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SHORT FORM ORDER

INDEX No. 07-21148

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 10 - SUFFOLK COUNTY

PRESENT:

Hon. JOHN J.J. JONES, JR.
Justice of the Supreme Court

MOTION DATE 3-5-10
ADJ. DATE 4-28-10
Mot. Seq. # 013 - MD

JOHN T. SIMMONDS, Individually and as Executor of the Estate of FORREST DEE BAKER, III, deceased, and JOHN T. SIMMONDS, Individually and on Behalf of the Next of Kin of FORREST DEE BAKER, III, deceased, Plaintiff, - against - PETER GLASS, STEPHEN PROBST, XIAO JUN GUO, DARYN MOLLER, ROBERT BUBER, ALLISON CREPEAU and SALIM ARMANI, Defendants.	WIDLITZ & STERN, P.C. Attorneys for Plaintiff 700 New York Avenue Huntington, New York 11743 HARRIS BEACH PLLC Attorneys for Defendants Glass & Guo 100 Wall Street New York, New York 10005 ANDREW M. CUOMO, ESQ., Attorney General By: Marcie Glass, Esq. Attorney for Defendants Probst, Buber, Crepeau & Armani 120 Broadway New York, New York 10271

Upon the following papers numbered 1 to 33 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (013) 1 - 22 ; Notice of Cross-Motion and supporting papers ; Answering Affidavits and supporting papers 23-28 ; Replying Affidavits and supporting papers 29-32 ; Other 34: Deft.'s Mem/Law; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion (013) by the defendant, Xiao Jun Guo, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied.

This is an action sounding in medical malpractice in which it is claimed that the death of the plaintiff's decedent, Forrest Dee Baker, III, was caused by the negligence of the defendants. The decedent died on July 2, 2006. On August 4, 2006, John T. Simmonds was duty appointed Executor of the Estate of Forrest Dee Baker, III, by the Register of Wills of Alleghany County, Pennsylvania. It is claimed that prior to June 27, 2006 until his death, the decedent was a patient of the defendants. The verified bill of particulars sets forth that the defendant Xiao Jun Guo, M.D. (Dr. Guo) rendered care and treatment and administered anesthesia during a surgical procedure to the plaintiff's decedent during his admission to Stony Brook University Hospital. It is claimed that during the administration of anesthesia the decedent aspirated stomach contents due to, inter alia, the defendant Dr. Guo's negligent use of a laryngeal mask airway, the failure to prevent aspiration of stomach contents, the failure to properly evaluate the decedent's medical history, and the failure to timely and appropriately perform endotracheal intubation for the administration of anesthesia.

Dr. Guo now seeks summary judgment dismissing the complaint as asserted against him on the basis that he did not make the decision to use the laryngeal mask airway, that he did not begin his shift until two and a half hours after commencement of general anesthesia and that he comported with all accepted standards of medical and anesthesia care at all times.

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]).

In support of this application, the moving defendant Dr. Guo has submitted, inter alia, an attorney's affirmation; the affidavit of defendant's out-of-state expert David Z. Ferson, M.D.; the Stony Brook University Hospital medical record; copies of the transcripts of the examinations before trial of Salim Amran, M.D., Allison Crepeau, Stephen Probst, Daryn Moller and Xiao Jun Guo; and copies of the complaint, amended complaint, bill of particulars, further bill of particulars as to defendant Guo, and answers of defendants Guo, Probst and Glass. The plaintiff opposes this application with, inter alia, the submission of an attorney's affirmation; the affirmation of the plaintiff's medical expert; and a copy of the report of autopsy.

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,* ***Derdiarian 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]).

Dr. Guo testified to the effect that he became board certified in anesthesiology in 2002 and started working at Stony Brook University Hospital anesthesia department in 2000. Forrest Dee Baker came under his care and treatment on June 27, 2006 when he received the room assignment for giving anesthesia to Mr. Baker

