Omane v Sambaziotis
2014 NY Slip Op 32847(U)
October 28, 2014
Sup Ct, Suffolk County
Docket Number: 09-9127
Judge: Joseph A. Santorelli

[* 1]

SHORT FORM ORDER

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

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

COPY

PRESENT:

Hon. JOSEPH A. SANTORELLI
Justice of the Supreme Court

MOTION DATE 9-18-14
ADJ. DATE 9-23-14
Mot. Seq. # 004 - 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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Upon the following papers numbered 1 to 19 read on this motion to renew and reargue; Notice of Motion/ Order to Show Cause and supporting papers (004)1 - 11; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 12-17; Replying Affidavits and supporting papers 18-19; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (004) by defendants, Hera Sambaziotis, M.D., Martina Frandina, M.D., Karen Coburn, NP, Nora Babbino, R.N., Corrine Buckley, R.N., Heather Findletar, R.N., Laura J.Pickering, RN, and Jill A. Leon, RN, pursuant CPLR 2221 (d) for leave to reargue their prior motion

which was brought pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them, and which was denied as untimely, is granted as to reargument, and upon reargument, summary judgment dismissing the complaint is denied as to defendants Hera Sambaziotis, M.D., Martina Frandina, M.D., Corrine Buckley, R.N., Heather Findletar, R.N., Laura J. Pickering, RN, and Jill A. Leon, RN, and is granted to Karen Coburn, N.P. and Nora Babbino, R.N. with prejudice.

CPLR 2221 (d) (2) provides a motion for leave to reargue shall be based upon matters of fact or law allegedly overlooked or misapprehended by the court in determining the prior motion but shall not include any matters of fact not offered on the prior motion. It is a basic principle that a movant on reargument must show that the court overlooked or misapprehended the facts or law or for some reason mistakenly arrived at its earlier decision (***Bolos v Staten Island Hosp.***, 217 AD2d 643, 629 NYS2d 809 [2d Dept 1995]). It is determined that counsel has demonstrated good cause for untimely serving the prior motion (001), and thus motion (004) is granted as to reargument.

Bathsheba Omane (Greene) commenced this medical malpractice action on behalf of her infant son, Samuel Omane. Bathsheba Greene, then 21 years of age, was seen for an elevated blood pressure and nose 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]).

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]).

The moving defendants submitted the expert affirmation of Marc Engelbert, M.D., a physician licensed to practice medicine in New York State who is board certified in obstetrics and gynecology. Although he indicates he is presently an attending physician at Mount Sinai Medical Center, he has not provided his work experience and training or a curriculum vitae to qualify as an expert. In considering his affirmation, however, Dr. Engelbert set forth that the care and treatment provided by residents, Dr. Sambaziotis and Dr. Frandina, did not depart from good and accepted medical practice, and none of the care and treatment provided by them contributed to or caused the alleged injuries; they did not make any independent judgment with regard to the obstetrical management; and they complied with the instructions and directions of the attending obstetricians. He continued that the care and treatment rendered by Dr. Sambaziotis, a first year resident approximately six months into the four-year obstetrical training program, and Dr. Frandina, a third-year resident, was at all times in accordance with their level of training and experience as residents, and was overseen by the attending physicians. Dr. Engelbert stated that none of the treatment plans designated by the supervising attending physicians were contraindicated by normal medical/obstetrical practice such that the residents should inquire as to whether the attending physicians were correct in their obstetrical medical management.

Dr. Engelbert stated that nurses Babbino, Coburn, Buckley, Findletar, Pickering, and Leon did not depart from good and accepted medical practice, and none of the care and treatment provided by them contributed to or caused the alleged injuries. Dr. Engelbert added that at all times the nurses complied with the instructions and directions of the physicians. He continued that nurses do not have the authority to medically diagnose or prescribe for a patient's condition, and that there were no

directions given by the physicians which deviated from normal obstetrical nursing practice such that it called for intervention by the nurses, or required them to inquire into whether the attending physicians were correct in their obstetrical medical management of the plaintiff. Dr. Englebert, however, did not comment upon the nurses' observations of the plaintiff mother's blood pressures, the fetal monitor strip tracings, and the decelerations reported and testified to, and whether they properly and timely reported those findings to the residents and attending physicians, raising factual issues. His opinion is conclusory and unsupported by any specific measures taken by the nursing staff mentioned.

