Rodriguez v Pathak
2018 NY Slip Op 31495(U)
July 3, 2018
Supreme Court, New York County
Docket Number: 805272/2012
Judge: George J. Silver

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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CHRISTINE RODRIGUEZ as Administrator of the Estate of E.A. DEC'D and CHRISTINE RODRIGUEZ Individually,

Index 805272/2012
Motion Seq. 003

DECISION & ORDER

Plaintiff(s),

-against-

ANIL PATHAK MD and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (HARLEM HOSPITAL CENTER),

Defendants.

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GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendants ANIL PATHAK MD and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (HARLEM HOSPITAL CENTER) ("defendants") move for summary judgment. Plaintiff CHRISTINE RODRIGUEZ (individually and administratively "plaintiff") opposes the motion. For the reasons discussed below, the court grants the motion in part and denies the motion in part.

At appropriately 4:15 a.m. on October 15, 2011, plaintiff, then at 24 weeks gestation, was transported to Harlem Hospital Center ("HHC") emergency department due to heavy vaginal bleeding and the urge to push. Plaintiff's obstetrical history included two living children, eight voluntary terminations of pregnancy, and two miscarriages. At the emergency department, plaintiff reported that she had been smoking cigarettes during her pregnancy and was taking antibiotics for a urinary tract infection. Plaintiff underwent an emergency Cesarean section, and due to placenta accreta, suffered a massive intraoperative hemorrhage that resulted in her having to undergo a hysterectomy.

At 5:22 a.m., plaintiff-decedent E.A. ("E.A.") was delivered at 1.3 pounds. He was limp and had a weak cry. E.A. was immediately carried to a radiant warmer where he was dried, stimulated, and warmed. His oxygen saturation levels were in the low 50s and his heart rate was greater than 120/min. He was initially given oxygen via Neopuff, but was intubated and given positive pressure ventilation via bag/mask when his oxygen level started to desaturate to the low 30s. At that time, E.A. appeared dusky and was less mobile than he had been at the time of his delivery. His oxygen saturation levels slowly increased to the high 80s, and he was transported to the Neonatal Intensive Care Unit ("NICU").

In the NICU, E.A. was placed in a humidified Giraffe incubator, and was intubated and connected to a mechanical ventilator. However, E.A. experienced episodes of desaturation and had to be reintubated when he dislodged the endotracheal tube. E.A. was also connected to an umbilical catheter and a nasogastric tube. E.A. was given two doses of surfactant for respiratory failure and was started on the antibiotics ampicillin and gentamicin. His lungs had reduced air bilaterally and his eyes were fused closed. E.A. moved all extremities, but had decreased tone. E.A. was diagnosed with extreme immaturity, sepsis, and respiratory distress syndrome. Consequently, total parental nutrition ("TPN") and double phototherapy were ordered. That same day, E.A. underwent serial chest x-rays to confirm the correct positioning of the endotracheal tube. A chest x-ray at 9:51 a.m. showed an early onset of pulmonary interstitial emphysema ("PIE") and a decreased intestinal gas pattern. At 5:00 p.m., phototherapy was administered to E.A. due to elevated bilirubin levels. At 6:25 p.m., E.A. had elevated glucose levels.

At 8:00 p.m., on October 15, 2011, neonatology attending Dr. Steven Chin ("Dr. Chin") observed that E.A. exhibited no spontaneous extremity movement, and at 8:25 p.m., nursing noted that E.A. was saturating in the low 90s and was receiving TPN with Heparin. At 9:21 p.m., E.A.

exhibited weak movement of all his extremities, and nursing noted that his condition was stable but guarded. Overnight, E.A. remained guarded and nursing provided chest physiotherapy (removal of mucus from the breathing passage). E.A. remained under phototherapy and orally intubated on TPN with Heparin. He also had pitting edema on both buttocks, but not on his extremities.

Throughout the early morning of October 16, 2011, E.A. experienced repeated episodes of oxygen desaturation, and a chest x-ray confirmed worsening PIE. At approximately 8:15 a.m., E.A. was placed on high frequency oscillatory ventilation ("HFOV") because he had severely abnormal arterial blood gases and could not maintain his oxygen saturation levels. His saturations improved thereafter, but at approximately 9:50 a.m., he was desaturating in the 60s and had to be manually resuscitated by pediatrician Dr. Sadia Haleem ("Dr. Haleem"). At 10:54 a.m., Dr. Haleem had to manually resuscitate E.A. again.

