Schwartz v Goldsmith
2017 NY Slip Op 32263(U)
October 24, 2017
Supreme Court, New York County
Docket Number: 805211/2014
Judge: Joan A. Madden
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 11
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ADELE SCHWARTZ, as Executrix of the ESTATE OF STEPHANIE SCHWARTZ,

Plaintiff,

Index No. 805211/2014

-against-

ERIC GOLDSMITH, M.D.,

Defendant.

--x

Joan A. Madden, J.

In this action for medical malpractice, defendant Eric Goldsmith, M.D. (Dr. Goldsmith) moves, pursuant to CPLR 3212, for summary judgment dismissing the complaint. Based on the reasons stated below, the court denies the motion.

Background

On or about April 25, 2011, and continuing thereafter until September 2, 2012, plaintiff's decedent, Stefanie Schwartz (Ms. Schwartz), was a patient of, and received psychiatric care from, Dr. Goldsmith. During that 16-month period, she had 32 in-person sessions and eight telephone sessions with Dr. Goldsmith. He administered both medicine and psychotherapy to Ms. Schwartz. She last saw him on August 20, 2012. Between the evening hours of September 1, 2012 and the morning hours of September 2, 2012, Ms. Schwartz committed suicide.

In this action, plaintiff that Dr. Goldsmith deviated from standards of accepted medical and psychiatric care in failing to (1) correctly prescribe and manage Ms. Schwartz's medications, specifically, Klonopin, Saphris, Pristiq, Valium, Lexapro and Elavil, (2) recognize that Ms.

Schwartz was at severe risk for suicide, particularly between the interval of May 8, 2012 and August 20, 2012, (3) refer Ms. Schwartz to an intensive outpatient treatment program, or recommend the she voluntarily commit herself to an inpatient psychiatric facility and/or take measures for her involuntary commitment. Plaintiff claims that Dr. Goldsmith's negligence resulted in Ms. Schwartz's suicide.

In April 2011, Ms. Schwartz was a 44-year-old, single woman. She was employed as an investment associate at UBS Financial Services, earning approximately $90,000 per year. Ms. Schwartz had been employed during the 20 years since she graduated from college, and had advanced her career from administrative assistant to investment associate. By 2011, she had worked as an investment assistant at UBS for the past 14 years. At around that time, in April of 2011, her boyfriend, Todd Gorman (Gorman), moved in with her. Gorman had previously been a patient of Dr. Goldsmith and gave her the referral.

On May 26, 2011, Dr. Goldsmith prepared a psychiatric report based on his initial psychiatric evaluation of Ms. Schwartz, which occurred on April 25, 2011 and May 10, 2011. In his report, he diagnosed her with borderline personality disorder (BPD), mood disorder not otherwise specified (NOS), and noted her history of alcohol abuse. He further noted and considered her previously diagnosed conditions of fibromyalgia, Graves Disease and hypertension.

In his report, he additionally noted that Ms. Schwartz reports "up and down mood, difficulty getting out of bed, reactive moods" (Levine affirmation, exhibit M at 1). Further, Ms. Schwartz's medications at the time included: Cymbalta 60 mg daily, Tapazole, Synthroid, Ambien 10 mg at night as needed, Klonopin 0.5 mg as needed for anxiety and Norvasc. Dr.

Goldsmith noted that when she was around 15, her father left her mother. At that time, she escalated her use of alcohol, and took "an overdose," for which she was treated in the emergency room. Of that episode, he noted "[d]uring that period of time, she was looking for attention and said 'no one really cared about me'" (*id.* at 2). According to Dr. Goldsmith's report, Ms. Schwartz reported a history of chronic depression, and at times, experienced greater depression with "chronic suicide thoughts . . . She has had two suicide attempts. The overdose as previously described, and, during spring break while in college, she impulsively turned the car on in the garage after becoming upset following a DUI. She reports being in Englewood Hospital in New Jersey for three days" (*id.* at 2). At the conclusion of the report, Dr. Goldsmith wrote: "MEDICATIONS: We will continue Cymbalta 60 mg daily and consider increasing dose. We will consider mood-stabilizing medications" (*id.* at 3).

