SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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TOURIA EL KASSMI and NABIL BOURAKKADI,

Plaintiffs,

- v -

LISA MCLEOD, D.O., JAZMIN FERRER, R.N., CHERRY L. FUENTES-COYLE, R.N., THERESE J. ZENKEWICH, R.N., NEW YORK-PRESBYTERIAN/LAWRENCE HOSPITAL, WESTCHESTER BRONX OB-GYN GROUP, P.C., and NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM, INC., doing business as NEW-YORK PRESBYTERIAN MEDICAL GROUP WESTCHESTER,

Defendants.

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INDEX NO. 805193/2019

MOTION DATE 10/15/2024

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 137, 138, 139, 143, 144

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based upon alleged departures from good and accepted practice and lack of informed consent, the defendants Lisa McLeod, D.O., and Westchester Bronx OB-GYN Group, P.C. (the WB defendants), together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them.[1] The plaintiffs oppose the motion. The motion is granted only to the extent that the WB defendants are awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them, and so much of the medical malpractice cause of action asserted against them as alleged a failure to treat obstructed labor, a failure to heed the personal requests of the plaintiff Touria El Kassmi (the patient) to perform a

[1] On March 20, 2023, the plaintiff discontinued the action against the defendant Cherry L. Fuentes-Coyle, R.N. Sometime in March 2023, the plaintiff discontinued the action against the defendant Jazmin Ferrer, R.N., and the defendant Therese J. Zenkewich, R.N. On May 25, 2023, the plaintiff discontinued the action against the defendants New York-Presbyterian/Lawrence Hospital and New York Presbyterian Health Care System, Inc., doing business as New-York Presbyterian Medical Group Westchester.

cesarean section, inadequate monitoring of the fetus and the patient, fetal mispositioning, a failure to treat fetal tachycardia, a failure to respond to an alleged lack of fetal heart rate (FHR) accelerations, and that they inappropriately directed the patient to push her cervical and vaginal muscles to facilitate childbirth. The motion is otherwise denied, since there are triable issues of fact as to whether the WB defendants departed from the applicable standard of care in failing timely to diagnose a uterine rupture and consequent chorioamnionitis, in administering Pitocin, and in failing to perform a timely cesarean section, and whether those departures caused or contributed to a stillbirth and the patient's ongoing emotional distress arising therefrom.

The crux of the plaintiffs' claims against the WB defendants is that they failed timely and appropriately to deliver the patient's fetus because they failed timely to administer appropriate drugs to induce delivery, and instead administered contraction-inducing drugs after signs of fetal distress were present, failed to diagnose uterine rupture and consequent chorioamnionitis, failed to perform a cesarean section procedure in a timely fashion, and failed properly to position the fetus, thus compelling the patient to undergo a late, emergency cesarean section procedure that nonetheless resulted in a stillbirth.

In their bills of particulars as to the WB defendants, the plaintiffs alleged that those defendants departed from good and accepted medical practice in causing or permitting an intrauterine fetal demise. Specifically, they averred that the WB defendants failed to consider or recommend delivering the fetus earlier because they failed timely to recognize the need to deliver it on an emergent basis, despite indications for earlier delivery. In addition, the plaintiffs alleged that the WB defendants failed adequately to monitor the patient herself or enter timely or accurate notes concerning her care, including a pelvic assessment, and failed to recognize that the patient's labor was not adequately progressing, was obstructed, and involved mispositioning of the fetus. They further faulted the WB defendants for ordering and administering the drug Pitocin despite the failure of the fetus to descend, and in continuing with the administration of Pitocin despite signs of fetal distress. The plaintiffs further asserted that the WB defendants

failed to recognize and timely respond to the signs of fetal distress, which included a change in FHR that culminated initially in tachycardia, followed by late decelerations. They also alleged that the WB defendants filed timely to react to the presence of meconium, and that they disregarded the patient's complaints concerning the progression of pain, such as severe back and abdominal pain, as well as vaginal warmth, and her inability to control her ability to push.

In addition, the plaintiffs averred in their bill of particulars that the WB defendants disregarded the signs and symptoms of uterine rupture, failed timely to appreciate such a rupture and, in fact, caused that rupture. The plaintiffs also alleged that the WB defendants departed from good and accepted practice in disregarding the patient's pleas to abandon her attempts at vaginal delivery and instead perform a cesarean section, which led to their negligent failure timely to perform that procedure, and the need for an ultimately unsuccessful emergency cesarean section that caused the patient to deliver a stillborn child.

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie

showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and such insufficient care or delay proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at

207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

The WB defendants established their prima facie entitlement to judgment as a matter of law with respect to the medical malpractice cause of action through the submission of the pleadings, the bills of particulars, the transcripts of the parties' deposition testimony, relevant medical records, and the expert affirmation of Iffath A. Hoskins, M.D., a board-certified obstetrician/gynecologist with a sub-certification in maternal fetal medicine. Dr. Hoskins asserted that the care that McLeod rendered to the patient was in conformity with the standards of care governing the practice of obstetrics and gynecology, and did not contribute to or cause the injuries that the plaintiff allegedly sustained.

Based on her review of the relevant medical records and the parties' testimony, Dr. Hoskins explained that, prior to August 5, 2017, the patient had never undergone any type of obstetric or gynecological surgery. Rather, in 2014, she had delivered her only child, a baby weighing 9 pounds and 8 ounces, via normal spontaneous vaginal delivery (NSVD) at 40.1 weeks of gestational age. During that delivery, the patient had been administered intravenous Pitocin to augment her labor for approximately 6.5 hours, at the rate of between one to four milliunits per minute. During that first pregnancy, the patient was in labor for 14 hours at a hospital before reaching full cervical dilation, while the second stage of her labor, encompassing

the time from full dilation until childbirth, lasted slightly more than 2 hours, with late and variable FHR decelerations present during those periods of time.

