Kraycar v Carter
2014 NY Slip Op 31830(U)
June 30, 2014
Supreme Court, Suffolk County
Docket Number: 09-40172
Judge: Daniel Martin

[* 1]

SHORT FORM ORDER

INDEX No. 09-40172
CAL No. 13-00292MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 9 - SUFFOLK COUNTY

PRESENT:

Hon. DANIEL MARTIN

MOTION DATE 12-9-13
ADJ. DATE 3-4-14
Mot. Seq. # 010 - MD

TIMOTHY M. KRAYCAR, as Administrator of the Goods, Chattels and Credits which were of DAWN E. BASCOMB, deceased,

Plaintiff,

- against -

FRED M. CARTER, M.D., JOHN J. RONGO, R-PAC, MARION R. GOLDEN, D.N.P., NORTH FORK ORTHOPAEDICS & SPORTS MEDICINE, P.L.L.C. and NORTH COUNTRY FAMILY PRACTICE,

Defendants.

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Upon the following papers numbered 1 to 34 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (010) 1 - 20; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 21-31; Replying Affidavits and supporting papers 32-34; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (010) by defendant, Marion R. Golden, D.P.N., pursuant to CPLR 3212 for summary judgment dismissing the complaint is denied.

In this medical malpractice action, Timothy M. Kraycar, as administrator of the estate of Dawn E. Bascomb, commenced this action asserting causes of action for the alleged negligent departures from good and accepted standards of medical care and treatment, lack of informed consent, and wrongful death. Plaintiff's decedent died from Fentanyl toxicity in combination with other central nervous system depressants. It is asserted that the moving defendant, Marion R. Golden, D.N.P., a nurse practitioner who maintained an office at North Country Family Practice, rendered care and treatment to the plaintiff's decedent commencing on or about September 28, 2006 until decedent's death on July 6, 2008. It is further

alleged that the defendants prescribed and/or renewed other physicians' prescriptions for medications, including opiates, antidepressants, antipsychotics, sedatives, and benzodiazepines, leading to decedent's death.

By way of the certification order dated February 5, 2013 (Martin, J.), the time for all parties to move for summary judgment was extended until 90 days after a decision and order was issued and served. Motion (008), concerning dismissal of the causes of action pre-dating April 14, 2007, is dated August 2, 2013. The order with notice of entry was served October 18, 2013. Thus, the instant motion served on November 8, 2013, is timely.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420 [1999]). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 224 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2nd Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

Defendant Marion R. Golden, D.N.P. seeks summary judgment dismissing the complaint as asserted against her. In support, Golden submitted, inter alia, an attorney's affirmation; the affidavit of Catherine Pearsall, PhD; copies of the summons and complaint, Golden's answer, plaintiff's verified bill of particulars; the double-sided transcript of the examination before trial of Dorothy Bascomb which is not in admissible form (*see* 22 NYCRR 202.5); the unsigned but certified transcript of the examination before trial of non-party witness Abigail Charlotte Kraycar, without proof of service upon said non-party witness; the unsigned but certified transcripts of the examinations before trial of Timothy Kraycar with proof of service, defendants Fred M. Carter M.D., John Rongo, RPA, and Marion R. Golden, D.N.P. which are

considered without objection (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); uncertified and unauthenticated copies of the Riverhead Police Department records and the autopsy report of the Medical Examiner, Stuart L. Dawson, M.D. (*see* CPLR 3212 and 4518); copy of the medical records certified by Marion R. Golden; and the uncertified records of North Fork Orthopedic and Sports Medicine, which are not in admissible form.

Abigail Charlotte Kraycar testified to the extent that she began living with her mother and grandmother in June of 2008. She knew her mother Dawn Bascomb attended AA. She was aware that her mother had shoulder surgery performed by Dr. Carter, her uncle, who is married to her mother's sister, Martha. In 2008, at her grandmother's house, she saw a box with patches that her mother was using for pain in her shoulder. She testified that her mother had a job, but had been fired just before she passed. Her mother complained to her that she had difficulty with falling asleep, and would sometimes stay up throughout the night. On the day of the mother's death, she went into her mother's room and found her lying face down; her face was blue.