Dr. Englebert indicated that the infant plaintiff's mother was seen on September 29, 1999 for her first prenatal visit at Stony Brook University Hospital, by Alan Monheit, M.D. and nurse practitioner Karen Coburn. No history of hypertension was noted, and she was placed on an antibiotic for a urinary tract infection. On November 18, 1999, the plaintiff's mother was seen in the emergency department at Stony Brook University Hospital by Dr. Adam Singer for nosebleeds occurring for a month. Her blood pressure was 146/88, 138/95, and 140/100, which Dr. Englebert stated were elevated blood pressures for which the patient was referred to follow-up with her obstetrician. That same day, Dr. Sambaziotis saw the plaintiff's mother for a prenatal visit at 14 weeks 3 days gestation. Dr. Sambaziotis noted she had been seen in the emergency room earlier for the nosebleed. She documented a stable blood count and recommended saline nose drops, and referred her to an ENT physician if the nosebleeds continued. Trace protein was noted in the plaintiff's mother's urine, which Dr. Engelbert stated was not significant at this stage of pregnancy. The second urine tested was negative for protein that same date. He continued that on December 17, 1999, when Dr. Sambaziotis saw the plaintiff's mother, her blood pressure was normal, and the sonogram was reassuring, and both Dr. Sambaziotis and Dr. Monheit entered a note in the prenatal record.

Dr. Engelbert opined that pre-eclampsia is a condition of high blood pressure in combination with other findings diagnosed no earlier than 20 weeks of pregnancy, and no diagnosis of pre-eclampsia is made before 20 to 22 weeks. He stated that bedrest in early pregnancy is not the standard of care to prevent preeclampsia, nor is serial blood pressure monitoring. Dr. Engelbert continued that on January 27, 2000, when the plaintiff's mother was 24 weeks 5 days gestation, she had gained 19 pounds since her first visit in September, 1999. Her due date was May 16, 2000. She had one plus pedal edema (fluid under the skin), however, stated, Dr. Engelbert, one plus pedal edema is common and normal at this stage. He opined that the plaintiff's mother did not have preeclampsia on January 27, 2000.

On February 4, 2000, when the plaintiff's mother was 25 weeks 4 days gestation, she was admitted to the labor and delivery unit at Stony Brook University Hospital by Dr. Anthony Royek. Dr. Englebert indicated that her blood pressure was elevated at 175/110, for which she was given Hydrazaline to lower it. Dr. Engelbert opined that Hyrazaline does not cure or treat preeclampsia, but can transiently lower the blood pressure to prevent stroke, seizure, and death of the mother, however, the blood pressures may worsen in any event. He stated that Magnesium Sulfate was given to prevent seizures also. Betamethasone, a steroid, was ordered to promote fetal lung maturity, and delivery would be considered 48 hours after its administration. He added that delivery would be sooner if there was evidence of worsening maternal/fetal status. Dr. Englebert stated that there was consultation at the neonatal intensive care unit, however, he did not indicate the nature of that consultation. A sonogram indicated the fetus was in a transverse lie which would not make a vaginal delivery possible unless the

fetus changed position prior to the performance of a cesarean section. Delivery of the fetus, stated Dr. Engelbert, is the only treatment for preeclampsia.

Dr. Royek reviewed the fetal monitor strips at 6:54 p.m. Dr. Engelbert stated that there were occasional decelerations at 6:54, 7:09, 9:16, 10:36 and 11:36 p.m. on February 4, 2000, and the morning of February 5, 2000 at 12:28 p.m., 2:00 a.m., and 5:00 a.m. He stated these decelerations were sporadic, not repetitive, and not in conjunction with contractions, and that the fetus was "overall stable." Dr. Engelbert continued that the mother's blood pressure ranged from 130/80 to 160/110 during the night of February 4th through 5th. At 7:15 a.m. on February 5, 2000, her blood pressure was 134/89. Throughout February 5th to 6th, continued Dr. Engelbert, the plaintiff's mother was under the care and treatment of Alan Monheit, M.D., and Hitesh Narain, M.D., who reviewed the fetal monitor strips. He stated that the residents, Dr. Frandina and Dr. Sambaziotis, did not participate in plaintiff's care on February 5, 2000. On February 6, 2000 at 10:00 a.m., Dr. Frandina documented that the patient was 25 weeks 6 days gestation, with severe preeclampsia, blood pressure of 148/92 and with protein in her urine. There were no contractions, and the fetal heart rate was in the 120s. Dr. Frandina noted the plan by Dr. Monheit at 10:40 a.m. for a cesarean section at 7:00 p.m. if the fetus remained in malpresentation, as well as his having a discussion with NICU and anesthesia. Dr. Engelbert did not indicate to whom Dr. Monheit spoke.

