Grill v Marks
2019 NY Slip Op 33085(U)
October 11, 2019
Supreme Court, New York County
Docket Number: 805487/16
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11

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STACEY GRILL and GLEN KOPP, As Administrator of the Estate of AK, Deceased, STACEY GRILL, individually and GLEN KOPP, individually,

INDEX NO. 805487/16

Plaintiffs,

-against-

JANICE MARKS, MD, JANICE K. MARKS, M.D, P.C., LENOX HILL HOSPITAL, NORTHWELL HEALTH INC, NORTH SHORE-LONG ISLAND JEWISH HOSPITAL SYSTEM, INC., KAMILLA GREENIDGE, M.D., LENOX HILL ANESTHESIOLOGY, PLLC, SHAKHIRA EVANS, R.N., JACQUELINE COLLINS, M.D., KATY MAGGIO, R.N., ANA DEGOY, M.D., and KAVITA KASAT, M.D.,

Defendants.

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JOAN A. MADDEN, J.:

In this medical malpractice action, defendants Kamilla Greenidge, M.D. ("Dr. Greenidge") and Lenox Hill Anesthesiology PLLC ("LHA")(together "Greenidge defendants"") move for summary judgment dismissing the complaint and all cross claims against them (motion sequence no. 003). Defendants Lenox Hill Hospital, North Shore Long Island Jewish Health Care System, Inc., ("Lenox Hill"), Northwell Health, Inc. ("Northwell"), Shakhira Evans, R.N. ("Nurse Evans"), Jacqueline Collins, M.D. ("Dr. Collins"), Katy Maggio, R.N. ("Nurse Maggio"), Ana Degoy, M.D ("Dr. Degoy"), and, Kavita Kasat, M.D. ("Dr. Kasat" together "the Lenox Hill defendants") separately move for summary judgment (motion sequence no. 004). Plaintiffs oppose the summary judgment motions, except as to the claims asserted against defendants Northwell, Nurse Maggio and Dr. Degoy, and separately move for partial summary

judgment on their claims against Lenox Hill, Nurse Evans, Dr. Greenidge, LHA, Dr. Collins and Dr. Kasat (motion sequence no. 005).[1]

Background

This medical malpractice action arises out of the care and treatment provided to plaintiff Stacey Grill ("Ms. Grill") in connection with the delivery of her son, AK, on February 26, 2015 by Cesarean section ("C-Section") at Lenox Hill Hospital, ("Lenox Hill"). Nurse Evans, a labor and delivery nurse, and Dr. Collins, who was in her final year of a residency in obstetrics and gynecology, and Dr. Kasat a pediatrician with a sub-speciality in neonatology, were on the staff of Lenox Hill. Dr. Greenidge was the anesthesiologist who provided services related to the C-section. Defendant Janice Marks, M.D. ("Dr. Marks") was plaintiff's private attending obstetrician.

Ms. Grill was admitted to Lenox Hill, on the February 25, 2015, at 9:10 pm for voluntary induced labor with Cervidil[2] (Marks EBT at 147-148; Lenox Hill Chart ("LH Chart") at 339). The next day, on February 26, Dr. Marks was present at 7:30 am to check the chart (Marks EBT at 153) and then returned at about 1:00 pm, and remained with Ms. Grill through delivery (Id at 336-337). At the time Dr. Marks returned Ms. Grill was six and a half centimeters dilated and she removed the Cervidil (Id at 337). Ms. Grill was fully dilated at 1:50 pm and began pushing at 1:54 pm (Id at 386). While she was pushing, Ms. Grill received intrauterine resuscitative measures of oxygen and IV hydration (Id at 343). Dr. Marks testified that based on her review of

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[1]Motion sequence nos. 003, 004, and 005 are consolidated for disposition.

[2]Cervidil is the trademark name for dinoprostone, which is a vaginal insert which is FDA approved "to start and/or continue the ripening of the cervix in pregnant women who are at or near the time of delivery and in whom there is a medical reason for inducing (bringing on) labor." See Cervidil website at https://www.cervidil.com (10/10/19).

the fetal heart strips that during the afternoon labor there were Category 1 and 2 tracings, tachysystole,[3] and variable recurrent decelerations of the baby's heartbeat during the pushing by Ms. Grill (Id at 252-276; 343-355;360-361). Although not indicated on the hospital chart, Ms. Grill testified that by 3:00 pm she was complaining of severe pain and noticed blood (Grill EBT at 60).

Dr. Marks called for a non-stat C-section at 4:44 pm based on "arrest of descent," i.e. the baby is not coming down as the head is "molded down into the pelvis" (Marks EBT at 79-80). Until 5:22 pm, when Ms. Grill was taken off the fetal monitor to go to the operating room ("the O.R.") there was a Category 1 fetal tracing (Marks EBT at 361-362), and no tachysystole (Id at 364, 371). While Dr. Marks estimated that the C-section should have been performed within 30 minutes of her calling for a C-section, she also testified that here where the C-Section was necessary due to the arrest of descent when the baby is a plus two, there was no harm in C-Section taking longer than 30 minutes from the time of the call (Id at 415).

Ms. Grill arrived at the OR at 5:26 pm (LH Chart at 362). Dr. Marks testified that when she arrived at the OR at approximately 5:34 pm, Ms. Grill was on the operating table and "they were looking for the (fetal) heart rate and they couldn't find it." (Id at 419). Dr. Marks did not know how long they had been looking for the fetal heart rate, and testified that no one called her because of issues related to the fetal heart rate in the OR. (Id at 425). Nurse Evans, who was in the OR from the time Ms. Grill was brought in, testified that she could not remember if she was trying to get a fetal heart rate (Evans EBT at 83). Nurse Evans also testified that if she had been unable to find a fetal heart rate she would have alerted the attending physician or Dr. Marks (Id at

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[3]Dr. Marks testified that tachysystole is characterized by six contractions in 10 minutes (Marks EBT at 339).

83). According to Nurse Evans, when it was noted on the chart that there was no fetal heart rate, and a call was made for more assistance (i.e "all hands on deck") Dr. Marks was in the room (Id at 82). Dr. Collins wrote in a progress note on February 26, 2015 that she "responded to an overhead page for neonatal rapid response [and that] upon entry to the OR, I was told that the current team has been unable to find a fetal heart rate since entry to the OR and were proceeding with a STAT c-section." (LH Chart at 340).