at 4:30 p.m. Surgery was in progress and he had conversation with Dr. Glass, the anesthesiologist who administered anesthesia to Mr. Baker at the commencement of surgery, and was advised by him that Mr. Baker was in a motor vehicle accident and was otherwise a healthy patient undergoing orthopedic surgery and that there was a nerve block and laryngeal mask anesthesia (LMA). He thought Dr. Glass also told him that Mr. Baker had a rib fracture, pneumothorax (collapsed lung), and maybe other things. He did not remember if Dr. Glass told him Mr. Baker had an abdominal trauma, and had a suspected lacerated spleen and suspected lacerated liver, that he was constipated and had abdominal pain the previous evening and had a partial bowel obstruction prior to being brought to the operating room. He then testified that he was unaware that Mr. Baker sustained those injuries. He assumed Mr. Baker's care as the attending anesthesiologist to provide anesthesia care to Mr. Baker, including monitoring Mr. Baker's general well-being and vital signs when Dr. Glass left. He supervised Dr. Probst, the anesthesiology resident administering anesthesia to Mr. Baker. He spoke to him about the patient and looked at the routine anesthesia record, looked at the monitor and the patient. He testified that the first page of the June 27, 2006 anesthesia record set forth ASA (Anesthesia Society of America) Category III indicating a moderate to severe medical condition, post motor vehicle accident, spleen laceration, rib fracture, fracture right humerus.

Dr. Guo testified that he did not feel it was important for him to know that Mr. Baker had two doses of magnesium citrate between 7 p.m. the previous evening prior to the commencement of the surgery and did not learn of the same until after this lawsuit was commenced. He did not have an opinion concerning whether the magnesium citrate contributed to the regurgitation and did not know if it could cause regurgitation of gastric contents during surgery if administered within a close enough time period. He did not discuss any of the foregoing with Dr. Probst and left the operating room after five or ten minutes with the patient as he had other responsibilities. He was in and out of the operating room every ten to fifteen minutes. He thought the use of the LMA was appropriate as the patient was doing well at the time. However, at 6:10 p.m., Mr. Baker began to regurgitate, and as he walked into the room, observed Dr. Probst suctioning dark coffee-like fluid. He ascribed no significance to the color of the fluid being regurgitated. He told Dr. Probst to help him as they had to do an emergency intubation of Mr. Baker and continue to suction the stomach contents. He did not know if Mr. Baker aspirated any of the stomach contents. They stopped surgery and Dr. Olezak, an anesthesiologist who responded to the emergency intubation, performed a bronchoscopy and found no "gross aspiration." Mr. Baker was placed on a ventilator, but he did not check to see if Mr. Baker could breathe on his own without assistive ventilation. He thought he saw Mr. Baker in the recovery room until 7:00 a.m. the following day when his shift was finished, but he did not write any notes. He did not at any time see Mr. Baker thereafter. A couple days later he was told by hospital administration that Mr. Baker expired. He did not take any steps to determine the cause of death. He had no opinion concerning whether the reguritation and its consequences contributed to causing Mr. Baker's death. He testified that a pre-induction note by Dr. Glass was not available to him when he went to write his anesthesia attestation statement. Dr. Guo testified that it is a risk of surgery that any patient coming to the operating room may aspirate or regurgitate.

Stephen Probst testified to the effect that in June 2006 he was a first year anesthesia resident (PGY-2) as a clinical anesthesiologist year one (CA-1). On June 26, 2006, he was scheduled to provide the anesthetic care for Mr. Baker with his attending and saw Mr. Baker for a preoperative anesthesia assessment. He did not recall what sections of the medical record he reviewed prior to seeing Mr. Baker. He completed a pre-anesthesia assessment form indicating Mr. Baker was a twenty-five year old male, who was to have surgery on June 27, 2006 for an open reduction/internal fixation of the fracture of the humerus by the surgeon Dr. Devarus. He noted the past medical history, including that Mr. Baker had been involved in a motor cycle accident with "splenic black", pulmonary contusion, left humerus fracture, rib fracture x3, and left tibial plateau fracture. He noted laboratory values. The hematocrit was low possibly due to blood loss during trauma or fluid resuscitation.