At 12:00 p.m. on February 6, 2000, Dr. Frandina noted the plaintiff's mother to be without complaints. Her blood pressure was 167/103. The fetal heart rate, still in the 120s, showed no decelerations, and the tocometer showed no contractions. However, at 4:00 p.m., the plaintiff's mother complained of pressure in her head and a headache, which Dr. Frandina documented. While the fetal heart rate was still in the 120s, there was fair variability, with no decelerations or accelerations, and there were no contractions. Dr. Engelbert stated that Dr. Frandina discussed the risk of waiting two hours until 7:00 p.m. for delivery versus continuation and worsening of blood pressures, however, he did not indicate with whom such discussion was had. Dr. Frandina further documented that due to uncontrollable blood pressures, they would proceed to immediate cesarean section, which was discussed with the mother and Dr. Hitesh Narain, the attending physician. A sonogram at 5:30 p.m. revealed the fetus to be in vertex position (head first), so Dr. Narain made the decision to proceed with an attempted vaginal delivery, if possible, and more optimal for future pregnancies for a young mother. Dr. Engelbert, however, did not address the benefits or risks to the fetus if a vaginal delivery is employed as opposed to those benefits or risks to the fetus if a cesarean delivery is employed.

Dr. Engelbert continued that Dr. Frandina ordered Labetalol at 7:10 p.m. to lower the mother's blood pressure, which began to improve. However, at 8:15 p.m. Dr. Frandina documented that the fetus was having persistent variable decelerations to the 80s with each contraction. She also noted that the fetus was intolerant of labor, and the need to proceed with a cesarean section. Dr. Narain reviewed the fetal monitor strips as well and documented that the fetus was not tolerating labor, there was worsening maternal blood pressures, and an emerging pattern of decreased variability. The infant was delivered by cesarean section at 8:45 p.m., stated Dr. Engelbert, due to the diagnosis of severe preeclampsia and the fetus being intolerant of contractions. The infant's APGAR scores were 1 at one minute and 8 at five minutes. He weighed 1 pound 8 ounces. Dr. Engelbert stated that the standard of care is to attempt vaginal delivery if the fetus can tolerate labor and the mother's blood pressures remain stable, or deliver

by cesarean section. Dr. Englebert stated that the time during the persistent variable decelerations made no difference in the infant's outcome as the decelerations were not an indication of hypoxia and the injuries were due overwhelmingly to prematurity and not hypoxia. However, Dr. Engelbert did not state his basis for this vague, conclusory and unsupported opinion with regard to causation of the injuries the infant is alleged to have suffered as a result of the alleged negligent departures from the accepted standard of medical/obstetrical care and practice.

Dr. Engelbert stated that nurse Pickering did not depart from the standard of care and appropriately followed orders to administer Hydrazaline at 1:02 a.m. on February 5, 2000. The fetal monitor strips were being reviewed by the attending physician. Dr. Engelbert opined that nurse Findletar, on February 5, 2000, noted administration of a bolus of normal saline fluid in accordance with the physician's order. On February 6, 2000, she confirmed that a sonogram had been done as ordered, and that she administered Pitocin as ordered by the physician. He stated that nurse Findletar did not depart from the standard of care as it is a nurse's function to administer fluids and medication as ordered by a physician, and that the fetal monitor strips were reviewed by the attending physician. Dr. Engelbert stated that with regard to nurse Leon, on February 5 and 6, 2000, she administered Hydrazaline in accordance with the physician's orders, that she did not depart from the standard of care, and that the fetal monitor strips were reviewed by the attending physician. Concerning nurse Buckley, Dr. Engelbert stated that on February 5, 2000, she administered Hydrazaline and Betamethasone, and later Pitocin and Labetalol, in accordance with the physician's orders, recorded the medications and the bedside sonogram, and did not depart from good and accepted standards of care and treatment. He stated that nurse Babbino documented the mother's discharge note and did not provide care and treatment of the mother during the prenatal period, labor or delivery of the infant, and did not depart from the standard of care. Dr. Engelbert opined that these aforementioned nurses did not cause or contribute to the alleged injuries sustained by the infant plaintiff.