The parties' motion submissions contain notes that Dr. Goldsmith created after each of his appointments with Ms. Schwartz. The notes are written on a form entitled "Outpatient/Office Psychiatric Progress Note Counseling and/or Coordination of Care," which contains labels for information including, interval history, interval psychiatric assessment and current diagnosis. In the notes for the June 16, 2011 appointment, Ms. Schwartz told Dr. Goldsmith that the police had been called after her boyfriend, Gorman, became intoxicated and pushed her, but she let him back into the home. Dr. Goldsmith spoke to her about issues of boundaries and protecting herself. He noted that she was "well-related with full affect," and that her mood was depressed, but she had no suicidal ideation, good impulse control and no reckless, impulsive, or dangerous behaviors" (Levine affirmation, exhibit M). He altered her diagnosis from post-traumatic stress symptoms to post-traumatic stress disorder (PTSD), and noted the plan to increase to Cymbalta

to 120 mg daily.

On September 29, 2011, Ms. Schwartz was attacked with a knife by Gorman, who stabbed her multiple times. The police arrested Gorman, who was later charged with attempted murder. Ms. Schwartz was taken to Jersey City Medical Center for treatment. On October 6, 2011, Ms. Schwartz reported the attack to Dr. Goldsmith, who noted that she felt "vulnerable and panicked" (Levine affirmation, exhibit M). He additionally noted that she was on disability from work, and was following up with physicians and a psychologist. He recorded her mood as having "muddled thoughts, was emotionally numb and distanced, and was having trouble sleeping. She had no suicidal ideations" (Levine affirmation, exhibit M).

On October 6, 2011, Dr. Goldsmith noted that Cymbalta was discontinued by Ms. Schwartz's rheumatologist in the past month, and replaced with Elavil. Dr. Goldsmith prescribed Paxil, 10 mg daily, and increased the Klonopin to 0.5 mg three times daily. He also directed Ms. Schwartz to follow-up with victim's services or an outpatient therapist for weekly psychotherapy sessions. On October 13, 2011, Ms. Schwartz spoke to Dr. Goldsmith about feeling physically unwell, anxious and concerned about Gorman, the potential trial and flashbacks. Dr. Goldsmith increased the Paxil to 20 mg.

On October 18, 2011, Dr. Goldsmith and Ms. Schwartz spoke by telephone. He added Seroquel 50 mg to her medications. He instructed her to be seen in the office the following week and keep in phone contact. He continued to see her approximately weekly for the next nine months. During that time, her anxiety and depression fluctuated, she returned to work three days per week in December 2011, and Dr. Goldsmith altered her medications.

On February 14, 2012, she continued to have persistent PTSD symptoms and avoidant

behaviors, such as feeling too depressed to attend work. On that date she reported "fleeting suicidal thoughts," but Dr. Goldsmith noted that she had good control over her impulses. Her diagnosis remained unchanged.

On May 8, 2012, Ms. Schwartz reported a return of suicidal thoughts "over the course of the prior two weeks with a plan to kill herself after July 1st" (Levine affirmation, exhibit M).

More specifically, on May 8, 2012, Dr. Goldsmith's notes indicate:

> "Discussed suicide risk factors. She experienced a return of suicide thoughts over the course of the last two weeks with a plan to kill herself after July 1 with ideas of making preparations to do so. She did not make the preparations, it was all thoughts and she instead engaged in reaching out to non-MD psychotherapist and began placing herself on internet dating site to distract her thoughts concerning her relationships with Todd. Suicide thoughts have resolved, but she continues to be symptomatic. Discussed risk factors including avoiding alcohol which she continues to do, maintaining functioning at work which she continues to do, and diminishing isolation. Looking for continued exercise and social interactions"

(*id.*).

Dr. Goldsmith next saw Ms. Schwartz on May 18, 2012, for which he wrote:

> "[d]oing somewhat better. Made it through the week at work, but complaining of persistent feelings of fatigue and other PTSD symptoms including triggered flashbacks in the morning when in her apartment and in her kitchen. Feeling drained by interpersonal interactions, avoidant of people. Depression. Discussed issues related to coping with symptoms, feeling of foreshortened future remains, but no active suicide thoughts"

(*id.*)[1]. According to Dr. Goldsmith's notes, on June 18, 2012, Ms. Schwartz's mood was depressed, but she had no negative or suicidal thoughts. Between July 26 and August 20, 2011, Dr. Goldsmith saw Ms. Schwartz five times.

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[1] Dr. Goldsmith defined "a feeling of foreshortened future" during his deposition as "in the context of having been traumatized she didn't see herself recovering, she didn't see herself having a bright future, that she saw a kind of bleak future if you will and that she wasn't going to thrive" (Levine affirmation, exhibit G at 92). He testified that it can be a risk factor for suicide.

