

**Yu Yun Dong v Ruiz**

2016 NY Slip Op 33093(U)

April 18, 2016

Supreme Court, New York County

Docket Number: 109135/2009

Judge: Alice Schlesinger

Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.

This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

-----X  
YU YUN DONG, as mother and natural guardian of  
, an infant,  
Plaintiff,

Index No. 109135/2009  
Motion Seq. Nos. 003, 004  
005

-against-

REGINALD RUIZ, M.D., DANIEL CLEMENT, M.D.,  
DANIEL ROSHAN, M.D., MARY MARRON-CORWIN,  
WALTER VON PECHMAN, M.D., EILEEN CASSIDY,  
M.D., ALEXANDER MAATVEEVSKI, M.D., RICHELLE  
GASKIN, M.D., TINA LEUNG, M.D., BETSY ARNALD,  
LEAHY, C.N.M., and ST. VINCENT'S CATHOLIC  
MEDICAL CENTERS,  
Defendants.

**FILED**  
APR 22 2016  
COUNTY CLERK'S OFFICE  
NEW YORK

-----X  
SCHLESINGER, J.:

There is absolutely nothing happy about this story. The boy child born on August 21, 1999 is now approximately 16 and is severely disabled. One of his treating physicians today believes that he is suffering from autism due to a genetic insufficiency. That diagnosis has a lot to do with the motion now before this Court. It is the plaintiff's position in this action that this child is not suffering from Autism but rather suffering from a Hypoxic Ischemic Encephalopathy or HIE ("HIE"). The plaintiff further believes that the many doctors at St. Vincent's Hospital who were involved in the labor and delivery of this child were responsible for this injury. Finally, it is the plaintiff's position that when the mother Yu Yun Dong appeared at the clinic on August 20, 1999, 4 days past her due date, that within 6 hours of the approximate 1:00 appearance by her, the doctors should have made a decision to deliver the baby by Cesarean section. They did not. In fact, it was not until 12:47 p.m. on August 21, 1999, that the baby was delivered vaginally.

Before me are three separate motions by the many doctors and residents involved in this delivery. All of the doctors and the hospital are moving for summary judgment. With

many experts supporting this position, the argument is that all of the doctors involved acted completely in accord with good obstetrical practice and even more significant, that the manner in which the baby was delivered is in fact irrelevant to the severe developmental issues that this child has suffered from since soon after his birth. After reading the papers, including the many affidavits which attempt to analyze why the child is the way he is, I have come to the conclusion that in fact this poor child is autistic and that the Autism was caused by a genetic malfunction. That malfunction is specifically described as a microdeletion of the 10 q 23.1 gene.

However, this Court is getting ahead of itself and more properly should describe the circumstances of the labor and delivery of the mother Yu Yun Dong and its aftermath. Ms. Dong was 35 years old when she was in the last stages of her pregnancy in August 1999. She first met Dr. Daniel Roshan in the afternoon on August 20, at the St. Vincent's obstetrical clinic where he performed a biophysical profile on her. Her score was 8 out of 10, 10 being the best score. The 2 missing points were attributable to a condition known as oligohydramnios or insufficiency of amniotic fluid. There was also an estimate of the birth weight of the baby of 7.1 pounds and further, something else which turned out to be true, evidence of a nuchal cord (a situation where the umbilical cord wraps itself around the baby's neck).

Dr. Roshan had her admitted to the hospital with the idea of inducing labor. This was at 2:30 p.m. At 3:00 p.m., Ms. Dong was placed on a fetal heart monitor. The most startling evidence that appeared on the monitor was that for a period of about 6 minutes the monitor displayed decelerations of 60 beats per minute. After this 6 minute period, there was a recovery to normal base line.

Throughout that afternoon, into the evening and into the morning of August 21, various procedures and medications were used in an effort to deliver the baby safely. The first medication of note was the use of Cervidil. This was placed vaginally in order to "ripen the cervix" since it was closed. The idea was to open the cervix and induce uterine contractions. This happened at about 4:00 p.m..