Dr. Hoskins concluded that the patient's pre-natal course with respect to the subject preganancy was not significant for anything of consequence, although she was treated for heart palpitations during the pregnancy, and her stable ovarian cysts were monitored via ultrasound. According to Hoskins, no clinical interventions were indicated for these conditions.

Dr. Hoskins interpreted the relevant medical records as reflecting that the patient's fetus was in the 45th percentile for gestational age, and was estimated to weigh 7 pounds and 7 ounces as of August 2, 2017. The patient began experiencing contractions at 8:00 a.m. on August 4, 2017, arrived at the former defendant New York Presbyterian/Lawrence Hospital (Lawrence) at approximately 1:30 p.m., and was immediately evaluated by McLeod. At that time, the patient was at 40.1 weeks of gestation, complaining of cramping labor pain, which she evaluated as a 2 on a scale of 10. McLeod performed a cervical examination, and reported that the cervix was dilated to the extent of two centimeters (cm), and was 50% effaced, that is, thinned in preparation for delivery. The fetus was at -3 station, that it, the fetus's head was -3 in relation to the ischial spine of the pelvis. The patient testified at her deposition that McLeod wanted to send her home, but she refused to be discharged due to severe pain, upon which McLeod agreed to re-evaluate her later that day. McLeod reported that a 4:45 p.m. cervical examination reflected that the cervix was dilated to 2 cm and 20% effaced, and that the fetal head was located at the -3 station, while a 6:15 p.m. examination showed the cervix to be 4 cm dilated and 50% effaced, with the fetal station remaining at -3. At that time, the patient was admitted to Lawrence.

At 7:20 p.m. on August 4, 2017, McLeod artificially ruptured the patient's amniotic membranes, a procedure known as AROM, purportedly to facilitate further progress of labor. In her 7:40 p.m. progress note, McLeod described light meconium in the amniotic fluid post-AROM, while a new cervical examination revealed that the cervix was now 5 cm dilated and

50% effaced, while the fetus remained at the -3 station. In that note, McLeod reported that the patient was complaining of painful contractions, and thus administered an epidural injection of anestheia to the patient at 7:50 p.m. Records from Lawrence reflect that, on August 5, 2017 at 12:15 a.m., registered nurse K. Christmas performed yet another cervical examination, and reported that the patient's cervix was dilated 8 cm and 60% effaced, while the fetus's position had moved to the -2 station.

Dr. Hoskins explained that there are three categories of fetal heart tracings, with Category I considered to be normal, inasmuch as such a tracing reflects a baseline FHR of 110 to 160 beats per minute, and moderate FHR beat-to-beat variability, regardless of whether accelerations are present. She stated that, although early decelerations may be present, a Category I tracing would not show any late or variable decelerations. According to Dr. Hoskins, this category of tracing is strongly predictive of a normal fetal acid-base, blood-gas oxygenation status, reflecting a low risk of an adverse neurological outcome. She asserted that, at the other end of the spectrum, a Category III FHR tracing is abnormal, and can depict either a sinusoidal pattern or the absence of variability, with recurrent late decelerations, recurrent variable decelerations, or bradycardia, that is, excessively slow heart rate. Dr. Hoskins asserted that Category III tracings require an urgent cesarean section to protect the health of the fetus. As she described it, a Category II tracing is "indeterminate," and may depict the presence of tachycardia, bradycardia with the absence of variability, minimal variability, the absence of variability without recurrent decelerations, marked variability, the absence of accelerations after stimulation, recurrent variable decelerations with minimal or moderate variability, a prolonged deceleration greater than 2, but less than 10, minutes, recurrent late decelerations with moderate variability, variable decelerations with other characteristics such as slow return to baseline, and "overshoot," which is a sudden, compensatory increase in FHR that occurs immediately after a uterine contraction peaks and the umbilical cord is compressed. According to Dr. Hoskins, Category II tracings require surveillance and evaluation, and do not require

surgical intervention, but do require the exercise of a physician's judgment concerning further management. Dr. Hoskins opined that a Category II tracing can occur despite the normal passage of a baby through the birth canal.

Dr. Hoskins interpreted the relevant FHR monitoring strips as depicting either a Category I or Category II, until "contact was lost" at approximately 7:08 a.m. to 7:10 a.m. on August 5, 2017. According to Dr. Hoskins, although the strips revealed many early and variable decelerations, and occasional late decelerations, the tracings consistently showed a normal FHR baseline, and appropriate beat-to-beat variability. As she characterized it, from the patient's admission on August 4, 2017 through midnight on August 5, 2017, the FHR tracings alternated between Category I and Category II, but predominantly were Category I, although accelerations were present. Although Dr. Hoskins asserted that her review of the FHR tracings was "consistent with the documentation" generated by McLeod and nursing personnel at Lawrence, she conceded that there was some subjectivity in their interpretation. Thus, although she asserted that it would not be unusual for different practitioners to believe that a particular deceleration either was "late" as opposed to "variable," or "variable" as opposed to "early," she opined that the "more important question is whether the tracings---taken as a whole---constitute Category 1, 2 or 3." According to Dr. Hoskins, there was no question that the tracings never were categorized as Category III.