Dr. Greenidge documented in her anesthesia note at an unspecified time that "FHR (i.e. fetal heart rate) difficult to obtain." (LH Chart at 106). Dr. Greenidge testified that she could not remember who in the OR said they could not find a fetal heart rate and that she "did not recall the specifics of that date." (Greenidge EBT at 58-59). She also testified that "[i]f there is difficulty in obtaining the fetal heart rate, it's typically first the nurses attempt, then the residents attempt and then the attending surgeon attempts, [and] the obstetrician attempts. If at this point the obstetrician was not in the room and I observed them having some difficulty, I would absolutely say 'Let's call Dr. Marks in to see if she can find it'" (Id at 59-60). Dr. Kasat was not in the O.R. before the STAT (i.e. emergency) C-Section was called and went to the O.R. after the neonatal rapid response was called and was there before the baby was delivered (Kasat EBT at 33-36). Dr. Kasat's note states that a "STAT C-Section was performed due to decelerations and no HR upon arrival at O.R." (LH Chart at 363). Dr. Kasat testified that on the evening of A.K.'s birth she learned that "it was suppose to be a C-section for failure to descend and then became a STAT when they arrived at the operating room and found there was no fetal heart rate." (Kasat EBT at 56).

Dr. Marks testified that when she learned that no fetal heart beat could be located, she asked to use the sono machine to confirm there was a problem with the heart rate, which Dr.

Marks estimated took a minute and a half and or two minutes, but the machine had to boot up and she decided to do a stat section (Marks EBT at 419). The first incision was made at 5:38 pm with delivery before 5:40 pm (Id at 428-430; LH Chart at 362). A.K.'s apgar scores were zero at one, five, and ten minutes and three at 15 minutes (LH Chart at 363). A.K. had no heart beat and no voluntary movement (Kasat EBT at 46). A.K. never had spontaneous breathing on his own and was supported by a ventilator and resuscitated after 11 minutes and 40 seconds (Kasat EBT at 48; LH Chart at 363). Due to severe brain damage, a DNR was signed and A.K. died on February 27, 2015 after being removed from the ventilator.

Following the C-section, Ms. Grill who was treated for a uterine rupture, had severe hemorrhaging, and underwent a complete hysterectomy. (Chart at 340). It is alleged that Ms. Grill's uterine rapture contributed to A.K.'s asystole (ie. cardiac arrest), which caused severe hypoxic induced encephalopathy (HIE) (i.e. reduced blood and oxygen supply to the brain) and death.

The deviations from good and accepted medical practice, at issue here[4], as set forth in the affidavits of plaintiffs' experts are:

> · The alleged failure of the Greenidge defendants, Lenox Hill defendants to properly respond to there being no fetal heart rate on arrival to the O.R. for c-section at 5:26 pm, including informing the Ms. Grill's obstetrician, Dr. Marks, M.D. that there was no fetal heart beat, which would have allowed for a stat C-section, which should have been performed by 5:32 pm at the latest.
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> The alleged failure by the Lenox Hill defendants to perform a C-section within 30 minutes starting at 4:44 pm, or by 5:14 pm

[4]The other departures asserted in plaintiffs' bill of particulars and amended bill of particulars against the Greenidge defendants and the Lenox Hill defendants are deemed abandoned.

The alleged failure of the Lenox Hill defendants to timely treat Ms. Grill for prolonged tachysystole (excessively frequent uterine contractions) which occurred between 1 and 4 pm, including by giving terbutaline and ordering an earlier c-section.

The alleged failure by Dr. Kasat to timely order and administer sodium bicarbonate and anti-seizure medication for A.K.

The Greenidge Defendants' Summary Judgment Motion

The Greenidge defendants move for summary judgment, arguing that the standard of care imposed no duty on Dr. Greenidge with regard to the care and treatment of the fetus during and before the surgery or C-setion at issue, and non of her actions or inactions were a substantial factor in causing any injury to plaintiffs.

In support of the motion, the Greenidge defendants submit the expert affidavit of Dr. James B. Eisenkraft, who is licensed to practice medicine in the State of New York and is trained in internal medicine and anesthesiology, and who reviewed the relevant medical records, bills of particulars and deposition transcripts. Dr. Eisenkraft states that "there is no evidence in the medical records or testimony that Dr. Greenidge ever took on the responsibility of monitoring or caring for the fetus at any time before or during the Cesarean section at issue [and that] no evidence supports the assertion that Dr. Greenidge delayed the induction of anesthesia and/or delayed the Cesarean section at issue." (Eisenkraft Aff. ¶ 8). He further states that "the plaintiff-mother is Dr. Greenidge's patient and the individual to whom Dr. Greenidge owes a duty as an anesthesiologist...[and that] Dr. Greenidge did not take on any added duty or monitoring or caring for the fetus or fetal heart rate" (Id ¶ 24). He notes that Dr. Greenidge testified at her deposition that "she would have appropriately referred any questions posed to her (which there is

no evidence of this happening) about the fetal heart rate to Dr. Marks ...[and that] Dr. Greenidge appropriately and timely induced anesthesia..."(Id).

Dr. Eisenkraft further opines that none of Dr. Greenidge's actions or inactions caused any of the claimed physical/emotional injuries to the plaintiff-mother...[and that] without Dr. Greenidge's efforts, the plaintiff-mother would likely not survived the bleeding secondary to the uterine rupture" (Id ¶ 35) He also opines that "Dr. Greenidge's care and treatment at issue did not cause any harm to the fetus/infant... [and that her] actions/inactions did not cause or create inter alia, the claims of brain damage, hypoxia, asphyxia and/or wrongful/premature death of the infant-plaintiff" (Id ¶ 36).