The history that I am now giving comes in large part from an affidavit by Dr. Adiel Fleischer. This doctor is board certified in OB/GYN and Maternal Fetal Medicine. He is now Chair of the department of OB/GYN at North Shore Long Island Jewish Health Systems. It is his position, after reviewing all the records of the labor and delivery, as well as all of the various defendants' depositions, that Dr. Roshan committed no departures from acceptable obstetrical services and that everything he did was in accord with good and accepted obstetrical practice.

Dr. Roshan, as noted earlier, an Attending at St. Vincent's was both the first to see Ms. Dong during the afternoon of August 20 and have her admitted and then again after he returned to the Hospital at approximately 8:30 a.m. on the following day August 21. He supervised the delivery of the baby later that day. In between Dr. Roshan two appearance's during this labor, was a Dr. Daniel Clement, also a defendant who is also moving for summary judgment. Dr. Clement supervised the labor during the intervening night time hours.

What happened during those hours? The Cervidil was removed at about 2:50 a.m. on August 21, 1999. Meanwhile there had been at least three episodes of decelerations, where the heart rate beat went down to between 70 and 90 beats per minute for approximately two minutes. This proceeded the removal of the Cervidil. Ms. Dong at the

time was having contractions very close together so that another medication, Terbutaline was administered to weaken the contractions and move them apart. This was an attempt to inhibit the uterine contractions, due in part to the cord compression from the lack of amniotic fluid.

At approximately 4:00 a.m. a decision was made to utilize Pitocin. This was to augment the contractions and the labor. What resulted in part was that at 7:00 a.m., Ms. Dong asked for an epidural. Further, IV fluid was provided to increase the overall blood volume. At 8:00 a.m. the fetal heart rate had gone down to 80 beats per minute. The patient was then turned from side to side in order to decrease the cord compression. At this stage, Ms. Dong's blood pressure had dropped to 85/43. The Pitocin was increased.

As noted earlier, at 8:30 a.m., Dr. Roshan returned and once again was the Attending, replacing Dr. Clement. He reviewed the fetal monitor strips and noted a deceleration to 80 beats per minutes for about 30 seconds, followed by a recovery. However, this was attributed to the epidural and some Ephedrine which was given to increase the placenta perfusion. This was ordered by Dr. Alexander Maatveevski, also a defendant, who is moving for summary judgment along with the other residents and the staff. Those other doctors named as defendants are Dr. Reginald Ruiz, Nurse Mary Marron-Corwin, Dr. Walter Von-Pechman, Dr. Eileen Cassidy, Dr. Richelle Gaskin, Dr. Tina Leung, Midwife Arnauld Leahy and St. Vincent's Catholic Medical Centers.

Getting back to the time that Dr. Roshan returned, third year resident Eileen Cassidy performed a vaginal exam and determined that her patient was only 1cm dilated. However, she was 90 percent effaced with a fetal heart rate of between 130 and 140 beats per minute with variable decelerations. It was decided at that time, despite the lack of amniotic

fluid, to hold up on an amnioinfusion. This was to provide some cushioning for the baby and avoid further cord compression. However at approximately 9:15 a.m., after Dr. Roshan assessed and reviewed the strips, he decided to begin the amnioinfusion and to reduce the Pitocin. Dr. Fleischer remarks at this point, that it was clear that a plan had been formulated by Dr. Roshan, who was in constant consultation with the various residents.

At 9:45 a.m. Dr. Cassidy determined that the patient was 3-5 cm dilated. The fetal heart rate was in the 140's with variable decelerations. She spoke to Dr. Roshan about this and he attributed these decelerations to the insufficiency of amniotic fluid. That is why he ordered the amnioinfusion, to try and prevent further decelerations. Dr. Fleischer comments that this was a good decision. There was then another deceleration of the heart rate to 90 beats per minute, but it was followed by a strong return to base.

At approximately 10:30 a.m., the fetal heart rate was noted to be reactive and in the 150's. This was a reassuring sign and suggested that the plan was working. At 11:00 a.m. Ms. Dong complained of pain and there was a bloody show. This was an indication that the mother was in advanced labor. At this time, Midwife Leahy did another vaginal examination that showed that the mother was 8 centimeters dilated. By 11:15 a.m., Ms. Dong was fully dilated and began pushing. The fetal heart rate dropped to the 50 and 60's. However at approximately 11:30 a.m., Dr. Roshan reviewed the strips, noting a few variable decelerations but also noting the good recovery from them.