As Dr. Hoskins further interpreted the relevant medical records, McLeod examined the patient on August 5, 2017 at 1:55 a.m., documented her findings at 2:08 a.m., and reported that the patient's cervix was 7 cm dilated and 80% effaced at that time, while the fetal station was -1, and the patient's contractions were "mild." Nonetheless, Dr. Hoskins noted that the patient then complained of pressure and contractions in her back, while the fetal assessment section of the relevant note reported an FHR of 150 beats per minute, with moderate variability, accelerations, and a late deceleration. According to those records, McLeod suspected an occiput posterior position, in which the baby's head is down, but facing the mother's umbilicus, as opposed to the

mother's spine, and she thereupon recommended moving the patient onto her side, and requested the anesthesiologist to "top off" the epidural injection, in response to which more anesthesia was administered.

The patient testified at her deposition that, at 2:30 a.m. on August 5, 2017, pain moved into her back and right hip, causing her to scream, upon which nurse Jazmin Ferrer arrived, and provided her with a ball to place under her legs, which was ineffective. McLeod responded to the patient, examined her, and, according to the patient, told her that there was nothing else that could be done except wait until she was fully dilated and the "baby's face change[d]." The patient recalled that she was 7 cm dilated at that time and was asked to push by Ferrer, but could not do so due to the severe pain, after which she was left alone in her hospital room for one to hours. Ferrer testified at her own deposition that she went on break at 3:30 a.m., that "everything was going well" at that time, a conclusion which, according to Dr. Hoskins, was bolstered by a contemporaneous nursing note indicating that the patient was "breathing well." Ferrer handed off the patient to nurse Cherry Lou Fuentes-Coyle at 3:30 a.m. in order to take a three-hour break. The patient testified that, after the lapse the one-to-two-hour period when she was left alone, McLeod entered the room and told her to push because her cervix was fully dilated, while Dr. Hoskins interpreted the medical records as reporting that the patient's cervix was not fully dilated until 6:15 a.m., that she was not asked to push until 6:30 a.m., and that the patient, in fact, pushed for 15 minutes at that time. According to Dr. Hoskins's review of the records, the patient refused to push due to pain, while the patient testified that, sometime between 3:00 a.m. and 4:00 a.m., McLeod refused her request for a cesarean section.

Medical records from Lawrence reflect that McLeod performed a cervical exam at 3:50 a.m. on August 5, 2017, at which time McLeod reported that the cervix was 8 cm dilated and 70% effaced, while the fetal station was at -1 and the FHR tracing continued to reveal a Category II, by virtue of "many early and variable decelerations." At 4:07 a.m., McLeod ordered and initiated the administration of Pitocin at one milliunit per minute, which was increased to two

milliunits per minute at 5:00 a.m., and continued at that rate until it was discontinued at either 6:30 a.m. or 7:03 a.m. According to Fuentes-Coyle, sometime between 6:00 a.m. and 6:15 a.m., the patient began complaining of left flank pain, which Fuentes-Coyle testified was related to contractions. At 6:15 a.m., Fuentes-Coyle performed a cervical examination, and reported that the cervix was fully dilated at 10cms, and fully effaced at 100%, while the fetus remained at station -1. Fuentes-Coyle reported her findings and the patient's complaints to McLeod, who instructed Fuentes-Coyle to direct the patient to "push."

According to a note generated by Ferrer many hours after Fuentes-Coyle related her conversation with McLeod to Ferrer, the patient pushed from 6:30 a.m. to 6:45 a.m., but could not continue pushing due to pain, began "thrashing" about, and requested that McLeod perform a cesarean section. Ferrer reported that, during one of the pushes, the fetus was at station -1, the patient felt warm internally, complained of back pain, and explained that, after her previous delivery, her child had been taken to the neonatal intensive care unit. Ferrer summoned McLeod to the patient's bedside and, when McLeod arrived at 6:48 a.m., she attempted to check the fetus, but could not. Nursing flow sheets reported that the resting abdominal tone was "soft" on palpation, while Ferrer's later note reported that McLeod then left the patient's room at that time to order an antibiotic and to request the anesthesiologist to increase the epidural medication.

Ferrer's reading of an FHR monitor revealed "loss of contact" at 6:58 a.m., after which Ferrer returned to the patient's room and adjusted the monitor, which reflected an FHR of 160 beats per minute at 6:59 a.m., with a deceleration down to 90 beats per minute at 7:03 a.m., after which Ferrer discontinued the administration of Pitocin, although both Ferrer and Fuentes-Coyle reported in their entries that the administration of Pitocin was discontinued as early as 6:30 a.m. McLeod reported, as did Ferrer's after-the-fact note, that the FHR recovered to 150 beats per minute at 7:04 a.m., with another deceleration to 70 beats per minute at 7:05 a.m. According to Dr. Hoskins, these two decelerations were "variable" because they "occurred

without a set pattern or shape and do not mimic the contraction pattern." As Dr. Hoskins interpreted the relevant chart, McLeod suspected chorioamnionitis, and formulated a plan to commence administration of antibiotics, and to call the anesthesiologist for a "top off" of epidural anesthesia. Ferrer's post hoc note further reported that resident anesthesiologist Ashley Wells, M.D., was at the patient's bedside at 7:09 a.m., and, at that time, Dr. Wells asked the patient "to move to her left because I cannot get a heart rate." Ferrer further reported that McLeod came to the patient's bedside at 7:13 a.m. and attempted to place fetal scalp electrode.