In opposition, plaintiffs argue that Dr. Greenidge departed from the standard of care and treatment when she did not notify Dr. Marks or any other medical personnel until they entered the operating room that there was no fetal heartbeat. In support of the opposition, plaintiffs rely on the affidavit of a New York physician, who is board certified in anesthesiologist, whose identity is redacted ("anesthesiology expert"). The anesthesiology expert opines, to a reasonable degree of medical certainty, that "Dr. Greenidge departed from good and accepted medical care when she failed to instruct the nurses and the resident in the room to timely informed the obstetrician (i.e. Dr. Marks) that there was no fetal heart rate upon Ms. Ms. Grill's arrival to the OR." (anesthesiology expert ¶ 3).

The expert further opines that "the standard of care required Dr. Greenidge, upon realization that there was no fetal heart rate upon arrival to the OR, to do whatever is necessary to make sure that the obstetrician is aware that there is no fetal heart rate" (Id ¶ 8). In addition, the expert opines that "had Dr. Marks been informed that there was no fetal heart rate, she would have returned to the OR immediately and spared the baby from additional minutes worth of

oxygen deprivation... [and that] as a result of Dr. Greenidge's failure to inform Dr. Marks, or to instruct the nurses and resident to contact Dr. Marks to inform her, and in the absence of fetal heart rate for approximately eight minutes, this baby was born with severe HIE (Id). The anesthesiology expert also opines that had "Dr. Greenidge acted in conformity with the standard of care and contacted Dr. Marks at 5:26 pm, the patient-mother would have been spared prolonged, undiagnosed bleeding from the uterine rapture that took place during those same eight minutes resulting in numerous sequelae." (Id).

Plaintiffs also rely the affidavit of Richard Luciani, M.D. who is board certified in obstetrics and gynecology and is license to practice medicine in New Jersey,[5] who has diagnosed and treated conditions and emergency conditions in obstetric patients, including during labor and delivery. Upon reviewing the bills of particulars the relevant medical records and deposition transcripts, he opines, to a reasonable degree of medical certainty, that:

> the standard of care when there is no fetal heart rate is to immediately call the attending obstetrician so that the obstetrician can assess the situation, which in this case, to a reasonable degree of medical certainty, would have resulted in an immediate or stat C-section, as there continued to be no fetal heart rate due to uterine rupture. This is more so here when there were numerous issues with the labor, including but not limited to experiencing excruciating abdominal pain, vaginal bleeding, prolonged tachysystole, recurrent decelerations on almost every contraction, no accelerations and/or prolonged, ineffective pushing. As such, it is my opinion to a reasonable degree of medical certainty that with Dr Marks' absence, when there was no fetal heart rate when entering the OR, the individuals in the OR were required to immediately call Dr. Marks so that a stat c-section could be called sooner than ten minutes later, during which time the baby's brain was getting no oxygen. The standard of care further required that as soon as it was noted that there is no fetal heart rate on the monitor, a stat c-section must be ordered, and the baby needs to be delivered immediately.

Luciani Aff. ¶ 9.

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[5]Dr. Luciani's affidavit is accompanied by a certification of conformity.

He also opines that "the obstetrician relies on a hospital's staff to inform her/him of emergent conditions that may indicate a need for a stat c-section [and that] if there was no fetal heart rate, she should notify the obstetrician right away. The standard of care is for the hospital staff, including its nurses, residents and anesthesiologist, to immediately inform the obstetrician when fetal heart rate cannot be found." (Id)

He then opines that "had Dr. Marks been advised when Ms. Grill entered the O.R. that no fetal heart rate was found, she would have called a stat c-section immediately, the baby would have been delivered within a couple of minutes and would not have been subjected to extended period without oxygen, which caused severe HIE[6]." (Id) He further opines that " the failure to timely contact Dr. Marks when there was no fetal heart rate on the fetal heart monitor was a departure from good and accepted medical and obstetric practice, that resulted in at least an additional eight minutes of untreated fetal asphyxia and hypoxic, and an additional eight minutes of untreated maternal bleeding, which led to disseminated intravascular coagulation, as it is known that this condition is caused by prolonged untreated internal hemorrhaging." (Id).

In reply, the Greenidge defendants argue that record, including the deposition testimonies of Dr. Greenidge, Nurse Evans and Dr. Marks, demonstrate that Dr. Marks did not need to be notified regarding the lack of fetal heart rate since Dr. Marks was in the room, or walked into the room shortly after, the absence of a fetal heart rate was noted. They also argue that plaintiffs' expert opinion that had Dr. Marks been called into the room earlier, that a C-section would have been performed by 5:32 is speculative and contrary to Dr. Marks' testimony

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[6]In this connection, he points to Dr. Marks' testimony that "if the baby was not breathing a c-section should be done immediately and all that needs to be done is bolusing the anesthesia which takes 20 seconds, putting betadine and drapes which takes 30 seconds to 1 minute, and putting gown and gloves which takes less than 1 minute." (Id).

that she did not immediately know upon entering the O.R. that an emergency C-section was necessary.

The Lenox Hill Defendants' Motion

The Lenox Hill defendants argue that they are entitled to summary judgment as Lenox Hill merely served as the "medical hotel" for Ms. Grill's labor and delivery, which was managed at all times by Dr. Marks, the hospital's staff did not commit any independent acts of malpractice and none of the individual defendants or other hospital employees caused injury to Ms. Grill or to A.K.

In support of their motion, the Lenox Hill defendants point to certain medical records and the affirmations of a maternal-fetal medicine expert, Dr. Joanne Stone ("Dr. Stone Aff"), a neonatology expert, Dr. Robert Angert ("Dr. Angert Aff"), as well as the Greenidge defendants' expert, Dr. Eisenkraft.

I) Labor and Delivery

Dr. Stone opines with regard to management of the labor and delivery, that Dr. Marks, as Ms. Grill's attending obstetrician was responsible for Ms. Grill's care and treatment in this regard, and that:

> Dr. Marks recommended that Ms. Grill undergo voluntary induction of labor with Cervidil; made the arrangements for her admission to Lenox Hill; and visited the patient the morning of February 26, 2015, returning in the afternoon around the time she expected to discontinue Cervidil...[and] remained with the patient the rest of the day, monitoring her... [and] determined when, and for how long,. Ms. Grill would push before delivering the fetus if it could not be accomplished by normal spontaneous vaginal delivery...[and] chose the mode and timing of delivery, both of which were reasonable, given the routine nature of Ms. Ms. Grill's labor (including her complaints of pain and vaginal bleeding) and the absence of any fetal heart tracings concerning for fetal compromise or demise.