As stated earlier, the baby was finally delivered at 12:47p.m., by Dr. Cassidy with Dr. Roshan supervising. During the period between 11:30 a.m. and the delivery time, various decisions were made involving the discontinuance and restarting of Pitocin at

around 12:20 p.m.. At 12:40 p.m., there was an indication that the fetal heart rate had gone down to the 60's for 10 to 20 seconds followed by a slow return. Dr. Fleischer attributes this to cord compression. Therefore, he opined that it was prudent to expedite the delivery, which came seven minutes later.

Dr. Fleischer opines with a reasonable degree of medical certainty that a C-section was not required. As to the decelerations, he says that these were due to cord compression and while there was variability in the fetal heart rate, the rate continued to be in the normal range or to soon recover to a normal range. He comments that these circumstances excluded the presence of fetal metabolic acidosis. He adds that there was a normal fetal heart rate for the most part and the accelerations after the decelerations were reassuring. He also adds that there were signs that the baby had good oxygenation. For all of these reasons, Dr. Fleischer emphasizes that an earlier C-section was not indicated.

After the delivery, the cord blood level was analyzed and it was normal. Dr. Fleischer further opines that there was no prolonged hypoxia suffered by the baby and despite the frequent decelerations, there was always a good recovery. Because of this Dr. Roshan opines in his deposition that there was no sign of fetal distress. On this point, Dr. Fleischer agrees with Dr. Roshan that the post delivery normal blood cord gases make the tracing ultimately non-relevant.

A second expert supporting Dr. Roshan's motions is Dr. Ram Kairam. He is board certified in Pediatrics with a sub-board in Neonatal Perinatal Medicine. He is also board certified in Neurology with a special competence in Child Neurology. He is now in private practice as a Pediatric Neurologist with a subspecialty in the Diagnosis and Interventions

of Autism.

There is also an affirmation submitted by other defendants in this case, Dr. Joseph Maytal, also a Pediatric Neurologist. Dr. Maytal who has reviewed these records, also reviewed an April 2003 MRI of the child's brain. He opines that Hypoxic Ischemia had no role in causing this child's neurologic deficits. It should be noted that the MRI was read as normal.

Getting back to Dr. Kairam, besides reviewing records, he also performed an examination of the child on July 23, 2014. At that examination, a Mandarin interpreter aided the doctor. Dr. Kairam's opinions, given with a reasonable degree of medical certainty, include a description of the child as being obviously dysmorphic in his facial features. This includes thick eyebrows, very large lips and a very large head, 1 cm above normal and in the 98 percentile. Dr. Kairam also relied on a DNA analysis performed at the Bellevue Genetic Center and ordered by Denny's treating physician Dr. John Pappas. As noted earlier, that test found a microdeletion of the 10Q23.1 gene.(more on that later)

Dr. Kairam also noted that the child did not talk at all. Relying on his own physical exam along with the normal 2003 brain MRI and a normal CT scan shortly after birth and after reviewing Dr. Daniel Adler's 2009 report prepared for the plaintiff and the child's school records, Dr. Kairam concludes that the HIE, as claimed by Dr. Adler has no support and that it did not play any role in Denny's neurologic deficits. Rather, it is his opinion, within the requisite standards, that Denny's disability was the result of a confirmed generic abnormality. Further this examining doctor says that Denny's dysmorphic appearance and autistic behavior supports this opinion. Dr. Kairam's position is that no act or omission by any of these doctors played any part in this diagnosis. Clearly, a prima facie case in favor

of Dr. Roshan has been made out by these experts.

Another motion before me, perhaps the first chronologically, is brought by the Hospital and the various defendant doctors and staff working there. First, counsel makes a general statement that there was no hypoxia and/or fetal distress during the labor warranting a C-section. Also, it is pointed out there was no proof that anyone on the St. Vincent's staff failed to carry out instructions given to them by Dr. Daniel Clement or Dr. Daniel Roshan.

Submitted on behalf of these defendants is first, an opinion provided by Dr. Burton Rochelson. He is board certified in Ob/Gyn and Maternal Fetal Medicine. He is presently Chief of the Division of Maternal Fetal Medicine for North Shore Long Island Jewish Health Systems and Director of Ob/Gyn at North Shore University Hospital in Manhasset. He is also a Professor at the School of Medicine at Hofstra North Shore Division. He has reviewed all of the labor and delivery records, including the tracings, the affidavit of Dr. Kairam and the various Examinations before Trial.