Marion R. Golden, D.N.P. testified to the extent that she earned a bachelors of nursing degree at Stony Brook University, a masters of science in nursing, and thereafter, a doctorate in nursing (D.N.P.) from Rush University in Chicago. She has since practiced as a nurse practitioner and maintains a practice under Marion R. Golden PLLC, called Family Nurse Practitioner Women's Health Nurse Practitioner. She has been licensed in New York State since 1994 as an RN, and since 1996 as a nurse practitioner. She has admitting privileges at Peconic Bay Medical Center in Riverhead. In June 2006, she opened her own practice, North Country Family Practice. Mark Koenig, D.O., subcontracted at her office for his private practice, and was also paid an hourly rate to see her patients. She recalled the decedent, Dawn S. Bascomb, and stated that Dr. Koeing saw her on one occasion on May 24, 2007, for concerns about high blood pressure, for which he ordered Benicar. She first saw the decedent during her employment with other physicians in May 2003, when the decedent came to the office with her mother.

Golden testified that when she first saw the decedent in her own office on September 28, 2006 for an eye irritation, the 46 year-old decedent reported having two shoulder surgeries, and advised that she was taking Effexor, an antidepressant, as well as Seroquel, an anti-anxiety medication, Advair for asthma, and Flonase for allergies. Her prescribing physician was Dr. Schlager, a psychiatrist. She did not obtain the decedent's psychiatric records. She asked for the medical records, however, she did not identify whose records she requested. Golden testified that she saw the decedent again on June 14, 2007. After examining the decedent, her assessment was that the decedent had anxiety. The decedent told her about her history of alcoholism, but stated she was not drinking and was in recovery. On June 22, 2007, the decedent returned for lab test results which showed high cholesterol, and an elevated blood sugar for which she was placed on Glucophage for non-insulin dependent diabetes. The decedent weighed 249 pounds, and lost 13 pounds, as noted on the July 20, 2007 visit. Because the decedent complained of insomnia, but could not afford to see the psychiatrist, Golden stated she prescribed Ambien 10 mg, thirty pills with no refills, and provided prescriptions for a three month supply of her other medication for depression and anxiety. She also gave the decedent a prescription for Chantix to stop smoking. On September 11, 2007, she made a clinical diagnosis of diverticulitis due to the decedent's complaints of diarrhea, vomiting and stomach pain, for which the decedent was to follow-up with a gastroenterologist. The decedent complained of bronchitis at her visit of October 8, 2007. On October 15, 2007, she presented with difficulty breathing, despite the antibiotic and Prednisone, prescribed on the prior visit. Golden continued to discuss the ongoing care and

treatment, including admission to Dr. Singh's service at Peconic Bay Hospital for status asthmaticus. Golden testified that Dr. Singh was her collaborating physician.