According to McLeod, she left the patient's room, but never had time to place the antibiotic order because the fetus experienced a deceleration and loss of contact of the FHR tracing. McLeod reported that she then applied a fetal scalp electrode at some time between 7:08 a.m. and 7:10 a.m. because of the loss of contact. McLeod asserted that, even after applying the scalp electrode, it was not clear to her whether the tracing reflected the maternal or the fetal heart rate, although she suspected that the "blips" that she then observed on the tracing correlated to the fetal heart, and that, in any event, they became "more consistent" at 7:14 a.m. At 7:18 a.m., McLeod called for an emergent cesarean section. As McLeod described it, she observed distorted tracings at 7:19 a.m. that she had never seen before and could not explain. At 7:20 a.m., the patient signed a consent form agreeing to the procedure.

At 7:28 a.m. on August 5, 2017, while in the operating room with the patient, Ferrer attempted to obtain a reading of the FHR, but was unable to do so, then removed the fetal scalp electrode prior to the commencement of surgery, and attempted to obtain an FHR reading with an external monitor. The surgery commenced at 7:33 a.m. McLeod testified at her deposition that, once she entered the patient's abdomen, she observed the fetus outside the uterus. She handed the baby to neonatologist Irina Kaminyar, D.O., at 7:35 a.m., who assigned Apgar scores of zero at 1, 5 and 15 minutes post delivery, and reported that meconium had passed inside of the patient's uterus. Although McLeod and her staff performed resuscitative measures, the fetus was pronounced dead at 7:50 a.m.

McLeod's operative report stated that she found a posterior uterine rupture and endometrial implants on the ovaries, bilaterally, with rupture at the left lower uterine segment, which she described as a vertical rupture that was medial to the infundibulopelvic ligament that extended down to the level of the utero-sacral ligament. A placental pathology study found a term placenta with mild, acute chorioamnionitis and a three-vessel cord.

According to Dr. Hoskins, a uterine rupture might be suspected by non-reassuring FHR tracings and non-specific complaints of pain, but she further asserted that a uterine rupture is an extremely rare cause of these complaints in a woman whose uterus has never been cut or scarred, while a posterior rupture is even more rare and presents atypically. Dr. Hoskins averred that in a woman such as the patient, other causes of the non-specific complaints were much more likely than uterine rupture, and reasonably should have been considered first in a differential diagnosis. As she described, it in these types of cases, "the most likely way a uterine rupture would be prevented is not because it is specifically suspected, but because it is found during a cesarean section ordered because there was a concern about the oxygenation status of the fetus based on the fetal heart tracings." Dr. Hoskins thus opined that there was no basis upon which McLeod should have suspected uterine rupture, and no basis, "for any reason," upon which she should have ordered a cesarean section sooner than she did. In this respect, Dr. Hoskins explained that the patient's labor was progressing adequately until approximately 7:08 a.m. until 7:10 a.m. on August 5, 2017, when FHR contact was "lost" and McLeod placed the fetal scalp electrode, since, until then, "the decision to allow the labor to progress was appropriate in this patient who had previously delivered a 9 lb baby vaginally."

Dr. Hoskins further opined that the monitoring undertaken by the WB defendants was appropriate and was properly documented in the medical record, both by the nursing staff at Lawrence and by McLeod.

Dr. Hoskins stated that fetal station is not the only indicator of progress in pregnancy that would warrant an obstetrician's conclusion that natural spontaneous vaginal delivery would be

appropriate, explaining that, while the fetal station progressed only from station -3 to station -1 from the time of the patient's admission to Lawrence, other indicators demonstrated significant progress. Specifically, she noted that the dilation of the patient's cervix progressed from 4 cm to full dilation of 10 cm in approximately 14 hours, and that effacement progressed a complete 100%, which she characterized as appropriate progress for a woman had previously had delivered a child vaginally. As Dr. Hoskins described it, the station progress "is not required in this setting, and this was not a 'failure' as alleged or reason to consider a cesarean section."

In addition, Dr. Hoskins concluded that, when FHR monitoring contact was lost, "appropriate and timely measures were taken to attempt to regain a fetal heart tracing, and the cesarean section was timely called when those efforts were unsuccessful." As she further explained it, the standard of care "did not require Dr. McLeod to call for a cesarean section earlier, and it was timely performed once called." She also concluded that, contrary to the plaintiffs' contention, the administration of Pitocin was not contraindicated, and was properly administered, and it was appropriate to have the patient push in an effort to deliver via natural spontaneous vaginal delivery. Based on McLeod's deposition testimony, Dr. Hoskins also opined that McLeod properly placed the fetal scalp electrode on the fetal scalp.

Dr. Hoskins rejected the plaintiffs' contention that the subject labor was an "obstructed labor," since she explained that that term applies only when there is a mechanical blockage preventing the baby from descending the birth canal, such as a pelvic shape that does not allow further descent of the baby, or the presence of a fibroid obstructing the passage, conditions not applicable to the patient's case. She also rejected the plaintiffs' contention that the subject labor was a "prolonger labor." In this respect, she asserted that, in general, active labor, in which cervical dilation progresses from 6 cm to 10 cm, takes approximately four to eight hours. Inasmuch as the patient first was documented as having reached 6 cm cervical dilation at 12:15 a.m. on August 5, 2017, and McLeod ordered the cesarean section at 7:18 a.m., Dr. Hoskins concluded that, since the patient remained within the typical four-to-eight-hour window for active

labor applicable to women who had experienced prior vaginal deliveries, she did not experience "prolonged labor." Dr. Hoskins further asserted that the second stage of labor, lasting from full dilation to delivery, generally takes from either several minutes to two or three hours. She concluded that the patient was within this typical window as well. Hence, Dr. Hoskins opined that there were no indications for a cesarean section procedure at any time up to the time when McLeod actually ordered it.