As to the resident physicians, Dr. Engelbert stated that the residency program is designed to provide training to residents such as Dr. Frandina and Dr. Sambaziotis during their care of obstetrical patients, and that they implemented treatment plans created by the attending physicians. The decision of whether and when to perform a cesarean section is within the judgment of the attending physician. He continued that the residents provided good and proper medical care to the plaintiff's mother, and they did not make any independent decisions concerning her care and treatment that resulted in the infant's injury or proximately cause his injury. Dr. Engelbert opined that the attending physicians did not depart from the standard of care because, with severe preeclampsia, the only safe treatment is delivery of the infant despite the very premature gestational age of the infant. Once the infant was found to be in vertex position, it was within the standard of care to attempt vaginal delivery, but once the fetus became intolerant of labor, as demonstrated by the persistent variable decelerations, the decision by Dr. Narain to proceed with a cesarean section was within the standard of care. Dr. Engelbert's opinion is conclusory and unsupported as he has not set forth the basis for stating this is the standard of care, and nor has he correlated the fetal monitor strips and condition of the fetus, except to state that the care and treatment provided by the various defendants comported with the standard of care.

The moving defendants also submitted the affirmation of Joseph Maytal, M.D., a physician licensed to practice medicine in New York, and board certified in pediatrics, clinical neurophysiology,

psychiatry and neurology, with special qualifications in child neurology. He indicated that the infant was born at 26 weeks and was at high risk for development of motor skills impairments, including cerebral palsy, visual impairment, cognitive delays, and behavioral problems, due to the immaturity of the cerebral vasculature, impaired vascular autoregulation, and a variety of cellular factors.

Dr. Maytal stated that the mother's blood pressures were normal in the prenatal clinic and the nose bleeds resolved. She was admitted to the hospital for the treatment of preeclampsia, for which vaginal delivery is the safest method of delivery. Due to the mother's high blood pressure and the emerging pattern of decelerations, it was within the standard of care to deliver the infant by cesarean section, due to the mother's dangerously high blood pressure. He does not address such factors as decreased uteroplacental perfusion as testified to by Dr. Samaziotis relating to the severe preeclampsia and decreased oxygen to the fetus. He concluded that the infant plaintiff sustained his injuries as a direct result of the premature birth, and not due to any departures from the standards of care by the moving defendants.

It is determined that Dr. Maytal's affirmation is conclusory and unsupported by the record. He does not correlate the high blood pressure from which he stated the mother was experiencing, or the decelerations, or identify which decelerations he is considering. He does not comment upon the effect of the high blood pressure upon the fetus, or the forces of contractions upon the fetus prior to delivery, and increasing indications of fetal compromise, and how these factors did or did not cause or contribute to the infant's injuries. His blanket conclusory statements raise factual issues with regard to proximate cause as he does not provide the bases for his vague and conclusive opinions.

Based upon the foregoing, it is determined that there are multiple factual issues and conclusory statements set forth in defendants' expert affirmations, which fail to contain the standard of care in most instances and fail to demonstrate that the infants' injuries are not causally related to the alleged departures by the moving defendants. Therefore, it is determined that the moving defendants have not demonstrated prima facie entitlement to summary dismissal of the complaint.

The plaintiff's expert averred that he/she is a physician licensed to practice medicine in Massachusetts, 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. She experienced chest pains, headaches, felt dizzy, and was very swollen. The baby was not due until May 16, 2000, but was born on February 4, 2000. On November 18, 1999, the plaintiff's mother, Ms. Omane, was taken by ambulance to Stony Brook Hospital with a blood pressure of 160/82, with complaints of nose bleed for one month. When she was seen by Dr. Singer, her blood pressure was 140/100. Dr. Singer's resident discussed Ms. Omane with some obstetrics resident and the plan was to have her follow that day with her obstetrician, which she did later that day, presenting with complaints of nose bleeds, chest pain, headaches and dizziness. She was seen by Dr. Sambaziotis who noted a blood pressure of 118/72 and trace protein in the urine, negative on a second test. The plaintiff's expert stated Dr. Singer testified,

when asked how Dr. Sambaziotis could learn what Ms. Omane's blood pressures were in the emergency room, that the physician could call and ask. Dr. Monheit also testified that Dr. Sambaziotis had discretion to request the emergency room records. Dr. Monheit testified that he did not think he saw the plaintiff's mother on that visit. Plaintiff's expert stated that Dr. Monheit's note was entirely inadequate and that he failed to document any history, complaints, signs or symptoms.