On July 26, 2012, Dr. Goldsmith wrote: "Very anxious. Telephone contact last week about car accident when she canceled an appointment. Today, very panicky, does not want to testify [at Gorman's trial]. A lot of catastrophic worries. Has been panicking during the day, difficulty concentrating. Klonopin is somewhat helpful, but wears off during midday. Flashbacks have lessened with the prazosin" (*id.*). He further noted: "Passive suicide thoughts, but no active thoughts. Good impulse control" (*id.*).

On August 13, 2012, he noted, "[r]emains extremely anxious. Telephone contact over the weekend. Gagging with anxiety, has not been able to find ways to calm down. We discussed medication changes and interventions to help her remain calm" (*id.*). He additionally wrote "[n]o active suicidal thinking, but passive suicide thoughts. Feeling at wit's end. No reckless or impulsive behaviors" (*id.*).

On August 15, 2012, Ms. Schwartz had an "emergency appointment" with Dr. Goldsmith, because she had "elevated anxiety levels" (Levine affirmation, exhibit M). She appeared tremulous, uncomfortable and restless, and she reported passive suicidal thoughts, with no active plans for self harm. Dr. Goldsmith discussed a plan with her and obtained permission to speak with "certain individuals to assist in obtaining additional counseling for her" (*id.*). He added elevated levels of anxiety to her diagnosis. He linked the restlessness to Pristiq and decreased the dose to 50 mg. He increased the Valium prescription to 10 mg TID and 10 mg at bedtime, and continued the Saphris and Elavil. He told her to return for her appointment on Friday.

At her appointment on August 17, 2012, Dr. Goldsmith noted that the Klonopin was much more helpful than Valium, and that Ms. Schwartz was able to go to work on that day. She had no suicidal ideation or impulsive behavior. Dr. Goldsmith's plan was to cross taper Pristiq

with Lexapro 10 mg daily, and then to discontinue the Pristiq on Monday. He continued the Saphris, Klonopin and Elavil. Dr. Goldsmith noted, on August 17th, that he had a conversation with an individual concerning a referral through Crimes Victim Services in New Jersey for psychotherapy for Ms. Schwartz.

On August 20, 2012, Ms. Schwartz reported less anxiety on Klonopin. She had safely transitioned to Lexapro, but she remained depressed. According to the notes, she did not have suicidal thinking or impulsive behavior. She died on or around September 2, 2012 after taking an overdose of Elavil. Dr. Goldsmith noted that he received a telephone call around that time from Ms. Schwartz's cousin, informing him that the police found her dead in her apartment.

This action for medical malpractice and wrongful death, was commenced by Ms. Schwartz's mother. The complaint contains two causes of action. In the first cause of action, for medical malpractice, Plaintiff alleges negligence to the extent that Dr. Goldsmith failed to properly diagnose and treat Ms. Schwartz's suicidal ideation, by failing to recommend to Ms. Schwartz that she voluntarily commit herself for inpatient care, by failing to initiate procedures to involuntarily commit Ms. Schwartz, by failing to prescribe proper medication, failing to warn of side effects of the medication. The bill of particulars states that plaintiff is not claiming that Dr. Goldsmith failed to properly diagnose Ms. Schwartz. The second cause of action is a claim for wrongful death.

Defendant's Expert's Report

In his affirmation in support of defendant's motion for summary judgment, Dr. Steven A. Fayer (Dr. Fayer) concludes that, to a reasonable degree of medical certainty, Dr. Goldsmith did not depart from accepted standards of psychiatric care, and Dr. Goldsmith did not do anything, or

fail to do anything, that caused or contributed to MS. Schwartz's injuries. It is Dr. Faye's opinion that Ms. Schwartz was not an imminent suicide risk and, therefore, did not require inpatient treatment.

He notes Dr. Goldsmith's detailed history and his recognition that there were no suicidal thoughts or ideations at the time of Ms. Schwartz's initial presentation. Likewise, Dr. Fayer found Dr. Goldsmith's management of Ms. Schwartz's medications was appropriate and met the standard of care. Dr. Fayer explains that because of Ms. Schwartz's multiple psychiatric conditions, she required "various combinations of drugs and medically stabilizing such patients is a continuous balancing act. The fact that this patient had BPD, coupled with depression, and exacerbated by PTSD . . ., made her medical management even more challenging" (Fayer affirmation, ¶ 11).