According to Dr. Hoskins, the fact that the patient previously had delivered a large baby via natural spontaneous vaginal delivery was an "important factor" that weighs heavily in assessing McLeod's decision-making process. Where, as here, a fetus generates Category II tracings for FHR, Dr. Hoskins asserted that a clinician must employ judgment in determining whether the best course for the mother and child was further surveillance and evaluation of labor progress, as opposed to a cesarean section procedure. In this context, she concluded that a mother, such as the patient, who previously had delivered a child via natural spontaneous vaginal delivery, "is expected to be able to do so again," and that natural spontaneous vaginal delivery is the "best outcome for the baby and mother when the risk profiles of N[atural] S[pontaneous] V[aginal] D[elivery] and cesarean section are compared." Dr. Hoskins opined that, since the Category II FHR tracings remained essentially constant since 2:30 a.m. on August 5, 2017, "labor was progressing appropriately," and that McLeod's determination to continue labor and to forego a cesarean section procedure until 7:18 a.m. was appropriate, despite the presence of multiple early and variable decelerations, and an occasional late deceleration, in light of the fact that the patient already had reached full cervical dilation. As Dr. Hoskins explained it, once the patient had reached full cervical dilation, the baby could be delivered quickly, and "a cesarean section would pose significant additional risk of surgical injury such as bleeding or injury to adjoining structures within the abdomen."

Dr. Hoskins opined that McLeod's determination to allow the patient to proceed with a natural spontaneous vaginal delivery remained appropriate, notwithstanding the plaintiffs'

contentions that other signs and symptoms necessitated an emergency cesarean section procedure earlier on August 5, 2017. Specifically, Dr. Hoskins asserted that the presence of light-to-moderate meconium found upon the artificial rupture of the uterine membrane is not uncommon, and not an indication to perform a cesarean section. She concluded that McLeod's interpretation of the FHR decelerations that occurred on August 5, 2017 were consistent with the standard of care, and that the FHR tracings, taken as a whole, evinced a Category II, and thus did not require a cesarean section, but continuous monitoring, which was done in this case.

Dr. Hoskins expressly opined that the fetus did not evince tachycardia, despite the fact that the FHR was briefly elevated above 160 beats per minute, since fetal tachycardia must be sustained for at least 10 minutes to be medically significant, which did not occur here. In addition, Dr. Hoskins averred that vague allegations of "[c]hanges in the fetal heart rate" are not medically significant, since FHR rate can fluctuate between 110 to 160 beats her minute, as it did in this case. Furthermore, she characterized the plaintiffs' allegations of "lack of accelerations" as inaccurate, since accelerations indeed had been observed in the fetus "several times, denoting a well oxygenated baby," and, even if accelerations were absent, that condition would be consistent with a Category II tracing. She asserted that the one episode of "minimal variability" on the FHR tracing, lasting approximately seven minutes during the evening of August 4, 2017, was of insignificant duration, and did not alter "the larger picture of these mainly reassuring fetal heart rate tracings over 16 hours." Dr. Hoskins also challenged the plaintiffs' characterization that the FHR tracing was "ominous" since there never was a Category III tracing at any time, and only such a tracing could be considered ominous. Additionally, she rejected the plaintiffs' allegation of fetal mispositioning, since she concluded that the mere fact that the fetus was in an occiput posterior position, while possibly contributing to a longer period of labor, did "not pose any additional risks to mother and baby."

Dr. Hoskins asserted that the medical chart contradicted the patient's contentions that she made complaints of severe pain, and a request for a cesarean section, between 3:00 a.m.

and 4:00 a.m. on August 5, 2017. Rather, as Dr. Hoskins interpreted the chart, those complaints and that request were communicated at approximately 6:30 a.m., and were immediately brought to McLeod's attention since McLeod was at the patient's bedside by 6:48 a.m., a response that Dr. Hoskins described as "timely." Moreover, since, according to Dr. Hoskins, the patient would not allow a physical examination, McLeod timely and appropriately acted on her complaints and the finding of vaginal warmth by ordering antibiotics for presumed chorioamnionitis, which turned out to be an accurate assessment, based on the placental pathology studies. Specifically, Dr. Hoskins opined that "[i]t was not a departure from accepted practice for Dr. McLeod to have not considered uterine rupture at this time based on Ms. El Kassmi's complaints of pain in the context of this labor and all of its features," particularly because "subjective complaints of pain alone are not an indication for Cesarean section."

As Dr. Hoskins continued, the patient's

> "request for a Cesarean section does not create the absolute right for surgery; and there was no clear indication for emergent surgery before it was called. At that time, with a presumed diagnosis of chorioamnionitis, and a Category 2 fetal heart rate tracing, it was appropriate to treat Ms. El Kassmi's pain and try to have at least one dose of an antibiotic administered before performing a Cesarean section. If Dr. McLeod was considering chorioamnionitis and performed non-emergent surgery without administering a dose of antibiotic, she would have ignored the risk of infection to the baby and mother, and other associated complications known to occur when operating in the setting of an infection."

Dr. Hoskins asserted that, after contact with the fetal heart was lost at approximately 7:05 a.m. on August 5, 2017, McLeod returned to the patient's room and properly placed a fetal scalp electrode to obtain a more accurate assessment of the FHR, after which, as McLeod testified at her deposition, she heard audible sounds that she believed to be the fetal heart, and properly obtained a tracing at 7:14 a.m., although it was unclear whether that tracing was reflective of the maternal or fetal heart rate. According to Dr. Hoskins, McLeod then timely ordered an immediate cesarean section procedure at 7:18 a.m., and timely commenced the surgery at 7:33 p.m. She asserted that "[t]he time period of approximately 15 minutes is with the 30-minute

A[merican] C[ollege of] O[bstetrics] and G[ynecology] standard from decision to skin incision for a STAT cesarean section."

