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SHORT FORM ORDER

INDEX No. 07-31530
CAL. No. 11-00005MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 43 - SUFFOLK COUNTY

COPY

*PRESENT:*

Hon. ARTHUR G. PITTS
Justice of the Supreme Court

MOTION DATE 3-1-11 (#005)
MOTION DATE 5-26-11 (#006)
ADJ. DATE 5-26-11
Mot. Seq. # 005 - MD
# 006 - MD

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ISAIAH MITCHELL, an infant, by his mother and natural guardian, VIVONNE MITCHELL,

Plaintiff,

- against -

PAUL LOGRANO, MD, DENNIS STRITTMATTER, MD, SEYMOUR MUSIKER, MD, ST. CHARLES HOSPITAL and SUFFOLK OBSTETRICS & GYNECOLOGY, LLP,

Defendants.

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Upon the following papers numbered 1 to 42 read on these motions for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (005) 1 - 8 ; Notice of Cross Motion and supporting papers (006) 9-28 ; Answering Affidavits and supporting papers 29-38 ; Replying Affidavits and supporting papers 39-40; 41-42 ; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

***ORDERED*** that motion (005) by defendant Seymour Musiker, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint is denied; and it is further

***ORDERED*** that this motion (006) by defendants Paul Lograno, M.D., Dennis Strittmatter, M.D., and Suffolk Obstetrics & Gynecology, LLP for an order pursuant to CPLR 3212 granting summary judgment dismissing plaintiff's complaint is denied.

This medical malpractice action is premised upon the alleged negligence of defendants and lack of informed consent, relating to the care and treatment rendered to the plaintiff, Vivonne Mitchell and her infant

son, Isaiah Mitchell, during their hospitalization at St. Charles Hospital. It is alleged that the defendants negligently departed from good and accepted standards of care in treating the infant plaintiff, commencing with his birth on May 24, 2003, and continuing through his discharge on May 27, 2003, proximately causing the infant to suffer serious and permanent injury.

Seymour Musiker, M.D. seeks summary judgment dismissing the complaint on the bases that he appropriately evaluated the infant plaintiff for hypoglycemia, that he appropriately ordered treatment, that he did not depart from the hypoglycemia protocol, and fully complied with the standard of care during his treatment of the infant plaintiff. It is further asserted that his care and treatment of the infant plaintiff was not the cause of the infant's alleged injuries.

Paul Lograno, M.D. seeks summary judgment dismissing the complaint as asserted against him on the bases that there is no evidence that he participated in the prenatal care and treatment of Vivonne Mitchell, and therefore, the claims asserted against him pertaining to the prenatal period should be dismissed. Dr. Lograno also contends that there is no evidence that he participated in the care and treatment of Vivonne Mitchell other than between approximately 11:15 a.m. and 6:00 p.m. on May 23, 2003, and that any claims pertaining to any other time period should be dismissed. Dennis Strittmatter, M.D. contends that there is no evidence that he participated in Vivonne Mitchell's prenatal care other than one office visit on February 13, 2003, and a consultation on April 10, 2003, and therefore, all other claims asserted against him should be dismissed. Both Dr. Lograno and Dr. Strittmatter contend that the prenatal care and treatment provided to Vivonne Mitchell was appropriate and within good and accepted medical practice, and that there is nothing that they did or did not do that proximately caused the infant plaintiff to suffer the injuries claimed in this action.

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]), and must submit evidence in admissible form (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]). 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 [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 [1981])

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]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the 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 defendant's 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 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

In support of motion (005), Dr. Musiker has submitted, inter alia, an attorney's affidavit, copies of the summons and complaint, his answer and the plaintiff's verified bill of particulars; plaintiff's medical records; the affirmation of the defendant's expert Dr. Roy H. Horowitz; an uncertified, partial hospital record; and the unsigned transcripts of the examination before trial of Dr. Musiker dated January 7, 2010. The uncertified copy of four pages of the St. Charles Hospital record is not in admissible form as required by CPLR 3212 (*see,* CPLR 4518 (c), ***Westchester Medical Center v Progressive Casualty Insurance Company***, 51 AD3d 1014, 858 NYS2d 754 [2d Dept 2008]), and the unsigned copy of the deposition transcript upon which Dr. Musiker's expert has relied is not in admissible form as required by CPLR 3212 (*see*, ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]). This court will consider Dr. Musiker's deposition transcript, as submitted by him, and as adopted by him, as accurate (*see*, ***Ashif v Won Ok Lee,*** 57 AD 3d 700, 868 NYS2d 906 [2d Dept 2008]). However, even if the evidentiary submissions were in admissible form, it is determined that Dr. Musiker has failed to establish prima facie entitlement to summary judgment.

MOTION (005)

SEYMOUR MUSIKER, M.D.