At approximately 11:36 a.m. on October 16, 2011, Dr. Haleem ordered 0.3 mcg of fentanyl via IV push for E.A. due to agitation. At 12:26 p.m., E.A.'s oxygen saturation was in the low 60s and he had to be manually resuscitated by Dr. Chin for two minutes. At 1:00 p.m., E.A. was manually resuscitated again for three minutes. Approximately five minutes later, inhaled nitric oxide therapy was initiated and E.A.'s oxygen saturation levels improved after 20 minutes. E.A. also received a blood transfusion that afternoon and remained under phototherapy. His eyes were still fused shut and he moved "very little." Dr. Chin assessed E.A. on the evening of October 16, 2011, and stated that E.A. had severe respiratory distress syndrome, hypoxic respiratory failure, metabolic acidosis, hyperkalemia, hypernatremia, and anemia. E.A. remained on ampicillin, gentamicin, and cefotaxime. Dr. Chin also noted that since nitric oxide carried a risk of intraventricular hemorrhage, E.A. had to slowly be weaned off nitric oxide and HFOV.

At 7:30 a.m. on October 17, 2011, E.A. received dextrose and calcium gluconate. A chest x-ray showed that his PIE was unchanged. At 8:30 a.m., E.A. received insulin, followed by a bolus of dextrose and a bolus of calcium gluconate. He also received a blood transfusion that morning and remained under phototherapy. A brain ultrasound performed at approximately 12:25 p.m. revealed a bilateral grade 3 IVH. At 3:15 p.m., a chest x-ray was performed, and a blood gas performed at 1:30 p.m. showed improvement in acidosis.

That afternoon, E.A. was seen by cardiology and respiratory therapy, and at 5:25 p.m., neonatology resident Dr. Weir noted that E.A. was sedated and attached to HFOV with nitric oxide. E.A. also received an infusion of dopamine to improve perfusion, make him less acidotic, and improve his blood urea nitrogen ("BUN") and creatinine levels. An arterial blood gas revealed improvement in acidosis, but E.A. was still hypernatremic. TPN was discontinued due to a rise in E.A.'s BUN and gentamicin was changed to cefotaxime due to an elevated creatinine level. Dr. Weir's impression was that E.A. was an extreme preemie and that his condition was "critical."

Attending neonatologist Dr. Anil Pathak ("Dr. Pathak") first became involved with E.A.'s care on October 17, 2017. That day, it was noted that E.A. had good chest wiggling and was moving all extremities. At 7:30 p.m., a chest x-ray was performed to place a peripherally inserted central catheter line and to ensure appropriate positioning of the ETT. A NICU nurse, Olawummi Oyebola noted that E.A. was moving frequently, and at 8:15 p.m., Dr. Pathak prescribed him with 1 mcg of fentanyl in 0.2 ml of saline because he was agitated.

E.A.'s father, Sebastian Armstrong ("Mr. Armstrong") testified that while he was at E.A.'s bedside, he overheard a conversation between Dr. Pathak and a nurse in which Dr. Pathak repeatedly asked the nurse what dosage of fentanyl to give E.A., and the nurse replied that he was

giving E.A. too much medication. Mr. Armstrong also testified that Dr. Pathak thereafter squirted more of the medication out of the syringe and injected it into E.A.

At approximately 8:27 p.m. on October 17, 2011, a 100 mcg vial of fentanyl was dispensed from Pyxis, a machine at HHC where narcotics such as fentanyl are stored and dispensed. Dr. Pathak administered the fentanyl to E.A., and the remaining 99 mcg of the 100 mcg was disposed of according to Pyxis records. At 8:35 p.m., nurse Oyebola documented that E.A. desaturated to 68% and had bradycardia at 47 bpm and a blood pressure of 29/11. Dr. Pathak further noted that E.A. had "acute deterioration" at 8:25 p.m. and when his heart rate dropped to the 40s, a code was called. Dr. Pathak was at E.A.'s bedside when he was extubated, reintubated, and provided with Ambubag ventilation. Resuscitative efforts were undertaken with chest compressions and epinephrine, but despite these efforts, E.A. was pronounced dead at 8:45 p.m.

On October 19, 2011, New York City Chief Medical Examiner, Dr. Candace Schoppe ("Dr. Schoppe") performed an autopsy of E.A. In the autopsy report, Dr. Schoppe listed the cause of death as "complications of Fentanyl administration for sedation" with a contributing cause of death of "extreme prematurity," and the manner of death as "therapeutic complication." A toxicology report showed 2 ng/mL of fentanyl in E.A.'s blood and 23.6 ng/g of fentanyl in his liver.

In 2013, defense counsel requested to meet with Dr. Schoppe, but because she was no longer employed at the New York City Chief Medical Examiner's office, Dr. Angela McGuire ("Dr. McGuire") reviewed the autopsy findings and determined that a more complete review of the autopsy was warranted. In 2015, Dr. McGuire issued an amended autopsy report that changed the cause of death to "complications of extreme prematurity" and the manner of death to "natural." The reference to rigid chest syndrome was also removed from the autopsy report.