Golden testified that on November 16, 2007, the decedent returned with right shoulder pain, without trauma, for which she prescribed 40 Vicodin tablets, an opiate pain reliever, because patients with digestive disorders cannot take non-steroidal anti-inflammatories without problems. Physical therapy was prescribed, and Ambien was renewed to address the complaint of insomnia. On December 14, 2007, she saw the decedent who complained that she fell and hurt her neck, and gave a history of herniated discs from 2005. She ordered an MRI, renewed the Ambien for thirty tablets, and prescribed Soma which she advised the decedent could have some sedating effect. Golden testified that she would have told the decedent not to take Vicodin with Soma. A colonoscopy and endoscopy were done on December 31, 2007, by Dr. Keschner. The January 3, 2008 visit was to provide the results of those procedures, to renew her prescriptions, and to prescribe Z-Pak and nebulizer treatments for her breathing. The decedent complained of neck pain, spasms, and insomnia on January 16, 2008. She prescribed 90 Soma pills, one three times a day as needed for the spasm, and Ibuprofen. Ambien was also renewed. Vicoprohen (combination of Vicodin and ibuprofen) was to be used if Ibuprofen did not work. On February 7, 2008, the decedent had an exacerbation of asthma secondary to inhaled solvents at work in the factory, so she advised the decedent to call OSHA, to wear a respirator at work, and take Prednisone. She filled out a form for Family Leave Medical Act due to herniated discs and asthma, but later testified that she did not complete the form until April 30, 2008. On February 28, 2008, the decedent presented with a sinus infection and reported that she was out of work on medical leave. Soma was renewed, and Vicoprofen was prescribed for neck pain. She did not recall considering a neurological consult for the decedent.

Golden testified that Vicodin is a central nervous system depressant; Soma is a muscle relaxant which can have an effect on the central nervous system; Ambien is a hypnotic; and Vicodin is an opiate. She never followed-up with the decedent's psychiatrist, and did not learn whether she had prior psychiatric admissions. On March 12, 2008, the decedent presented to the office, upset and complaining that she had been date raped and was seen in Peconic Bay Hospital emergency room and was prescribed antiviral medication. She was instructed to continue the antiviral medication. Ambien was renewed. On March 24, 2008, the decedent had a sinus infection and advised she had an appointment with Dr. Schlager, her psychiatrist. Golden prescribed Trazodone, a quadricyclic antidepressant sleep agent because the Ambien was not working. She gave her a prescription for 30 Ambien tablets and told her to take a half tablet at night. On April 11, 2008, she returned for medication renewal, evaluation, and pain management. Ambien and Valium 10 mg were prescribed. It was not documented that any medications were discontinued. The decedent advised her that the week before, Dr. Adipietro, the pain management physician, administered an epidural injection. She then referred the decedent to Dr. Litman for pain management. They discussed Fentanyl patches and she ordered 10 Duragesic (Fentanyl) patches, 75 mcg, one patch every 72 hours, to renew the medication until she could see Dr. Litman. She also prescribed Soma. All prior medications were in effect. On May 6, 2008, the decedent advised that she had an appointment with Dr. Litman. She was very anxious and had not slept in two days. Her posture was stiff, and she was speaking rapidly. Golden stated she made an assessment of mania. She referred the decedent to her psychiatrist, but did not feel she needed to be admitted to the hospital. She prescribed 60 Risperdal .5 mg, an atypical antidepressant for mania, to help with sleep and balancing the condition, and Lidoderm analgesic patches.

Golden testified that on May 7, 2008, the decedent advised her she had been treated for anaphylactic shock at Peconic Bay Hospital due an allergic reaction to Risperdal wherein her tongue swelled, and for

which she was prescribed Prednisone. Golden stated that the decedent did not appear manic at this visit, but she prescribed Xanax for anxiety, which, she stated, can have an effect on the central nervous system. She advised the decedent's mother that the decedent was to take the Xanax and Ambien safely. She was concerned because the decedent had the anaphylactic reaction and advised her to watch her daughter for a reaction. She also noted the decedent had lost more weight and weighed 198 pounds. On a return visit on May 16, 2008, the decedent advised her she was going for an MRI and wanted breakthrough pain medication and Valium for the MRI procedure, so she ordered a non-steroidal anti-inflammatory, Diclofenac, and two 10 mg Valium tablets. Pre-surgical clearance was given on May 29, 2008 for rotator cuff surgery of the decedent's right shoulder scheduled for June 5, 2008. She also prescribed ten Fentanyl 75 mcg patches because the decedent advised her Dr. Carter was not available to prescribe it for her, and Mr. Rongo, Dr. Carter's physician's assistant, could not write a prescription for Duragesic (Fetanyl). She did not recall if she called Dr. Carter's office, but ordered the patches so the decedent would not go through physical withdrawal. She also prescribed 30 Ambien 10 mg tablets for chronic insomnia. Golden testified that they would have discussed safe use of the medications. On that date, in addition to the Ambien and the Fentanyl patches, the decedent was also taking Effexor 75 mg daily, Xanax .5 mg as needed for anxiety, as well as the medication for her asthma and diabetes.