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 at the emergency visit, and lead to the suspicion that she was preeclamptic on January 27, 2000. He stated that the plaintiff's mother testified that she again complained of nose bleeds, swelling, chest pains, and dizziness, however, Dr. Monheit again thought he did not see her on this visit.

Ms. Omane was admitted to Stony Brook University Hospital on February 4, 2000, at 3:48 p.m. for severe preeclampsia. Her complaints were feeling dizzy, headaches, nosebleeds, nauseousness, difficulty sleeping, difficulty breathing, chest pains, and swelling in her arms, legs, and face. Her blood pressure was 175/110. She had bilateral two plus edema. Dr. Royek was the attending of record from 5:00 p.m. until 8:00 a.m. February 5, 2000. It was his plan to order IV fluids and Hydrazaline, urinalysis and other testing, including an ultrasound which demonstrated the fetus was in transverse lie. 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 and variable. 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 in the fetal heart rate. 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.

It is noted that the plaintiff's expert's reading of the fetal monitor strip demonstrates multiple, prolonged variable decelerations, and raises factual issues with the opinion set forth by the expert for Dr. Monheit and Dr. Royek. 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, however, nothing was done by the nursing staff.

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. Her blood pressures were 150-160/90-110. The plaintiff's expert stated that, as the mother's condition worsened, and fetal heart decelerations occurred at 5:33 a.m. and 6:00 a.m., no action was taken in response to either the decelerations or the mother's worsening condition. Her blood pressure was 130-160/80-110. 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.

The plaintiff's expert continued that Dr. Monheit took over for Dr. Royek as the infant's mother's attending at 8:00 a.m. on February 5, 2000, and agreed that she had severe preeclampsia based upon her blood pressure. 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 variable deceleration that lasted about two minutes with minimal beat-to-beat variability. The plaintiff's expert stated 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. This raises factual issues with Dr. Engelbert's opinion wherein he stated that the time during the persistent variable decelerations made no difference in the infant's outcome as the decelerations were not an indication of hypoxia and the injuries were due overwhelmingly to prematurity and not hypoxia, although he does not state his basis for this opinion. It is noted that the infant's mother was being cared for by nurses Buckley, Leon, Pickering and Findletar, and there are factual issues concerning whether they reported persistent decelerations and worsening maternal condition to the attending physicians and/or residents.

The plaintiff's expert indicated that Dr. Sambaziotis testified that she first saw Ms. Omane in the

hospital at 10:15 a.m. on February 5, 2000, and continued to evaluate her through February 6, 2000 at 6:00 a.m., as she was responsible for evaluating the mother every hour or two for worsening signs of preeclampsia, as well as for magnesium sulfate toxicity. Plaintiff's expert described Ms. Omane's complaints and blood pressure up to 180/110 at 2:00 p.m. on February 5, 2000. At 3:30 p.m., Corrine Buckley, R.N. reviewed the chart.

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 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. This raises factual issues concerning the care and treatment rendered to the mother during these hours, and what effect, if any, the findings had upon the fetus.

The plaintiff's expert stated that Dr. Samaziotis and Dr. Frandina, among others, 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 does not agree 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 prolonged 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. 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 when 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, and which demonstrated 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 Apgar 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. There are conflicting expert opinions concerning whether or not the fetal monitor tracings were reassuring or demonstrated that the fetus was suffering stress and hypoxia prior to birth, and whether or not the findings were, or should have been, reported

timely by the nursing staff providing care and treatment during the time frame in question. It is noted that in opposing defendants' motion, plaintiff offers no opposition to summary dismissal of the complaint as asserted against Karen Coburn, N.P. and Nora Babbino, R.N.

Accordingly, summary dismissal of the complaint as asserted against Karen Coburn, N.P. and Nora Babbino, R.N. is granted with prejudice, and is denied as to defendants Hera Sambaziotis, M.D., Martina Frandina, M.D., Corrine Buckley, R.N., Heather Findletar, R.N., Laura J. Pickering, R.N., and Jill A. Leon, R.N.

Dated: OCT 2 8 2014

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

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION