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SHORT FORM ORDER

INDEX No. 09-9127
CAL. No. 13-01675MM

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

PRESENT:

Hon. JOSEPH A. SANTORELLI
Justice of the Supreme Court

MOTION DATE 2-25-14 (#001)
MOTION DATE 2-13-14 (#002 & #003)
ADJ. DATE 6-10-14
Mot. Seq. # 001 - MD
002 - MD
003 - MotD

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SAMUEL OMANE, an infant by his mother and natural guardian, BATHSHEBA OMANE,

Plaintiff,

- against -

HERA SAMBAZIOTIS, M.D., ALAN MONHEIT, M.D., ADAM SINGER, M.D., ANTHONY ROYEK, M.D., HITESH NARAIN, M.D., MARTINA FRANDINA, M.D., KAREN COBURN, N.P., NORA BABBINO, R.N., CORINNE BUCKLEY, R.N., HEATHER L. FINDLETAR, R.N., LAURA J. PICKERING, R.N. and JILL A. LEON, R.N.,

Defendants.

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KRAMER, DILLOF, LIVINGSTON & MOORE
Attorney for Plaintiff
217 Broadway
New York, New York 10007

ERIC T. SCHNEIDERMAN
ATTORNEY GENERAL STATE OF NY
Attorney for Defendants Sambaziotis, M.D., Frandina, M.D., Coburn, N.P., Babbino, R.N., Findletar, R.N., Buckley, R.N., Pickering, R.N., & Leon, R.N.
300 Motor Parkway, Suite 205
Hauppauge, New York 11788-5127

KELLY, RODE & KELLY, LLP
Attorney for Defendants Monheit, M.D., Singer, M.D., & Royek, M.D.
330 Old Country Road
Mineola, New York 11530

FUMUSO, KELLY, DEVERNA, SNYDER SWART & FARRELL, LLP
Attorney for Defendant Narain, M.D.
110 Marcus Boulevard, Suite 500
Hauppauge, New York 11788

Upon the following papers numbered 1 to 91 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (003)1 - 29; (002) 30-53); (001) 54-67, further affirmation and exhibits 68-70 ; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 71-83 ; Replying Affidavits and supporting papers 84-85; 86-87;88-89; 90-91 ; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by defendants, Hera Sambaziotis, M.D., Martina Frandina, M.D., and Karen Coburn, NP, Laura J. Pickering, RN, and Jill A. Leon, RN, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied as untimely; and it is further

ORDERED that motion (002) by defendant, Hitesh Narain, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against defendant Narain, is denied; and it is further

ORDERED that motion (003) by defendants, Alan Monheit, M.D., Adam Singer, M.D., and Anthony Royek, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is denied as to defendants Alan Monheit, M.D. and Anthony Royek, M.D., and is granted as to defendant Adam Singer.

The note of issue and certificate of readiness were filed with this court on September 24, 2013, and pursuant to the court's computer, the last date on which to serve a motion for summary judgment was on January 22, 2014. The moving defendants did not serve their motion until January 23, 2014, and supporting papers and further affirmation by counsel were served on January 27, 2014. Therefore, all the moving papers in motion (001) were served beyond the 120 days provided for by CPLR 3212. Although counsel for these moving defendants affirms that this motion has been timely served, it was not, and counsel offers no excuse for the failure to serve this motion by January 22, 2014. "Good cause" in CPLR 3212 (a) requires a showing of good cause for the delay in making the motion a satisfactory explanation for the untimeliness-rather than simply permitting meritorious, non-prejudical filings, however tardy. No excuse at all, or a perfunctory excuse, cannot be good cause" (*see* ***Brill v City of New York***, 2 NY3d 648, 781 NYS2d 261 [2004]; ***First Union Auto Finance, Inc.***, 16 AD3d 372, 791 NYS2d 596 [2d Dept 2005]; ***Tucci v Colella***, 26 Misc 3d 1234A, 907 NYS2d 441 [Sup Ct New York, Kings County 2010]). Based upon the failure of counsel to ascertain the last date upon which said motion could be served, and upon the failure to offer any excuse for not having timely served motion (001), it is determined that good cause has not been demonstrated.

It is noted that counsel for the moving defendants in motion (001) avers in the reply that the plaintiff does not oppose motion (001) with respect to the relief sought by defendants Karen Coburn, NP and Nora Babbino, RN. Although the motion is untimely, the parties are not precluded from entering into a stipulation of discontinuance, if so advised.

Accordingly, motion (001) is denied.

In this medical malpractice action, Bathsheba Omane (Greene) commenced this action on behalf of her infant son, Samuel Omane. Bathsheba Greene, then 21 years of age, was seen for an elevated blood pressure and noses bleeds on November 18, 1999, by Adam Singer, M.D., an emergency room attending at Stony Brook University Hospital. She was discharged with instructions to follow-up with her obstetrician, and later that day, she was seen in the clinic by Dr. Hera Sambaziotis, M.D. Ms. Omane was thereafter admitted to Stony Brook University Hospital on February 4, 2000, under the care of Dr. Anthony Royek. The following day she came under the care of Dr. Alan Monheit, in place of Dr.