On June 9, 2008, Golden saw the decedent who complained of increased anxiety, so she prescribed 60 Xanax 1 mg. tablets. She testified that the decedent stated she was going to go for counseling, but Golden did not know where. She did not recall if she asked the decedent if anyone else was prescribing medication for anxiety. On June 19, 2008, the decedent returned for renewal of her pain medication, but Golden did not recall where the decedent's pain was. The decedent received Dilaudid, a narcotic opiate, from Dr. Carter, but she wanted more pain medication. Golden stated that she did not order pain medication on that visit and was advised to seek pain management treatment and consult her psychiatrist. Golden did not recall if she made contact with any of the decedent's treating physicians. On June 29, 2008, the decedent advised that she had insomnia, anxiety, and pain, that she was losing her insurance and wanted a renewal of her medications. She did not know where the decedent's pain was. She made a telephone call to the decedent's mother to hold the bottles of Xanax and Ambien, and to have her daughter follow-up with psychiatric care. She then prescribed 30 Ambien 10 mg and 60 Xanax 1mg. On July 6, 2008, she received a telephone call from decedent's cousin advising the decedent passed away in her sleep, and an autopsy was pending. When she spoke to decedent's mother thereafter, she was advised that the decedent had three Fentanyl patches on when found by decedent's daughter.

Fred Carter, M.D. testified that he became board certified in orthopedics in 1997. He is affiliated with Eastern Long Island Hospital in Greenport and Peconic Bay Hospital in Riverhead. His practice is limited to orthopedic surgery and he is also assistant medical director of the physician's assistant program at Touro College. John Rongo, a physician's assistant, has been employed by his office since 2002. He stated the decedent was his cousin and he was a pallbearer at her funeral. The decedent was his patient beginning on June 23, 2003.

Dr. Carter testified that he saw the decedent for a rolled left ankle on June 23, 2003, for which he prescribed Ultracet, a non-narcotic painkiller. At that time, he stated, the decedent drank heavily. He continued to discuss her care and treatment. In February 2005, the decedent experienced a problem with pain in her left shoulder which had previously been operated on by another surgeon. Physical therapy and

Ultracet were ordered. On February 10, 2005, he performed surgery on her left shoulder consisting of arthroscopic repair of the rotator cuff and anterior capsular shift repair. The decedent gave a social history of alcohol and chemical use on the Eastern Long Island questionnaire, but he stated he was not aware of her chemical use. He referred the decedent for pain management in January 2006. On February 22, 2006, when she was seen postoperatively by P.A. Rongo, she was prescribed 25 Vicodin pills. He described additional visits, including her use of a Lidocaine patch, but he did not know who prescribed the patch. On December 20, 2005, she presented with impingement type complaints in her right shoulder, associated with trauma. On January 4, 2006, she was given a prescription for Oxycontin 20 mg., a narcotic pain medication. On January 9, 2006, after reviewing the MRI studies, he prescribed Oxycontin 40 mg for the pain in her upper extremities and right shoulder, Soma for muscle relaxation, and referred her for pain management.

