Thomas v Reddy
2010 NY Slip Op 32232(U)
August 3, 2010
Supreme Court, Nassau County
Docket Number: 7864/08
Judge: Denise L. Sher
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SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK

PRESENT: HON. DENISE L. SHER
Acting Supreme Court Justice

TRIAL/IAS PART 32
NASSAU COUNTY

ROBERT THOMAS as Executor of the Estate of DEBORAH THOMAS and ROBERT THOMAS, individually,

Plaintiffs,

Index No.: 7864/08
Motion Seq. No.: 02
Motion Date: 03/04/10

- against -

STANLEY REDDY, M.D., CESAR FLORITA, M.D., JOVITA CRASTA, M.D., PATRICK McMANIS, M.D and SOUTH NASSAU COMMUNITIES HOSPITAL,

Defendants.

The following papers have been read on this motion:

	Papers Numbered
Notice of Motion, Affirmations, Affidavit and Exhibits	1
Affirmation in Opposition and Exhibits	2
Reply Affirmation	3

Upon the foregoing papers, it is ordered that the motion is decided as follows:

Defendants move in the above captioned psychiatric malpractice action seeking an order of this Court, pursuant to CPLR § 3212, granting Summary Judgment against the plaintiffs and dismissing the complaint in its entirety as against the defendants. Plaintiffs oppose the motion but have agreed to discontinue the claims against defendants Cesar Florita, M.D. and Jovita Crasta, M.D.. Additionally, the claims against Patrick McManus, M.D. have previously been withdrawn.

This is a wrongful death action based on a medical malpractice theory in that Ms. Deborah Thomas ("Decedent") committed suicide one day after her discharge from an inpatient

psychiatric hospitalization at defendant South Nassau Community Hospital ("SNCH"). She was 33 years of age, married to Robert Thomas, and 31 weeks pregnant with her second child. The Decedent had a long standing psychiatric history of depression and substance abuse, which included two suicide attempts; one at the age of 14, and the other at the age of 21. There is no record or documentation of any other suicide attempt since the last incident. The Decedent, prior to her last inpatient hospitalization, was being treated on an outpatient basis at defendant SNCH's outpatient clinic since December 2006 where she was diagnosed with bipolar depression, mixed episodes. She was engaged in a psychiatric therapeutic program and placed on a medication regiment. Such medication included: Zyprexa, an atypical antipsychotic medication used to treat bipolar disorders; Prozac, an antidepressant used to treat major depressive disorders; Klonipin, to treat panic episodes; Symbax, a combination of Prozac and Zyprexa; and Ambien, a sleeping aid. Upon Decedent's pregnancy, certain medications, notably Klonipin, were medically determined to be contraindicated relative to the developing fetus and to the Decedent herself, given her substance abuse history.

Decedent was referred for psychiatric inpatient admission to defendant SNCH on or about February 28, 2007, upon her expression of suicide ideation at the office of her gynecologist, Dr. McManus, in that she stated the she wanted to shoot herself and the unborn child. She was brought to the defendant SNCH's Emergency Room and admitted on February 28, 2007, with a diagnosis of depression. Upon admission, Decedent did state that she wanted to die and wished that her unborn child would die but then added that she "wasn't going to do anything." Decedent's course of treatment included evaluation and therapy by a professional team of psychiatrists, nurses, social workers and activities therapists. There is no dispute as to whether Decedent exhibited symptoms of depression throughout her hospitalization and at the time of her discharge on March 14, 2007.

Defendant Dr. Cesar Florita ("Florita"), the Decedent's attending psychiatrist, determined that Decedent's condition had improved since her admission and, as she was leaving for vacation on March 9, 2007, she transferred the case to defendant Dr. Stanley Reddy ("Reddy"), on that date. Defendant Florita, in her briefing of Decedent's case to defendant Reddy and upon her final examination of the Decedent on March 9, 2007, recommended that

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Decedent be discharged the following week if her condition continued to improve. Defendant Reddy, upon his initial examination of Decedent on March 12, 2007, determined that she was less depressed and not at risk for suicide. Defendant Reddy noted that the Decedent was eager to leave the hospital and that she and her husband agreed to the post hospitalization treatment plan of continued outpatient psychiatric treatment at defendant SNCH's partial hospitalization program. Defendant Reddy determined that the Decedent was ready for discharge on March 14, 2007 and he arranged her first outpatient treatment appointment for the morning of March 15, 2007. The Decedent was discharged and she committed suicide by self suffocation on the morning of March 15, 2007. Her unborn child did not survive.