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiff cannot establish that defendants' medical treatment deviated from accepted standards of care or proximately caused E.A.'s alleged injuries.

In support of their motion, defendants annex the affirmation of neonatologist Dr. Lance Parton ("Dr. Parton"). In his affirmation, Dr. Parton asserts that E.A. was "a very ill severely premature infant" who could not be saved despite the rigorous efforts by Dr. Pathak and the HHC staff. Dr. Parton points out that less than 50% of extremely premature infants with such low birth weight survived in 2011. Dr. Parton further elaborates that E.A. had multiple co-morbidities and various medical issues that contributed to his inability to survive, including PIE, acute respiratory distress syndrome, and persistent metabolic acidosis, among others.

In Dr. Parton's opinion, Dr. Pathak acted within the acceptable standard of care. For example, Dr. Parton notes that Dr. Pathak correctly ordered a dose of fentanyl to treat E.A. for anxiety and pain to avoid the risk of E.A. pulling out the life-sustaining tubes since fentanyl is a generally accepted form of analgesia and sedation in premature neonates. Dr. Parton also points out that E.A. was given fentanyl prior to October 17, 2011 with no adverse effect and highlights that there were no contraindications for administering fentanyl on October 17, 2011. According to Dr. Parton, the dose of fentanyl to be given is based on an infant's weight, which allows a dose of up to 5 mcg/kilogram to be given to an infant. Therefore, Dr. Parton concludes, Dr. Pathak's administration of 1.6 mcg/kilogram of fentanyl was within the standard of care because 1 mcg of fentanyl in 0.2 ml solution was an acceptable dose for an infant of E.A.'s weight.

Defendants further contend there is no evidence in the medical records, depositions, or autopsy report that E.A. was given more than 1 mcg of fentanyl. According to Dr. Parton, E.A.

was not overdosed. Rather, Dr. Parton agrees with Dr. McGuire's amended autopsy report which changed the cause of death to "complications of extreme prematurity" and the manner of death to "natural." Dr. Parton also underscores that Dr. Schoppe later conceded that she should have listed "extreme prematurity" as the underlying cause of death in the death certificate, and notes that Dr. Schoppe's autopsy report statement "complication of Fentanyl administration" does not mean that fentanyl was inappropriately given, should not have been given, or was given in an inappropriate dose. Rather, Dr. Parton points out that Dr. Schoppe indicated that fentanyl may have contributed to E.A.'s death because he suffered a known complication from using fentanyl.

Dr. Parton further opines that there is no evidence that E.A. had rigid chest syndrome. Specifically, Dr. Parton asserts that Mr. Armstrong's observations of E.A. just prior to death were consistent with the dying process, not chest wall rigidity. Dr. Parton also avers that Dr. Schoppe had no basis to diagnose E.A. with rigid chest syndrome since she is not a clinician, never spoke to Dr. Pathak or any other personnel from HHC, and may not have had a full set of medical records before performing the autopsy. According to Dr. Parton, Dr. Schoppe concluded that E.A. had rigid chest syndrome based on information provided by his family and a literature search she conducted after another neonatologist with no connection to E.A. or this case referred her to the topic. Indeed, Dr. Parton points out that the records from HHC do not contain any references to a clinical diagnosis of chest wall rigidity. Dr. Parton further illustrates that even if E.A. had chest wall rigidity, "the treatment with naloxone or neuromuscular blocking agents is controversial [and thus] . . . it was not the standard of care to give naloxone or other neuromuscular blocking agents to a premature baby." According to Dr. Parton, "naloxone would not be given" to E.A. because "there was no diagnosis of chest wall rigidity."

Dr. Parton also contends that Mr. Armstrong's claim that he overheard a nurse question Dr. Pathak about giving E.A. fentanyl was a classic "time out" procedure. Dr. Parton explains that a "time out" question is a standard, routine custom and practice in hospitals nationwide before any narcotic is given. According to Dr. Parton, a "time out" is a very effective method to prevent exactly what plaintiff claims occurred in this case. Dr. Parton further states that there is no testimony by any of the medical personnel that suggests that Dr. Pathak was being questioned because he was giving too much medication to E.A.

Furthermore, defendants also annex the affirmation of toxicologist Dr. Shan Yin ("Dr. Yin"). In his affirmation, Dr. Yin asserts that defendants properly administered fentanyl to E.A. after he showed signs of agitation, including hyperactivity and frequent movement, the symptoms that fentanyl was designed to treat. According to Dr. Yin, fentanyl is commonly used in the NICU for sedation and as an analgesic because it provides rapid analgesia with minimal hemodynamic effects. Dr. Yin further points out that fentanyl was administered to E.A. in appropriate amounts, and that it is acceptable to administer a neonatal premature patient an initial bolus of 1 to 2 mcg/kg, then 0.5 to 1 mcg/kg, before titrating to the usual accepted dosage of 1 to 3 mcg/kg. Dr. Yin explains that the appropriate concentration of fentanyl is a clinical decision determined by the infant's weight rather than the infant's gestational age, and therefore, a dose of 0.3 mcg on October 16, 2011 and a dose of 1 mcg/kg on October 17, 2011 were within the acceptable range.

In Dr. Yin's opinion, the dose of fentanyl administered and the concentrations found in E.A.'s liver and blood are not consistent with an overdose. According to Dr. Yin, the 1.3 mcg/kg of fentanyl found in E.A.'s liver postmortem is lower than what is generally found in fatal cases. Dr. Yin also asserts that only a low concentration of fentanyl was found in E.A.'s bloodstream, and that 2 ng/ml is lower than what is generally found in cases of overdose. Dr. Yin also points

out that postmortem redistribution may cause the postmortem concentration to become higher than the concentration antemortem.

Dr. Yin also opines that based on the medical records and depositions, E.A. was critically ill before fentanyl was administered. According to Dr. Yin, a newborn is considered "extremely preterm" if born at or below 28 weeks, which exposes them to great risk of respiratory arrest, sepsis, intracranial hemorrhage, retinopathy of prematurity, hypothermia, and limited/impaired lung function among other conditions. Dr. Yin notes that E.A. was born at 24 weeks gestation, had a birth weight of 635 g, and was diagnosed with respiratory distress syndrome, acute respiratory failure, apnea/bradycardia, septicemia, hyperosmolality and/or hypernatremia, hyperpotassemia, metabolic acidosis, and anemia. Dr. Yin also states that Dr. Schoppe cannot diagnose E.A. with chest wall rigidity after his death because chest wall rigidity is a clinical, not pathological diagnosis, that only a clinician who treated the patient can make.

Defendants further argue that plaintiff's lack of informed consent claim should be dismissed. In her pleading papers, plaintiff argues that defendants failed to obtain her consent to administer fentanyl to E.A., and failed to inform, discuss, or offer alternative medical treatments. Defendants contend that informed consent was not required because fentanyl was administered under an emergency since E.A. was critically ill, as illustrated by Dr. Pathak's testimony that he issued a verbal order instead of a written order for the fentanyl. Dr. Parton also opines that because the risk of chest wall rigidity from such a low dose of medication is very remote and rare, and the benefits outweighed the risks, it would not have been reasonable or within the standard of care to inform plaintiff of such risks.

Defendants alternatively argue that even if there was no emergency, they properly obtained plaintiff's informed consent to administer fentanyl. Defendants highlight plaintiff's testimony that

on October 17, 2011, she and Mr. Armstrong were at E.A.'s bedside when Dr. Pathak told them that he was going to administer fentanyl to sedate E.A. According to Dr. Parton, this was a reasonable statement to give plaintiff a basis for his recommendation to use fentanyl.

Defendants also argue that plaintiff's claim for punitive damages should be dismissed because there is no evidence to support this claim. Defendants also contend that because New York City Health and Hospital Corporation is a government entity, it is immune from punitive damages. Defendants further assert that plaintiff cannot establish that Dr. Pathak acted with willful or wanton negligence, malice, or recklessness, or that he manifested evil or malicious conduct to justify punitive damages. Rather, defendants maintain that plaintiff's allegations amount to ordinary negligence and do not warrant punitive damages.

In opposition, plaintiff asserts that questions of fact exist as to the timing in which the fentanyl was dispensed from the Pyxis machine and injected into E.A. According to plaintiff, defendants' argument that a 1 mcg dose of fentanyl was given on October 17, 2011, as ordered by Dr. Pathak, is incomplete and contradictory based on E.A.'s medical chart and the testimonies of Dr. Pathak, nurse Cabrera, and nurse Oyebola. Plaintiff points out that although Dr. Pathak stated that he ordered fentanyl "around 8 pm," his progress notes were not computerized in the hospital chart until several hours later. Moreover, plaintiff highlights that because Dr. Pathak verbally ordered fentanyl, there was no written order or record to verify the time of the order. Plaintiff also argues that while nurse Cabrera's progress notes show that fentanyl was not ordered prior to 8:00 p.m., nurse Oyebola's progress notes indicate that fentanyl was prescribed by Dr. Pathak at 8:15 p.m. and the Pyxis machine recorded that 100 mcg of injectable fentanyl in a 2 ml vial was dispensed at 8:27 p.m. Accordingly, plaintiff concludes that based on defendants' records, fentanyl was not prepared for IV administration earlier than 8:27 p.m.

Plaintiff also questions the actual dose of fentanyl administered to E.A., and argues that the Pyxis printout, defendants' depositions, and the written records are ambiguous and unreliable. Instead, plaintiff claims that these records show that a dose of ten times the prescribed 1 mcg dose was administered. In support of her motion, plaintiff annexes the affirmation of Dr. Richard Parent, a board-certified toxicologist and Dr. Carolyn Crawford, a board-certified neonatologist. According to both experts, defendants' records reveal that Dr. Pathak ordered 1 mcg of fentanyl by IV, however, the records do not indicate what dose was actually administered. Plaintiff states that the Pyxis printout shows that a vial of 100 mcg of fentanyl in a 2 ml injectable solution was dispensed, but that nurse Oyebola's testimony and progress note entered at 10:46 p.m. show that a syringe containing 10 mcg, not 1mcg of fentanyl was injected into E.A.'s IV. Further, plaintiff contends that nurse Oyebola was incorrect to believe that 0.2 ml of the 100 mcg solution contained in the 2 ml vial of fentanyl (1/10 of the vial) would equal 1 mcg, when it in fact equaled 10 mcg.

Additionally, plaintiff's toxicologist determined that E.A. was mistakenly dosed with 10 mcg of fentanyl based on the values from the toxicology report. Under the volume of distribution ("Vd") analysis, which describes how fentanyl is distributed in the body, Dr. Parent calculated a Vd of 3.81 L based on E.A.'s body weight and the Vd for fentanyl (635 g x 6 L/kg). Dr. Parent explains that since fentanyl was administered to E.A. by IV, the concentration of fentanyl in E.A.'s blood can be calculated immediately after the injection is given. Dr. Parent also uses the rate of clearance to calculate the concentration of fentanyl in E.A.'s blood postmortem. According to Dr. Parent, the elimination rate for fentanyl from E.A.'s body was 11.4 ml/kg/min based on the rate of clearance from the body and E.A.'s body weight (17.94 ml/kg/min x 635 g). Dr. Parent further states that if the IV push was given 30 minutes before E.A. was pronounced dead, there would be a 9% clearance of fentanyl over a period of 30 minutes from dosing to death (11.4 ml/min x 30 =

342 ml; then divide 342 ml by 3.81 L = 9%). Therefore, if E.A. was dosed with 1 mcg of fentanyl, he would have had an approximate blood concentration of 0.262 mcg/L or 0.262 ng/ml, nearly eight times than the prescribed 1 mcg dose (1 mcg/3.81 L = 0.262 mcg/L = 0.262 ng/ml).

Dr. Crawford also notes that the level of fentanyl found in E.A.'s blood and liver postmortem demonstrates that E.A. was mistakenly dosed with 10 mcg, not 1 mcg of fentanyl. Dr. Crawford asserts that based on the postmortem fentanyl concentration found in E.A.'s blood, if E.A. was dosed with 0.2 ml of fentanyl instead of the 50 mcg/ml fentanyl solution, he would have received a dose of 10 mcg, not 1 mcg. Plaintiff also contends that there are issues of fact as to whether the entire 2 ml was drawn into a syringe containing a premeasured volume of normal saline, whether 1/100 of the vial was aspirated into a syringe with scoring marks to measure volume, or whether the dose was measured in some other way. As such, plaintiff argues that these issues regarding the dose of fentanyl administered preclude summary judgment.

Plaintiff further asserts that fentanyl toxicity was a substantial contributing cause and the proximate cause of E.A.'s death. Plaintiff points out that the original autopsy report, dated April 12, 2012, correctly listed "complications of fentanyl administration for sedation" as the cause of death. Dr. Parent notes that the forensic toxicology report showed 2 ng/ml of fentanyl in E.A.'s blood and 3.6 ng/g of fentanyl in his liver. Dr. Parent points out that contrary to Dr. Yin's opinion, 2 ng/ml of fentanyl in E.A.'s blood is close to the range of reported fatalities in adults and 3.6 ng/g of fentanyl in his liver is within the range of reported fatalities in adults. According to Dr. Parent, what might be a borderline lethal dose of fentanyl for an adult will certainly be a lethal dose for two-day old premature infant weighing 635 g.

In Dr. Crawford's opinion, defendants' failure to treat E.A. with naloxone during the CPR code was also a departure from accepted practice and the proximate cause of E.A.'s death.

According to Dr. Crawford, E.A.'s cardiorespiratory collapse immediately after he received fentanyl on October 17, 2011 is consistent with Dr. Parent's opinion that 10 mcg of fentanyl was administered. Plaintiff further avers that treating E.A. via endotracheal tube rather than intravenously during the attempted resuscitation was a departure from accepted practice, and that the failure to administer IV epinephrine was a substantial contributing and proximate cause of death because it "deprived E.A. of a substantial opportunity of survival." According to Dr. Crawford, had epinephrine been given by IV during the CPR code, there would have been a substantial opportunity to correct E.A.'s terminal bradycardia and successfully resuscitate him. Plaintiff further refutes defendants' assertion that E.A. had a slim chance of survival.

In reply, defendants attack the credibility of plaintiff's expert toxicologist, and contend that Dr. Parent lacks a medical degree and the requisite qualifications to testify about the standard of care in the field of toxicology and/or the applicable standards of medical care. Defendants also reiterate that plaintiff's lack of informed consent and punitive damage claims should be dismissed because plaintiff did not oppose those portions of defendants' motion. Defendants further argue that plaintiff cannot assert a new claim in his opposition that Dr. Pathak deviated from the standard of care by giving epinephrine via endotracheal tube rather than intravenously during resuscitation.

Defendants' reply also argues that the court should not consider the articles cited in plaintiff's opposition because they are impermissible hearsay. In support of their reply, defendants annex supplemental affirmations of Dr. Parton and Dr. Yin, who both assert that the articles cited by plaintiff's toxicologist do not support his opinion of a fentanyl overdose. According to Dr. Yin, the literature submitted by Dr. Parent does not support his calculations, and his use of the calculations is not reliable because it is not generally accepted in the medical community. Defendants' further request a *Frye* hearing if their motion for summary judgment is denied to

determine whether there is any support in the medical/scientific communities for plaintiff's theories and mathematical calculations.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept

2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendants set forth a *prima facie* case in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendants' expert affidavits, all of which attest to the fact that defendants' administration of fentanyl to E.A. was in accordance with accepted standards of care and did not proximately cause E.A.'s alleged injuries. To be sure, defendants' expert affirmations are detailed and predicated upon ample evidence within the record. As defendants have made a *prima facie* showing, the burden shifts to plaintiff.

I. Triable Issues of Fact Regarding the Administration of Fentanyl and Infant's Cause of Death

To rebut defendants' *prima facie* showing, plaintiff argues that there are triable issues of fact as to the timing in which the fentanyl was dispensed and administered to E.A. In doing so, plaintiff correctly highlights contradictions between Dr. Pathak's progress notes stating that fentanyl was administered "around 8 pm," nurse Cabrera's progress notes indicating that fentanyl was not ordered prior to 8:00 p.m., nurse Oyebola's progress notes stating that fentanyl was prescribed by Dr. Pathak at 8:15 p.m., and the Pyxis record indicating that the fentanyl was dispensed at 8:27 p.m. Based on the timing discrepancies leading up to E.A.'s death at 8:45 p.m., the court finds that sufficient issues of fact exist here to preclude summary judgment, especially because the timing of when E.A. was administered fentanyl is likely to shed light upon whether the drug played a substantial role in his death.

Triable issues of fact also exist regarding the dosage and lethality of fentanyl administered. While plaintiff asserts that the toxicology report shows an overdose of ten times the 1 mcg dose that Dr. Pathak prescribed, defendants argue that 1 mcg of fentanyl in 0.2 ml solution was an acceptable dose for an infant of E.A.'s weight, and that Dr. Pathak's administration of 1.6

mcg/kilogram was within the standard of care. Defendants also contend that there is no evidence that E.A. was given more than 1 mcg of fentanyl. Plaintiff and defendants' experts also dispute whether the concentration of fentanyl found in E.A.'s blood and liver was consistent with what is known to be a fatal level in adults. While plaintiff's expert asserts that the concentration in E.A.'s blood was close to the range of reported fatalities in adults, which would certainly be a lethal dose for a two-day old premature infant weighing 635 g, defendants' toxicologist notes that this concentration was lower than that generally found in cases of fentanyl overdose. Plaintiff's neonatologist also remarks that the fentanyl found in E.A.'s liver was within the range of reported fatalities in adults, however, defendants' toxicologist contends that the fentanyl found in E.A.'s liver postmortem was lower than what is generally found in fatal cases of fentanyl. The parties also disagree over whether the nurse's questioning of Dr. Pathak suggested that Dr. Pathak was giving E.A. too much medication or whether this "time out" question demonstrated a standard hospital custom and practice. Because there are disputes concerning the dosage of fentanyl administered, the analysis of the toxicology report, and the credibility of the witnesses, triable issues of fact have been raised that are sufficient to preclude summary judgment.

There are also triable issues of fact as to whether E.A. had chest wall rigidity. Defendants' neonatologist asserts that there is no evidence or basis to diagnose E.A. with rigid chest syndrome, and that Mr. Armstrong's observations of E.A. just prior to death were consistent with the dying process, not rigid chest syndrome. Defendants' toxicologist also notes that Dr. Schoppe cannot diagnose chest wall rigidity after death since it is a clinical, not pathological, diagnosis that only a clinician who treated the patient can make. Because plaintiff's toxicologist does not address the issue of chest wall rigidity, and because plaintiff's neonatologist does not assume that E.A. had

chest wall rigidity nor base her opinion on the original autopsy report's reference to rigid chest syndrome, there are issues of fact here sufficient to preclude summary judgment.

Notably, the parties also reasonably dispute the actual cause of E.A.'s death. Plaintiff asserts that fentanyl toxicity was a substantial contributing and proximate cause of E.A.'s death, and concurs with the original autopsy report that listed "complications of fentanyl administration for sedation" as the cause of death. Defendants, however, agree with Dr. McGuire's amended autopsy report that changed the cause of death to "complications of extreme prematurity" and the manner of death to "natural," and points out that Dr. Schoppe later conceded that she should have listed "extreme prematurity" as the underlying cause of death in the death certificate. Based on these disputed facts regarding the cause of death and the autopsy report, the court finds issues of fact exist here sufficient to preclude summary judgment.

Furthermore, defendants incorrectly assert that plaintiff's toxicologist is unqualified as an expert. Contrary to defendants' assertion, Dr. Parent does not need a medical degree to render an opinion as he is not making a medical diagnosis nor attesting to any medical processes or procedures. Rather, Dr. Parent's opinion is specifically based on determining the approximate dosage of fentanyl administered to E.A. by intravenous injection shortly before his death (*People v. Menegan*, 107 A.D.3d 1166, 1168 [3d Dept. 2013] [citations omitted] [a board-certified toxicologist is properly qualified as an expert witness where he "possessed sufficient education, training and experience from which [the court] could infer that [his] opinion would be reliable"]; *Roy v. Volonino*, 262 A.D.2d 546, 547 [2d. Dept. 1999]; *Tropp v. State*, 56 Misc. 2d 814, 816 [Ct. Cl. 1968] [court accepted expert toxicologist's opinion as to the cause of death due to a medicine overdose]). Because Dr. Parent relies on a formulaic calculation to determine what level of toxicity is considered lethal based on an infant's body weight and known facts about the properties of

fentanyl, any medical or specialized expertise in neonatology or pre-mature infants is irrelevant and unnecessary. In that regard, Dr. Parent has laid the proper foundation for his theories and calculations, and the court is satisfied that he possesses sufficient "education, training and experience from which [to] infer that his opinion would be reliable" (*id.*). Any issues regarding the credibility of Dr. Parent may be challenged during *voir dire* at trial.

II. Other Claims (Lack of Informed Consent, Punitive Damages, New Claim)

Plaintiff fails to raise a triable issue of fact regarding her claims for lack of informed consent and punitive damages. Plaintiff's opposition failed to rebut defendants' *prima facie* showing that informed consent was not required and that it would not have been reasonable or within the standard of care under the circumstances to inform plaintiff of the risks of administering fentanyl. Plaintiff's opposition also failed to rebut defendants' showing that there is no evidence to support a claim for punitive damages and that New York City Health and Hospital Corporation is nevertheless immune from punitive damages as a government entity. Because plaintiff failed to challenge defendants' *prima facie* showing on these grounds, no triable issues of fact exist sufficient to defeat summary judgment. Accordingly, defendants are entitled to summary judgment on these claims.

Additionally, defendants properly contend that plaintiff cannot now assert a new claim that Dr. Pathak inappropriately administered epinephrine via endotracheal tube rather than intravenously during resuscitation. A plaintiff cannot defeat a motion for summary judgment by asserting a new theory of liability (*Sutin v. Manhattan & Bronx Surface Transit Operating Auth.*, 54 A.D.3d 616, 616 [1st Dept. 2008]; *Abalola v. Flower Hosp.* 44 A.D.3d 522, 522 [1st Dept. 2007]). In her opposition, plaintiff alleges for the first time that Dr. Pathak inappropriately administered epinephrine to E.A. However, plaintiff made no allegations of an improper

administration of epinephrine or even mentioned epinephrine in her initial pleadings. In plaintiff's verified bill of particulars, for instance, her only reference to an "inappropriate administration" related to fentanyl citrate. Because this inappropriate administration of epinephrine claim was not previously alleged, it is insufficient to raise a triable issue of fact as a matter of law (*id.*). Thus, defendants are entitled to summary judgment on this issue.