(Stone Aff at 8-9).

In addition, Dr. Stone opines that "these decisions belonged exclusively to Dr. Marks...[who]... was the most knowledgeable about Ms. Grill's history, having managed the patient's two term pregnancies...[and given] her training and experience as an obstetrician... Dr. Marks was the clinician best suited to plan and implement intrapartum care, and direct the hospital staff accordingly" (Id at 9).

Dr. Stone further opines that "[w]ith Dr. Marks as the 'captain of the ship,' the hospital's employees provided appropriate support. For the nursing staff, this principally entailed observing the clinical status of the patient (her appearance, complaints, and related), monitoring the fetal heart tracings, carrying out intrauterine resuscitative measures and, if the attending were not present, reporting on any material changes in status to someone senior (i.e., nurse reporting to a doctor, a resident to an attending), as necessary... [t]he chart and deposition testimony make clear that the nurses and residents properly fulfilled their supportive role, observing and examining Ms. Grill and reporting to Dr. Marks as necessary. At all times Ms. Grill received appropriate observation and care by the hospital staff, and there is no indication that Dr. Marks's orders were not followed" (Id at p 9).

As for causation, Dr. Stone opines that the hospital staff

> did not cause the plaintiffs' alleged injuries. The chart and testimony both point to a sudden occult placental abruption (the breaking away of the placenta from the uterine wall) as a precursor to uterine rupture, which occurred after Ms. Ms. Grill was transported to the O.R. Just prior, the fetal heart tracing was Category 1, which is reassuring, and there is no clinical documentation that Ms. Ms. Grill was in distress, or experiencing an obstetric emergency, until after the unsuccessful attempts to detect the fetal heartbeat in the O.R. Moreover, as discussed above, none of the complaints during labor about which Ms. Grill testified were consistent with uterine rupture or an abruption.

(Id at 12).

She also opines that " [t]he rupture occurred suddenly en route to the O.R., but did not manifest outwardly. Moreover, from the condition of A.K. on delivery, and Dr. Collins's observations, the rupture was precipitous and progressed quickly, causing such uterine and fetal compromise that even the timely obstetric surgery could not alter the outcome" (Id).

In opposition, plaintiffs rely on the Dr. Luciani's affirmation submitted in opposition to the Greenidge defendants' motion. Plaintiffs also submit the affidavit, with the name redacted, of a physician who is licensed to practice medicine in the State of Massachusetts, and is board certified in obstetrics and gynecology ("Ob-Gyn expert").[7] The Ob-Gyn expert opines as to the medical care provided by the staff of Lenox Hill, including Nurse Evans and Dr. Collins. Upon reviewing the bills of particulars, the relevant medical records and deposition transcripts, the OB-Gyn expert opines, to a reasonable degree of medical certainty, that defendants departed from good and accepted medical practice "when there was a complete and utter failure to properly respond to there being no fetal heart rate on arrival to the OR, which occurred at approximately 5:26 pm...[and] a stat c-section was not called until approximately ten minutes later[8]" (Ob-Gyn expert ¶ 3). The expert further opines that "defendants' failure to take action as soon as it was

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[7]The Lenox Hill defendants argue that the court should not consider the out-of-state affidavit from the Ob-Gyn expert as it is not accompanied by a certificate of conformity and is therefore inadmissible. However, while the Ob-Gyn's affidavit was notarized in Massachusetts and therefore under CPLR 2309(c) should be accompanied by a certificate of conformity, this defect is not a fatal to plaintiffs' opposition. See Matapos Technology Ltd. v. Compania Andina de Comercio Ltda, 68 AD3d 672, 673 (1st Dept 2009)(the absence of a certificate as required under CPLR 2309(c) "is a mere irregularity, and not a fatal defect"); Rivers v. Birnbaum, 102 AD3d 26, 44 (2d Dept 2012)(trial court improvidently exercised its discretion in refusing to consider plaintiff's expert affidavit submitted in opposition to summary judgment motion where affidavit was notarized in Massachusetts but did not include a certificate of conformity as required by CPLR 2309(c)).

[8]Later in the affirmation, the expert states that it was about eight minutes later.

clear that there was no fetal heart upon arrival at the OR substantially caused A.K.'s brain damage and his premature death. The baby was stillborn without any chance of survival...(Id).

The Ob-Gyn expert also opines that "the Hospital and its staff ...deviated from accepted medical practice when the cesarean-section did not take place within thirty minutes starting at 4:44 pm....[t]here is no reason given for the delay and that this mother and baby sat around for no apparent reason from 4:44 pm and 5:21 pm is a deviation from the standard of care that was a substantial contributing factor to the baby's and mother's injuries, as the uterine rupture, brain damage and maternal hemorrhaging and sequelae would not have occurred with a timely delivery." (Id ¶4).

The Ob-Gyn expert also opines that there were departures in connection with Ms. Grill's labor during the period between 1:00 pm to 4:00 pm when, the expert states, Ms Grill experienced excruciating abdominal pain, vaginal bleeding, prolonged tachysystole, recurrent decelerations on almost every contraction, no accelerations and/or prolonged, ineffective pushing. Specifically, the expert states that under these circumstances, "Ms. Grill should have been given intrauterine resuscitative measures including being put on her left side with oxygen..[but that] the only intrauterine resuscitative measures were oxygen and increased intravenous fluids at 2:06 pm and 3:09 pm." (Id ¶7) The expert opines, with a reasonable degree of medical certainty that "the failure to treat tachysystole predisposed Ms. Grill to uterine rupture...[and that] the standard of care is to treat tachysystole by giving terbutaline (an anti-contraction medication to delay labor), which can be given by doctors, nurses or residents...[and that] the failure to order an earlier c-section during the three hours of tachysystole and in the face of recurrent deceleration ...was a deviation from the standard of care and caused Ms. Grill's

uterine rupture and A.K.'s period of oxygen deprivation which lead to severe brain damage, severe HIE and premature death." (Id ¶ 20).