Dr. Carter stated that he saw the decedent on April 8, 2008, at which time she gave history of slamming the brakes of her car and injuring her right shoulder. An MRI was planned, physical therapy advised, and Soma 350 mg every eight hours was prescribed, as were Duragesic (Fentanyl) patches, 50 mcg per hour, which he described as a narcotic transdermal delivery patch. Dr. Carter stated that he had also prescribed the Duragesic patches in January 2006 when the decedent's pain was not relieved with Oxycontin. He continued that the Duragesic patch was a strong medication, with one patch to be used every three days, and to be removed on the fourth day before applying an additional patch. He testified that he told the decedent that it was a narcotic medication, and warned her regarding drinking, any other type of central nervous system depressants, and its use when doing anything of consequence due to its central nervous system depression. Dr. Carter stated that the decedent did not document that she was taking medications prescribed by Dr. Golden. The Valium he prescribed at this visit was a one time dose for the an MRI, with no refills. On April 16, 2008, he wrote her a prescription for fourteen Oxycontin tablets 40 mg, twice a day for shoulder pain. She was referred for cervical epidural injections. Duragesic patches were not helping her intractable pain.

On May 13, 2008, she reported that the neck pain settled down, but she had significant right shoulder pain while standing and letting her arm hang down. She was having difficulty sleeping due to the pain and muscle spasm. The decedent did not report to him that she was taking other medications. He prescribed an increased dose of Fentanyl patches 100 mcg per hour, one every three days, as she was still having pain. He also prescribed Soma. He never suspected that the decedent might be abusing medication as she had appropriate issues to go with the complaints of pain in her right shoulder. He did not consider referring her to a psychologist as he evaluated her for orthopedic issues and she reported only insomnia due to the pain. On May 28, 2008, P.A. Rongo saw her for pain in her right shoulder, for which he prescribed Vicodin (Hydrocodone). On May 30, 2008, she presented to P.A. Rongo expressing that she would like something with less Tylenol in it, so he gave her a prescription for 45 Norco pills, another manufacturer's Hydrocodone product which contains less Tylenol. Rongo also administered a cortisone injection into her shoulder.

Dr. Carter continued that shoulder surgery was scheduled, Dr. Golden gave medical clearance, indicating that the decedent was taking Effexor for depression, which is a central nervous system depressant; Fentanyl patch, 75 mcg (which he thought was the medication he was prescribing except he ordered 100 mcg); and Xanax, a sleeping pill. He did not contact defendant Golden about the decedent's

medications. The history of depression and anxiety was then noted by him for the first time. Surgery was performed on June 5, 2008 on a day surgery basis. She was prescribed Oxycontin 40 mg twice a day for pain for five days. On June 13, 2008, she presented to his office, at which time he gave the decedent a prescription for 33 Valium pills 10 mg, every eight hours as necessary for muscle spasm; and 44 Oxycontin pills, 40 mg. On July 3, 2008, the decedent presented to P.A. Rongo, advising she had pain from overextended rotation. Dr. Carter testified he was in the office and wrote the prescription for ten Fentanyl patches, 100 mcg per hour, every three days, to enable her to do her shoulder exercises. He added that she was instructed about its use and precautions, including refraining from alcohol.

Dr. Carter was shown the Eastern Long Island emergency room document which reported that the decedent was seen requesting detox; that she had been drinking for seven or eight weeks, was under a lot of stress, was seen on May 29, 2008 by Dr. Carter, and was splinted, however, he had no recollection of splinting her and no knowledge of her admission for detoxification. He was not aware of another admission from June 3 to June 8, 2006 for detoxification at Eastern Long Island Hospital. He had no documentation to show that she was on any medications or tranquilizers. The decedent's history sheet, he stated, only listed medications he prescribed. He had no recollection of seeing the decedent impaired or anxious, and she did not complain of difficulty sleeping. He had no conversations with Marion Golden about the decedent at any time.

The autopsy report of September 15, 2008 by Dr. Stuart L. Dawson stated that the decedent was found with four Fentanyl 100 mcg/hr patches over the epigastric area of the trunk. The cause of death is reported as Fentanyl toxicity in combination with other central nervous system depressants.