He begins by saying that all of his opinions are held with a reasonable degree of medical certainty. He then expresses two of these opinions: 1) that this child did not suffer from hypoxic ischemic encephalopathy. In this regard he indicates his disagreement with the conclusions by Dr. Daniel Adler in his 2009 report after examining the infant on behalf of the plaintiff. 2) that HIE played no role in causing Denny's neurologic deficits. He, like all of the other experts for the defendants, opines that the injuries here are the result of a confirmed genetic disorder.

He begins his discussions of the circumstances involved in this labor by talking

about the Fetal Heart Rate monitoring. He says that it was certainly known in 1999 that abnormal or non-reassuring tracings were not necessarily predictive of abnormal fetal acid base status or of hypoxic events. However, such tracings do require close continuous evaluation and assessment and if necessary corrective measures. He adds that if these are ineffective, you then move on towards an expedited delivery.

Dr. Rochelson then discusses a task force put together by ACOG, a gynecological association. This dealt with the subject of Neonatal Encephalopathy and Cerebral Palsy. The task force released a publication on the subject, wherein it outlined the criteria which was essential to establishing a causal link between intrapartum hypoxic events and neonatal encephalopathy. In this regard, certain criteria were listed. First, there must be, at delivery evidence of metabolic acidosis in the fetal umbilical cord's arterial blood. This specifically translates to a Ph of under 7 and a base deficit of  $\geq$  of 12 mmol/L. Additionally there is a criteria that the infant's Apgar score must be no greater than 0 and 3, the latter at 5 minutes. Finally, another criteria would be an early imaging study showing evidence of acute non-focal cerebral abnormality. Dr. Rochelson opines that none of the criteria occurred here.

In his discussion of the relevant events, the doctor points to 3:15 p.m. on August 20, where there was an extended 6 minute deceleration. However, despite the fact that a C-section was being seriously considered, what happened next was a good recovery to base line with the FHR (fetal heart rate) in the 140's and with moderate FHR variability. This then led to the plan to allow labor to persist with close monitoring. Here, this expert agrees with Dr. Clement's interpretation of the FHR pattern and his decision to continue with labor.

He then discusses the period of time from 7:50 a.m. to 9:30 a.m. on

August 21, 1999. At this time, the nurses were recording plaintiff's blood pressure and heart rate every five minutes, which indicated close monitoring. But more important, in this expert's opinion, was the infant's condition after delivery. The infant's Apgar score at 5 minutes was 7, up from 0 at 1 minute. Also, the arterial cord blood Ph was 7.23 with a base excess of -7. In this doctor's opinion, these values together with the Apgar scores made it highly unlikely that intrapartum hypoxia played any role in injury to the infant.

Dr. Rochelson concludes his statement with the following opinions. He says first that everyone who worked with this patient at the hospital, including the residents, the midwives, and the nursing staff, exercised sound, correct professionalism and at all times exhibited good clinical judgment during the fetal monitoring parts of the labor. Hand in hand with this comment is his further opinion that at no time did anyone depart from accepted standards of gynecologic practice. He goes on to say that there was never an indication to perform a C-section because of abnormal labor or fetal distress. He further says that there was no reason here or in most situations for the residents or other staff members to overrule or question what the doctors did. As to the anesthesiologist there was no reason why he should have intervened to urge a C-section. Finally, and importantly, the claimed injuries here are, in his opinion not related to any negligence by the Hospital or its staff. He also believes that the injuries here are the result of a confirmed genetic disorder.

The next expert put forward by these defendants is an Israeli trained physician, Dr. Joseph Maytal. He is board certified in Neurology with Special Competence in Child Neurology. He is Chief of the Division of Pediatric Neurology at Cohen's Children's Hospital and a Professor at Hofstra North Shore-LIJ School of Medicine. Very similar to

the discussion by Dr. Rochelson, this doctor also discusses the ACOG Task Force criteria. His opinions mirror Dr. Rochelson, but from a Pediatric Neurologist point of view. I find here that a prima facie case on behalf of the Hospital and its staff has been made out.