Dr. Hoskins rejected the plaintiffs' allegations of inadequate monitoring as "inaccurate," since nursing personnel at Lawrence documented assessments of the patient every 15 to 30 minutes, as required, and McLeod was present throughout the night and early morning of August 4, 2017 through August 5, 2017. Dr. Hoskins averred that McLeod performed her own evaluations every several hours, as documented in the hospital records, a frequency that Dr. Hoskins described as "appropriate." She further opined that the frequency of cervical examinations also was appropriate, explaining that "[t]oo many cervical examinations are generally avoided in order to avoid the risk of an infection in the mother and fetus." Dr. Hoskins averred that the nature of the monitoring also was appropriate, involving as it did the placement of an external monitor throughout the labor, which provided appropriate and sufficient information regarding the fetal status and the patient's contractions, up until the events that occurred at approximately 7:08 a.m. on August 5, 2017. In addition, Dr. Hoskins concluded that the documentation generated by the nurses at Lawrence and by McLeod was appropriate. In this respect, she explicitly opined that the generation of after-the-fact notes in a medical chart was the "standard in the community," since, "[w]hen healthcare providers are focused on providing timely care to patients, notes are entered later because chart documentation does not take priority over appropriate and timely patient care." Thus, Dr. Hoskins asserted that the events that occurred between 6:30 a.m. on August 5, 2017 and the commencement of the cesarean section procedure at 7:33 a.m. "were not required to have been entered until after the Cesarean section was performed."

Dr. Hoskins opined that the administration of Pitocin was not contraindicated in the patient's case, and was not contraindicated merely because there was a Category II FHR tracing. She deemed the duration of the Pitocin treatment to have been short, and the dosing to have been very low, regardless of whether it was discontinued at 6:30 a.m. or 7:03 a.m. on

August 5, 2017. She expressly concluded that the administration of Pitocin in this case "played no role in the uterine rupture," noting that the patient had received higher doses of Pitocin for a longer time in connection with her previous labor and delivery.

Additionally, Dr. Hoskins asserted that, contrary to the plaintiffs' allegations, it was appropriate for McLeod to instruct the patient to push when she did, even if the fetus had last been observed at station -1, since Dr. Hoskins concluded that the fetal position was not a contraindication to pushing in a patient who has had a prior vaginal delivery. Dr. Hoskins also opined that McLeod properly placed the fetal scalp electrode, and that there was nothing in the medical records to contradict McLeod's deposition testimony that she felt the fetal head, rendering the plaintiffs' allegations of improper placement of the electrode as mere conjecture. With respect to this issue, Dr. Hoskins asserted that the fact that the fetal scalp electrode did not return a clear cardiac tracing did not establish it was improperly placed.

Ultimately, Dr. Hoskins concluded that,

> "there was no way for Dr. McLeod to have anticipated what occurred here. Ms. El Kassmi suffered a very rare event, i.e. a primary posterior wall uterine rupture without a history of prior surgery to the uterus. There is nothing in my review of these materials that indicates Dr. McLeod failed to suspect that extremely rare occurrence, or should have performed an earlier Cesarean section based on the maternal or fetal presentation. Accordingly, there is no basis for concluding that Dr. McLeod caused or contributed to the alleged injuries."

She opined that the cause of fetal death was related to the uterine rupture, resulting in decreased blood flow to the fetus, and that there was no way of precisely timing the death, as there was no basis to conclude that the fetus was alive after 7:14 a.m. on August 5, 2017 in the absence of reliable evidence that a heartbeat existed by that time. Dr. Hoskins explained that, since 15 to 17 minutes elapsed from the time when McLeod ordered a "STAT" cesarean section until the delivery of the baby, it must be assumed that "it would have taken the same amount of time if a Cesarean section was called for earlier." Accordingly, she opined that there was no basis upon which to conclude that, had McLeod called for a cesarean section at 6:57 a.m., or at any time thereafter until 7:14 a.m., a live baby would have been delivered.

In opposition to the WB defendants' prima facie showing of entitlement to judgment as a matter of law in connection with the medical malpractice cause of action, the plaintiffs relied upon those defendants' submissions, and also submitted an attorney's affirmation and the affirmation of a board-certified obstetrician/gynecologist. After recounting the history of the patient's treatment by McLeod at Lawrence, the plaintiffs' expert asserted that McLeod departed from the accepted standard of practice in the care that they provided to the patient during her labor and delivery, and that these departures caused or contributed to her injuries and the stillbirth of her fetus.

The plaintiffs' expert explained that, as a patient's labor progresses, and the fetal head descends into the pelvic inlet, the station number increases and, thus, a fetus going from 0 to -2 station is "an abnormal progression of labor and is indicative, not of a fetus moving through the pelvic inlet toward delivery, but instead of a fetus moving in the reverse direction." The expert asserted that this type of "loss of station" is a possible sign of uterine rupture, and is most directly associated with instances where the uterus ruptures and all or part of the fetus enters into the peritoneum, as the expert averred had occurred in the patient's case. The expert opined that, where a patient has a loss of station from 0 to -2, the standard of practice would require that an ultrasound be performed to confirm the position of the fetus, and to rule out a possible ruptured uterus. Since, according to the expert, it did not appear from the medical records that McLeod took especial note of the loss of fetal station, or performed any examination or evaluation of the patient in connection with the regression of her fetus up into the uterus, McLeod departed from the standard of care. Moreover, the expert asserted that, when the patient made complaints of abnormal lower back and hip pain over a period of several hours, and that the pain was not adequately controlled by the initial administration of an epidural anesthesia, or the "topping off" of the anesthesia, McLeod should have suspected uterine rupture. As the expert phrased it, "[m]aternal pain---particularly severe and acute pain---is also a possible symptom of uterine rupture.