It is Dr. Fayer's opinion that Dr. Goldsmith's notes reflect his properly monitoring of Ms. Schwartz for any adverse effects, including suicidal ideation. For this, Dr. Fayer uses the example of February 14, 2012, when Ms. Schwartz reported fleeting suicidal thought, but "nonetheless exhibited good control over her impulses, which is contrary to suicidal tendencies" (*id.*, ¶ 35). At her next two appointments, on February 28, 2012 and March 15, 2012, Ms. Schwartz did not express suicidal thoughts/ideation. Based upon this, Dr. Fayer concludes that Dr. Goldsmith used proper judgment to determine that Ms. Schwartz did not require a referral for more intensive outpatient therapy on February 14, 2012.

Likewise, Dr. Fayer finds that Dr. Goldsmith used appropriate medical judgment on May 8, 2012, when Ms. Schwartz reported that she had suicidal thoughts with a plan to kill herself after July 1st, at which point, she further reported that she "reached out to her psychotherapist and

placed herself on an internet dating website"(*id.*, ¶ 36). Dr. Fayer opines that Dr. Goldsmith appreciated Ms. Schwartz's complaints and used his medical judgment to determine that she had no "active/immediate plans for how she was going to kill herself and as such, was not an imminent suicide risk" (*id.*).

According to Dr. Fayer, from April 2011 through August 2012, Dr. Goldsmith properly assessed for suicidal ideation and risk, and properly counseled Ms. Schwartz, while providing instructions to her for further treatment. Dr. Fayer opines that Ms. Schwartz showed no signs that she was in imminent danger of harming herself, for example, establishing a plan, method or means for suicide, and, therefore, there was no reason to recommend her for voluntary inpatient therapy or involuntary inpatient treatment. Specifically, Dr. Fayer notes Ms. Schwartz's reports of passive suicidal ideation during her June 4th, July 26th, August 13th, and August 15th 2012 appointments, which, he opines, did not include active suicidal ideation and, thus, there was no need for voluntary or involuntary inpatient therapy or treatment. As for her last two appointments with Dr. Goldsmith, Dr. Fayer notes that during these last appointments, on August 17th and August 20th of 2012, "she had no suicidal ideations" (Levine affirmation, exhibit A, ¶ 39). He additionally opines that, on those dates, as there was no articulation by Ms. Schwartz of a plan, or a method means of suicide, "there were no indications that she was in imminent danger of harming herself" (*id.*, ¶ 40).

Dr. Fayer finds that Ms. Schwartz was receiving appropriate outpatient care from Dr. Goldsmith and, therefore, there was not a need to refer her to a more intensive outpatient program. On this point, Dr. Fayer notes that "Dr. Goldsmith recommended the decedent follow with an outpatient psychologist for supplemental psychotherapy sessions following the traumatic

attack of her ex-boyfriend, and that the decedent indeed presented for same" (*id.*).

Finally, Dr. Fayer addresses Ms. Schwartz's diagnosis of borderline personality disorder, and states that "[w]hile borderline patients are prone to suicidal ideations and suicidal threats . . . not all borderline patients who have ideations will attempt or commit suicide," yet, some do, "despite receiving appropriate psychiatric care and treatment" (*id.*). Ultimately, according to Dr. Fayer, "[Ms. Schwartz's] suicide was unpredictable and unforeseeable" (*id.*, ¶ 16). Thus, Dr. Fayer concludes that "Stefanie's suicidal ideations and eventual suicide were not the result of any medication or lack of supervised treatment, but rather, part and parcel of her underlying mental illness" (*id.*, 43).

With respect to Dr. Goldsmith's management of Ms. Schwartz's medication, Dr. Fayer opines, within a reasonable degree of medical certainty, that "the medications recommended/managed/discontinued by Dr. Goldsmith at all times were appropriate and indicated for the plaintiff-decedent" (*id.*, ¶ 10).

Plaintiff's Expert's Report

In her affirmation in opposition to defendant's motion, Joyce S. Pere MD (Dr. Pere), opines that, within a reasonable degree of medical certainty, Dr. Goldsmith departed from the standards of accepted medical and psychiatric care, particularly on and after May 8, 2012. This departure is established by his failure to recognize Ms. Schwartz's deteriorating condition, and thereby discuss with, and strongly urge, Ms. Schwartz to voluntarily commit herself to an inpatient psychiatric facility, or in failing to begin proceedings for involuntary commitment, or, alternatively, he failed to refer Ms. Schwartz to an intensive outpatient program. (Pere affirmation, ¶ 6).