He noted that general anesthesia was administered to Mr. Baker without complications on June 25, 2006 for external fixation of the right knee. He noted the vital signs and did an visual observation of Mr. Baker's oral cavity and anticipated he could be intubated without difficulty. He spoke to Dr. Glass about Mr. Baker and they discussed his management but he did not remember the specifics. A LMA was discussed and he did not remember if they discussed that Mr. Baker had been intubated for the surgery of June 25, 2006. He wrote in the chart about Mr. Baker being suspected of having a lacerated spleen or liver stated these conditions would not directly increase regurgitation but could lead to ileus with associated abdominal trauma which could lead to increased risks for regurgitation. Dr. Probst testified that an ileus would influence or change his prospective anesthetic care as it would put a patient at risk for regurgitation and he would have elected to use a more secure airway such as a cuff endotracheal tube to prevent regurgitant contents from traveling into the lungs as the cuff endotracheal tube helps seal the trachea from gastric aspiration. A distended abdomen or absence of bowel sounds would constitute an ileus. He did not recall checking Mr. Baker's bowel signs the evening of the 26th but it is not his custom and practice to do so. He did not recall if Mr. Baker had abdominal complaints subsequent to his seeing him on the 26th. If a patient complained of abdominal discomfort the evening before surgery, in and of itself, it would not have had any significance to him with regard to his proposed course of treatment, including if the stomach were slightly distended. The absence of bowel signs would add to the entire clinical picture and it could be a sign of ileus. No BM indicated there was no bowel movement. An abdominal x-ray was ordered and magnesium citrate was prescribed. If the note was addressed by a surgical note, accepted standards of good medical practice did not require that he be aware of the contents of that note before inducing anesthesia. There was a trauma note on June 27th at 5:20 a.m. taking precedence over the nurses' note. He did not recall becoming aware of the result of an abdominal x-ray taken prior to the induction of anesthesia and did not know if he had been aware of there being residual contrast in the colon from three days prior, and if it was a finding of significance. He stated he had no obligation to bring Dr. Glass's attention to that note as the attendings read all the paperwork themselves. He stated that there is no note from a surgical attending as to any ileus or findings of that nature, but with regard to the note containing diffuse ileus and retained contrast, he testified that he had an obligation or responsibility to bring it to the attention of Dr. Glass before the induction of anesthesia. On the day of surgery, he spoke with Dr. Glass about Mr. Baker in the holding area of the operating room at which time LMA was discussed. He did not remember the specifics but something about avoiding positive pressure and allowing the patient to breathe on his own. He did not believe there were any contraindications to LMA at that time. Endotracheal intubation was not contraindicated either.

Daryn Moller testified to the effect that he is licensed to practice medicine and surgery in New York State and completed his anesthesiology residency in 2001 and is board certified in anesthesiology with a certificate in transesophageal echocardiography. He was involved in Mr. Baker's care on June 25, 2006 as the attending anesthesiologist during surgery along with a resident, Dr. Bustos. Mr. Baker had mucous and it was decided to perform an endotracheal intubation as a pulmonary toileting issue. LMA was not a useful option in order to provide pulmonary toileting, so it was not considered. When Mr. Baker was intubated, there was continuous suctioning. He was not sure if Mr. Baker aspirated any of the gastric contents. Prior to administering anesthesia, he reviewed the history and physical sheet, the trauma service note, and discussed with Dr. Bustos his review of the chart. On June 27, 2006, he did walk into the operating room in the early evening when Mr. Baker was there. Although he was not assigned to the case, he heard there was an event which occurred. Dr. Probst was present when he entered the operating room and remained for approximately ten minutes. Mr. Baker had been intubated prior to his arrival. Dr. Probst told him that the patient required intubation as there was vomitus or gastric contents. There was discussion concerning whether the patient was stable or whether any help was needed. Dr. Guo entered the room about five minutes after he arrived.

David Z. Ferson, M.D., Dr. Guo's expert, sets forth in his affidavit that he is licensed to practice

medicine in the State of Texas and is certified in anesthesiology by the American board of Anesthesiology. It is his opinion within a reasonable degree of medical and anesthesia certainty that Dr. Guo comported with the accepted standards of anesthesiology practice. He states that the decedent underwent orthopedic surgery consisting of an open reduction internal fixation of the right humerus on June 27, 2006 at Stony Brook University Hospital. Dr. Peter Glass, M.D. commenced anesthesia at approximately 2:01 p.m.. The case continued for approximately two and one half hours without incident or complication and at 4:30 p.m., anesthesia care of the decedent passed from Dr. Glass to Dr. Guo, the on-call attending anesthesiologist for the night shift. This was Dr. Guo's first involvement in the decedent's care. He was involved in a brief conversation with Dr. Glass who informed him the decedent was undergoing orthopedic surgeries for injuries sustained in a motor vehicle accident, that a nerve block had been administered and that anesthesia had been commenced by way of a laryngeal mask airway (LMA). He opines that Dr. Guo was not required to change the method by which anesthesia was delivered to another mode of anesthesia administration. He further opines that Dr. Guo properly monitored the decedent by regularly returning to the operating room to check on the decedent's status during surgery and appropriately supervised the anesthesia resident, Dr. Probst. After the decedent regurgitated gastric contents, Dr. Guo's actions comported with accepted standards of anesthesiology practice; he thereafter properly intubated the decedent and aided the resident in ongoing suctioning; and Dr. Guo did not contribute to the alleged injuries and subsequent death of Mr. Baker.