Although the plaintiffs' expert agreed with Dr. Hoskins as to the nature and meaning of a Category II FHR tracing, the expert opined that "the standard of care requires that resuscitative measures be initiated in an attempt to resolve the Category 2 tracing." The expert asserted that, although it appeared that resuscitative measures were initiated, as reflected by multiple nursing notes made over a three-hour period, indicating that oxygen had been administered to the patient, and she had been placed in the left lateral position, variable decelerations continued, and the Category II tracing did not resolve. As the expert explained it, at 3:50 a.m. on August 5, 2017, the patient's cervix was 8 cm dilated and 70% effaced, while the fetus was at the -1 station, and the patient had made no progress in dilation in almost four hours. In light of these conditions, and because the patient had experienced both an earlier loss of fetal station and was experiencing severe pain that had not been controlled, despite the administration of additional anesthesia one hour and 40 minutes earlier, the expert opined that it was a deviation from accepted medical practice to order Pitocin augmentation at that time. More specifically, the expert concluded that the administration of Pitocin was improper in light of those signs of possible fetal distress, and because a uterine rupture had not been ruled out. The expert expressly concluded that, at 3:50 a.m., McLeod should have proceeded with cesarean section surgery, as the patient previously had given birth, her cervix was dilated greater than 6 cm, she had ruptured membranes, and the fetus failed to make progress over the prior four hours, thus meeting the definition of "arrest of labor during the active phase" of labor.

The plaintiffs' expert noted that, after the administration of Pitocin, the fetus continued to have what the expert characterized as "recurrent" decelerations in FHR, inasmuch as a variable deceleration occurred in connection with at least 50% of the patient's contractions, and became more frequent after the Pitocin dosage was increased at 5:00 a.m. on August 5, 2017. The expert further noted that, after that time, decelerations became deeper, decreasing in some instances below 60 beats per minute. As the expert explained it, more frequent and severe variable decelerations are more predictive of fetal hypoxia and are concerning for fetal distress.

The expert thus concluded that a cesarean section delivery was necessitated by the recurrent decelerations occurring between 5:00 a.m. and 6:00 a.m. The plaintiffs' expert continued that,

> "[s]hortly after 06:00, the fetal heart tracing began experiencing periods of loss of contact. This impacts the interpretation of the fetal heart tracing as the tracing is usually interpreted in approximately 20-minute segments, which are continuous. When a portion of the strip is interrupted, you may be able to determine the fetal heart rate at a particular moment in time, but you may no longer be able to ascertain the character and quality of the strips overall---such as fetal baseline heart rate or whether there are decelerations or accelerations."

The expert opined that, by virtue of the loss of contact, it was not possible thereafter either to monitor the FHR, or to assess fetal wellbeing based solely upon the final FHR monitoring strips generated at 6:06 a.m., and that, in those circumstances, the standard of practice is to attempt to place a fetal scalp electrode to gain more accurate monitoring and reestablish continuous fetal monitoring. In the patient's case, since no attempt was made to place a fetal scalp electrode until 7:10 a.m., more than an hour after the last FHR monitoring strip was interpreted, the plaintiffs' expert concluded that McLeod failed timely to place the electrode, and that this failure constituted a deviation from the accepted standard of care and practice. Moreover, the expert explicitly opined that, "had a scalp electrode been successfully placed shortly after 06:06, . . . it would have demonstrated a non-reassuring tracing that would have necessitated delivery via cesarean section."

The plaintiffs' expert further concluded that, in light of the extreme pain that the patient experienced between 6:30 a.m. and 6:45 a.m., her concomitant inability to push, her elevated body temperature, a consequent concern for infectious chorioamnionitis, the indeterminate FHR since 6:06 a.m. due to frequent loss of contact, and the failure of the fetus to descend beyond -1 station for more than four hours,

> "a STAT cesarean section should have been called immediately. To permit this patient to labor further was a deviation of the standard of care, as was delaying until 07:10 to place a fetal scalp electrode and then further delaying until 7:18 to call for a cesarean delivery."

The expert opined that a cesarean section should have been ordered between 3:50 a.m. and 6:45 a.m., and that, had it been timely ordered, the "fetus would have been born alive." The expert expanded upon this opinion by explaining that,

> "[t]he cesarean section was called by Dr. McLeod at 07:18 and the fetus was delivered at 07:35---17 minutes later. Dr. McLeod testified that a fetal heartbeat was present until 07:23. If a cesarean section had been called at any point between 06:06 and 06:45, it would have provided more than adequate time for a STAT cesarean to be performed prior to 07:23. Even using the more conservative time of 07:14, which the defendants use, as the time when the infant's heartbeat was last observed, it is my opinion with a reasonable degree of medical probability that the fetus would have been born alive had the STAT cesarean been called by 06:45. In fact, in light of the fact that on this day at this hospital, a cesarean was performed in less than 20 minutes, it is my opinion with a reasonable degree of medical certainty that even if the cesarean section delivery had not been called until 06:55, it still would have resulted in a live birth."

The expert thus concluded that, had the cesarean section procedure been performed, at the latest, by 6:55 a.m., there would have been a live birth, and the patient would have avoided the emotional distress and pain and suffering attendant thereto and. Hence, the expert concluded that the deviations from the accepted standards of practice delineated above were the proximate cause of the patient's injuries.