Royek. At that time, she was in her twenty fifth week of pregnancy, with a history of two prior pregnancies which were electively terminated. The infant, Samuel Omane, was born on February 6, 2000, by cesarean delivery performed by defendant Dr. Hitesh Narain. The infant weighed one pound five ounces and had Apgar scores of 3 at one minute and 8 at five minutes, and was admitted to NICU. The infant's mother alleges the defendants negligently departed from good and accepted standards of care and practice prior to, and during the labor and delivery of her infant son, and failed to provide her with informed consent. The plaintiff alleged that due to the negligence of the defendants, the infant was caused to suffer asphyxia, hypoxia; hypoxic ischemic encephalopathy; premature birth; blood loss; retinopathy of prematurity; anemia; cerebral palsy with spasticity; motor development delays; limited and/or inability to speak; seizures; cognitive delays and/or impairment; and, among other things, loss of enjoyment of life; and the need for physical, occupational, and speech/language therapy.

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 (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***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 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 [2d Dept 1981]).

In support of motion (002), defendant Hitesh Narain, M.D. submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, his answer, plaintiff's verified and amended verified bills of particulars; the uncertified Stony Brook Hospital record, including fetal tracings, which is not in admissible form pursuant to CPLR 3212 and 4518 (*see* ***Friends of Animals v Associated Fur Mfrs.***, *supra*); unsigned and uncertified copies of the transcripts of the examinations before trial of Bathsheba Omane dated July 30, 2010, and continuing examination, Hera Sambaziotis, Alan Monheit, M.D., and continuing transcript, Adam Singer, M.D., Martina Frandina, which are not in admissible form (*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]); the unsigned but certified transcript of the moving defendant Naran which is deemed adopted as accurate by the moving party and is considered (*see* ***Ashif v Won Ok Lee***, 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]) and Samuel Omane, which is considered (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); and the affirmation of Adiel Fleischer, M.D.

In motion (003), defendants Monheit, Singer and Royek, submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, his answer, plaintiff's verified and amended verified bills of particulars; exhibits E, F G, H, I, J, K, L, M, O, P, Q, R which consist of a single page each advising to "contact our office if you are in need of this exhibit," and therefore cannot be considered as

the exhibits are not submitted with the moving papers; various uncertified copies of the Stony Brook University Hospital record which are not in admissible form pursuant to CPLR 3212 and 4518 (*see* ***Friends of Animals v Associated Fur Mfrs***., *supra*); the affirmations of Gerald M. Brody, M.D., Victor R. Klein, M.D.; and the unsigned and uncertified transcript of the examination before trial of Bathsheba Omane which is not in admissible form.

Expert testimony is limited to facts in evidence (*see* ***Allen v Uh***, 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom***, 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts, Inc.***, 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]).

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[2d Dept 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 [2d Dept 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 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 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 (002) by Hitesh Narain, M.D., the affirmation of Adiel Fleischer, M.D. has been submitted. Dr. Fleischer affirms that he is licensed to practice medicine in New York State and is board certified in obstetrics and gynecology, and maternal fetal medicine. He has not set forth his education and training, but did provide information concerning his employment status involving obstetrics and gynecology. He set forth the records and materials which he reviewed in rendering his opinion. Dr. Fleischer stated that it is his opinion within a reasonable degree of medical certainty that Dr. Narain, M.D. treated the plaintiff appropriately and did not deviate from the standard of medical practice in any of the care and treatment provided, and that the care and treatment rendered to the plaintiff did not cause or contribute to any of the injuries alleged.

Dr. Fleischer stated that the plaintiff, Bathsheba Greene, was being seen at Stony Brook University Hospital for prenatal care. She was seen at Stony Brook University Hospital on November

18, 1999, four months pregnant, suffering from nose bleeds. On February 4, 2000, she presented to the emergency room with swelling in her extremities, and was admitted to the maternal fetal medicine service with an initial diagnosis of preeclampsia. Dr. Royek was the admitting doctor and followed her care and treatment that day. Dr. Monheit took over her care the following day, November 5, 2000. Dr. Narain was the on-call obstetrician on February 6, 2000. Defendant resident, Dr. Frandina, was on duty on February 6, 2000, and saw Ms. Greene at about 5:23 p.m. Dr. Frandina alerted Dr. Narain that Ms. Greene's blood pressure remained uncontrolled. Dr. Narain evaluated the infant's mother at about 5:30 p.m., and also evaluated her sonogram which indicated the infant's position moved from a transverse to vertex presentation. Dr. Narain made the decision to order Pitocin to induce contractions and attempt a trial of labor to deliver the infant vaginally because of the change in the infant's position and the mother's worsening preeclampsia. Pitocin was started at 5:55 p.m., and discontinued at 8:16 p.m. A cesarean section was started at 8:37 p.m. and the infant, Samuel Omane, was delivered at 8:45 p.m. with Apgar scores of 3 at one minute and 8 at five minutes. He was admitted to NICU.