The final motion for dispositive relief is made on behalf of Attending Gynecologist, Dr. Daniel Clement. His motion is supported by an affirmation from Dr. Victor Klein. Dr. Klein is an Ob/Gyn who specializes in Maternal Fetal Medicine. He has obtained Fellowships in this field as well as in Clinical Genetics at the University of Texas. He is board certified in Clinical Genetics, Ob/Gyn, and Maternal Fetal Medicine. Dr. Klein begins his discussion by stating that at all times, Dr. Clement met appropriate Obstetrical standards. He then states with reference to all of the plaintiffs' claims that they, "are misguided and without merit." (§2)

Dr. Klein then discusses Ms. Dong's admission and treatment. He points out that when she received treatment by Dr. Clement, who was the on-call Physician after Dr. Roshan, he evaluated the tracings which showed deceleration down to 60 beats per minute for 6 minutes soon after her admission. Dr. Clement allowed labor to continue because he found that there was a full recovery from these decelerations. Dr. Klein, along with the other defense experts, opines that these decelerations were probably caused by the cord compression and decreased amniotic fluid. He then opines that all of the medications, earlier described, were appropriately given at the appropriate times. Further, at approximately 7:00 a.m. an epidural was properly ordered.

Dr. Clement left the hospital at 8:00 a.m. on August 21, 1999. At that time, the fetal tracing was reassuring with no medical necessity to deliver at that time. Dr. Klein concludes his statement by noting that he carefully reviewed the fetal monitor tracings up

to 8:00 a.m. on August 21 when Dr. Clement left. He opines that while there were some decelerations, there was a return to baseline with good beat to beat variability .He concludes that none of the strips revealed an indication for a C-section. Finally, Dr. Klein points out that after the infant's delivery, based on the normal Ph of 7.23, there was no evidence of neonatal encephalopathy. Once again a prima facie case has been made out, this time on behalf of Dr. Clement.

There is opposition to these several motions. Before getting to those however, counsel for the plaintiff points to certain actions and inactions taken by the various players in these events. One of those things noted and later commented on in the Reply is that the infant's arterial cord blood Ph of 7.23 was below the Hospital's acceptable range of 7.38 to 7.42. I am noting this, as something important because intentionally or unintentionally, the Reply statements make it clear that this range related by plaintiff's counsel was one for adults, not for children. In fact, pursuant to the range for children, the rate of 7.23 was absolutely appropriate. An additional score pointed out by the plaintiff was the oxygen saturation level soon after birth of only 10 percent. This number everyone concedes was low. Counsel in opposition also points out that Denny was born hypotonic. This means that he had a floppy appearance, with his muscles lacking normal tone or tension.

Plaintiff presents three experts. The first, is an affirmation from a board certified practicing Ob/Gyn. That is all I am told of this person. The second, is from a physician board certified in Pediatrics and Neurology, with Special Qualifications in Child Neurology and Electro Diagnostic Medicine. The third expert is an individual, board certified in Pediatrics and Medical Genetics. This person says that he/she is actively involved in

Human Genetics Clinical Care and Research and is fully familiar with the field of Pediatric Medical Genetics.

The gynecologist for the plaintiff, not unexpectedly expresses his opinion that a C-section was indicated, at least 6 hours after plaintiff's "induction" on August 20, 1999, and that it was a departure of the doctors not to proceed in this fashion. This doctor also opines that the failure to do a C-section was a substantial factor in causing birth injuries, including Hypoxic Ischemic Encephalopathy.

He first discusses the biophysical profile that Ms. Dong underwent which showed that she had low amniotic fluid. There was also a nuchal cord. He points to what was discussed earlier, the 3:00 note on the 20<sup>th</sup>, which displayed the prolong deceleration for 6 minutes. During those 6 minutes the infant's BPM was 60 and dropping. He also points to other times during the first day of further decelerations. For example, at 5:00 there were 60 BPM for 1 minute and at 5:20 there was a deceleration for 2-3 minutes. Further at 10:30 p.m. there was a BPM of 70 for several minutes. There was also a further deceleration at 1:30 a.m. and at 2:50 a.m. It was also important to this doctor, that at 2:50 a.m the cervix was still closed. He further documents various decelerations for short periods of time throughout the morning of August 21.