In reviewing the defendant's evidentiary submissions, it is determined that Dr. Guo has not demonstrated *prima facie entitlement* to summary judgment dismissing the complaint as asserted against him. It is determined that Dr. Ferson's opinions are conclusory and unsupported as he does not set forth the proper standards of care or the basis for his opinions with regard to Dr. Guo's review of the decedent's medical history prior to taking charge of the anesthesiology care of the decedent, that Dr. Guo obtained all the information necessary for him to assume care of the decedent, and that he was not required to change the method by which anesthesia was administered. In addition to Dr. Ferson's opinions being conclusory and unsupported, defendant's submissions raise factual issues precluding a demonstration of prima facie entitlement to summary judgment.

Dr. Guo testified he did not remember reviewing any portion of the hospital record other than the anesthesia record. Dr. Probst testified a chart review would have been done by him to see if there were any medical circumstances which had arisen from the time he last saw Mr. Baker the day before. Good medical practice required that he review the progress notes created between the time he saw the patient the evening before and the time just before anesthesia was to be administered. It would have been a departure from accepted standards of good medical practice at the time, barring an emergency situation, not to check the progress notes. It is Dr. Ferson's opinion that Dr. Guo reviewed the anesthesia record, assessed the decedent's medical status and evaluated the decedent at the time he assumed the anesthesia care and that Dr. Guo was not required to review the entire medical chart and obtained all information necessary for him to assume care of the decedent. Further, Dr. Daryn Moller testified to the effect that during the course of his residency he learned that there was the risk of aspiration of gastric contents during the course of anesthesia and that factors which can increase the risk of gastric contents during anesthesia include anything that can delay or hinder gastric emptying; pyloric stenosis in a child; pregnancy; full stomach; someone who has just finished a meal; known small bowel obstruction; and the timing of abdominal trauma in relation to a full stomach.

Dr. Ferson does not address the issue that Mr. Baker had a suspected partial bowel obstruction and suspected ileus and whether Mr. Baker should have had endotracheal intubation for the administration of anesthesia in light of the signs and symptoms presented and the risk of regurgitation. Dr. Ferson does not comment on whether or not LMA was appropriate under the circumstances presented in this action relative to the suspected partial bowel obstruction and ileus. Although Dr. Ferson opines that Dr. Guo "was not required to

change the method by which anesthesia was to deliver anesthesia to another mode of anesthesia administration," he does not comment on the appropriate standard of care and whether or not good and accepted medical and anesthesia practice would have required endotracheal intubation prior to the regurgitation and aspiration.

Based upon the foregoing, it is determined that the defendant has failed to demonstrate prima facie entitlement to summary judgment dismissing the complaint.

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see,* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.,*** 7 AD3d 759, 776 NYS2d 907 [2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.,*** 242 AD2d 282, 660 NYS2d 739 [1997]). Even if the defendant Dr. Guo demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against him, the plaintiff has opposed this motion for summary judgment with a physician's affirmation which raises factual issues precluding summary judgment.

The plaintiff's expert, a board certified anesthesiologist licensed to practice medicine in the State of New York, opines that Mr. Baker was admitted to Stony Brook University Hospital on June 23, 2006 following involvement in a motor vehicle collision from which he sustained serious injuries consisting of multiple rib fractures, a dislocated knee cap, lateral tibial plateau fracture, a fracture of the right humerus; and a severe blunt abdominal trauma resulting in injuries and lacerations to his spleen, kidney and liver. Mr. Baker underwent surgery under general endotracheal anesthesia on June 25, 2006 for application of an external fixator to his left knee. He underwent surgery on June 27, 2006 for an open reduction and internal fixation of this right humeral shaft. During that June 27, 2006 surgery, Mr. Baker was administered general anesthesia via a laryngeal mask airway. Approximately four hours into the procedure, Mr. Baker regurgitated approximately 500 cc (approximately sixteen ounces) of dark brownish fluid which entered his airway and which required mechanical ventilation with an Ambu bag in the operating room and upon leaving the operating room, and further required continuous mechanical ventilation until his death on July 2, 2006.

The plaintiff's expert opines that tracheal intubation involves insertion of an endotracheal tube into the patient's trachea (windpipe). The plastic tube had an inflatable cuff which is inflated after the tube is inserted and prevents aspiration of secretions or foreign material into the trachea and lungs. LMA anesthesia involves the use of a device known as a laryngeal mask which is placed around the laryngeal inlet and is only appropriate when tracheal intubation is not necessary as it does not fully seal the larynx and does not protect against aspiration of secretions or foreign substances into the trachea and lungs. LMA is therefore contraindicated in a patient who presents an increased risk of aspiration as aspiration can result in catastrophic and life threatening injuries. The anesthesiologist must evaluate the patient to determine all relevant factors in the patient's condition or prior treatment which may increase the probability of regurgitation of stomach contents and the increase risk of aspiration. It must be determined when the patient last ate or ingested fluids or medication and whether or not there have been any injuries to the patient which may slow or retard the digestive process and delay emptying of the stomach.

The plaintiff's expert states that there was ample evidence in Mr. Baker's hospital record prior to the June 27, 2006 surgery that Mr. Baker was at significantly increased risk for aspiration of stomach contents during general anesthesia as he was believed to have sustained significant abdominal trauma including a lacerated spleen, liver and kidney, indicative of blunt trauma which is sufficient to slow digestive motility and slow emptying of the stomach. There was a suspicion of a partially obstructed or slowed bowel as evidenced by

the absence of a bowel movement and persistent constipation for which he was administered a powerful drug, magnesium citrate, to cause him to evacuate his bowel by bringing fluid into the abdomen, increasing the likelihood of a full or partially full stomach at the time of surgery, thereby increasing the risk of aspiration or regurgitated stomach contents during general anesthesia. The combination of abdominal trauma and the administration of magnesium citrate increased the risk of aspiration or regurgitated stomach contents and required tracheal intubation to seal Mr. Baker's trachea for the administration of general anesthesia.

It is plaintiff's expert's opinion that although co-defendant Dr. Glass made the determination to administer anesthesia via LMA, it did not relieve Dr. Guo of his separate, distinct and independent responsibilities to Mr. Baker. That Dr. Guo took over the case from Dr. Glass who provided a history to him, does not relieve Dr. Guo from his own separate obligations to Mr. Baker, including the responsibility to correct the errors or improprieties in anesthesiology care that preceded his entry into the case and which represented a danger or heightened risk to Mr. Baker. The proper standard of care does not permit one anesthesiologist to continue administering anesthesia to a patient in a dangerous or risky manner because it had been commenced by another anesthesiologist and mandates that each individual physician participating in Mr. Baker's care do so in accordance with safe and proper practice and not to continue unsafe or risky practice initiated by another physician.

The plaintiff's expert further opines that Dr. Guo also had a separate and distinct responsibility to ascertain Mr. Baker's history and to review those portions of the patient's medical record containing information which might impact anesthesiology care, consisting of those few pages of the hospital record which would have revealed to him the nature of Mr. Baker's underlying condition, whether he received any drugs, medications or treatments capable of impacting the administration of anesthesia, including which anesthetic agents to be used and which methods and techniques of administration of anesthesia. In that Dr. Guo testified that he only reviewed the anesthesia record, that contrary to Dr. Ferson's opinion, Dr. Guo did not properly assess the decedent's medical status nor properly evaluate the decedent at the time he assumed anesthesiology care and treatment of him, did not apprise himself of the fact that Mr. Baker received magnesium citrate prior to surgery and that Mr. Baker sustained abdominal trauma. The plaintiff's expert opines that these were two pivotal factors which proper practice required be taken into consideration in formulating the proper method of administering anesthesia and that the failure to properly review the patient's medical record which resulted in Dr. Guo lacking knowledge of those factors which absolutely contraindicated administration of general anesthesia via laryngeal mask airway, rendering it risk-ridden and dangerous. The plaintiff's expert further sets forth that Dr. Glass testified that he would not have administered LMA had he known Mr. Baker received magnesium citrate.

It is the plaintiff's expert's further opinion that the aforementioned departures from accepted standards of anesthesia care and administration were the significant contributing factors in causing Mr. Baker's death due to aspiration pneumonitis caused by the aspiration of regurgitated stomach contents during the June 27, 2006 surgery caused by the failure to appropriately administer general anesthesia via tracheal intubation rather than LMA.

Accordingly, motion (013) is denied.

Dated: 16 July 2010

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**