In reply, the Lenox Hill defendants submit two supplemental affirmations from Dr. Stone. In the first supplemental affirmation, Dr. Stone avers that based on the record, including the chart showing that Ms. Grill arrived at the OR at 5:26 pm and that the induction anesthesia was given at 5:27 pm, which induction would take approximately four minutes to administer, and that the fetal heart beat would not be located until after such induction, "the amount of time the hospital staff may have attempted to locate the fetal heartbeat absent Dr. Marks was between mere seconds and no more than two minutes from induction." (Stone 1st Supp Aff at 4). She further opines that "to the extent Dr. Marks *might* not have been present in the OR, following the induction, the time the staff spent in her absence attempting to confirm the fetal heart beat was proper in all respect...[and that] assuming Dr. Mark's absence there was no communication with her since the fetal heartbeat was reassuring up until the moment Ms. Gill was transported from the delivery room to the OR." (Id at 4)(emphasis in the original). She further opines that "there is still no objective support for the argument that the hospital staff's alleged departures in the OR caused the medical outcome...[since] even if Dr. Marks was absent , it was for a minimal amount of time ...and in that time it is unlikely A.K. experienced hypoxic injury causing severe neurological injury....(Id at 5).

In her second supplemental affirmation Dr. Stone states that plaintiffs' experts "ignore that Dr. Marks...was solely responsible for directing the course of Ms. Grill's labor and delivery...[and that her] management of the patient, not the staff's involvement, affected the outcome [and that]..the hospital's obstetric staff reasonably followed Dr. Marks' decisions" (Stone 2d Supp Aff at 1). She also states that plaintiffs' experts "falsely claim that there was

prolonged uterine tachysystole after 1:00 pm on February 26, 2015...[and that] their opinion that it weakened the uterine wall leading to rupture later in the day...is false" (Id at 3). Moreover, she opines that even if there had been tachysystole, "it is against the standard of care for an obstetric nurse or resident to administer a tocolytic drug to the patient absent an attending obstetrician's order...[and that] [s]ince Dr. Marks decided to admit Ms. Grill for voluntary induction, the decision whether to initiate tocolysis–which would slow or even halt contractions, thus prolonging labor–belong to Dr. Marks." (Id at 4). As for the time elapsed between the ordering of the c-section, she states that "the plaintiff s are wrong that the standard of care required it to be completed in 30 minutes...[since the applicable guidelines] suggest a C-section take place in that time frame when there was an obstetric emergency...which was never present in this case." (Id at 5).

ii. Neonatal treatment of A.K.

With respect to the neonatal treatment of A.K, the Lenox Hill defendants argue that there is no merit to the remaining departures with respect to such treatment, which is that Dr. Kasat departed from good and accepted medical and neonatal practice in failing to timely order and administer Dilantin to stop the baby's seizures, and sodium bicarbonate to prevent prolonged acidosis, and that both departures worsened A.K.'s brain injuries. With respect to the administration of anti-seizure medications, including phenobarbital and Dilantin, the Lenox Hill defendants' neonatal expert, Dr. Angert opines that such administration "was appropriate and that [a]nti-seizure drugs are not administered prophylactically, but only in response to evidence of suspected seizure activity, which includes, in the neonate, the appearance of tremors in the extremities and midsection." (Angert Aff at 6). He further states that, "the chart shows that, shortly after 8 p.m., the nursing staff observed that the infant was unresponsive and had

continuous tremors of the abdomen and extremities. Within 15 minutes, A.K. Received a loading dose of phenobarbital, which met the standard of care [and that] [a] second dose was properly administered at 10:40 p.m., in response, once again, to repeated clinical evidence of seizure activity. Finally, at 11:22 p.m., A.K. received Dilantin in response to nurses' observations of twitching. The timing and choice of antiseizure medications all met the standard of care, and were successful in reducing seizure activity in A.K." (Id).

As for the departure related to sodium bicarbonate, Dr. Angert opines that:

> By 2015 (and for years before then), administration of bicarbonate was discretionary and much less frequent, for a couple of reasons. First, in the acute phase (i.e., the first 1 to 15 minutes of life) bicarbonate can worsen acidosis, causing fluid shifts and edema that make organ failure more likely. Second, after successful resuscitation, a clinician may consider administering bicarbonate to manage persistent acidosis that causes myocardial dysfunction (e.g., hypotension), since bicarbonate helps raise the blood pH, thus mitigating acidosis, only when there is adequate ventilation. In this case, following the successful resuscitation of A.K., his blood pressure was within normal limits and his perfusion was acceptable (based on the appearance of his mucous membranes and normal pulses). Therefore, it was reasonable to administer bicarbonate around 13 hours of life, when the baby exhibited persistent acidosis and was adequately ventilated. This was an appropriate exercise of judgment, but by no means required by the standard of care. Furthermore, regardless of the timing, the administration of bicarbonate is not considered to be a measure associated with neurologic protection, and therefore, had no effect on the infant's neurological status, or the outcome of his care.

(Id at 6-7)

As for causation, Dr. Angert opines that "Ms. Grill's uterine rupture just prior to the C-section, not the care by the neonatology team, caused the injuries involving the infant. A.K. was born with extreme neurological compromise because the occult abruption compromised blood supply through the umbilical cord. The severity of this pre-terminal intrauterine insult

explains why A.K. was so neurologically depressed at birth, and, despite the valiant efforts by the neonatology team, A.K.'s neurologic status was unlikely to improve." (Id at 7).

In opposition, plaintiff submit the affirmation of a physician who is admitted to practice medicine in the State of Connecticut and is board certified in pediatrics with a speciality in neonatology, whose name is redacted ("neonatal expert").[9] The neonatal expert opines that, to a reasonable degree of medical certainty, that "the uterine rupture and failure to timely deliver the baby cause severe brain damage to the point that the baby's condition was incompatible with life...[t]he baby had no heart rate, no movement, and he could not breathe..[and] [t]he only reason that his heart started and maintained was due to mechanical and medical support and interventions and once discontinued the baby died. Therefore it is my opinion, to reasonable degree of medical certainty, that the baby was a stillborn." (neonatal expert aff. ¶ 12).