This doctor then discusses the baby's condition after his birth. He stayed in the NICU at St. Vincent's due to respiratory and meconium issues. He was hypotonic, meaning he was flaccid. He also had a weak cry and poor head control. Further, in October 1999 he spent about a week at Bellevue's PICU. Continuing with this history, this physician points out that the child did not walk until he was over 2 years old and was not toilet trained until he was 5. He has been in special education. Finally, at age 16, he

cannot speak.

This physician believes that there existed risk factors for fetal distress which included advanced maternal age of 35, post date delivery, nuchal cord and low amniotic fluid. The doctor opines that the 6 minute deceleration was a clear sign of fetal distress. In fact, the operating room was notified to setup for a C-section but then the doctors decided to wait. This doctor believes that decision was wrong because there were continued decelerations in the FHR and a continued closed cervix despite the use of medications, all this together with the nuchal cord and the low level of amniotic fluid. According to this physician, all of Ms. Dong's failure to progress through the 20<sup>th</sup> and into the 21<sup>st</sup> demonstrated that the baby was not receiving sufficient oxygen and should have been delivered by C-section.

This doctor also discusses the plaintiff's blood pressure which was very low. It is this doctor's belief that the mother was not appropriately monitored and caused the infant to suffer additional stress by depriving him of oxygen.

In paragraph 70 this doctor states, "I categorically reject the assertion of defendants' experts that a C-section was not indicated because there was no evidence of fetal distress during labor". In this regard, he states that the numerous noted variable decelerations were not reassuring. Additionally, though the defendant doctor did perform an amnio fusion, he criticizes waiting to do this until 9:45 a.m. on August 21, 18 hours after her admission. Further, it did not even elevate her fluid.

What is particularly significant to me and is a reason for why I am skeptical of the position of the plaintiff, is the analysis, by this doctor of the child's blood gas measurements taken immediately after his birth. A central issue in this case is did the

infant actually suffer any hypoxic injury, a deprivation of oxygen? According to this physician, the Ph value of 7.23 demonstrated acidosis. He also discussed the infant's low PaO<sup>2</sup> and his high PaCO<sup>2</sup>, all of these values according to this doctor, pointing to respiratory deprivation. Finally on this point, this expert says that the oxygen saturation level of 10.7% unequivocally demonstrated that the infant was not properly oxygenated. He concludes his statement by opining that all of the Ob/Gyn physicians involved in the labor and delivery of this infant between 10:00 .pm. on August 20 and the delivery on August 21, departed from accepted standards in failing to perform an indicated C-section. But as noted earlier, this expert's reliance on the too low arterial blood values is wrong. In fact the child's score of 7.23 was normal using the proper value range for children.

The plaintiff's Pediatric Neurologist expert then gives his opinion that the negligence by these doctors was the cause of the infant's injuries, which included hypoxic ischemia encephalopathy. By this time, the defendants had made it clear that the child had been subjected to genetic testing by his treating physician, Dr. Pappas. However, this expert for the plaintiff notes the defense failure to proffer the underlying data for the diagnosis of the 10q23.1 micro-deletion. Because, in part, no lab report or DNA microarray confirming the existence of this was provided, this doctor opines that the child's injuries are consistent with HIE.

This doctor also points out that in August 2002, the infant was noted to have suffered a seizure and was still hypotonic. He remarks that there were further seizures in 2004, 2007, 2008 and 2009. It should be noted here that the experts on behalf of the defendants do not accept the fact that this child ever suffered from seizures and explain this opinion, although the mother believes that her child did have them.

As noted earlier, an IME by Dr. Kairam was conducted. The plaintiff's expert accuses that report of being conclusory and further that it fails to explain Dr. Kairam's diagnosis of Autism. In paragraph 72 this doctor insists that Denny is not autistic but rather is brain damaged. In this regard, he differs from the defense experts' analysis of what an April 2003 MRI found. This was a normal reading. However according to this expert's opinion, even a normal MRI like this one, does not exclude HIE because the injury could often be microscopic and not visible.