Plaintiffs commenced this malpractice action on or about May 23, 2008, alleging, *inter alia*, that the defendants' treatment of the patient deviated from the proper standard of psychiatric care. They allege, in essence, that defendant Reddy failed to conduct a thorough evaluation of the patient during her hospitalization, which led to a misdiagnosis of her condition and premature discharge from the hospital. The Bill of Particulars' basic allegations against the defendants aver that defendant Reddy breached his duty to the Decedent by failing to: timely and properly diagnose Decedent's condition; take and properly complete Decedent's medical history; document previous "psychological" history; document assessment for risk of suicide; take note of Decedent's depression and lack of judgment; consider Decedent's heightened risk of post-partum depression relative to her pregnancy; timely and properly prescribe mood stabilizing medication; consider Decedent's statement's regarding suicide ideation and taking life of unborn child; ignoring and partially treating depression at time of Decedent's discharge; and failing to keep Decedent in hospital until the delivery of the baby.

Defendants moved for summary judgment dismissing the complaint based, in part, on an affidavit from psychiatric expert, Eric Goldsmith, M.D. Dr. Goldsmith avers that defendant Reddy's evaluation and treatment of the patient fell within the bounds of acceptable psychiatric practice and that defendant Reddy's treatment of the Decedent and his decision to discharge her was not a departure from good and accepted psychiatric practice. In opposition to defendants' motion, plaintiffs offered an affidavit from an unnamed psychiatric expert, who opines that defendant Reddy departed from the acceptable standard of care, *inter alia*, by failing to obtain

the Decedent's previous medical and psychiatric records and failing to review the Decedent's hospital records during her hospitalization. The expert contends that had defendant Reddy properly examined and reviewed the Decedent's records, he would have discovered that the patient attempted suicide on two occasions. He would have also realized that while Decedent was an inpatient under his care, she was still depressed, exhibiting symptoms of poor judgment and preoccupied with dying as she expressed that she did not want the baby to survive or wished that it would die in utero. Further, the expert opines that, as certain medications that would have been effective in Decedent's treatment were contraindicated due to her pregnancy, she should have remained in the hospital until her baby was born.

On a motion for summary judgment, the moving party bears the initial burden of making a *prima facie* showing of entitlement to judgment as a matter of law after tendering evidence sufficient to eliminate any material issue of fact from the case. *See Beck v. Westchester County Health Care Corp.,* 52 A.D.3d 555, 858 N.Y.S.2d 895 (2d Dept. 2008). Defendant has the burden of affirmatively demonstrating the merits of its defense. Until the movant establishes its entitlement to judgment as a matter of law, the burden does not shift to the opposing party to raise an issue of fact and the motion must be denied . Further, the courts are required upon a defendant's motion for summary judgment to view the evidence in the light most favorable to the plaintiff. *See Healy v. Spector,* 287 A.D.2d 541, 731 N.Y.S.2d 740 (2d Dept. 2001). However, once the moving party establishes its entitlement to judgment through the tender of admissible evidence, the burden shifts to the non-moving party to raise a triable issue of fact. *See Pierson v. Good Samaritan Hosp*., 208 A.D.2d 513, 616 N.Y.S.2d 815 (2d Dept.1994).

These standards are of course equally applicable to motions for summary judgment in medical malpractice actions. The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damage. On a motion for summary judgment, a defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured as a result. *See Rebozo v. Wilen*, 41 A.D.3d 457, 838 N.Y.S.2d 121 (2d Dept. 2007). In opposition, the plaintiff must submit a physician's affidavit attesting to the defendant's departure from accepted practice, and such departure was a competent producing cause of the injury. General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical

malpractice are insufficient to defeat summary judgment. *See Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320 (1986); *Zak v. Brookhaven Memorial Hosp. Medical Center* 54 A.D.3d 852, 863 N.Y.S.2d 821 (2d Dept. 2008).