In an attorney's reply affirmation, the WB defendants asserted that the plaintiffs' expert did not address the opinions of Dr. Hoskins with respect to the plaintiffs' allegations that the WB defendants failed to treat obstructed labor, that they departed from the standard of care by failing to heed the patient's earlier requests for a cesarean section, that they inadequately monitored the fetus and the patient, that they permitted fetal mispositioning, that they failed to treat fetal tachycardia, that they failed to respond to alleged lack of FHR accelerations, and that they inappropriately directed the patient to push, either between 3:00 a.m. and 4:00 a.m. on August 5, 2017, as the patient asserted, or between 6:30 a.m. and 6:45 a.m., in accordance with the medical records. They characterized the plaintiffs' expert's opinion as insufficient to raise a triable issue of fact because it failed explicitly to conclude that McLeod should have performed a cesarean section due to suspicion of uterine rupture.

While the WB defendants correctly argued that they established their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice action, the plaintiffs raised triable issues of fact as to whether those defendants departed from good and accepted medical practice in failing to diagnose a uterine rupture and consequent chorioamnionitis, in administering Pitocin at 3:50 a.m. on August 5, 2017, and in failing to order a cesarean section at any time between 3:50 a.m. and 6:55 a.m. on that date in light of FHR readings, the course of cervical dilation and effacement, the positioning of the fetus, and the patient's complaints of severe, uncontrolled pain. The plaintiffs also raised a triable issue of fact as to whether those departures caused or contributed to the stillbirth and the patient's ongoing emotional distress arising therefrom. Since the plaintiffs' expert did not address Dr. Hoskins's opinions concerning claims alleging obstructed labor, failure to heed the patient's requests for a cesarean section, inadequate monitoring, fetal mispositioning, fetal tachycardia, lack of response to FHR accelerations, and their directions to the plaintiff that she physically push her vaginal muscles, they did not raise a triable issue of fact in opposition to the WB defendants' showing with respect to those claims. Hence, summary judgment must be awarded to the WB defendants dismissing only so much of the medical malpractice cause of action as was addressed to those claims, and the branch of the motion seeking summary judgment dismissing that cause of action must otherwise be denied.

The elements of a cause of action to recover for lack of informed consent are:

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a

statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Nonetheless, "expert testimony concerning what a reasonable person would have done in plaintiff's position is not necessary to maintain a cause of action premised upon lack of informed consent" (*Gray v Williams*, 108 AD3d 1085, 1087 [4th Dept 2013]; *see Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept 2000]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]; *see Godel v Goldstein*, 155 AD3d 939, 942 [2d Dept 2017]). Nonetheless, a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a claim where a patient signs a detailed consent form, and there is also evidence that the necessity and benefits of the procedure, along with known risks and dangers, were discussed prior to the procedure (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456). In addition to invasive diagnostic testing arising from a failure properly to diagnose a medical condition, the administration of nonindicated medications arising from a misdiagnosis may also be the basis

for a lack of informed consent cause of action (*see Lyons v Vassar Bros. Hosp*., 30 AD3d 477, 478 [2d Dept 2006]).

Dr. Hoskins concluded that, inasmuch as the cesarean section procedure constituted an emergency, the patient's informed consent to that surgery was not required, but nonetheless was obtained, and that there was no requirement that a physician obtain a woman's informed consent when there is a decision to continue labor, as the mother in such an instance already had consented to proceed with a vaginal delivery. As Dr. Hoskins phrased it, "it seems plaintiffs are arguing that a consent should have been obtained for a surgery that was not performed." In addition, she rejected the plaintiffs' contention that the patient was unaware of the alternatives to natural spontaneous vaginal delivery inasmuch as the plaintiffs also claimed that she explicitly requested a cesarean section.

The WB defendants established their prima facie entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action insofar as asserted against them. Since the plaintiffs' expert did not address that issue, the plaintiffs failed to raise a triable issue of fact in opposition to that showing, and summary judgment must be awarded to the WB defendants dismissing that cause of action insofar as asserted against them.

Where a physician who works for a professional corporation renders medical care to a patient "within the scope of his or her employment" for that corporation, the corporation may be held vicariously liable for the negligence of the physician (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]). Thus, to the extent that there are triable issues of fact as to whether McLeod committed malpractice, there also are triable issues of fact as to WB's liability.

Accordingly, it is,

ORDERED that the motion of the defendants Lisa McLeod, D.O., and Westchester Bronx OB-GYN Group, P.C., is granted only to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them, and so much of the medical malpractice cause of action insofar as asserted against them

as alleged a failure to treat obstructed labor, a failure to heed the personal requests of the plaintiff Touria El Kassmi that they perform a cesarean section upon her, inadequate monitoring of the fetus and Touria El Kassmi, fetal mispositioning, a failure to treat fetal tachycardia, a failure to respond to an alleged lack of fetal heart rate accelerations, and that they inappropriately directed the patient to push her cervical and vaginal muscles to facilitate childbirth, the motion is otherwise denied, and the lack of informed consent cause of action and so much of the medical malpractice cause of action as alleged the foregoing claims are dismissed insofar as asserted against the defendants Lisa McLeod, D.O., and Westchester Bronx OB-GYN Group, P.C.; and it is further,

ORDERED that that all remaining parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on December 11, 2024, at 11:00 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

11/1/2024
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:	[ ]	CASE DISPOSED		[X]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[ ] DENIED	[X]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[ ]	REFERENCE