Defendant Golden submitted the affidavit of Catherine Pearsall, PhD., who averred that she is a family nurse practitioner and an adult nurse practitioner, licensed to practice in New York State and is familiar with the general nursing practitioner and procedures. It is Pearsall's opinion within a reasonable degree of nurse practitioner certainty that Marion R. Golden did not depart from the standards of care in the community; conformed with all rules, regulations, practices and guidelines of the Department of Education and the Commission of Education; exercised the appropriate degree of care, caution, prudence, skill and ability, and professional knowledge in treating and providing care and treatment to the plaintiff's decedent; and that no causal connection exists between any treatment rendered by Golden and the injuries allegedly suffered by the decedent. She continued that the decedent placed numerous Fentanyl patches on her upper abdomen at one time, which ultimately led to Fentanyl toxicity and her subsequent death; that those Fentanyl patches, prescribed in doses of 100 mcg, were ordered by Dr. Carter, as indicated by the prescription written by him on July 3, 2008; and that the last prescription written by defendant Golden was on May 30, 2008. Nurse Pearsall also opined that based upon a review of the written protocols, as required under New York State Education Law § 6902 (3), and Rules of the Commission of Education § 29.1 (9) and 20.2 (1), defendant Golden was acting and practicing in accordance with those practices and protocols, well within the statutory limitations of a nurse practitioner prescribing medication for decedent's various medical conditions, and that she appropriately evaluated the decedent, obtained a history, and referred the decedent to the appropriate physicians for follow-up care.

Pearsall stated that the decedent had a history of significant bilateral shoulder issues relating back to 1999, including arthroscopic surgery to both shoulders in 1999, followed by left shoulder surgery on February 10, 2005 by Dr. Fred Carter. During this time, the decedent underwent physical therapy and was

managed on pain medications. On September 28, 2006, the decedent began treating with defendant Golden for the management of her general medical conditions. In November, 2007, when the decedent began complaining of right shoulder pain, Golden prescribed Vicodin to manage the pain and referred the decedent to Dr. Carter, her orthopedic surgeon. After sustaining a fall, the decedent presented to Golden with complaints of pain in her neck, for which Golden prescribed Soma, a muscle relaxant for the muscle spasms found upon examination. Soma was renewed upon the decedent's return visit on January 16, 2008 due increased neck pain and muscle spasms. Ibuprofen, over the counter anti-inflammatory medication was also prescribed.

Pearsall continued that Dr. Carter's pain management specialist, Dr. Adipietro, managed decedent's pain and prescribed a Fentanyl patch for the decedent' right shoulder and neck pain. Beginning on April 8, 2008, Dr. Carter subsequently prescribed Fentanyl. When the decedent presented to defendant Golden on April 23, 2008 with persistent right shoulder pain, Golden referred her to Dr. Litman, a pain management specialist at John T. Mather Memorial Hospital, and prescribed Fentanyl patch 75 mcg, to hold her over until seen by Dr. Litman. On May 30, 2008, the decedent presented to Goldman for pre-operative medical clearance for surgery to her shoulder, which was done by defendant Carter on June 5, 2008. Golden also prescribed Fentanyl patches 75 mcg., in anticipation of the surgery, and upon being advised by the decedent that because Dr. Carter was unavailable, she was unable to obtain the prescription from him.

Pearsall stated that the decedent obtained post-operative care from Dr. Carter, who prescribed Fentanyl patches 100 mcg on June 13, 2008 and July 3, 2008. Three days later, on July 6, 2008, the decedent died. The Riverhead Town Police Report indicated that the decedent had placed Fentanyl patches, 100 mcg, on her upper stomach, and that the prescription for those patches had been written on July 3, 2008 by Dr. Carter. Therefore, stated Pearsall, Golden did not prescribe those patches, as Golden only prescribed 75 mcg. Fentanyl patches to the decedent.

Based upon the foregoing, defendant Golden has demonstrated prima facie entitlement to summary judgment dismissing the complaint.