Dr. Fleischer continued that when Dr. Narain became involved in the mother's care and treatment, on February 6, 2000, she had already been diagnosed with pre-eclampsia and had been started on medications, including magnesium sulfate, betamethasone, and hydralazine. Dr. Fleisher stated that the only way to treat preeclampsia is to deliver the fetus, as that is the only thing which will change the condition. He continued that Dr. Narain promptly saw the mother when called by Dr. Frandina, evaluated the mother, and determined the fetus was now in an ideal vertex position for vaginal delivery, and started Pitocin to induce labor. He continued that giving Pitocin to a woman who is not in labor poses no additional risk, and giving Pitocin along with a trial of labor is within the standard of care. Dr. Fleischer stated that although Dr. Monheit had written on February 5, 2000 that the plan was for a cesarean delivery, that was due to the transverse lie of the fetus. Once the position changed to vertex, it was appropriate within the standard of care to attempt a vaginal delivery.

Dr. Fleischer opined that the administration of Pitocin to stimulate contractions, regardless of the gestational age, and a trial of labor were appropriate and not contraindicated. A vaginal delivery of an infant at 25 and 26 weeks gestational age is not contraindicated, whether or not the mother has preeclampsia. Dr. Fleischer stated that the fetal heart rate strips show that the mother did not experience contractions, and therefore, it can be concluded that Pitocin did not have any effect whatsoever on the fetus. Dr. Fleischer stated that in evaluating the infant's fetal monitor strips, there were some decelerations noted, but none that required an emergency cesarean section. Given that labor would have led to the increase in the frequency and depth of decelerations, and the mother was remote from delivery, Dr. Narain performed the cesarean section. Dr. Fleischer stated that the infant's Apgar scores were good considering the fetal age of the infant. He continued that a child born at 25 to 26 weeks gestational age is severely premature and there is a probability that it will suffer some negative effects as a result of the need to be delivered. Dr. Fleischer concluded that the care provided by Dr. Narain was at all times appropriate and within the standard of care and was not the proximate cause of the injuries alleged by the plaintiff.

Based upon the foregoing, while Dr. Fleischer's opinions are somewhat vague and conclusory, it is determined that Hitesh Narain, M.D. has established prima facie entitlement to summary judgment dismissing the complaint and any cross claims which may be asserted against him.

In motion (003), defendant physicians, Monheit, Singer, and Royek, have submitted the affirmation of Gerald M. Brody, M.D. on behalf of Adam Singer, M.D., and the affirmation of Victor Klein, M.D. on behalf of Anthony Royek, M.D. and Alan Monheit, M.D.

Dr. Brody affirmed that he is licensed to practice medicine in New York State and that he is board certified in emergency medicine and internal medicine. His practice involves all aspects of emergency medicine, and he indicated that he is fully familiar with generally accepted standards of care in emergency medicine, and offers his opinions based upon such standards in existence in 1999. He set forth the materials and records he reviewed, and offered his opinions within a reasonable degree of medical certainty. Dr. Brody stated that Dr. Singer saw the plaintiff mother in the emergency room at Stony Brook Hospital on November 18, 1999, when she presented with epistaxis (nosebleeds) and/or hypertension. Upon arrival, she complained of nasal congestion, with nosebleeds occurring two times a day for one month, and a recent cough and cold. She was also four months pregnant at the time. Her blood pressure was 160/82. She denied dizziness, shortness of breath, blurred vision, vomiting, chest pain, or hematuria. She was seen by the resident, and then by Dr. Singer, the emergency room attending physician.

Dr. Singer noted that Ms. Greene's blood pressure was 140/100, there was no active bleeding from her nose, and there was no swelling in her extremities. Dr. Brody set forth the diagnostic studies ordered by Dr. Singer, but indicated that the hospital record does not contain a print-out of the laboratory results for the studies ordered and sent to the laboratory on November 18, 1999. However, he stated, Dr. Hera Sambaziotis saw the infant plaintiff's mother on November 18, 1999, following her discharge from the emergency room, and recorded the laboratory results in the record which was incorrectly dated November 17, 1999. Dr. Singer called for an obstetrical consult, and after the infant plaintiff's mother was seen by the obstetrical resident, it was decided that she should be seen the same day with Ob/Gyn. She was discharged with instructions to do so, and to notify the obstetrician of her elevated blood pressure. This was when Dr. Hera Sambaziotis saw the infant plaintiff's mother that same day. Dr. Brody stated that Dr. Sambaziotis was not aware of the patient's elevated blood pressures documented in the ambulance sheet or emergency room record, but she Dr. Sambaziotis reviewed the laboratory studies which had been performed earlier that day. He set forth Dr. Sambaziotis' plan of care, and noted that the infant plaintiff's mother's blood pressure was recorded in the clinic record as 118/72, and that the urine was negative for protein. Thereafter, sonograms were obtained on December 1, 1999 and December 17, 1999, indicating fetal growth was normal, and the fetus' size was appropriate for gestational age.