Alternatively, the neonatal expert opines that if, as defendants claim, the baby was born alive, "that means that Dr. Kasat's deviations from the standard of care, were substantial contributing factors to this baby's injuries." Specifically, the neonatal expert opines that while "there were immediate indications on the chart that this baby had movements consistent with seizures until 1:20 am, despite phenobarbital being given every four hours prior at 8:25 pm and 8:40 pm,[10] yet dilantin was not given until 12:25 am [and that] the standard of care requires immediate anti-seizure to prevent further brain damage „„[and that] the failure to immediately

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[9]While the Lenox Hill defendants assert that "the affirmation"by a physician licensed in Connecticut is insufficient as executed in Florida before a Florida notary public, and lacks a certificate of conformity, as noted in footnote 5, this failure to comply with CPLR 2309(c) is not a fatal to plaintiffs' opposition. Matapos Technology Ltd. v. Compania Andina de Comercio Ltda, 68 AD3d at 673.

[10]The expert affidavit is inconsistent with the neonatal flow chart showing that phenobarbital was given at 8:25 pm and 10:40 pm (not 8:40 pm), which appears to be a typographical error. The reference to four hours prior in the expert affidavit is unclear.

give dilantin after the phenobarbital did not quell the seizures was a substantial contributing factor to further seizure activity and worsening brain damage to this baby." (Id ¶ 13)

The expert also opines that "there was a delay in giving the sodium bicarbonate [and that] [t]he standard of care is give bicarbonate immediately after confirmation that there is metabolic acidosis [that] [t]here was such confirmation by 5:40 pm when the ph was 6,67 [y]et the bicarbonate was not given until 7:05 the next morning...[and therefore] Dr. Kasat departed from good and accepted medical and neonatal practice in failing to timely order and administer bicarbonate...and the failure to do so caused prolonged acidosis and worsening brain damage for this baby." (Id ¶ 14).

In his supplemental affirmation submitted by the Lenox Hill defendants in reply, Dr. Angert states that:

> Consistent with my years of experience in neonatology, as before, I completely dispute the notion that A.K. was stillborn. In so doing, I repeat that stillbirth means that a fetus died in utero. Therefore, it completely lacks both brain and cardiac function at delivery, with no possibility of restoring either, which makes resuscitation in a stillborn impossible. By contrast, A.K. was born neurologically depressed, but alive, as evidenced by his successful resuscitation by the neonatology team at Lenox Hill. He was not stillborn, and there is no support in any neonatology literature corroborating the argument that he was. Furthermore, it is a falsehood for plaintiffs' anesthesiologist to state that the application of life supporting measures (e.g., mechanical ventilation) means A.K. was dead. This makes no sense, medically or otherwise, because one cannot administer life support where life does not exist. It follows that patients on life support are considered to be alive.

(Angert Supp Aff. at 3).

Discussion

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204,

206 (1st Dep't 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the Bill of Particulars. Id The expert opinion relied on by defendant must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must also "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dep't 2003]).

Once a 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, 324-325 (1986). Specifically, in a medical malpractice action, this requires that a plaintiff opposing a defendant's summary judgment motion "submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact… General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant['s]… summary judgment motion." Id.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 AD3d 303, 307 (1st Dep't 2007) (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation… the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 N.Y2d 542, 544 (2002). On the other hand, "where there are conflicting

expert affidavits, issues of fact and credibility are raised that cannot be resolved on summary judgment." Cregan v. Sachs, 63 AD3d 101, 109 (1st Dept 2009)(internal citations and questions omitted).

The court will first address the departure alleging the failure of the Greenidge defendants and Lenox Hill defendants, to properly respond to there being no fetal heart rate upon Ms. Grill's entry to the OR for a C-section at 5:26 pm, including informing Dr. Marks, M.D., and that such departure was a substantial factor in delaying the delivery of A.K. causing injury to A.K. and Ms. Grill.

With respect to this departure, the Greenidge defendants have met their burden based on the opinion of Dr. Eisenkraft that Greenidge defendants did not depart from good and accepted practice in connection with Dr. Greenidge's treatment of Ms. Grill, that the standard of care imposed no duty on Dr. Greenidge with regard to the care and treatment of the fetus during and before the surgery or C-section at issue, and that no action or inaction by Dr. Greenidge caused injury to Ms. Grill or A.K. Accordingly, the burden shifts to the plaintiffs to controvert this showing. Alvarez v. Prospect Hosp., 68 NY2d at 324.

As for the threshold issue of whether the Greenidge defendant owed a duty of care to A.K., the court notes that while "whether a duty of care is owed in the first instance 'is a question for the court, and generally not an appropriate subject for expert opinion,'...[t]he nature of the duty ... is a different issue. The law generally permits the medical profession to establish what the standard is ...[and] [o]nce the existence of a duty has been established, resort to an expert is usually necessary." Cregan v. Sachs, 63 AD3d at 109 (internal citations and quotations omitted). At the same time, "[i]n certain circumstances, the doctor's general duty of care may be limited to those

medical functions undertaken by the physician and relied on by the patient." Id at 100 (internal citation and quotation omitted).

Here, contrary to the Greenidge defendants' position, Dr. Greenidge owed a duty as the anesthesiologist, not only for the care of Ms. Grill in respect to her C-section but also to A.K. with respect to his delivery and birth. Significantly, under the circumstances here, the care for Ms. Grill, as mother, and of A.K., as fetus, cannot be separated. In this connection, plaintiffs have submitted affidavits from experts who opine that the applicable standard of care required Dr. Greenidge to notify Dr. Marks upon learning there was no fetal heart beat. Moreover, while Dr. Greenidge testified that the nurse and the resident are first responsible for notifying the obstetrician in the event there was no fetal heart beat, she further testified that she would notify the obstetrician if other staff failed to do so. The court concludes as discussed below that while Greenidge defendants owed a duty of care to A.K., triable issues of fact exist as to nature and scope of this duty and whether Greenidge defendants departed from the standard of care. See e.g. Clarke v. Union Hosp. of the Bronx, 6 AD3d 229 (1st Dept 2004)(record raised triable issues of fact as to whether the defendant on-call anesthesiologist had a duty to respond when called to assist with to assist with emergency c-section).