It is well settled that a psychiatrist may not be held liable for a mere error in professional judgment. *See Weinreb v. Rice,* 266 A.D.2d 454, 698 N.Y.S.2d 862 (2d Dept. 1999); *Ibguy v. State,* 261 A.D.2d 510, 690 N.Y.S.2d 604 (2d Dept. 1999). However, a psychiatrist may be held liable if a treatment decision was "something less than a professional medical determination." *See Bell v. New York City Health & Hospitals Corp.*, 90 A.D.2d 270, 456 N.Y.S.2d 787 (2d Dept. 1982); *Weinreb v. Rice, supra.* A decision that is without proper medical foundation, that is, one which is not the product of a careful examination, is not to be legally insulated as a professional medical judgment. *See Seibert v. Fink,* 280 A.D.2d 661, 720 N.Y.S.2d 564 (2d Dept. 2001). Where a treatment decision is based upon a careful examination, an expert's opinion that an alternative treatment should have been followed is insufficient to establish a prima facie case of malpractice. *See Bell v. New York City Health & Hospitals Corp., supra* at 280-281.

Defendants' expert, Dr. Goldmith, bases his findings on his twenty years of professional and extensive experience in the field of psychiatry and on his experience in the care and treatment of suicidal patients. Dr. Goldsmith addressed the allegations of negligence as set forth in the plaintiffs' Bill of Particulars and reviewed the Decedent's medical records from defendant SNCH's inpatient and outpatient facilities in preparation of his affidavit. He specifically notes factually erroneous assertions in plaintiffs' allegations, notably that defendant Reddy failed to diagnose and consider Decedent's risk of post-partum depression and that defendants failed to document the Decedent's previous psychological treatment. He states that Decedent could not have been treated for post-partum depression as she was still pregnant and that condition would not be applicable to her, and that the hospital record indicates that the Decedent's documented medical history from defendant SNCH's outpatient facility was faxed in its entirety to its inpatient facility and there are constant references to Decedent's outpatient treatment records. Finally, Dr. Goldsmith notes that there is nothing in the record to indicate that Decedent had expressed a desire to take her own life during her hospitalization and defendant Reddy's treatment of her was certainly in accordance with good and accepted standards of medical and psychiatric practice. His factually detailed affidavit and/or report was therefore sufficient to

demonstrate defendant's entitlement to judgment as a matter of law. *See Abbotoy v. Kruss*, 52 A.D.3d 1311, 860 N.Y.S.2d 364 (4th Dept 2008). As such, defendants made a *prima facie* showing that defendants met this standard of care customarily exercised in treating such patients.

The burden then shifts to plaintiffs to demonstrate both a deviation from the standard of care and that the deviation was a proximate cause of Decedent's death. *See Grzelecki v. Sipperly,* 2 A.D.3d 939, 768 N.Y.S.2d 47 (3d Dept. 2003). To this end, plaintiffs submitted an unnamed affirmation of a physician, specializing in psychiatry, licensed to practice in New York, who cites substantial experience in treating psychiatric patients of similar diagnosis and familiarity with the measures available to treat patients on an inpatient basis. The affirmation inasmuch is sufficient as it establishes his qualifications as a medical expert and his familiarity with the standard of care applicable to bipolar depressive patients and protocols in facilities such as defendant SNCH's.