Seymour Musiker, M.D. testified that he is a physician licensed to practice medicine in New York State since 1961 and practices as a sole practitioner as Seymour B. Musiker, M.D., P.C. He is board certified in pediatrics. Dr. Musiker testified from the St. Charles Hospital record that the male infant plaintiff was born by spontaneous delivery on May 24, 2003 at 5:12 a.m. at a gestational age of 39 and 5/7 weeks, to a 41 year old mother for her first child. The infant weighed seven pounds four ounces and was noted to be at gestational age. He stated the infant's Apgar scores were 8 at one minute and 9 at five minutes. The infant had a low blood sugar of 21 (30 by Lab) , which increased after feeding to 50 (by Lab). Dr. Musiker stated that the record indicated that there was meconium stained fluid after the infant delivered, which meant the infant had a bowel movement when it was being delivered. He then noted that there was meconium with delivery of the infant's head. He continued that stress can cause meconium at any time during the pregnancy, not just terminal meconium. He

stated that meconium is usually of no concern, as long as the baby starts breathing appropriately. He then testified that terminal meconium could be indicative of fetal distress. He stated that between 10 and 20 percent of deliveries have meconium. The infant was suctioned with a bulb syringe, and breathed with stimulation. He was admitted to the newborn nursery as opposed to NICU. He also testified that the mother of the infant had a history of high blood pressure and Lupus, and took Methyldopa, 500 mg every 12 hours. Prior to delivery, the mother was administered Ampicillin as she was positive for strep B.

Dr. Musiker testified that there are conditions which alert the practitioner to potential problems in the infant. He set forth that hypoxia and fetal hypoxia can cause meconium stained amniotic fluid, and that meconium can alert a physician to the possibility that the infant may have suffered some hypoxia during labor and delivery. He testified that after delivery, the infant was seen by Tracy Sullivan, NNP, the neonatal nurse practitioner, who recommended routine care and blood glucose monitoring, however, he did not have an understanding as to what, if any, indications there were for blood glucose monitoring at 5:55 a.m. after the infant was born. He continued that meconium fluid would not be an indication for doing blood glucose monitoring, but that blood glucose monitoring is one way of evaluating how the baby is doing, and might be an indication of stress that the baby may have gone through. Dr. Musiker continued that, physiologically, if there is stress, the baby would use up its glucose, and as a newborn, the infant may not have the mechanism physiologically to respond to the low glucose level. He stated that a low glucose level in a newborn infant can be consistent with the newborn having suffered some fetal distress. He believed he wrote his note on May 23, 2003 between 9 a.m. and 10 a.m., signed off on routine orders, and added that the hypoglycemic protocol be continued.

Dr. Musiker testified that he was not sure of the hypoglycemic protocol in existence at the time, and stated that all babies were getting blood sugars at one, two and three hours of age. He also thought that there might be a screening test, by heel stick, and the blood would be sent to the lab for confirmation. He thought the normal glucose level was approximately 40, plus or minus five, but the criteria changes and he did not know the criteria for 2003. Dr. Musiker testified that signs of hypoglycemia in the newborn would be listlessness and/or lethargy (just lying there, not responding or crying, attempting to feed but may not nipple), seizures, rapid breathing, and tachypnea. He continued that apnea could be a sign of hypoglycemia in a newborn infant. Dr. Musiker testified that prolonged hypoglycemia over an extended period can cause brain damage and seizures, as it would deprive the brain of the sugar that is needed for it to function. He stated that the blood sugar of 21 was abnormally low. He did not know the glucose protocol at St. Charles at the time, but stated the infant would be given glucose water or formula, and the blood sugar would then be repeated afterwards within the hour. If the infant did not respond, there would be an indication for starting an intravenous. He did not know the level the blood sugar was expected to rise to, to be satisfied that the infant responded, however, he felt 50 was an acceptable level. He did not know the time frame in which follow-up glucose levels were to be tested, or the time frame in which the glucose level should respond.

Dr. Musiker testified that he did not consider starting an intravenous when he learned of the blood sugars on the morning of May 24, 2003. Thereafter, multiple attempts were made at starting an intravenous, peripherally, without success. He continued that if the nurse had been successful in starting the intravenous at 6:20 a.m., the infant would have been transferred to NICU at that time, but since the attempt was unsuccessful, the infant was not transferred. Thereafter, when he saw the infant's blood sugar was responding, he did not consider transferring the infant to NICU. He continued that if the intravenous was not started, the infant should be fed more frequently, but he did not indicate how frequently or the times the infant was fed. The next glucose

level at 9 a.m. was 53. A 9:10 a.m. glucose was 32. The next feedings were at 10:20. 13:10 and 15:00 with formula. At 1 p.m., the infant's blood sugar was 29. He was not sure if that was an indication to transfer the infant to NICU or to have the infant seen by a neonatologist. He did not know if the glucose protocol called for intravenous dextrose, but stated that the glucose protocol, under certain circumstances, called for the transfer to the neonatal intensive care unit. However, he did not recall the protocol. At some point on the afternoon of May 24, 2003, the infant was transferred to NICU. There were no feedings between 2:00 a.m. and 10:20 a.m. On May 26, 2003 at 16:40 hours, the glucose value was 54 or 74. Dr. Musiker testified that he did not have an understanding as to whether hypoglycemia in a newborn can lead to metabolic acidosis. He continued that there could be other causes for the metabolic acidosis, such as apnea, which leads to metabolic acidosis.

ROY HOROWITZ, M.D.

Roy Horowitz, M.D. has set forth in his expert affirmation that he is licensed to practice medicine in New York State and is board certified in pediatrics. He set forth that he reviewed relevant portions of Dr. Musikers' deposition testimony and pertinent medical records, which he does not identify and which have not been provided. He also reviewed the St. Charles Hospital medical records. Dr. Horowitz states that all facts are based upon the St. Charles Hospital medical records of May 24, 2003, unless otherwise noted by him. He states that his opinions are made within a reasonable degree of medical certainty. However, Dr. Horowitz has not set forth his training and experience as a pediatrician upon which he bases his expertise and has not qualified himself as an expert in the field of pediatrics. It is further determined that Dr. Horowitz's opinions are conclusory and unsupported. There are factual issues which preclude summary judgment, even if Dr. Horowitz qualified as an expert, and the materials upon which he based his opinions were properly certified and provided to this court.

Dr. Horowitz states that when Dr. Musiker arrived at the hospital and examined the infant, he noted that the infant had low blood sugar and was responding to oral feedings. However, Dr. Horowitz does not set forth the normal glycemic values for a newborn, and what he meant by his statement that the infant was "responding to oral feedings." He does not indicate if the response was acceptable and sufficient. Dr. Horowitz states that Dr. Musiker ordered that the hypoglycemic protocol be followed, however, he does not indicate what that protocol is, nor does he demonstrate how Dr. Muskier complied with the protocol, or what the standard of care was for treating a newborn with hypoglycemia, or the appropriate follow up. Dr. Horowitz states that the first time Dr. Musiker was notified of any problems, he immediately transferred the infant to the NICU to Dr. Friedman's care and treatment. It was at 4:00 p.m. that the infant was noted to have metabolic acidosis with episodes of tachycardia, duskiness and apnea. Dr. Horowitz does not set forth how long the acidosis was present, the cause of it, or what testing was done prior to ascertain the infant's status in light of the low blood sugar levels.

Dr. Horowitz opines that transient hypoglycemia is not rare, however, he has not established that the infant suffered a transient hypoglycemia. Although he states that Dr. Musiker's actions or claimed omissions were not the cause of the infant's injuries, he does not opine as to the causes or the injuries to which he is referring. Although Dr. Horowitz states that it is his opinion with a reasonable degree of medical certainty that Dr. Musiker did not depart or deviate from good and accepted medical practice, Dr. Horowitz did not define what that good and accepted medical practice was sufficient to establish prima facie entitlement to summary judgment dismissing the complaint. The hypoglycemic protocol was not established for the relevant time period to demonstrate that Dr. Musiker adhered to the protocol. Such factual issues preclude summary judgment.

Accordingly, motion (005) by Seymour Musiker, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint is denied.

MOTION (006)

In support of motion (006), Paul Lograno, M.D., Dennis Strittmatter, M.D. and Suffolk Obstetrics & Gynecology have submitted, inter alia, an attorney's affirmation; the affidavit of Hilma Yu, M.D.; copies of the summons and complaints, defendants' answers, and plaintiff's verified bill of particulars; uncertified and incomplete copies of the plaintiff's medical records from St. Charles Hospital; signed transcripts of the examinations before trial of Vivonne Mitchell dated September 29, 2008, Paul Lograno dated August 26, 2009, Seymour Musiker, M.D. dated 7, 2010; the unsigned copies of transcripts of the examinations before trial of Dennis Strittmatter dated November 19, 2009, Daniel Mitchell dated May 4, 2010, Debra Sansoucie dated October 21, 2010. The uncertified and incomplete copy of the St. Charles Hospital record, and the defendants' office records are not in admissible form pursuant to CPLR 3212 (*see,* CPLR 4518 (c), ***Westchester Medical Center v Progressive Casualty Insurance Company***, supra). The unsigned copies of the deposition transcripts of Dennis Strittmatter, Daniel Mitchell, and Debra Sansoucie are not in admissible form as required by CPLR 3212 (see, ***Martinez v 123-16 Liberty Ave. Realty Corp.***, supra; ***McDonald v Maus***, supra; ***Pina v Flik Intl. Corp.***, supra). Dr. Strittmatter's unsigned second deposition is considered, however, as it has been submitted by him as a moving party and is therefore deemed adopted by him as accurate (*see*, ***Ashif v Won Ok Lee,*** supra). It is additionally noted that the moving defendants have further failed to provide the Stony Brook University Hospital medical records upon which the defendants' expert has relied in part in rendering the expert opinion. The records and materials relied upon by the expert are to be provided in admissible form in support of the motion (***Friends of Animals v Associated Fur Mfrs.,*** supra; *see also,* ***Hornbrook v Peak Resorts, Inc.***, 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tompkins County 2002]). Based upon the foregoing, it is determined that even if the evidentiary submissions were in admissible form, that there are factual issues which preclude summary judgment, and this court is left to speculate as to the testimony contained in Dr. Strittmatter's first deposition.

HILMA YU, M.D.

Hilma Yu, M.D. has submitted an expert affidavit on behalf of Dr. Lograno, Dr. Strittmatter and Suffolk Obstetrics & Gynecology and avers to being licensed in New York State and certified in obstetrics and gynecology. The defendants' expert bases his/her opinion upon review of the pleadings, the depositions, medical records of Suffolk Obstetrics & Gynecology, St. Charles Hospital, and the Stony Brook University Hospital Medical Center. It is Dr. Yu's opinion within a reasonable degree of medical certainty that all the care and treatment provided by the moving defendants was well within the standards of good and accepted medical practice from September 24, 2002 to May 24, 2003.

In setting forth the care and treatment, and events which occurred during the subject hospitalization, Dr. Yu states that Ms. Mitchell was forty years old when she became pregnant in August 2002, and that the physicians and other staff at Suffolk Obstetrics and Gynecology LLP (Suffolk Ob/Gyn) were aware of her advanced age and other relevant medical history, including hypertension and lupus. Dr. Yu continues that her pregnancy was appropriately managed as a high risk pregnancy with increased monitoring and surveillance, although he/she does not indicate what that consisted of, and what the standard of care for a high risk pregnancy

was at the time. Dr. Yu states that Ms. Mitchell presented to the group, advising that she was attempting to become pregnant, and was referred for consults in maternal and fetal medicine and genetics. She was also advised of the risks of birth defects associated with her age, background, and medical conditions, although her background and the specific risks are not set forth by the defendant's expert. Her expected date of confinement was May 25, 2003.

Dr. Yu states that Ms. Mitchell's visited at Suffolk Ob/Gyn on November 1, December 2, and December 30, 2002; January 27, February 18, March 6, March 20, March 26, April 3, 10, 14, 21, and 29, May 6, 13, 16, 20 and 23, 2003. Dr. Yu indicates that Ms. Mitchell was appropriately evaluated in terms of her blood pressure, weight gain, urine, fundal height, edema, fetal heart rate, movement, tone, breathing movements, and amniotic fluid. Methyldopa was prescribed for hypertension. He/she did not indicate who saw Ms. Mitchell on these dates.

Dr. Yu states that Ms. Mitchell had a sonogram on November 11, 2002. The fetal stomach and urinary bladder could not be visualized by ultrasound on December 31, 2002, but they were later visualized by sonogram on January 14, 2003. When Ms. Mitchell complained on January 30, 2003 of dark urine and blood on her tissue upon urination, she was evaluated at Suffolk Ob/Gyn and appropriately tested and treated with antibiotics. She was evaluated on February 8, 2003 for gestational diabetes with a one hour glucose challenge test, which produced elevated results. Thereafter, a three hour test was performed which result was stated to be normal. Her contractions and cramping were monitored on February 12, 2003 by "a physician" from Suffolk Ob/Gyn and she was treated for dehydration. He does not indicate who saw Ms. Mitchell at this time.

Dr. Yu states that Dr. Strittmatter saw Ms. Mitchell on February 13, 2003 and sets forth the medical care and treatment during the remainder of the plaintiff's pregnancy, which care included a non-stress test on March 18, 2003, various blood testing and examination. Serial ultrasounds with biophysical profiles and non-stress tests were conducted on March 20, 26, and April 3, 2003, with scores of 10/10 on each occasion, indicating that the infant appeared to be doing well. Dr. Yu continues that on April 10, 2003, when another biophysical profile was conducted, the score was 6/10, and the infant required further evaluation. He states that Dr. Strittmatter was advised of the score, the ultrasound was repeated that day, and the new score was 8/10. Another biophysical profile was completed on April 14, 2003, which rendered results of 10/10. The ultrasounds with biophysical profiles on April 21, 29, and May 6, 2003 yielded scores of 10/10, 10/10, and 8/10, on those respective dates. Dr. Yu states that on May 13, an ultrasound with biophysical profile was 8/8, but the non-stress test was non-reactive, making the total score 8/10. Dr. Yu does not set forth what the indications of a "non-reactive stress test" are, if any. On May 16, 2003, the stress test was reactive. On May 20, 2003, the ultrasound with biophysical profile was 10/10. On May 23, 2003, when the stress test was non-reactive, the plaintiff was sent to St. Charles for further evaluation, but Dr. Yu does not indicate who performed the evaluation or the results. Dr. Yu states that at no time prior to May 23, 2003, did the plaintiff or the fetus require bed rest or admission to the hospital for evaluation and treatment.

PAUL LOGRANO, M.D.

Dr. Lograno testified that he is licensed to practice medicine in New York State. He joined Suffolk Obstetrics & Gynecology initially as an employee, along with Dr. Strittmatter, also an employee at the time. While working at the practice, he performed and interpreted ultrasounds. In 2004, he became board certified in

obstetrics and gynecology and became a partner in the practice. He first saw Ms. Mitchell as a patient on May 23, 2003 at about 12:00 p.m. at St. Charles Hospital, but had no independent recollection of her. He was working on call from 6:00 p.m. May 22nd through 6:00 p.m. on May 23rd. Dr. Lograno testified that the reason he saw Ms. Mitchell was because, "the tracing was, as she quoted, flat." He stated that his note indicates that she was sent to the hospital for a non-reactive NST (non-stress test), which is performed by observing the baby's heart beat by electronic fetal monitor, without stressing the fetus. He continued that the doctor who sent her felt that the NST did not produce good accelerations in the fetal heart rate, which accelerations, he stated should be about fifteen beats per minute for fifteen seconds in a term baby. Dr. Lograno testified that he couldn't say that a non-reactive non-stress test is a good predictor of hypoxia, but that Ms. Mitchell was sent to the hospital to see if the tracing would become reactive or if it continued to be non-reactive. He stated that hypoxia is in the realm of possibility relative to a non-reactive tracing. To determine that everything is ok with the fetus, a biophysical profile can be done, or a prolonged NST, and sometimes, Doppler studies.

When questioned about early, late, and variable decelerations, on the fetal monitor strips, Dr. Lograno testified that variable decelerations could mean the baby is lying on the cord or that there is cord compression. Early decelerations can be attributed to head compressions. He stated he could not answer with regard to the significance of late decelerations. His opinion with respect to the fetal monitoring strips he read at approximately 12:00 noon on May 23, 2003, was that there was good variability and accelerations, and it was reactive. He ordered a biophysical profile to further evaluate the infant for, inter alia, fetal breathing, fetal movements, fetal tone, amniotic fluid, with a potential score of 0 or 2 for each. A perfect score, including the NST, would be 10/10. Dr. Lograno testified that the score for this testing was 4/8 as there was a minus 2 each for fetal breathing and fetal movement, which indicated to him that the baby was not moving, and that it did not have fetal breathing movements for a period of thirty minutes. When asked if there was any significance to the infant's fist being clenched during the thirty minute exam, he testified that the significance was that the infant had his hand closed. He did not feel that 4/8 score indicated hypoxia, and that, in and of itself, it had no significance. However, he continued, it could be an indicator as to whether or not the patient needed to be delivered. He received the results of the testing at about 3:00 p.m. He stated that the nurse's entry in the record at 14:55 indicated that Ms. Mitchell was seen by Dr. Lograno and was to be admitted for delivery. He testified that he discussed the risks, benefits and alternatives of induction with Pitocin with Ms. Mitchell and it was decided to proceed with the induction of labor. He did not remember the risks he discussed with Ms. Mitchell or if he discussed the risks of delivery. He did not consider performing a c-section after he received the 4/8 biophysical profile of the infant, as he did not feel it was indicated based upon the entire clinical picture.

Dr. Lograno testified that there were no maternal or fetal contraindications to the induction of labor with Pitocin, including the biophysical profile of 4/8. He did not consider, and it was not indicated, that Doppler studies should be obtained to measure the blood flow through the umbilical cord to the baby. Dr. Lograno testified that the Ms. Mitchell had an amniotic fluid level of 24 which was on the high side but he could not say it was abnormal. He continued that there were a lot of conditions which could cause polyhydramnios (increased level of amniotic fluid), including diabetes, or a large placenta, or no cause. He testified that up to about 12:10 p.m. on May 23, 2003, that there was no fetal distress evidenced on the fetal monitoring strips. Thereafter, until 6:00 p.m., the tracings were reassuring, and his opinion remained thus when also considering the biophysical profile of 4/8. Relative to the fetus, he stated that it did not appear from the testing that there would be anything that one could say was wrong with the baby at that time.

DR. YU

Dr. Yu states that Dr. Lograno first saw Ms. Mitchell on the late morning of May 23, 2003 after she first presented to St. Charles Hospital at 11:15 a.m. and that he did not see her or have any involvement in her care during the prenatal period. He states that Dr. Lograno ordered that Ms. Mitchell be observed for labor. An external fetal monitor was applied to measure the fetal heart rate and monitor her uterine contractions. Dr. Yu continues that when Ms. Mitchell felt the fetus move, the fetal heart rate accelerated to 165 beats per minute from the baseline. He states that the infant's heart rate indicated that he was doing well, that a c-section was not indicated, and that it was good medical practice not to deliver the infant at that time. Dr. Yu states that the fetal monitor strips from 11:22 a.m. through 12:10 p.m., were reactive, with good long term variability, with a baseline of 130 to 140 beats per minute, which were reassuring signs. At 1:10 p.m., a biophysical profile was performed, as were laboratory tests, which indicated that there was no preeclampsia. The result of the biophysical profile was 4/8. Dr. Yu states that the fetal heart monitoring at the hospital, which included a reactive non-stress test, was 6/10.

Dr. Yu states continues that Ms. Mitchell was admitted to the hospital on the basis of that biophysical profile and the fetal heart rate continued to be monitored externally. Dr. Yu opines that the biophysical profile of 4/8 and 6/10 with the non-stress test, did not require delivery by c-section, however, he gives no basis for that opinion, or the significance of the biophysical profile results, or why such results required admission to the hospital. Dr. Yu continues that according to the biophysical profile report, there was a history of polyhydramnios[1], which was also present on May 23, 2003. He states that the right fetal hand appeared to be in a partially clenched position throughout the entire exam. Dr. Yu does not opine to the significance or relevance of the fetus' clenched fist, but states that it is not an indication to perform a c-section or different testing or treatment from what was provided. Dr. Lograno was notified of these results at about 3:00 P.M. Dr. Yu states that Dr. Lograno saw the plaintiff at 2:35 p.m. and explained all the risks, benefits, and alternatives of induction of labor with Pitocin with Ms. Mitchell, at length, and that Ms. Mitchell verbalized understanding. However, Dr. Yu did not indicate the risks, benefits, and alternatives of induction of labor which were communicated to Ms. Mitchell, and Dr. Lograno could not remember what he told her they were. Dr. Yu states it was Dr. Lograno's plan for Ms. Mitchell to have a vaginal delivery with Pitocin induced labor. Dr. Yu continues that Ms. Mitchell remained on the fetal monitor until the end of Dr. Lograno's shift at the hospital at 6:00 p.m. The monitor showed no decelerations, absence of long term variability, no tachycardia or bradycardia, and no accelerations. Dr. Yu states that there was no indication that the fetus was hypoxic and required utero resuscitation or any other treatment. Dr. Yu concludes that at all times Dr. Lograno acted within good and accepted standards of medical practice by not performing fetal scalp sampling, sonography, or utero resuscitation as the fetal monitoring was reassuring of fetal well being.

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1 Dr. Yu states that polyhydramnios is a condition in which there is an abnormally high level of amniotic fluid in the uterus and is sometimes caused by poorly controlled maternal diabetes, which he states was ruled out in Ms. Mitchell. Dr. Yu states that another possible cause is fetal abnormalities which prevent the fetus from swallowing amniotic fluid or fetal abnormalities causing production of excess amniotic fluid, but based upon prenatal testing, it did not appear that the mother or fetus had any such abnormalities, and polyhydramnios can have no known cause.

Based upon the foregoing, although Dr. Yu provides information concerning Ms. Mitchell's care and treatment during her pregnancy and labor while under the care of Dr. Lograno, Dr. Yu does not set forth the significance of the non-reactive stress tests and low biophysical profiles for which Ms. Mitchell was admitted to St. Charles Hospital, and how this relates, in any way, to the well-being of the fetus. He has not set forth the standard of care from which he opines that Dr. Lograno did not depart. Nor has he set forth the risks which were presented to Ms. Mitchell to demonstrate she received informed consent. These factual issues preclude summary judgment dismissing the complaint as to Dr. Lograno.

DENNIS STRITTMATTER, M.D.

It is indicated on Dr. Strittmatter's deposition transcript that this is a continuation of the previous testimony taken of him, but such prior testimony, leaving off with his interpretation of the fetal heart monitoring strips, has not been provided to this court. Dr. Strittmatter testified that he had no independent recollection of Ms. Mitchell other than his notes. He testified that Karen Stolz, the nurse practitioner from his office, saw Ms. Mitchell on April 10, 2003 and advised him that a sonogram attempt was 4/8 on the biophysical profile as there was no fetal breathing movement, no fetal movement, and the NST was reactive after 45 minutes. After a repeat sonogram, the score was 8/10, which he stated was reassuring. There was no growth restriction noted. Dr. Strittmatter ordered a biophysical profile with a doctor thereafter. He testified that a score of less than 8/10 does not mean that the fetus is doing poorly, but is an indication that further testing is needed.

Dr. Strittmatter testified that he saw Ms. Mitchell at St. Charles Hospital on May 23, 2003 after she was admitted after a NST, when he took over for Dr. Lograno at 6:00 p.m. He testified that Ms. Mitchell's NST was not reactive, and did not show two accelerations of the fetal heart rate at 15 beats per minute. He agreed with the plan to induce her labor with Pitocin due to the biophysical profile of 6/10, and because she was at term, and the biophysical profile was not reassuring. Dr. Strittmatter testified that the fetus' clenched fist revealed by the sonogram was of no significance medically. He stated that Pitocin was not contraindicated in this case. He stated that repeating a biophysical profile once labor began was uncommon or unusual. He continued that Ms. Mitchell's blood pressure during labor had mostly normal diastolic values, but there were a couple diastolic readings in the 90's range, and the systolics varied significantly from 121 to 164. He then testified that elevated blood pressures can result in utero/placental insufficiency and pose a risk for growth restriction. Ms. Mitchell, he stated, had six episodes of a diastolic reading of 90 or higher from 5:00 p.m. until 4:00 a.m. He did not recall diagnosing her with pre-eclampsia when he considered her elevated blood pressure readings.

Dr. Strittmatter testified that at 1:00 a.m. on May 24, 2003, the nurse documented that Ms. Mitchell complained of rectal pressure, and upon examination, found her cervix to be dilated to nine centimeters and noted "bulging forewater." He stated that the nurse used that term because it had been documented at 0200 hours that there was a spontaneous rupture of the membranes with clear fluid noted. At 1:15 a.m. when Dr. Strittmatter examined Ms. Mitchell, he ruptured the forewater, and noted clear fluid. At 1:30 a.m., when he examined Ms. Mitchell, he determined she was eight centimeters dilated. At 1:45 a.m., he examined her again and ordered a reduced dose of Stadol for pain so as to keep the baby vigorous and taking a first breath at birth. He felt the labor was progressing quickly. At 12:20 a.m., there was a nurse's note indicating the Toco was readjusted frequently as there was difficulty monitoring contractions which could be palpated. The fetal heart rate was decelerating to 95 at the peak of contractions with a return to the baseline. At 3:00 a.m., Ms. Mitchell's cervix was nine centimeters dilated. At 4:15 a.m., she was fully dilated, moaning through contractions, and feeling the urge to

push. She was instructed by the nurse on pushing, and the infant was born at 5:12 a.m. with an Apgar of 8/9. Dr. Strittmatter testified that at 5:10 a.m., just prior to the infant's birth, he asked for a nurse practitioner to be present in the delivery room due to Ms. Mitchell's whole clinical picture and history of hypertension. The infant passed terminal meconium with the delivery. Dr. Strittmatter did not testify as to whether the meconium was present after the last examination and prior to delivery. He did state that meconium could be present with a post-term baby or with fetal distress, and continued that this was not a post-term baby. He stated that the presence of meconium at delivery was not an indication of the need to perform cord gases as the infant came out with good Apgars.

Dr. Strittmatter testified that late decelerations of the fetal heart rate can be caused by decreased perfusion through the placenta during a contraction as caused by uterine placental insufficiency, cord compression, abduction, preeclampsia, or intrauterine growth restriction. With cord compression, the baby senses a decrease in blood return and then an increase in resistence and the heart rate lowers in response to the baroreceptors. Variable decelerations increase resistance for the heart to pump blood in the fetal circulation and are a healthy response for a baby and do not represent impairment. Dr. Strittmatter continued that absence of variability is a concern, but when variability is present, it is assuring that the baby does not have acidemia. Dr. Strittmatter also stated that repetitive late decelerations, can occur on their own, or can be present before transient hypoxemia. If there is a lack of variability, the decelerations can represent fetal myocardial depression. He continued that acidemia can develop as a result of metabolic acidosis and hypoxia affecting the baby's heart and brain, and presents with a showing of decreased variability and repetitive late decelerations.

Dr. Strittmatter discussed his interpretation of the fetal monitoring strips, noting accelerations, early, late and variable decelerations, and periods of nonreactivity of the infant. Dr. Strittmatter testified that there was no internal monitor placed throughout Ms. Mitchell's labor. At 2:33 a.m., the fetal heart rate was about 140's, nonreactive, with moderate variability and some early decelerations with contractions. Two decelerations were present up to 2:53 a.m. He testified that a paper jam occurred from 3:12 a.m. to 3:20 a.m. and the next panel is not timed until 4:10 a.m. Thereafter, after four minutes of tracing, there was another gap in the fetal monitoring recording which gap lasted until 4:29 or 4:40 a.m., commencing with panel number 37839. He then testified that the next panel is "broken up" and it is hard to characterize the baseline, and that there appears to be moderate variability, but he could not comment on reactivity or decelerations. He did not state how the fetal heart rate was monitored and how the fetal status was assessed during those periods that there were no fetal monitoring recordings. He did not recall if he considered performing a c-section at any time while he was following Ms. Mitchell in labor, but stated that there was no indication that indicated a c-section was needed. He stated that there was no contraindication to a vaginal delivery. He stated that a nonreactive fetal monitoring strip, and a biophysical profile of 4/8 were not contraindications to Pitocin induction or augmentation of labor, as, if there is variability and no decelerations, there is assurance of fetal well-being.

