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

---------- X Index No.: 805420/14

HUIZHEN LIU,

Plaintiff,

-against-

LENOX HILL HOSPITAL,

Defendant,

---------- X

Joan A. Madden, J.:

In this action for medical malpractice, defendant Lenox Hill Hospital (LHH) moves for summary judgment, dismissing the complaint. Plaintiff Huizhen Liu ("Liu" or "plaintiff") opposes the motion, which is denied for the reasons below.

Background

Plaintiff commenced this action to recover damages for personal injuries she suffered on May 23, 2012, when her husband, Kang Lin Wang (Wang),[1] who had been discharged from LHH's psychiatric unit on May 22, 2012, struck her with a meat cleaver at their home in Flushing, New York. Liu alleges that the attack occurred as result of the departures of LHH's treatment team. Specifically, plaintiff alleges that LHH's treatment team departed in failing to accurately assess Wang's mental state, including by underestimating his potential danger to himself and his family members; in failing to have an effective medication treatment regiment; in failing to have a proper, comprehensive and safe discharge plan; in negligently and prematurely discharging Wang when he was a potential threat to himself and others; and in negligently failing

[1] Wang was originally named as a defendant. However, in an April 21, 2015 decision and order, Justice Alice Schlesinger severed and dismissed Liu's claims against Wang.

to warn Liu of Wang's potential threat to her safety and that of her family. Plaintiff alleges that these departures were a substantial factor in causing injury to Liu.

Prior to his hospitalization at LHH, Wang had been discharged on April 30, 2012, from Gracie Square Hospital, where he had been admitted for psychiatric in-patient care. According to Liu, Wang was treated multiple times at Elmhurst Hospital between 1998 and 2003, and would be given medication to take on a daily basis to treat his "mental issues." On May 4, 2012, Liu accompanied Wang to LHH for admission for psychiatric treatment. At the time, Wang resided with Liu and their two adult children, a son and a daughter. Two days earlier on May 2nd, Wang had attempted to sexually assault their daughter, which ultimately led to Wang's presentation to LHH. He was admitted to LHH on a voluntary basis and a diagnosis of schizoaffective disorder was given by the treatment team at LHH. Since Wang spoke only Chinese (Fuzhou and Mandarin), a telephone translation service was used during his admission. Wang remained at LHH for 18 days, until May 22nd, when he was discharged. On May 23, 2012, Wang attacked Liu with a meat cleaver in their home.

During his admission at LHH, Wang was under the care of a treatment team that included Dr. Lisa Coram, the attending psychiatrist (Dr. Coram), Dr. Emily Deringer, a second-year resident (Dr. Deringer), and a medical student, Phillip Chuang (Chuang), who spoke some Mandarin. On arrival at LHH, Wang's chief complaints were recorded as depression and suicidal ideation without a plan, auditory hallucinations and inability to sleep. Liu reported of Wang that he was not always compliant with medication and was unable to identify the medications he was taking. Liu further reported that Wang had been walking around the house and in the street aimlessly, was yelling and wanted to hit their daughter at home.

Upon admission, Wang's chief complaint was:

> I cannot sleep. I have thoughts of hurting myself. I just can't sleep. I need to stay here. Every time I leave here my thoughts do not slow down. I have thoughts of hurting myself sometimes.' denies having a plan, noted to have burn on left wrist. Pt slow to answer. States he 'has been out walking a lot

(Hospital Chart, Stone affirmation, exhibit N at 19).

Also, upon admission, the chart states of Wang:

> There is not a current or recent suicide attempt: [-] There are current or recent thoughts of suicide or self-harm. Suicide risk assessment positive; constant observation initiated and upgraded to ED Attending. There is evidence of disorganized or psychotic thinking, such as paranoia or hallucinations: [+] There is evidence of depression, agitation or severe anxiety: [+] The patient is hopeless about his/her condition or the future: [+]

(*id.* at 20).

Additional notes upon admission reflect Liu's concern about Wang's violence:

> Patient reports he was recently hospitalized in psych unit for 10 days, and was discharged for 3 days, now presents reports unable to sleep. Patient reports he feels depressed, and has suicidal ideation. Denies homicidal ideations. Denies hallucinations. Wife reports patient walks around the house and on the street aimlessly, and patient yells and wants to hit their daughter at home, who is in her 20's

(*id.*).