Specifically, plaintiffs' expert affidavits raise triable issue of fact as to whether Dr. Greenidge departed from the applicable standard of care by failing to notify Dr. Marks until she entered the operating room that there was no fetal heartbeat Furthermore, while the Greenidge defendants argue that the record establishes that Dr. Marks was in the room when the absence of a fetal heart beat was discovered, or was there seconds later, such argument is belied by evidence raising factual questions in this regard. Moreover, plaintiffs' experts opinions raise issue of fact as to whether any delay in performing the c-section related to this departure, was a substantial factor

in causing injury to plaintiffs. See Frye v. Montefiore Medical Center, 70 AD3d 15, 25 (1st Dept 2009)(rejecting defendants' argument that the opinions plaintiff's experts were speculative and finding that their opinions were sufficient to raise issues of fact, including whether in not properly treating plaintiff's diabetic condition or properly ascertaining a severe fetal condition during her pregnancy, proximately caused her child to be born with severe disabilities);Anyie B. v. Bronx Lebanon Hosp., 128 AD3d 1, 6-7 (1st Dept 2015)(plaintiff's expert opinion was sufficient to raise triable issues of fact as to whether as a result of defendant's malpractice the infant plaintiff suffered intrapartum hypoxia resulting in brain damage).

As for the Lenox Hill defendants, as a preliminary matter, the court notes that "[i]t is well settled that a hospital is not vicariously liable for the acts of a private attending physician at its facility who is retained by a patient and is immune from liability where its employees follow the direction of the attending physician, unless that physician's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders." Garson v. Beth Israel Medical Center, 41 AD3d 159, 160 (1st Dept 2007). At the same time, a hospital can be held liable "for independent acts of negligence by its employees or where the attending physician's orders are contraindicated by normal practice." Cerny v. Williams, 31 AD3d 881, 883 (2d Dept 2006).

At issue with the instant departure is whether the Lenox Hill defendants committed independent acts of negligence with regard to their action/inaction upon discovering that there was no fetal heart beat. In support of their summary judgment in this regard, these defendants rely on the opinion of Dr. Stone that the uterine rupture occurred suddenly en route to the O.R., and caused such uterine and fetal compromise that even the timely obstetric surgery would not have changed the result, and that the amount of time the hospital staff may have attempted to locate the

fetal heartbeat absent Dr. Marks was between mere seconds, and no more than two minutes from induction of anesthesia, and that this minimal amount of time makes it unlikely to have changed the medical outcome. Dr. Stone also opines that even assuming Dr Marks' absence, any failure to communicate with her was not a departure, since the fetal heartbeat was reassuring until Ms. Grill entered the O.R., so that it would be reasonable to conclude that the inability to find the heart beat was from a benign cause.

As noted above, as the record raises factual questions as to the amount of time that elapsed between the point at which the hospital staff first learned that the fetal heart beat could not be found, and when Dr. Marks became aware of the lack of fetal heart beat, Dr. Stone's opinion as to when Dr. Marks learned that there was no fetal heart beat is based on her interpretation of conflicting factual inferences in the record. In addition, to the extent the Lenox Hill defendants have met their burden on summary judgment, plaintiffs have controverted this showing based on Dr. Luciani's affidavit, and that of the Ob-Gyn expert, that the staff of Lenox Hill departed from the standard of care by failing to properly respond to the lack of fetal heart rate on arrival to the O.R., and that this departure was a substantial factor in causing injuries at issue.

That said, however, as there is no evidence that Dr. Collins was in the operating room at the time at issue, there is no basis for her liability based on this departure. Specifically, Dr. Collins, who was not deposed, states in her affidavit that on February 26, 2015, her shift started shortly before 5:00 pm and the record shows she was at Ms. Grill's bedside at 4:54 pm, and that she was present in the delivery room for about ten minutes during which time she helped Dr. Marks "to confirm fetal station" (Collins Aff. ¶ 3). She states that about 20 minutes after leaving the delivery room to complete her rounds she was going to the break room when she observed several people transporting Ms. Grill to the operating room (Id ¶ 5). She further states that "[n]ot

long thereafter I heard over the public address system 'neonatal rapid response' [and] I came out of the break room into the hallway [where she] learned at the nurses' station...that the call was made from the operating room. I rushed to the O.R., and on arrival I observed Dr. Marks, who had already made an incision for the C-section." (Id ¶ 6).

Likewise, there is no basis for liability as to Dr. Kasat who, based on the record , was not present in the O.R. at the time in issue.

Accordingly, with the exception of Dr. Collins and Dr. Kasat, summary judgment regarding the departure alleging the failure to timely notify Dr. Marks of the absence of a fetal heartbeat is not warranted in favor of the Lenox Hill defendants. As for plaintiffs' motion for summary judgment as to liability against certain Lenox Hill defendants with respect to this departure, such motion is also denied based on the existence of triable issues of fact as indicated above.

The next departures alleged with respect to the Lenox Hill defendants are the failure to timely treat the prolonged tachysystole (excessively frequent uterine contractions) which occurred between 1 and 4 pm, including by giving terbutaline and ordering an earlier C-section, and the failure to perform a C-section within 30 minutes of it being called at 4:44 pm, or by 5:14 pm.

As for the alleged failure to timely treat the prolonged tachysystole (excessively frequent uterine contractions) which occurred between 1 and 4 pm, including by giving terbutaline and ordering an earlier C-section, the Lenox Hill defendants have met their burden as to this alleged departure based on Dr. Stone's opinion that the hospital staff did not cause plaintiffs' injuries as the hospital's employees properly fulfilled their supportive role, by observing and examining Ms. Grill and reporting to Dr. Marks as necessary, and there is no indication that Dr. Marks' orders were not followed.

In opposition, the Oby-Gyn's affidavit fails to raise triable issue as to whether the Lenox Hill defendants deviated from the standard of care in the treatment of Ms. Grill's labor and the decision as to the timing of the C-section, both of which the record shows were managed by Dr. Marks, Ms. Grill's private obstetrician. In addition, the record is devoid of evidence that in connection with treating Ms. Grill's during labor, the hospital staff committed independent acts of negligence, or complied with any order from Dr. Marks that were "so clearly contraindicated by normal practice" that the staff should have inquired into the accuracy of such orders, or that the staff failed to follow Dr. Marks' directions. Garson v. Beth Israel Medical Ctr., 41 AD3d at 159; See Welch v. Schienfeld, 21 AD3d 802, 807 (1st Dept 2005)(in medical malpractice action arising out of injuries sustained by mother and infant during delivery summary judgment was warranted in favor of defendant hospital where record showed that its employees did not commit an independent acted of negligence, kept the private obstetrician apprised of the plaintiff/mother's condition and did not deviate from the private obstetrician's directions).