The final expert for the plaintiff is one in Medical Genetics. He accuses the defendant experts of failing to set forth the underlying evidence to sufficiently confirm that the child has 10q23.1 microdeletion syndrome. He notes that no lab report with the exact genomic coordinates of this chromosomal abnormality was produced. The doctor says without this report and worksheet there can not be a definitive diagnosis of this syndrome.

The Replies from the defendants, in this Court's opinion, puts to rest the theories espoused by the plaintiff. First, there are supplemental affidavits on behalf of Dr. Roshan by Dr. Adiel Fleischer, Dr. Ram Kairam and Dr. John Pappas. The Pappas affidavit is, I believe most significant as it is from this child's treating physician at Bellevue Hospital. There is also a statement from a Dr. Kwame Yeboa along with the Chromosomo MicroArray report from Labcorp Specialty Testing Group. The report is dated April 28, 2012.

Dr. Yeboa is board certified in Pediatric and Medical Genetics. Dr. Yeboa states that he certainly agrees with plaintiff's experts that accepted standards of gynecological care require treating physicians to monitor the well being of the fetus during labor and delivery. Further, he agrees that in the presence of signs of fetal distress, care must be

taken to prevent injury to the fetus, including, where indicated, the performance of a C-section. However, he says that he and the other defense experts believe that Dr. Roshan did precisely that.

In Dr. Fleischer's supplementary affidavit, he criticizes plaintiff's expert for failing to discuss the swift recovery to baseline that the child experienced and the reassuring accelerations. He opines that these decelerations were caused by cord compression and not anything else dangerous to the baby. Most important is his discussion of the blood gases and what their value show here. He states that the Ph level of 7.23 was not in the least hypoxic. Here, as alluded to earlier, he accuses the plaintiff's expert of using the adult range for this value and points out that the actual range for a newborn baby is 7.2 to 7.3 thereby proving that this infant's value of 7.23 was absolutely normal. With regard to the oxygen saturation level of 10.7%, Dr. Fleischer agrees that this was low, but he also points out that within a few minutes it had risen to 93.5 which was normal for a newborn. Dr. Fleischer finally states his agreement with the experts that attribute Denny's disabilities to a confirmed genetic abnormality resulting in dysmorphic appearance and autistic behavior.

In supplemental papers by Dr. Kairam, he goes back to his IME of July 23, 2014. He says that he certainly did consider the possibility of HIE but dismissed it because there was simply no evidence of it. Here he points to his findings, which were consistent with Autism but inconsistent with HIE. Dr. Kairam measured the child's head and found that it was macrocephalic at 98% rather than microcephaly. The latter could be a sign of HIE. Also, he was hypotonic as opposed to hypertonic. He also states that Autism is the only neurological disorder where there is a language regression, which occurred here after the

infant was 15 months old. As to seizures, Dr. Kairam says that there is no radiological evidence that the child was ever diagnosed with a seizure disorder. Nor was he ever treated for one. Despite what some of the records show, this doctor concludes that the episodes described by Ms. Dong, the mother were something other than seizures.

As to the normal MRI, Dr. Kairam says that certainly if there was HIE it would be shown. He also criticizes the neurological report by the plaintiff for ignoring the child's dysmorphia. He concludes that the injury was certainly not caused by HIE. The child's dysmorphic features were noted in the child's birth and pediatric records. Finally, he points out that here there was a confirmed genetic abnormality characterized by dysmorphia and the microdeletion in one of Autism's "hot spots". He says it is clear that this child has Autism and not HIE brain damage.

As noted earlier, what I find most impressive about the Reply statements is the one from Denny's treating physician at Bellevue hospital, Dr. John Pappas. In his affidavit he states that he first saw Denny as a patient on August 30, 2001. He saw him again on February 14, 2013, when he diagnosed him with a 10q23.1 microdeletion syndrome which followed a chromosomal microarray performed by Lab Corp. Dr. Pappas is the Director of NYU Clinical Genetic Service. He is also board certified in Pediatrics and Medical Genetics. He explains that his diagnosis of this microdeletion syndrome is consistent with Autism and the child's developmental delays as well as his macrocephaly, dysmorphic features and hypotonia.