It is Dr. Pere's opinion that Dr. Goldsmith did not properly evaluate Ms. Schwartz on or after May 8, 2012, when she made the statement that she would kill herself after July 1st. In her report, Dr. Pere finds that Ms. Schwartz's May 8th statements, coupled with the previous notes, would:

> "put a treating psychiatrist on very high alert that the patient was at high risk for suicide. [Ms. Schwartz] had decided on a date for suicide – after July 1. That should have prompted the treating psychiatrist to actively probe whether she had decided on a means of killing herself, as that is another critical factor in assessing suicide risk. Further, these statements necessitated inpatient commitment or at the very least far more frequent outpatient therapy and evaluation. It was a departure from the standard of care to fail to take more aggressive action for the patient's protection. Unfortunately, Dr. Goldsmith's notes do not indicate that he elicited this information"

(Costello affirmation, exhibit 1, ¶ 30).

In her affirmation, Dr. Pere opines that the statement made by Ms. Schwartz on May 8, 2012,

> "has to be considered as active suicidal ideation necessitating inpatient commitment, or, at the very least, far more frequent outpatient therapy and evaluation. Absent a dramatic decrease in her symptoms over the next week or two, it was a departure from the standard of care to fail to take more aggressive action for the patient's protection, at the very least, far more intensive outpatient treatment"

(*id.*, ¶ 32).

Dr. Pere further opines that Dr. Goldsmith did not give sufficient weight to Ms. Schwartz's previous suicide attempts over two decades earlier (*id.*, ¶ 31).

Dr. Pere finds, based upon Dr. Goldsmith's records, that Ms. Schwartz was deteriorating during the last four months of her life, and was at an increased risk of suicide. She notes that Ms. Schwartz had four in-person therapy appointments in a row during the month of August 2012,

and that Dr. Goldsmith described the August 15th session as an "emergency session" (*id.*, ¶ 19).

Dr. Pere lists numerous suicide factors as exhibited by Ms. Schwartz as early as February 2012, which are revealed by Dr. Goldsmith's notes. She notes that on February 14, 2012, Ms. Schwartz

> "has had persistent PTSD symptoms, days where she feels too depressed to go to work, avoidant behaviors persist. Anxiety has escalated to even levels of paranoia, feeling that HR and Tom are conspiring against her . . . Fleeting suicide thoughts . . . Feels hopeless for the future in the context of her persistent PTSD symptoms and low level of support"

(*id.*, ¶ 22).

She notes Dr. Goldsmith's February 14, 2012 letter to Ms. Schwartz's job, which states " . . . her clinical condition regressed in the context of medication changes . . . These are days where she experiences overwhelming symptoms such that she cannot work. I request accommodation for this period of time . . . " (*id.*, ¶ 23). She then indicates '[t]he notes of 3/15/12, unlike the others, states "much improved . . ." "Getting to work every day" (*id.*, ¶ 25).

It is Dr. Pere's opinion that the psychiatric records show "persistent suicidal ideation, the trauma of assault by her boyfriend resulting in severe PTSD, and progressing difficulty coping with her daily life and work" (*id.*, ¶ 46).

With respect to Dr. Goldsmith's medication management for Ms. Schwartz, Dr. Pere does not "opine that any particular medication was improperly prescribed, contraindicated, or that dosage was too high or too low, or that any prescribed combination of medications was improper" (Dr. Pere affirmation, ¶ 48). Instead, it is Dr. Pere's opinion that her "objection is non-technical and common sense. When you have tried the medication 'balancing act' over many months and the patient keeps deteriorating, you don't just keep doing the same thing. Even

Dr. Fayer acknowledges in paragraph 11 of his affirmation that Ms. Schwartz "did not always respond adequately to appropriate courses of antidepressants" (*id.*, at ¶ 49).

Discussion

On a motion for summary judgment, the initial burden is on the defendant to establish in evidentiary form the absence of any material issues of fact (*Winegrad v New York Univ. Med. Center*, 64 NY2d 851 [1985]. Once the defendant has made this prima facie showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of a triable issue of fact, "but only as to the elements on which the defendant met the prima facie burden"(*Reilly v Cohen*, 121 AD3d 961, 962 [2d Dept 2014]). "In a medical malpractice action, this burden is met by the submission of a medical expert's affidavit showing that the defendant's actions were a departure from the accepted standard of care in the medical community, and a proximate cause, i.e., a substantial factor, in bringing about the injury" *Sisko v New York Hosp.*, 231 AD2d 420, 422 [1st Dept 1996][internal citations omitted]).

It is well settled that "a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective . . ." (*Park v Kovachevich*, 116 AD3d 182, 190 [1st Dept 2014] *lv den* quoting *Nestorowich v Ricotta*, 97 NY2d 393, 398 [2002]). "Liability is imposed 'only if the doctor's treatment decisions do not reflect his or her own best judgment, or fall short of the generally accepted standard of care'" (*id.* at 190 quoting *id.* at 399). "In order for a psychiatrist to be held liable for malpractice based upon a decision made in connection with a patient's treatment or a decision to discharge a patient from a hospital, it must be shown that the treatment decisions represented 'something less than a professional medical determination'" [*Ozugowski v City of New York*, 90 AD3d 875, 876 [2d

Dept 2011]). "Because psychiatry is not an exact science, decisions with respect to the proper course of treatment often involve a calculated risk and disagreement among experts as to whether the risk was warranted or in accord with accepted procedures" (*Schrempf v State of New York*, 66 NY2d 289, 295 [1985]).

"In the context of mental health providers, the courts have held that 'when a psychiatrist chooses a course of treatment, within a range of medically accepted choices, for a patient after a proper examination and evaluation, the doctrine of professional medical judgment will insulate such psychiatrist from liability'" (*Durney v Terk*, 42 AD3d 335, 336 [1st Dept 2007] quoting *O'Sullivan v Presbyterian Hosp. in City of N.Y. at Columbia Presbyt. Med. Ctr.*, 217 AD2d 98, 100 [1st Dept 1995]). "The mere fact that plaintiff's expert may have chosen a different course of treatment, without more, is insufficient to sustain a prima facie case of medical malpractice" (*id.*, 42 AD3d at 336). Further, where "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" (*Park*, 116 AD3d at 191 [internal quotations and citations omitted]).

In *Park v. Kovachevich*, (116 AD3d 182 [1st Dept 2014]), the Court granted the defendants' motions for summary judgment as the Court found that the plaintiff's expert's report was not sufficient to create a question of fact. The plaintiff's expert contended that, among the other defendants, the Payne Whitney defendants failed to perform a proper assessment of plaintiff prior to discharge, however, the court found "the expert did not elaborate on how the defendant hospital's evaluation, conducted by at least seven health care professionals in several different disciplines, was deficient or what steps they should have taken to bring it within

acceptable medical standards" (*id.*). In *Fotinas v Westchester County Med. Ctr.* (300 AD2d 437, 439 [2d Dept 2002]), the Court denied summary judgment to the defendant as the plaintiffs offered evidence sufficient to raise a question of fact as to whether the defendant's treatment decision was based upon "'something less' than his professional medical judgment'" (*id.*). The Court found that "in failing to review the patient's hospital records or to discuss his condition with hospital staff, the defendant failed to obtain pertinent information," (*id.*), and, on this ground, denied summary judgment.

In *Winters v New York City Health & Hosps. Corp.*, (223 AD2d 405 [1st Dept 1996]), the Court affirmed the denial of the defendant's motion for summary judgment on the ground that the court found questions of fact as to whether there was a careful psychiatric examination of the patient. The Court based this finding on the fact that the "resident psychiatrist failed to inquire in to the nature of the patient's auditory hallucinations and the phrase the patient kept repeating to himself . . . [n]or is it clear whether the patient's records from prior psychiatric hospitalizations at the same institution were read prior to the patient's release on April 27, 1988"" (*id.*, 223 AD2d at 405; *see also O'Sullivan v Presbyterian Hosp. in the City of N.Y. at Columbia Presbyt. Med. Ctr.*, 217 AD2d 98 [1st Dept 1995][prima facie case of psychiatric malpractice where defendants committed numerous deviations, including failure to diagnose major depression, formulate a proper treatment plan, order physical examination, assign a primary therapist and prescribe appropriate medication]).

In *Tkacheff v. Roberts*, (147 AD3d 1271, [3d Dept 2017]), the Court denied summary judgment to Roberts and Decker, two mental health professionals who treated plaintiff shortly before she committed suicide. The Court found that:

> "Roberts, a psychiatrist at Saratoga Hospital, discharged plaintiff from the hospital, and instructed her to return to the hospital if her depression worsened and, if it did not, to take two prescription medications and follow up with an outpatient provider. The outpatient provider was Decker, a psychiatric nurse practitioner, who met with plaintiff within 4 days of her discharge. Plaintiff promised to send Decker information regarding an inpatient facility to which she might seek admission–she killed herself within days"

(*id.*, 147 AD3d at 1272).

