for well being within several days.” A further departure was found when on June 8, an immediate cesarean section was not ordered based upon significant complaints, a lack of fetal movement with vaginal bleeding and more than 41 weeks gestation. The lack of fetal movement, according to the physician, “suggests that the fetus was experiencing some distress.” Further, according to the physician, the tracing obtained in the office was nonreactive and revealed very little variability. He opined that Judge should have known that, given the large size of the fetus and the lack of significant dilation, “delivery without intervention would not occur shortly” and that “[t]here was no reassurance that the baby could withstand delivery.” According to the physician “the only acceptable, reasonable and safe plan of care was delivery by Cesarean section that morning.” The physician disagreed with the affidavit by Rosenfeld “as to the timing of the hemorrhage in this infant. I absolutely disagree that this infant had already sustained a massive hemorrhage the night before the delivery date when the mother reported decreased fetal movement. If the baby had already lost a massive amount of blood as the defense experts have opined, the fetus’ heart rate would have been much different on the morning of June 8, 2005. The fetal heart rate pattern would have been sinusoidal and/or severely bradycardic by the time Dr. Judge saw Mrs. Golub. If the fetus had already suffered a massive hemorrhage on the night of June 7, 2005, the fetus would not have been able to compensate for such a long period of time, and would have died, or been close to death at the time of the visit to Dr. Judge, the blood loss was slow and was not significant enough to have caused the fetus to use up its fetal reserves. The fetal heart rate at that time was still within normal range and revealed a fetus that was not yet significantly compromised. As blood loss continues, it can be expected that the fetus will use up its glycogen stores and if the hemorrhage becomes massive then hypovolemic hypoxic ischemia to the fetal brain will occur. The tracing obtained at the office was consistent with a fetus which is still compensating; it was not consistent with a fetus who had suffered a hypovolemic hypoxic ischemia.” The physician further opined that Judge departed from the standard of care in not communicating to Lockhart “the true status of both the mother and the infant. Dr. Judge should have informed Dr. Lockhart of the fetal baseline, nonreassuring fetal heart rate tracing and signs of preeclampsia in the mother which were apparent that morning.” The physician opined that Lockhart departed from the standard of care “in failing to timely assess this patient.” Specifically, the physician stated that Lockhart “knew that there was a nonreactive tracing and there were signs of preeclampsia. These two conditions in a postdate pregnancy with a macrosomic fetus, required, at the very least, immediate assessment of maternal and fetal status to see if delivery by Cesarean section was required.” The physician also opined that Lockhart departed from the standard of care by failing to see Golub, who was known to have had a nonreactive tracing at 41 weeks, three days gestation and, assuming she had not been made aware of the tracing, should have reviewed the tracing or preeclampsia prior to 1:00 p.m. He further opined that Lockhart departed from the standard of care by failing to order an immediate cesarean section and that “it was unacceptable” to leave Golub unattended without checking her status.

Golub v Good Samaritan

Index No. 07-7214

Page No. 7

It would have been "at the very least" appropriate to have ruptured the membranes at that time which would "have revealed thick meconium and would also have allowed better assessment of the fetal heart tracing via internal monitoring." Such monitoring, according to the physician, would "have confirmed the non-reassuring fetal status and the need for immediate delivery."

The physician also opined that Cecere departed from the standard of care "in failing to detect and report the decreasing heart rate and failing to notify an attending physician of same between 1:00 - 1:50 p.m." Such decrease, according to the physician, "was indicative of decreased perfusion to the fetus" and would be expected to "progress and become more severe and result in compromise to the fetus which is in fact what happened in this case." According to the physician, a further departure by Cecere occurred in permitting Golub to go to the bathroom at 1:50 p.m. In sum, plaintiffs' expert affirmed that all defendants departed from the standard of care.