Dr. Pappas gives his opinion that all of Denny's clinical signs are the result of a confirmed genetic disorder and not related to any medical treatment to his mother had while he was in utero. He explains that the child was referred back to him in February

2012 pursuant to his "autistic disorder", a medical diagnosis recorded at Bellevue. Dr. Pappas then ordered the chromosomal microarray, an advanced technique that allows for detection of small changes in the amount of DNA. He further explains where this microdeletion was located, which he identifies as a known autism region. He also points out that HIE does not cause any of the child's clinical features. He further opines that the April 28, 2012 testing conclusively established the size and location of Denny's deletion on chromosome 10q. He concludes by saying that no additional testing is required to confirm this diagnosis.

Then there follows a somewhat redundant statement by Dr. Yeboa. I say redundant because this doctor agrees with all the other defense doctors that the plaintiff's claims have no merit. He says emphatically that this child does not have Hypoxic Ischemic Encephalopathy and that the intrapartum treatment played no role in causing any of this child's deficits. He points out in this regard, that as far back as May 2008, the child's treating pediatric neurologist at Bellevue diagnosed him with Autism. Further on August 26, 2010, the clinic records noted his dysmorphic features and his nonverbal status, all features of Autism. He concludes by saying that a C-section would not have changed anything.

There is also a reply from the Hospital and residents. Much of this is redundant to Dr. Roshan's reply. Specifically, counsel deals with certain of the residents who should be let out of the case because they had no involvement with the mother after 10:00 p.m. on the 20th. The rest of the reply merely repeats points made in the moving papers.

Finally, there is a reply on behalf of Dr. Clement. This is a supplemental statement from Dr. Klein who shares the opinions of Dr. Pappas, Dr. Yeboa, and Dr. Kariam.

I allowed the plaintiff to submit a Sur-Reply because it was in the Reply papers that the actual report by Lab Corp was furnished. Therefore the Sur-Reply, by a licensed board certified doctor who has expertise in both Pediatrics and Medical Genetics, was relevant. He actually reviewed the microarray report from April 2012. In this regard, he describes where the alleged microdeletion was found. He says that the deletion in this chromosomal region is not necessarily associated with developmental delays or autism. He gives his opinion despite what Dr. Pappas and Dr. Yeboa say about the deletions in chromosome 10q23.1. He disagrees that this is a known autism region. He accuses the doctors of failing to acknowledge this and opines that it is also associated with heart defects. In other words, he believes it is not exclusively in the region involving autism.

This is a difficult case and were it not so, I would say that there were factual issues with regard to the care given to the plaintiff during labor and to the kind of injury that this child suffered. However, I believe that if I were to do that, I would not be conducting a thorough and meaningful analysis of the proffered opinions. I am granting the motion made by all of the defendants and I am doing that for the following reasons.

First, there is a complete lack or failure to note the dysmorphic features that this child has suffered from since birth as well as other clear indicia of autism, including his large head size, large lips, his hypotonia, and his absence of language. Second, I find it much more convincing that the MRI given to the child in 2003, which had a normal result, would not have had that result if there had been a hypoxic ischemic event that the plaintiff argues occurred. I am also relying on the diagnosis by his treating physicians, since 2008

of Autism.


Finally, I consider the misstatements of the meaning of the values at birth to be meaningful. Not only did the plaintiff's expert misstate or use values which were identified with adult values, but it is clear that the values that the child actually had were normal. I also must consider the child's normal Apgar score at 5 minutes of 7. Therefore, I am forced to conclude that there was simply no signs, much less clear signs, that this child suffered from a serious deprivation of oxygen or from a Hypoxic Ischemic Encephalopathy.

All of these things, together with Dr. Pappas' ordering of the genetic test in 2012, which test according to him, the child's treating physician, as well as the other defense experts, clearly show that this genetic deletion was in the area where Autism would be.

Therefore I feel compelled to find that wherein the moving defendants made out prima facie cases in favor of granting the motion, since the plaintiff's opposition failed to successfully put into issue the kind of injury suffered by this child, I must find for the defendants and dismiss the action. Thus, I am granting the dispositive motions made by all the defendant doctors as well as other staff at St. Vincent's Hospital as well as the Hospital.

Dated: April 18, 2016

APR 18 2016

  
J.S.C.  
ALICE SCHLESINGER

**FILED**  
APR 22 2016  
COUNTY CLERK'S OFFICE  
NEW YORK