Dr. Roberts stated at her deposition that she conducted a suicide risk assessment and documented the results of that assessment in the discharge summary. The discharge summary did not state that the assessment had occurred–or detail its findings. The summary set forth a plan that amounted to little beyond directing the decedent to take her medication and present herself to an outpatient care provider over a week later on September 1, 2011.

The Court found that there were questions of fact as to whether Dr. Roberts treatment of plaintiff deviated from the minimum standard of care in failing to document a proper suicide risk assessment and then discharging her without ensuring that she obtain psychotherapy and medication management within two days.

With respect to Decker, Decker conducted a psychiatric assessment of plaintiff on September 1st and wrote that suicidal ideation was present and that decedent, in the past, had planned to overdose, and was still cutting herself. She diagnosed her with severe major depression and noted that this was untreated because the prescribed antidepressant had been discontinued at the hospital–she set forth a plan that place further psychotherapy and medication review on hold until plaintiff decided whether to check herself into a facility or provide more information about the facility to Decker.

Thus, the court found that Decker deviated from the minimum standard of care by failing

to properly conduct and document a suicide risk assessment of plaintiff who was experiencing anxiety and depression, and by placing the medication and psychotherapy on hold with the expectation that plaintiff, a severely compromised person, would provide more information on inpatient treatment.

Here, the evidence submitted by Dr. Goldsmith, including Dr. Goldsmith's deposition testimony, the medical records he maintained for Ms. Schwartz's treatment, and the affirmation of Dr. Fayer, a psychiatrist, establishes, prima facie, that the defendant did not depart from the applicable standard of care in connection with his treatment of Ms. Schwartz, including that Ms. Schwartz was not at imminent risk of self harm, and that his medical decisions were, therefore, appropriate.

Dr. Pere's affirmation, in opposition, raises a triable issue of fact as to whether, in consideration of the warning signs shown by Ms. Schwartz in the final weeks or months of her life, Dr. Goldsmith failed to make a careful evaluation of Ms. Schwartz, or utilized "something less than a professional medical determination," thereby deviating from the generally accepted practice in his field (*Ozugowski*, 90 AD3d at 876).

According to Dr. Pere, after May 8, 2012, Dr. Goldsmith failed to apprehend the severity of Ms. Schwartz's mental state, as she exhibited passive suicidal ideation, a heightened state of anxiety and depression, avoidance of work and social interaction, flashbacks concerning her boyfriend's assault upon her and a fear of testifying in connection with that assault. These findings, coupled with Ms. Schwartz's diagnoses, raise questions concerning whether Dr. Goldsmith's failure to strongly urge Ms. Schwartz to voluntarily commit herself to an inpatient facility, or, alternatively, to refer her to an intensive outpatient program constitutes a deviation

from generally accepted medical practice.

Based upon the parties' submissions, Dr. Goldsmith did not talk to Ms. Schwartz about voluntary commitment to an inpatient facility, nor did he take steps to involuntarily commit her to a psychiatric hospital, nor did he refer her to an intensive outpatient treatment program.
It appears from his records, that Dr. Goldsmith saw Ms. Schwartz over a period of 16 months for a combination of medication and psychotherapy. According to his notes, he saw her 13 times during the seven months of treatment in 2011, and spoke to her on the telephone six times during that year. After she was the victim of a violent assault in September 2011, he began seeing her with more frequency, approximately three times per month. In 2012, Dr. Goldsmith saw Ms. Schwartz 16 times during the eight months of treatment in 2012, which is about twice a month, on average.

Based upon his notes, he spoke to her on numerous topics, including medication, the trauma inflicted by Gorman in September 2011, her flashbacks in connection with that trauma, her difficulties getting to work, her relationships, and dating. During the course of Ms. Schwartz's treatment, Dr. Goldsmith wrote letters to Stefanie's employer on her behalf, he wrote to the New Jersey District Attorney on her behalf, and he contacted Crimes Victim Services in New Jersey on Ms. Schwartz's behalf to obtain psychotherapy for her.

It was not until her appointment on February 14, 2012 that Ms. Schwartz first expressed "fleeting suicide thoughts." Then, on May 8th, she told Dr. Goldsmith that she "had a return of suicide thoughts over the course of the last two weeks with a plan to kill herself after July 1st with ideas of making preparations to do so" (*id.*). Subsequently, he continued to record the presence of suicidal ideation in his notes for each of her appointments on June 4, July 26, August 13, and

August 15, 2012. During the last few weeks of her life, he additionally noted her acute feelings of anxiety for her appointments on June 4th, July 5th, and on July 26th, he wrote "today, very panicky," and on August 13, 2012, he noted: "[g]agging with anxiety, had not been able to find ways to calm down" (*id.*). Describing August 15th as an "emergency appointment," Dr. Goldsmith notes on that date that Ms. Schwartz's anxiety remained extremely high.