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

The plaintiff has submitted the unredacted affirmation of his expert physician which has been compared to the redacted affirmation submitted with the moving papers. Except for the redacted name of the expert, the affirmations are identical. Plaintiff's expert is a physician licensed to practice in New York, and sets forth his education and training. Having served ten years on the faculty of New York Medical College in Valhalla, New York in the departments of psychiatry and medicine, he is fully familiar with the customary expectations, responsibilities, and roles of all practitioners, including Doctors of Nursing Practice with a degree in D.N.P. who prescribe medications such as opiates (narcotics), anxiolytic agents to treat anxiety, sedatives, and other psychoactive medications. He is also familiar with the need of practitioners to obtain continuity of care records and documentation from other treating practitioners, and

also the cautions that must be taken in caring for patients whose history includes drug and/or alcohol abuse or habituation to medications prescribed by physicians. He continued that the medical practitioner who provides medical clearance has the obligation to alert the surgical and hospital practitioners about the patient's risk factors that would be expected to impact the pre-operative, operative, and post-operative course. Plaintiff's expert set forth that defendant Golden is held to the standard of care of a primary care provider, and that all departures mentioned are departures from good and accepted medical practice and good and accepted nurse practitioner practice.

The plaintiff's expert opined that Marion R. Golden, D.N.P. treated the decedent for approximately two years prior to her death, and prescribed, and/or renewed other physicians' prescriptions of medications, including opiates, antidepressants, antipsychotics, sedatives, and benzodiazepines without proper communication and/or consultation with the other treating practitioners. These medications had well known risks of habituation (psychological tolerance to a drug resulting from repeated use), addictions, and risks of respiratory depression. Plaintiff's expert opined that Golden's failure to properly coordinate the decedent's medical treatment and/or to properly prescribe medications were departures from good and accepted medical practice, which were the proximate cause and/or substantial contributing factor of the decedent's death.

The plaintiff's expert stated that Golden did not obtain the decedent's records from her other health care providers, and the failure to do so was a departure from the accepted standard of care. Golden affirmed that the decedent identified she was treating with Dr. Schlager, a psychiatrist, who prescribed Effexor for depression and anxiety, and Seroquel, an antipsychotic, however, Golden did not obtain Dr. Schlager's records. Nor did Golden obtain the records from decedent's prior treating physician, Dr. Burmeister, which records clearly indicated that the decedent had a long history of drug abuse and alcoholism, that she had multiple surgeries, and chronic asthma, and was being treated for depression and anxiety. While Golden testified that she was unaware of the history of drug and alcohol abuse, had she obtained the records, as required by the standard of care, she would have learned of this history. Golden then prescribed Effexor and failed to coordinate care or consult with Dr. Schlager. It was not until June 14, 2007 that Golden documented on the decedent's record, "ETOH in recovery" and noted the decedent had anxiety. The plaintiff's expert further opined that when Golden learned of this, she was obligated to request releases and obtain those records, or consult and coordinate care and treatment with decedent's other physicians, especially when undertaking to renew and/or refill a prescription of another treating physician.

The plaintiff's expert further opined that it was a departure from the standard of care to fail to properly document the past and present medical history of the decedent and a violation of New York Education Law. He continued that the decedent's history of drug and alcohol abuse required a vigilant and cautious approach to the prescription medications she was providing to the decedent, including Ambien, Vicodin, an opiate for pain management, Fentanyl (Duragesic patch), and Soma. Golden failed to heed the patient's history, departing from the standard of care. The plaintiff's expert opined that by prescribing Fentanyl as she did, Golden nursed the decedent's narcotic addition, dependency, and habituation, did not apply proper diagnostic and treatment methods and risked the decedent's death from respiratory arrest during sleep.