Plaintiffs also submitted an affirmation by a physician with board certification in pediatrics and with a subcertification in perinatal/neonatal medicine. The physician, upon review of the record, defendants' experts' affidavits and the deposition transcripts of the various parties, opined with a reasonable degree of medical certainty that "defendants' failure to timely deliver the now deceased infant [caused] massive perinatal fetal blood loss, hypoxia and anoxia, severe anemia, and resulting significant insult to the brain, severe metabolic acidosis, meconium aspiration syndrome, hypoxic ischemic encephalopathy, seizures, persistent pulmonary hypertension, and death." She also opined that "[t]here were also departures in the newborn care rendered to [decedent] at Good Samaritan Hospital." It was the opinion of the physician that the failure to timely deliver the infant "greatly diminished" his chances for survival and "significantly increased the degree of hypoxemia and acidosis which the infant suffered." She further opined that the baby "suffered a massive blood loss within hours prior to delivery." In addition, the physician opined that the "onset of labor with the resulting tetanic contractions superimposed further stress on the fetus as there was less oxygen getting to the fetus. The diminishment in volume and oxygen getting to the fetus over the several hours prior to birth had a cumulative effect on the fetus and greatly increased the damage to the fetus." The physician disagreed with defendants' experts, stating that "the baby could not have had a massive hemorrhage prior to Mrs. Golub arriving at the office of the obstetrician on the morning of June 8, 2005. The fetal tracing, while it was not reactive, was not consistent with the fetus losing half of its blood." She also disagreed with Rosenfeld as to the timing of the hemorrhage. The physician also articulated the manner in which, in her opinion, the hospital staff departed from the standard of care in the resuscitation of the infant. Specifically that the "[a]ccepted standards of care required that prior to the placement of the endotracheal tube, that the neonatologist first use a laryngoscope to visualize the cords and also suction any meconium from the trachea." She further opined that the "placement of a 3.0 endotracheal tube constituted a departure from accepted standards of care," because a tube of that size "allowed air to escape, resulting in less oxygen to the lungs." She also opined that "once the fetus was resuscitated, he was conscious and endured pain and suffering." In support, the physician pointed to the records of the hospitals which she opined "reveal that the baby was responsive to pain." She further noted that the "infant underwent numerous procedures which cause pain, such as reintubation and bladder catheterization."

Golub v Good Samaritan

Index No. 07-7214

Page No. 8

Plaintiffs have also submitted a “supplemental affirmation in opposition” which directs the court to *Amin v Soliman*, 67 AD3d 835 (2009), where the Appellate Division, Second Department found that “a triable issue of fact existed as to whether the fetus was stillborn, where there was no respiratory response upon delivery and the fetus’ Apgar scores were zero at 1, 5 and 10 minutes. The fetus was dependent on a ventilator for the following three weeks and the fetus was declared deceased within 10 minutes of having been removed from the ventilator.” The plaintiffs assert that they have pled in the alternative and only seek to recover for the emotional distress of the mother if the jury finds that the infant had no conscious pain and suffering.

Defendants, by their respective replies, point to the “universally adopted definition within the medical community” of a “live birth” to support the position that the infant was not stillborn or dead at birth. They reiterate Rosenfeld’s position that a fetomaternal hemorrhage was experienced by the infant “at least 12 hours before” Golub went to see Judge on June 8, and that such hemorrhage caused significant brain injury and organ damage. It is also noted that no death certificate was issued by Good Samaritan. Defendants contend that plaintiff’s expert in neonatology did not comment on whether the infant was stillborn and opined, instead, on the conscious pain and suffering experienced by the infant prior to his death. It is noted that the signs of life exhibited by the infant comported with the criteria established by the World Health Organization’s definition of a “live birth.” According to defendants’ submissions, a live birth is defined as “[t]he complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such birth is considered a live birth.” Defendants also argue that it would be “extremely prejudicial” to permit plaintiffs to pursue the “completely inconsistent” claims that the infant was stillborn, potentially permitting Golub to recover, or born alive, potentially permitting the infant’s estate to recover.

“The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damage” (*Ramsay v Good Samaritan Hosp.*, 24 AD3d 645, 646 [2005]). “In a medical malpractice action, the party moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether defendant physician [and/or hospital] were negligent” (*Taylor v Nyack Hospital*, 18 AD3d 537 [2005]). Thus, a moving defendant doctor or hospital has “the initial burden of establishing the absence of any departure from good and accepted medical malpractice or that the plaintiff was injured thereby” (*Chance v Felder*, 33 AD3d 645 [2006], quoting *Williams v Sahay*, 12 AD3d 366, 368 [2004]). Generally, a hospital is protected from tort liability if its staff follows the orders of the patient’s private physician unless the staff knows that the doctor’s orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders (see *Cook v Reisner*, 295 AD2d 466 [2002]).

Here the parties have submitted conflicting opinions by medical experts as to whether malpractice occurred, thus precluding summary determination (see *Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623 [2003]). In those instances in which experts offer such conflicting opinions, a question

Golub v Good Samaritan  
Index No. 07-7214  
Page No. 9

as to the issue of credibility arises requiring resolution by the finder of fact (*see Halkias v Otolaryngology-Facial Plastic Surgery Assoc.*, 282 AD2d 650 [2001]). In addition, the experts offer conflicting opinions regarding the viability of the fetus. While Dr. Rosenfeld concluded that the infant was not stillborn, the plaintiffs' neonatologist opined that the infant was born with no signs of life and was initially dead but was resuscitated. Therefore, issues of fact exist with respect to the viability of the fetus and the appropriate damages, if any, recoverable by the plaintiffs (*see Amin v Soliman*, 67 AD3d 835 [2009]).

Accordingly, the respective motions by the defendants for summary judgment are denied.

Dated: 6-22-10

  
\_\_\_\_\_  
J.S.C.

       FINAL DISPOSITION      X   NON-FINAL DISPOSITION