In the August 17, 2012 notes, Dr. Goldsmith indicates that he had a conversation with someone concerning a referral for psychotherapy for Ms. Schwartz, however, he does not indicate whether he reached out to the psychotherapist, what his intentions were with regard to this contact, what plans were made, or whether he discussed this conversation with Ms. Schwartz. In the notes of August 20, 2012, Dr. Goldsmith indicated that he was only "discussing interventions" with Ms. Schwartz. Furthermore, although, on August 17th, Dr. Goldsmith indicated that Klonopin was more helpful than Valium, his diagnosis now included "elevated levels of anxiety" (*id.*). Unlike his previous diagnoses of Ms. Schwartz, his diagnoses for August 13th and August 15th included "elevated levels of anxiety" (*id.*). The diagnoses for August 20, 2012, the last appointment, includes "elevated levels of anxiety and depression" (*id.*).

The court concludes that based on the foregoing records and on the experts' affirmations, there are questions of fact concerning whether Ms. Schwartz's condition posed an imminent risk of suicide, and whether Dr. Goldsmith departed from generally accepted medical principles by not providing greater intervention, such as inpatient commitment or intensive outpatient therapy.

The record thus establishes that during the last few weeks of her life, Ms. Schwartz was reporting her increasing anxiety, and depression, as well as frequent suicidal ideation to Dr. Goldsmith. He spoke of her persistent PTSD symptoms and her avoidant behaviors, including

feeling too depressed to attend work. Dr. Goldsmith was aware, at that time, of Ms. Schwartz's lack of support and her isolation. Furthermore, his repeated attempts to alter her medications, during those last weeks, underscore his awareness that she was in increasing distress.

During his deposition, Dr. Goldsmith testified with respect to the distinction between passive suicide thoughts and active suicide thoughts. He stated:

> "People with – like Stephanie [sic] Schwartz with chronic psychiatric problems – . . . and having been traumatized and developing post-traumatic stress disorder demonstrate chronic feelings of emptiness, feelings that life is not worth living . . . [w]hen her symptoms escalate and she is much more anxious and she is much more depressed, her thoughts can become more intense, I should say that her depressive and anxious thoughts could become more intense leading her to think of ways she would harm herself and that would be what we would call an active suicide thought"

(Levine affirmation, exhibit G at 98, 99).

With this knowledge, as well as the information concerning Ms. Schwartz's multiple diagnoses for psychiatric illness, Dr. Goldsmith, despite speaking to Victims Crime Services about psychotherapy for Ms. Schwartz, ultimately left the decision to Ms. Schwartz to seek more intensive treatment, including whether to engage in additional psychotherapy. There is no indication in the record that he encouraged her to seek additional help.

Additionally, despite repeated observations that Ms. Schwartz had good impulse control, Dr. Goldsmith also noted that she was experiencing "elevated anxiety," "gagging with anxiety," "at wit's end," "unable to calm down," and articulating passive suicidal ideation. On August 15, 2012, she came in for an emergency appointment. Moreover, Dr. Goldsmith's notes do not reflect any contact between Ms. Schwartz's psychotherapist, who was mentioned during her May 8th appointment, or any other psychotherapist mentioned in the record, which further raises

questions as to whether Dr. Goldsmith completed a careful psychiatric evaluation of Ms. Schwartz.

That said, as Dr. Goldsmith has made a prima facie showing that his recommending, managing and discontinuing of medications for Ms. Schwartz was appropriate and met the standard of care, and plaintiff's expert has not controverted this showing, summary judgment is appropriately granted dismissing plaintiff's malpractice claims to the extent they are based on allegations that Dr. Goldsmith deviated from the standard of care in prescribing and managing Ms. Schwartz's medications.

Accordingly, it is

ORDERED that defendant Eric Goldsmith, M.D.'s motion for summary judgment is granted only to the extent of dismissing the plaintiff's claims relating to allegations that Dr. Goldsmith deviated from the standard of care in prescribing and managing Ms. Schwartz's medications, and is otherwise denied; and it is further

ORDERED that the parties appear for a pre-trial conference in Part 11, at 60 Centre Street, Room 351, on December 21, 2017 at 11:20 am.

Dated: October 24, 2017

ENTER:

J.S.C.

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