III. *Frye* Hearing

Defendants' argument that plaintiff cannot establish the medical and scientific validity that E.A. suffered respiratory depression due to fentanyl is not an appropriate basis for a *Frye* hearing. "A *Frye* inquiry is directed at the *basis for the expert's opinion* and does not examine whether the expert's conclusion is sound" (*Lugo v. New York City Health & Hosps. Corp.*, 89 A.D.3d 42, 56 [2d Dept. 2011] [emphasis added] *citing Nonnon v. City of New York,* 32 A.D.3d 91, 103-105 [1st Dept. 2006] [toxicological evidence is admissible without a *Frye* hearing]). "*Frye* is not concerned with the reliability of a certain expert's conclusions, but instead with 'whether the experts' deductions are based on principles that are sufficiently established to have gained general acceptance as reliable'" (*Nonnon*, 32 A.D.3d at 103, *supra*). Here, plaintiff's neonatologist and toxicologist have shown a sufficient basis on which to support plaintiff's causation theory (*Marsh v. Smyth*, 12 A.D.3d 307, 311–12 [1st Dept. 2004]). Because plaintiff's experts are not relying on a "newly minted procedure or test," but are instead "simply offering their informed opinion" that fentanyl caused E.A. to suffer respiratory depression, a *Frye* hearing is not warranted (*id.* ["Expert testimony as to whether the asserted conduct of the defendants was the causative agent for the plaintiff's injury does not really involve anything novel or experimental as contemplated by the *Frye* test," [and] "does not warrant a preliminary *Frye*-type hearing; these types of competing

claims are adequately dealt with at trial."]). According, defendants' request for a *Frye* hearing regarding plaintiff's theory is denied.

Similarly, defendants' contention that a *Frye* hearing is necessary to determine the medical/scientific validity of plaintiff's toxicologist's VD and clearance calculations is without merit. The articles and explanation advanced by plaintiff's toxicologist demonstrate a sufficient basis for the mathematical computations on which he relies to form his opinions and conclusions (*Cokeng v. Ogden Cap Properties, LLC*, 104 A.D.3d 550, 551 [1st Dept. 2013] [affirming denial of a motion seeking a *Frye* hearing on expert toxicologist "as the expert's opinions are based on well-established and accepted methodologies"]). Likewise, defendants' argument that plaintiff's toxicologist's use of the calculation is a novel science is inadequate (*Nonnon*, 32 A.D.3d at 103, *supra*, *citing* Reference Manual on Scientific Evidence, Reference Guide on Toxicology 403 [2d ed.] ["Toxicology is not a novel field of science," but rather, "classically it is known as the science of poisons."]). As such, any issue involving plaintiff's toxicologist's use of the calculation on which he bases his conclusions is an issue of credibility and weight to be resolved at trial (*Cokeng*, 104 A.D.3d at 551, *supra*] ["arguments regarding the report by [expert toxicologist] constitute issues of credibility and accuracy, the resolution of which are matters within the province of the jury"]). Accordingly, defendants' request for a *Frye* hearing regarding plaintiff's toxicologist's calculation is denied.

Likewise, defendants' various challenges to the articles and studies cited by plaintiff's toxicologist goes to "the weight to be given to the testimony concerning the study, but . . . does not preclude its admissibility" (*Likos v. Niagara Frontier Transit Metro Sys., Inc.*, 149 A.D.3d 1474, 1476 [4th Dept. 2017] [*denying* motion to preclude expert toxicologist testimony despite argument that the studies relied upon by the expert were irrelevant and hearsay]). As such,

defendants' request that the articles cited by plaintiff's toxicologist not be considered by the court is denied.

Accordingly, based on the foregoing, it is hereby ORDERED that defendants' motion for summary judgment is GRANTED to the extent that plaintiff's cause of action for lack of informed consent is dismissed, and plaintiff's requests for punitive damages and to assert a new claim based on the inappropriate administration of epinephrine are denied; and it is further

ORDERED that defendants' request for summary judgment as it relates to the administration of fentanyl is DENIED; and it is further

ORDERED that defendants' request for a *Frye* hearing is DENIED; and it is further

ORDERED that the parties are directed to appear for a pre-trial conference on August 14, 2018 at 9:30 A.M. at 111 Centre Street, Room 1227 (Part 10) New York, New York 10013; and it is further

ORDERED that the clerk is directed to enter judgment accordingly.

This constitutes the decision and order of the court.

July 3, 2018

George J. Silver

HON. GEORGE J. SILVER