The plaintiff's expert stated that on May 6, 2008, when Golden diagnosed the decedent with mania due to her anxiety and not sleeping in two days, Golden did not consult with decedent's psychiatrist, or with

Dr. Carter to determine what other treatment options were available, and which pharmaceutical drugs they were prescribing. Instead, Golden prescribed Risperdal .5 mg, which is used to treat schizophrenia and bipolar disorder, and Lidoderm, a non-narcotic analgesic pain patch. Although the decedent developed an allergic reaction to Respirdal the following day, Golden did not obtain the hospital records from Peconic Medical Center concerning her care and treatment there, or speak with any of the physicians who treated her there. Instead, she ordered Xanax, an anti-anxiety medication, and spoke to decedent's mother to make sure that she took her medication as directed. The plaintiff's expert further opined that it was a departure from the standard of care to prescribe Xanax (alprazolam) in view of the Ambien and Fentanyl, which exponentially increased her risk of death from respiratory depression and arrest during sleep.

When the decedent advised Golden that Dr. Carter was unavailable to refill the Fentanyl patch, Golden refilled it without alerting the hospital staff about a drug abuse problem and failed to caution to omit all narcotic therapy. The plaintiff's expert opined that Golden failed to understand and/or appreciate the responsibility and role of the medical practitioner who performs the medical clearance in advance of surgery. On June 9, 2008, when the decedent presented for renewal of the Xanax prescription and complained of increased anxiety, stating she was going for counseling, Golden did not document and/or consult with the psychiatrist. Rather, she simply refilled the prescription, again departing from the standard of care in view of the history of drug and alcohol abuse and increased risk of respiratory depression and arrest during sleep from the "polypharmacy" of Xanax, Ambien, and Fentanyl. When the decedent presented on June 30, 2008, stating her insurance was going to run out and she needed refills of her medication, Golden assessed the decedent with insomnia, anxiety, and pain. Her plan was to call the decedent's mother to hold the bottles of Xanax. Less than one week later, the decedent was found dead.

Plaintiff's expert set forth that the autopsy report by the Suffolk County Medical Examiner found the cause of death of the decedent from "fentanyl toxicity in combination with other central nervous system depressants " Four Fentanyl patches were found on Ms. Bascom's upper stomach. Toxicology revealed Xanax (alprazolam) 33.5 mcg/L; Nordiazepam .09 mg/L (metabolite of Valium); Fentanyl 53.1 mcg/L; and Mirtazapine (Remeron) and Ambien (zolpidem) .11 mg/L in the decedent's blood at the time of her death. Plaintiff's expert opined that Golden's expert, Pearsall, is not qualified to render an opinion as to decedent's cause of death, as Pearsall failed to grasp that the decedent's death was proximately caused, by the cumulative negligent treatment she received by the improperly prescribed medications. Pearsall failed to recognize that good and accepted standards of care required termination of all decedent's narcotic therapy instead of continuing to nurse that addiction. It is plaintiff's expert opinion that the combination of the polypharmacy assortment of medications significantly increased the risk of the decedent's death from respiratory suppression and respiratory arrest during sleep on July 7, 2008.

Plaintiff's expert opined that Golden failed to investigate the decedent's concurrent medical care, including issues of polypharmacy, which medications in combination with one another risked fatal pulmonary arrest. Such combination of narcotics, sedatives, and benzodiazepine anxiolytic therapy was contraindicated in this patient, and Golden failed to adequately address the potentially lethal concern for the polypharmacy with the patient, her mother, and/or her other treating physicians concerning medication issues. No written list and plan for the administration of all treatment medications was provided by Golden for the family member to monitor, administer, and manage home therapy for safety. Golden failed in her responsibility as the primary provider to consult with other treating physicians with regard to the errant prescription of medications, and to effectuate and/or assist in discontinuing their use.

Based upon the foregoing, plaintiff's expert has raised multiple factual issues which preclude summary judgment.

Accordingly, the motion by defendant, Marion R. Golden, D.P.N., for summary judgment dismissing the complaint is denied.

Dated: JUNE 30, 2014.

A.J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**