Dr. Brody stated that hypertensive disorders (elevated blood pressures) represent a significant complication of pregnancy, and treatment during an emergency department presentation is guided by the degree of blood pressure elevation, gestational age of the fetus, signs of acute target-organ injury, and whether the blood pressure put the patient at risk for a hypertensive emergency. He described an hypertensive emergency when there is an acute target-organ injury present in the setting of markedly elevated blood pressures and/or severe preeclampsia. Dr. Brody stated that because the infant's mother's blood pressure was monitored in the emergency room on November 18, 1999, on three occasions, Dr. Singer timely and appropriately determined that she did not have an hypertensive emergency. He continued that Dr. Singer determined that the mother did not have a severely elevated blood pressure, defined with a systolic pressure of 160 mm Hg or greater, and/or a diastolic pressure of 110 mg Hg or

greater. Dr. Brody stated that the target-organ damage associated with a severely elevated blood pressure can include renal failure, hepatic failure, and central nervous system injuries, such as seizures and stroke, which the mother did not have.

Dr. Brody also opined that Dr. Singer timely and appropriately evaluated the infant's mother for preeclampsia and determined that she had no evidence of it based upon the then gestational age of 14 and 3/7 weeks, lack of proteinuria, normal platelet count, normal hepatic enzymes, and no symptoms of headaches, visual disturbances, or epigastric pain. There was no edema noted in her extremities. Although the infant's mother experienced weight gain in the former half of her pregnancy, Dr. Singer was not required to intervene concerning her weight gain while she was a patient in the emergency room. He ordered and reviewed laboratory studies and determined that they were normal prior to discharging her home. He also provided for Ob/Gyn follow-up. Dr. Brody stated that Dr. Singer appropriately determined that the infant's mother had mildly elevated blood pressure, and did not require antihypertensive therapy. Dr. Brody indicated that there is no evidence that lowering mildly elevated blood pressures will prevent the incidence of preeclampsia, pre-term labor, or placental abruption. He added that reducing blood pressures in mildly hypertensive patients has been shown to decrease placental perfusion to below necessary to maintain adequate placental perfusion.

Dr. Brody continued that with no evidence of end-target damage, including proteinuria, Dr. Singer appropriately determined that the infant's mother could be followed on an outpatient basis, and he properly instructed her. Before she was discharged, he stated, Dr. Singer timely and appropriately requested an obstetrical consultation due to the elevated blood pressure. He added that there was no mismanagement of the mother's epistaxis as she had no active bleeding in the emergency room. Dr. Brody stated that while hypertension does not cause epistaxis, it may prolong it, and that treatment would be focused on controlling the bleeding and not reducing the blood pressure.

Dr. Brody stated that the care and treatment provided by Dr. Singer was timely and appropriate and within the standard of care of emergency medicine, and was not the proximate cause of the injuries alleged to the infant plaintiff. He stated that on February 4, 2000, at 25 and 4/7 weeks pregnant, the infant plaintiff's mother was admitted to Stony Brook Hospital with complaints of swelling in her face, arms and legs. Her blood pressure was 175/110 and her urine had a trace of protein. She was diagnosed with severe preeclampsia. She was observed and monitored, and delivered by cesarean section 48 hours from when the first steroid medication was administered.

Based upon the foregoing, it is determined that Adam Singer, M.D. has established prima facie entitlement to summary judgment dismissing the complaint and any cross claims which may be asserted against him.

Dr. Monheit and Dr. Royek submitted the affirmation of Victor Klein, M.D., who affirmed that he is a physician licensed to practice in New York State and is board certified in obstetrics and gynecology, with subcertification in maternal fetal medicine, and in clinical genetics. He set forth his current employment, and stated that he is fully familiar with the generally accepted standards of care and practice in obstetrics and gynecology in 1999-2000. He did not set forth when he became licensed or board certified, how long he has been practicing, and the basis for his familiarity with the accepted

standards of care and practice in obstetrics and gynecology in 1999-2000. It is Dr. Klein's opinion within a reasonable degree of medical certainty that the obstetrical and maternal fetal care rendered by defendants Alan Monheit, M.D. and Anthony Royek, M.D. to Bathsheba Omane from November 18, 1999 to February 6, 2000, conformed to accepted obstetrical and maternal fetal care standards of care and treatment, and was not the proximate cause of the infant plaintiff's alleged injuries.

Dr. Klein stated that the infant's mother presented to Stony Brook University Hospital prenatal clinic on September 9, 1999, and was seen by Karen Coburn, NP, who determined she was at seven weeks gestation with positive group beta streptococcus, with no prior history of hypertension. The infant's mother missed her October 25, 1999 appointment at the clinic, but presented to the emergency room on November 18, 1999 with complaints of nosebleeds. There she was seen and evaluated by the resident, and by the emergency room attending physician, Dr. Singer, and was found to have a blood pressure of 140/100, with no bleeding, and no swelling of the extremities. She was discharged from the emergency room with instructions to advise her obstetrician of her elevated blood pressures. That same day, she was seen by her obstetrician, Dr. Hera Sambaziotis, who found her blood pressure was 118/72, and urinalysis negative for protein. Follow-up sonograms on December 1 and 19, 1999 found the fetal growth was consistent with normal, and the infant was size appropriate for gestational age. The amniotic fluid volume, fetal biometry, and fetal anatomy were all normal. On December 17, 1999, the infant's mother presented to the clinic with a blood pressure of 114/70, and was seen by Dr. Sambaziotis, who discussed the mother's care with Alan Monheit, M.D. On January 27, 2000, the infant's mother was found to have a blood pressure of 116/70 and 1+ pedal edema, and was seen by Dr. Sambaziotis, who discussed the mother's care with Alan Monheit, M.D.

Dr. Klein also opined with regard to the infant's mother's earlier prenatal care, noting that there were four elevated blood pressures experienced by the infant's mother on November 18, 1999, and at her emergency room visit, and that the subsequent normal blood pressures indicated that her elevated blood pressures in the emergency room were transient. He stated that the two urinalysis of November 18, 1999, which showed trace and negative protein, did not correlate with proteinuria, as the protein was not significant and did not prompt the need for further testing at that visit. Dr. Klein continued that the normal blood pressure readings on November 18, 1999, December 17, 1999 and January 27, 2000, did not meet the criteria for chronic hypertension and did not warrant further blood pressure surveillance. He stated that the nose bleeds were not a sign of target-organ damage and are so common in pregnancy due to increased vascularity of the maternal system, that a definitive association has not been established between hypertension and epistaxis. Dr. Klein opined that had Dr. Monheit known of the three elevated blood pressures in the emergency room on November 18, 1999, that he would not have changed antepartum management of the infant's mother as there was no evidence of proteinuria, no signs of target-organ damage, headache or epigastric pain. Dr. Klein opined that there is no evidence that lowering blood pressure will prevent or reduce the incidence and progression of preeclampsia, and that treatment of mildly chronic hypertension has not been shown to alter the risk of pre-term labor, placental abruption, and small for gestational age infants. Thus, opined, Dr. Klein, Dr. Monheit appropriately determined that treatment of the infant plaintiff's mother with antihypertensive medication from November 18, 1999 through February 4, 2000 was not indicated, that he appropriately monitored the infant's mother and fetal well being, and appropriately excluded preeclampsia at each antepartum visit. Dr. Klein continued that to diagnose preeclampsia, a woman must be at 20 weeks gestation, have an

elevated blood pressure of at least 140/90, and have proteinuria. It is his opinion that the infant's mother did not have preeclampsia until she presented to Stony Brook Hospital on February 4, 2000. He indicated that weight gain of the infant and of the mother did not warrant further testing as there is a negligible effect of edema or weight gain during pregnancy on perinatal morbidity.

Dr. Klein discussed the infant's mother's admission to Stony Brook Hospital labor and delivery service on February 4, 2000, when she was admitted for complaints of nosebleeds, swelling, difficulty breathing, and chest pain, with a blood pressure of 174/114, and urine protein at 300 mg/dL, as noted by Dr. Royek, the admitting physician. Dr. Klein described the mother's care and treatment, including sonograms, intravenous magnesium sulfate to prevent seizure activity, and betamethasone to promote fetal pulmonary maturity, hydralazine to control her blood pressure, and the plan to consider delivery after 48 hours of betamethasone, or earlier if there was evidence of worsening maternal-fetal status.

Dr. Klein stated that on February 5, 2000, Dr. Monheit took over for Dr. Royek and noted the mother's condition of severe preeclampsia with no deterioration. The plan was that monitoring was to continue, she was to be administered a second betamethasone injection, and it was hoped that she would reach 48 hours from the first injection for maximum benefit for the fetus. Dr. Klein stated that Dr. Monheit saw the infant's mother at 10:40 a.m. on February 6, 2000, noted her multiple episodes of blood pressure greater than 180/110, and planned for delivery of the infant that evening, 48 hours after the first injection of betamethasone. If the infant was still in malposition, a cesearean section would be done.

About 5:00 p.m. on February 6, 2000, the infant's mother complained of pressure in her head and dizziness, and was seen by Dr. Martina Frandina, who notified Dr. Hitesh Narain, who was covering that day for Dr. Monheit. Dr. Klein continued that Dr. Narain saw the infant's mother at 5:30 p.m., evaluated the sonogram which now showed the infant in a vertex position, and decided to give a trial of labor with Pitocin, but delivered the infant when some decelerations appeared on the fetal monitor strips.

Dr. Klein stated that optimal management of severe preeclampsia depends on balancing the risks to the mother and the fetus from pregnancy prolongation versus the risk of prematurity from immediate delivery. If gestational age is remote from term, expectant management, when possible, should be attempted with the aim of improving neonatal outcome without jeopardizing maternal safety. Dr. Klein opined that Dr. Royek appropriately managed and monitored the mother's condition and provided the necessary care and treatment to her. His plan to deliver after 48 hours from administration of the betamethasone to maximize fetal lung maturity was appropriate, and that if there was deterioration of either maternal or fetal status, that delivery should be sooner. The administration of hydrazaline by Dr. Royek was appropriate to lower the blood pressure to prevent cerebral hemorrhage, and despite the administration of said medication, the infant's mother still had multiple episodes of blood pressure greater than 180/110. Therefore, Dr. Klein stated, it was appropriate for Dr. Monheit to make the decision to deliver the infant 48 hours from the administration of betamethasone. Infants born to pregnancies complicated by hypertension syndromes, including severe preeclampsia, and who are administered corticosteroids, have significantly reduced risk of neonatal death, respiratory distress syndrome, cerebrovascular hemorrhage, and necrotizing enterocolitis. Thus, he opined, it was appropriate for Dr. Royek to order the first dose of betamethasone, and Dr. Monheit to order the second dose.

Dr. Klein continued that Dr. Royek and Dr. Monheit appropriately administered magnesium sulfate intravenously and monitored the serum levels, as well as the mother's clinical status, and that the mother showed no signs of magnesium toxicity. Dr. Klein stated that the relatively flat, non-reactive appearance of a fetal tracing is typical in a preterm fetus as its central nervous system is not fully developed. He continued that fetal heart rate decelerations in the absence of uterine contractions often occur as a normal pattern in preterm fetuses between 20-30 weeks gestation. Thus, he stated, the fetus' heart tracings were reassuring to Dr. Monheit and Dr. Royek, when considered along with the reassuring biophysical profile of February 6, 2000 by Dr. Sambaziotis.

Based upon the foregoing, Alan Monheit, M.D. and Anthony Royek, M.D. have established prima facie entitlement to summary judgment dismissing the complaint as asserted against them.

The plaintiff's expert averred that he/she is a physician licensed to practice medicine in Massachusetts, and is board certified in obstetrics and gynecology and has managed and participated in hundreds of labors and deliveries. He stated that he is familiar with the standard of care in 1999 applicable to prenatal care, obstetrical care, labor and delivery, and the care provided by maternal fetal specialists, obstetricians, nurses, and residents. The plaintiff's expert set forth the infant's mother's history and care and treatment, and the problems she experienced during her pregnancy with heavy and frequent nose bleeds, and weight gain of over 50 pounds by February, 2000. The baby was not due until May 16, 2000, but was born on February 4, 2000.

The plaintiff's expert stated that Dr. Sambaziotis testified that trace protein in the urine and elevated blood pressures would increase the awareness for potential preeclampsia. The plaintiff's expert opined that preeclampsia would have been considered had Dr. Monheit been made aware of the mother's hypertension on November 18, 1999 emergency visit, and lead to the suspicion that she was preeclamptic on January 27, 2000.

The plaintiff's expert reviewed the fetal monitor strips and noted that on the night of February 4, 2000, into the morning of February 5, 2000, there were decelerations at 6:45 p.m., 7:09 p.m., 9:16 p.m., 10:36 p.m., 11:36 p.m., and into February 5, 2000 at 12:28 a.m., 2:00 a.m., and 5:00 a.m. The 6:45 p.m. decelerations were sharp, variable decelerations. He stated that Dr. Royek testified that he would have been notified of the decelerations during the night, and had he been informed, he would have written a note to that effect, however, there is no indication that Dr. Royek was informed. At 7:20 p.m. magnesium sulfate was ordered. At 9:16 p.m. there was a sharp variable deceleration. At 10:36 p.m., there was a prolonged variable deceleration for approximately two minutes. At 11:36 p.m. another deceleration lasted for approximately two minutes. The infant's mother's blood pressure was 160-170/90s. The plaintiff's expert's reading of the fetal monitor strip demonstrates multiple, prolonged variable decelerations, and raises factual issues with Dr. Klein's opinion that the fetal monitor tracings of the fetus' heartbeat was relatively flat, and that they had a non-reactive appearance. He disagreed with Dr. Klein's reliance on the biophysical profile performed by Dr. Sambaziotis because it does not assess oxygenation to the fetus' brain, and it was incomplete, as it did not document the fetal position. The plaintiff's expert stated that while oxygen could have been given by the nursing staff without a doctor's order, for these decelerations, nothing was done.

The plaintiff's expert continued that while the mother was still under Dr. Royek's care on February 5, 2000, at 2:00 a.m., there was another deceleration for approximately two minutes, and at 5:00 a.m., there were three variable decelerations. From 4:00 a.m. until 5:30 a.m., the infant's mother vomited seven times, she appeared more ill with more malaise, and was more uncomfortable compared to her condition on admission. As the mother's condition worsened, and decelerations occurred at 5:33 a.m. and 6:00 a.m., no action was taken in response. Thereafter, the fetal baseline was 130-140 with decreased variability at times. Variable decelerations were noted at 6:46 a.m. for approximately two minutes. Dr. Monheit took over for Dr. Royek as the infant's mother's attending at 8:00 a.m. on February 5, 2000. The plan was that delivery would be a very strong consideration 48 hours after the first dose of betamethasone, but if the mother's blood pressure remained severely elevated despite medications and bed rest, then that would be a strong factor for delivery. At 10:39 a.m. there was a two minute variable deceleration that lasted about two minutes with minimal beat-to-beat variability. The plaintiff's expert stated that it is documented, and Dr. Monheit testified, that the mother's blood pressure was at times elevated into the severe range of more than, or equal to, 180/110.