Dr. Yu states that Dr. Strittmatter only saw Ms. Mitchell for one office visit in the prenatal period, and continues that, on May 23, 2003, Dr. Stittmatter took over the management of Ms. Mitchell's labor from approximately 6 p.m. and delivered the infant plaintiff at 5:12 a.m. on May 24, 2003. Dr. Stittmatter did not conduct a vaginal exam when he first assumed her care, because Ms. Mitchell was Strep B positive and the exam could have increased the risk of an infection. He also stated that an exam was not indicated at that time. Pitocin was started at 7:50 p.m., pursuant to Dr. Lograno's plan, and Ampicillin was given to prevent the Strep B from infecting the infant. Intravenous fluids were ordered with sugar and electrolytes. Dr. Yu opines that Pitocin was

not contraindicated due to the results of the non-reactive stress test on May 23, 2003, and the biophysical profile of 6/10 that day, but he does not state why. Methyldopa was ordered for Ms. Mitchell's blood pressure. At 1:00 p.m., Ms. Mitchell complained of rectal pressure, so Dr. Strittmatter performed a sterile vaginal examination, noting that her cervix was dilated to 9 cm. and that there were bulging forewaters. Dr. Yu states that the nurse's note at 12:20 p.m. states there was a spontaneous rupture of Ms. Mitchell's membranes and the amniotic fluid was clear. However, Dr. Yu states that Dr. Strittmatter ruptured the membranes in front of the infant's head to release the extra fluid.

At 1:30 a.m., when Dr. Strittmatter examined the plaintiff, he noted that the cervix was dilated to 8 cm. Dr. Yu states that "it appears a nurse changed a notation that the dilation was at 9 centimeters to one indicating it was at 8 centimeters after Dr. Stittmatter conducted his exam." Dr. Yu states that while dilation could have decreased between the time of the nurse's exam and his exam after the forewaters were released, he thought his assessment could have just differed from the nurse's assessment by one centimeter. At 4:15, Ms. Mitchell was moaning through contractions and had the urge to push. Dr. Stittmatter, upon examination, found Ms. Mitchell's cervix to be fully dilated. Thereafter, Ms. Mitchell was instructed to push with contractions. The infant was delivered at 5:12 a.m.

Dr. Yu states that Dr. Strittmatter ordered that a nurse practitioner be present for the delivery of the infant based upon the whole clinical picture including Ms. Mitchell being a 41 year old with chronic hypertension. Dr. Yu set forth the Apgar scores of the infant as 8/9, as evaluated by T. Sullivan, the nurse practitioner, who advised that the baby should be admitted to the normal newborn nursery, with glucose monitoring. Dr. Yu states that such glucose monitoring is a function of the hospital staff and any pediatric/neonatal consultants, and not the obstetrician. Dr. Yu opines that Dr. Strittmatter acted in accordance with good and accepted medical care and treatment in inducing labor with Pitocin to deliver Ms. Mitchell vaginally; that neither the biophysical profile of 4/8 (6/10 with the non-stress test), nor any other results required delivery by c-section. Dr. Yu continues that the fetal monitor strips showed long term variability with no decelerations, however, this absence of decelerations is not supported by Dr. Strittmatter's interpretation of the tracings, raising a factual issue.

Dr. Yu then states that between 12:45 a.m. and the delivery at 5:12 a.m., the fetal monitoring strips showed some early and variable decelerations, but no late decelerations, and that early and variable decelerations are normal in labor and are not indicative of fetal distress. The fetal heart rate of 120 to 150, with no bradycardia or tachycardia, was reassuring that the fetus was doing well and was not in distress, and thus no scalp monitoring was indicated. Despite this opinion, Dr. Yu states that there are no fetal monitoring strips available between approximately 3:21 a.m. or 3:22 a.m. and 4:10 a.m. and between approximately 4:17 a.m. and 4:29 a.m. However, states Dr. Yu, Ms. Mitchell and the fetus were appropriately monitored during those periods regardless of the availability of the strips. However, Dr. Yu does not state how the fetal status was evaluated without the monitor tracings, or upon what he bases his opinion that the infant was not in distress, or the cause of the meconium at delivery.

Based upon the foregoing, it is determined that although Dr. Yu stated that there was no departure from the standard of care and set forth the events and progress of the pregnancy, labor and delivery, no opinion was stated as to the significance and indications of the non-reactive stress tests, the low biophysical assessment results, and the standard of care when such results are obtained. Dr. Yu has not commented upon the mother's blood pressure during the pregnancy and labor although a history of hypertension has been noted by Dr. Yu, as

well as on the vital sign sheet prior to delivery. Dr. Yu opines in a conclusory manner that although the fetal monitoring strips are missing for the indicated time periods, that Ms. Mitchell and the fetus were appropriately monitored during those periods regardless of the availability of the strips. Dr. Yu does not state how Ms. Mitchell and the fetus were appropriately monitored. Importantly, Dr. Yu does not address the presence of meconium with the delivery of the infant's head, thus raising a further factual issue concerning whether the infant suffered fetal distress prior to delivery. Such factual issues preclude summary judgment.

In that the moving defendants have failed to establish prima facie entitlement to summary judgment dismissing the complaint, this court need not consider whether the plaintiff's opposition to the motion was sufficient to raise a triable issue of fact (***Papadonikolakis v First Fid. Leasing Group,*** 283 AD2d 470, 724 NYS2d 87 [2d Dept 2001]; ***Chaplin v Taylor,*** 273 AD2d 188, 708 NYS2d 465 [2d Dept 2000]).

Accordingly, motion (006) for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint is denied as to both defendants Lograno and Strittmatter.

Dated: August 2, 2011

J.S.C.

_____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**