Although defendants satisfied their initial burden of establishing a *prima facie* case for summary judgment, plaintiffs offered evidence sufficient to raise a triable issue as to whether defendant Reddy's treatment decision was based on "something less" than his professional medical judgment. Plaintiffs offered evidence that in failing to review Decedent's hospital records or to discuss her condition with hospital personnel, defendant Reddy failed to obtain pertinent information. *See Seibert v. Fink*, *supra*; *Bell v. New York City Health & Hospitals Corp.*, *supra*; *Krapivka v. Maimonides Medical Center,* 119 A.D.2d 801, 501 N.Y.S.2d 429 (2d Dept. 1986). Plaintiffs, in addition to the other evidence provided, specifically refer to a March 11, 2007 notation in the Decedent's inpatient hospital chart indicating that "plan of care" for the Decedent has not been met (*see* Exhibit Appendix for Motion for Summary Judgment, Exhibit F, Progress Note), and the following exchange during the deposition of defendant Reddy indicating that he did not read the progress note and that he did not review the Decedent's prior medical records from 2007:

"Q. Did you do a physical examination on March 12 [of the decedent] that was a Monday?
A. Monday.
Q. Did you do a physical examination of her or a psychiatric emanation?
A. Psychiatric, yes."

...

"Q. When you came in on March 12th, did anybody inform you that the plan of care

was not met as of that time?

A. No.

Q. Did you ever see a progress note on March 11th that the plan of care had not been met?

A. No.

Q. Did anybody express an opinion to you on March 12th that as of March 11th that the plan of care had not been met?

A. No." (*see* Tr. Stanley Reddy, MD. p. 132, 133, Affirmation in Opposition, Exhibit B)

...

"Q. Doctor, did you ever try to obtain any prior psychiatric records of hers [Decedent] when you were treating her in 2007?

A. 2007, no." (*see* Tr. Stanly Reddy, MD. p. 167, Affirmation in Opposition, Exhibit B).

In addition, plaintiffs argue that defendant Reddy "extensively relied" on the Decedent's word regarding her intent to harm herself or others, which is insufficient in making a determination regarding her course of treatment and discharge from the hospital. Based on a detailed review of Decedent's medical records and reports of her suicide ideation and expression of not wanting the baby to survive, plaintiffs opine that defendant Reddy did not properly evaluate the Decedent's risk of suicide in light of her psychiatric history and prior attempts. In particular, plaintiffs note that the hospital and clinic records indicate that Decedent attempted suicide on at least two occasions, and that Decedent continued to exhibit depression, restricted affect and poor judgment. *See Fotinas v. Westchester County Medical Center*, 300 A.D.2d 437, 752 N.Y.S.2d 90 (2d Dept. 2002). Accordingly, the expert affidavit submitted by plaintiffs sets forth in detail the manner in which the defendants deviated from the standard of care and how those deviations caused or contributed to the Decedent's death. *See Abbotoy v. Kruss, supra.*

In sum, the deposition testimony of the parties and the affidavit submitted by plaintiffs' expert were sufficient to raise a triable issue of fact as to whether the defendants were negligent. According to plaintiffs' expert, defendant Reddy departed from good and accepted medical practice in failing to make further inquiries or failing to review the medical information regarding the Decedent's condition and that such departure contributed to the Decedent's almost immediate suicide upon her premature discharge from the hospital. In view of both experts' conflicting affidavits as to whether the defendants were negligent, summary judgment should be denied. *See Zarzana v. Sheepshead Bay Obstetrics & Gynecology, P.C.*, 289 A.D.2d 570, 735 N.Y.S.2d 627

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(2d Dept. 2001). Finally, whether defendant Reddy's alleged negligence was a proximate cause of the patient's injuries presents an issue for the jury. *See Bell v. New York City Health & Hospitals Corp., supra.*

Accordingly, defendants' motion for Summary Judgment is denied. The matter continues against defendants Stanley Reddy. M.D. and South Nassau Communities Hospital. Plaintiff and the remaining defendants shall appear All parties shall in Nassau County Supreme Court, Central Jury Part on October 25, 2010 at 9:30 a.m.

This shall constitute the decision and Order of this Court.

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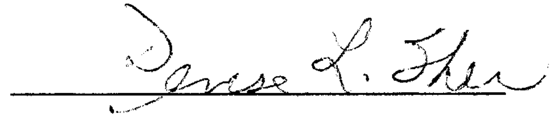

DENISE L. SHER
A.J.S.C.

Dated: Mineola, New York
August 3, 2010

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