The Lenox Hill defendants also have met their burden based on the opinion of Dr. Stone that the standard of care did not require the c-section to be "completed in 30 minutes...[since the applicable guidelines] suggest a C-section take place in that time frame when there was an obstetric emergency...which was never present in this case." Moreover, this opinion is supported by Dr. Marks' testimony that "there was no harm from the section taking longer than 30 minutes when the section is called, as in this case, due the arrest of descent when the baby is a plus two."

Moreover, plaintiffs' expert has not controverted this showing. While their expert opines that "the Hospital and its staff ...deviated from accepted medical practice when the cesarean-section did not take place within thirty minutes starting at 4:44 pm....[t]here is no reason given for the delay and that this mother and baby sat around for no apparent reason from 4:44 pm and 5:21

pm is a deviation from the standard of care that was a substantial contributing factor to the baby's and mother's injuries," this conclusory opinion, which is unsupported by the record, is insufficient to raise a triable issue of fact. In this connection, the court notes that Dr. Marks, who managed Ms. Grill's labor, and called for a non emergency C-Section gave no instruction that the C-section had to be performed within 30 minutes. And, significantly, the record is devoid of evidence that the staff at Lenox Hill knew, or had reason to know, that the fetus was in distress until they reached the O.R. and found no fetal heart rate.

The next issue is whether A.K., as argued by plaintiffs, was stillborn in which case Ms Grill may recover damages for emotional harm (see Ward v. Safajou, 145 AD3d 838 (2d Dept 2016), lv denied 29 NY3d 906 (2017)), or whether if A.K. was born alive, as argued by defendants, in which case plaintiffs would not be able to recover such damages. The final issue in this connection is whether there are factual questions as to whether Dr. Kasat departed for the applicable standard of neonatal care with respect to the administration of bicarbonate and the anti-seizure medications phenobarbital and dilantin, and whether such departures were a substantial factor in causing injuries to A.K..

As to whether A.K, was born alive, the court finds that the record, including the parties' conflicting expert affidavits on this point, raises issues of fact in this regard based on evidence that A.K. had no heartbeat at birth, never breathed on his own, and had no voluntary movement. In addition, his Apgar scores were zero at one, five, and ten minutes after birth. It was only after he was resuscitated more than 11 minutes after birth (and placed on a ventilator) that his Apgar score rose to three. Moreover, when removed from the ventilator a day later, he was unable to breath on his own and died. See Amin v. Soliman, 67 AD3d 835 (2d Dept 2009)(finding that plaintiff raised

an issue of fact as to whether the infant was born alive where at the time of delivery, there was no respiratory response, the Apgar score was zero at one, five and ten minutes after birth and the infant died within ten minutes after being removed from a ventilator upon which she had been placed); compare Levin v. New York City Health and Hosp. Corp., 199 AD3d 480 (1st Dept 2014), lv dismissed 25 NY3d 962 (2015)(finding that premature infant was born alive based on evidence that at the time of delivery she had a heart rate and weak movement of extremities, and when no resuscitation was attempted, the infant died approximately 3 ½ hours after delivery).

Regarding the alleged departures as to the administration of sodium bicarbonate and the anti-seizure medications phenobarbital and dilantin, the Lenox Hill defendants have made a prima facie showing that the administration of these medications was proper based on the expert opinion of Dr. Angert that the decision to administer sodium bicarbonate was discretionary and within Dr. Kasat's medical judgment, and that the administration of the anti-seizure medication was correctly timed. However, plaintiffs have controverted this showing based on the opinion of the neonatal expert that the standard of care requires that sodium bicarbonate be immediately given upon confirmation that there is metabolic acidosis, and that dilantin should have been administered as soon as the phenobarbital failed to quell A.K.'s seizures, which the expert opines was not done in this case, and that these departures worsened A.K's brain damage.[11]

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[11]In reply, the Lenox Hill defendants assert that based on the hospital chart dilantin was administered around 11:30 pm on February 26, and not at 12:25 am on February 27, as stated by plaintiffs' neonatal expert. Notably, however, the Neonatal Intensive Flow Sheet is consistent with the statements of plaintiffs' expert regarding the timing of the administration of dilantin. In any event, any discrepancy is insufficient to eliminate issues of fact as to this departure since plaintiffs' expert opines that the dilantin should have been given immediately after phenobarbital, which was administered earlier, failed to quell the seizures.

Conclusion

In view of the above, it is

ORDERED that Greenidge defendants' motion for summary judgment is denied; and it is further

ORDERED that the Lenox Hill defendants' motion for summary judgment is granted only to the extent of dismissing the complaint in its entirety as against Dr. Collins, and dismissing the medical malpractice claim against all of the Lenox Hill defendants insofar as it is based on the alleged failure to timely treat Ms. Grill's condition during labor or to perform a C-section earlier, including within 30 minutes of the C-section being called, and with respect to Dr. Kasat insofar as it is based on the departures alleging the failure to timely notify Dr. Marks of the lack of fetal heart beat, and the motion is otherwise denied;[12] and it is further

ORDERED that plaintiffs' motion for partial summary judgment is denied; and it is further

ORDERED that a pre-trial conference shall be held in Part 11, room 351, 60 Centre Street, on November 14, 2019 at 11:30 am.

DATED: October 11 2019

J.S.C.

HON. JOAN A. MADDEN
J.S.C.

[12]Accordingly, the medical malpractice claim against the Lenox Hill defendants survives to the extent that it is asserted against Nurse Evans and Lenox Hill based on the departure alleging the failure to timely notify Dr. Marks of the lack of fetal heart beat, and as against Dr. Kasat and Lenox Hill based on the alleged departures as to the administration of sodium bicarbonate and the anti-seizure medications phenobarbital and dilantin to A.K in the event the fact finder determines that A.K. was born alive.