The plaintiff's expert continued to set forth the many decelerations in fetal heart rate experienced by the fetus, and opined that when the infant's mother was admitted to Stony Brook Hospital on February 4, 2000, that Dr. Royek, and specific nursing staff, departed from good and accepted medical practice in a number of respects with regard to the nonreassuring fetal heart rate tracings at the time. Dr. Royek failed to institute intrauterine resuscitative measures during any of the episodes of variable decelerations that occurred in the evening of February 4 into the morning of February 5, 2000. He continued that variable decelerations are indications that the fetus is in distress. It is the plaintiff's expert's opinion that it was at this point that the mother's preeclampsia was affecting perfusion of the placenta resulting in diminished supply of oxygen to the fetus. He set forth the resuscitative measures that should have been employed and were not. He continued that it was incumbent upon Dr. Royek to monitor the infant's mother and review the fetal heart tracings himself, even if he was not notified of the decelerations by nursing, and that it was a departure from the standard of care for Dr. Royek not to review those tracings. The plaintiff's expert stated that Dr. Englebert stated that Dr. Royek reviewed the fetal monitor tracings, but there is no indication that he did so until the following morning. It was not until 6:16 a.m. on the morning of February 5, 2000 that a bolus of saline was given, and at 7:45 a.m., oxygen was provided. This, he stated, would not have been done if the fetus was doing well. The plaintiff's expert stated that these tracings indicated the fetus was not getting enough oxygen, and that the failure to treat the numerous and prolonged decelerations on February 4 into February 5, 2000 was a departure from the standard of care and a substantial contributing factor to Samuel's neurological injuries.

The plaintiff's expert continued that on February 6, 2000 at 12:09 a.m., there was a variable deceleration followed by another deceleration at 12:53 a.m. Variability was absent for about five or six minutes during this time. He stated that fetal heart rate beat-to-beat variability is an important indicator of a healthy nervous system. He continued that hypoxia, tachycardia, and congenital heart defects can cause decreased or absent beat to-beat-variability. While there may be decreased variability in a fetus at an earlier gestational age, it is plaintiff's expert's opinion that the infant, Samuel, was at a stage where beat-to-beat variability should have been in the normal range. He continued that while there were times that the nurses did institute intrauterine resuscitative measures when the fetal heart rate was good, and in

some instances where variability was absent or minimal, however, these measures were not taken timely, were ineffective, and not properly followed-up to ensure a more reassuring fetal heart rate pattern. Dr. Sambaziotis noted that decreased variability, a sign of hypoxia, started around midnight on February 6, 2000, and the fetus continued with absent beat to beat variability to 1:40 a.m. Dr. Monheit was not informed and no resuscitative measures were instituted except for one bolus of saline at 12:15 a.m.

The plaintiff's expert stated that Dr. Monheit, Dr. Narain, Dr. Samaziotis, and Dr. Frandina departed from good and accepted standards of care and practice in failing to administer Labetalol to the infant's mother sooner than February 6, 2000 at 7:10 p.m. because her blood pressure was severely elevated through that time despite the administration of Hydralazine. Dr. Monheit documented on February 6, 2000 at 10:40 a.m. that there were multiple episodes when the mother's blood pressure was 180/110 or greater. At 2:45 p.m. it was 167/103. At 3:00 p.m. and 3:10 p.m., Hydralazine was ordered. At 4:00 p.m.,the infant's mother complained of increased pressure in her head and some dizziness. At 5:00 p.m., her blood pressure was 160/112, and she continued to complain of pressure in her head and some dizziness, which are symptoms of increased blood pressure. The plaintiff's expert stated that the infant's mother was not responding to Hydrazaline, and that the standard of care required Labetalol be administered on February 5, 2000 when it became evident that Hydrazaline alone was not lowering her blood pressure. The improvement in her blood pressure was significant after the Labetalol was administered on February 6, 2000 at 7:10 p.m. However, due to the worsening blood pressure, it was decided to proceed with the delivery, which could have been avoided, stated plaintiff's expert, had her blood pressure been properly controlled.

The plaintiff's expert disagrees with Dr. Klein's opinion that Labetalol is no more effective than Hydralazine, because it was more effective in lowering the plaintiff's mother's blood pressure when it was administered. Instead of sitting around waiting, the alternative Labetalol was available, and the standard of care required its administration far sooner than February 6, 2000. It was known from the facts in this case, he continued, that the mother's blood pressure did respond to Labetalol, and if used in conjunction with Hydrazaline, would have lowered her blood pressure to acceptable levels, as was accomplished late on February 6, 2000. The failure to timely administer Labetalol sooner was a departure from good and accepted medical practice and a substantial contributing factor to Samuel's prolonged hypoxia and related neurological injuries. He stated that Samuel was born severely depressed and had suffered a neurological injury from the prolongs periods of hypoxia and lack of oxygen to the brain that occurred throughout the February 4, 200 admission until delivery.

The plaintiff's expert stated delivery is the only treatment for preeclampsia, but the treatment when dealing with a patient with preeclampsia is to lower the blood pressure for as long as possible so the baby can continue to develop in utero. He continued that Dr. Narain departed from good and accepted standards of care and treatment by ignoring the infant's mother the entire day of February 6, 2000, without checking on her even once, which significantly contributed to the infant's neurological injuries. He stated that it was a departure from the standard of care for Dr. Narain to induce labor instead of performing a cesarean section delivery. Once induction was started, Dr. Narain did not continue to monitor the infant's mother or the infant and did not continuously review the fetal monitor strips to ascertain the fetus' welling. The plaintiff's expert noted that Dr. Frandina testified that she did not want the infant's mother to wait to deliver until 7:00 p.m. as she was fearful the mother would suffer

a stroke from the ongoing elevating blood pressures and worsening symptoms.

The plaintiff's expert continued that Dr. Monheit testified that the mother's cervix was 'unfavorable for induction and that induction might take a long time, and this patient is ill and ... it might not be in her best interest to go through a long induction...," ... and in "some situations like this one, the fetus might not tolerate going through labor ...." "because the baby might not tolerate all the contractions in going through the labor leading to delivery." He stated that Dr. Monheit also stated that in preeclampsia there can be decreased uteroplacental perfusion and a fetus may not be able to tolerate repeated contractions that would be needed to achieve delivery through the induction process and labor leading to birth. It is plaintiff's expert's opinion that, because the infant's mother had severe preeclampsia when the labor was initiated, the infant suffered hypoxia when the labor was attempted. He continued that Dr. Narain erroneously and inexplicably decided to induce labor with Pitocin, over a two and one half hour period, during which time it was documented that the "fetus almost immediately had deep variables" which persisted through 8:15 p.m., down to the 80s with each contraction, demonstrating the fetus's intolerance of labor, as noted by Dr. Frandina. The plaintiff's expert opined that Dr. Narain's proceeding with a Pitocin induction of labor was contrary to the best interests of the mother and child and was a departure from good and accepted medical practice, as the standard of care required a cesarean delivery immediately at 5:30 p.m. Had good practice been followed, the infant would not have suffered the more than two hours of oxygen depletion and deprivation, hypoxia and asphyxia, which were substantial contributing causes of the infants neurological injuries.

The plaintiff's expert also raises factual issues with the defendants' experts in that it is his opinion that the infant's hypoxic brain injuries were not caused by premature birth. He stated that while there is some general risk of complications when a baby is born at 26 weeks gestation, the majority of 26 week old babies are viable and are born normal, which was supported by the testimonies of Dr. Monheit, Dr. Royek, and Dr. Sambaziotis. The plaintiff's expert bases his opinions on the nonreassuring fetal heart monitor strips, the infant's condition and Apar scores at birth prior to resuscitative measures being employed, his injuries, including seizures and his condition from birth to present. He stated that Dr. Sambaziotis testified that due to the infant mother's severe preeclampsia there would be some decreased uteroplacental perfusion, which, over time, would be detrimental to the baby's development. The infant's mother testified that she was told by the NICU nurses that the infant suffered when he was born and that he was losing oxygen when he was born.

Based upon the foregoing, it is determined that the plaintiff's expert has raised factual issues which preclude summary judgment from being granted to Hitesh Narain, M.D., Alan Monheit, M.D., and Anthony Royek, M.D. However, plaintiff has failed to raise a factual issue to preclude summary judgment from being granted to Adam Singer, M.D. The plaintiff's expert has offered no opinion with regard to the care and treatment rendered by Dr. Singer to the plaintiff's mother while she was a patient in the emergency room on November 18, 1999. The plaintiff's expert stated only that Dr. Singer testified that, when asked how the obstetrician (Dr. Sambaziotis) could learn what Ms. Omane's blood pressures were in the emergency room, he stated that physician could call up and ask. Dr. Monheit also testified that Dr. Sambaziotis had discretion to request the emergency room records.

Accordingly, motion (002) by defendant, Hitesh Narain, M.D., and that part of motion (003) by defendants, Alan Monheit, M.D., and Anthony Royek, M.D., for summary judgment dismissal of the complaint as asserted against them are denied as to defendants Hitesh Narain, M.D., Alan Monheit, M.D., and Anthony Royek, M.D., and granted as to Adam Singer, M.D.

Dated: AUG 0 4 2014

HON. JOSEPH A. SANTORELLI
J.S.C.

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