The staff at LHH contacted Wang's out-patient psychiatrist:

> Collateral from patient's outpatient psychiatrist Dr. Liu… was obtained. He has treated patient for 10 years; diagnosis is schizoaffective disorder. He says patient has been stable for 4-5 years. He says patient has never had hallucinations, but gets paranoid and "nervous." He was not aware of a history of violence and denied that the patient had been suicidal. Most recent hospitalization at Gracie Square, [discharge] 4/30/12

(*id.* at 6).

During Wang's admission, the staff attempted to meet with Liu:

> Patient maintained behavioral control throughout the admission and there were no episodes of aggression or significant agitation. We attempted to arrange a family meeting, but the patient's wife did not come at the scheduled time and later said that she would not be able to come at all due to her work schedule. She did not return phone messages left for her to coordinate discharge planning, but the patient told us on 5/21 that he had talked to his wife and she was comfortable with him returning home

(*id.* at 7).

The notes from May 8th indicate: "Continued hospitalization is warranted due to the severity of the patient's psychosis, as well as due to concerns of safety raised by the wife,

including prior history of violence when he has been in a decompensated state" (*id.* at 59). This is repeated in the notes of May 9th, May 10th, May 18th, and May 21st.

The notes from May 9th indicate that Wang went voluntarily to the "med room" to get his meds *(id.* at 60). It is indicated in several places in the notes that Wang was not comfortable at LHH due to his inability to communicate with others there, because of the "non-Chinese speaking population and staff." Notes from May 9th indicate an attempt to transfer Wang to Elmhurst or Bellevue, but there are no beds.

The notes from May 10th indicate that Wang's

> thought blocking has improved since admission, about the same as yesterday, and he continues to deny [suicidal ideation/homicidal ideation/auditory hallucinations/visual hallucinations]. He does not seem to have the increased activity he described prior to his presentation. [Patient] does not feel comfortable in this treatment environment due to the inability to communicate because of the non-Chinese speaking population and staff . . . Continued hospitalization is warranted due to the severity of patient's psychosis, as well as concerns of safety raised by the wife, including her not feeling safe, and his prior history of violence during a decompensated state

(*id.* at 73).

The notes from May 13, 2012 describe Wang as having a "depressed affect. Pacing and guarded. Scheduled meeting wife did not show" (*id.* at 91).

The notes from May 15, 2012, state that "[Wang] has been stable the past 5-6 years prior to [hospitalization at] Grace Sq. [hospital] on Depakote and Risperdal as [outpatient]" (id. at 95). The notes from that date further indicate:

> Patient refusing to return home. States he will kill himself by hanging if he returns home. Wife refused to come to the hospital for family meeting. She doesn't feel he is at his baseline "Not talking normally". She doesn't feel it's safe as he "beat people" was violent prior to hosp.

(*id.* at 95).

The May 18, 2012 notes report: "[c]ontinued hospitalization is warranted due to the severity of patient's psychosis, as well as due to concerns of safety raised by the wife" (*id.* at 111).

The May 21, 2012 notes indicate that Wang is compliant with his medications and that the staff is unable to contact Wang's wife for discharge planning. "Will continue to call to confirm [patient] may return home" (*id.* at 128). There were two attempts to contact Wang's wife: "left messages, wife did not call back" (*id.* at 131). On that same day, the notes state: "I asked patient why he had refused to take his medications this morning and he said "I feel better . . . I don't need those medicines. I'm ready to leave the hospital" (*id.* at 131).

On that same day, May 21st, the notes state:

> Continued hospitalization is warranted due to the severity of the patient's psychosis, as well as due to concerns of safety raised by the wife, including prior history of violence when he has been in a decompensated state. While patient's symptoms are showing improvement, continued hospitalization is warranted for at least one more day to confirm a safe discharge plan including giving patient's wife reasonable time to respond to messages left today informing her of the discharge and to confirm she is comfortable with him going back home

(*id.* at 132).

On May 22, 2012, the day Wang was discharged from LHH, the records indicate:

> [Patient] interviewed with interpreter phone in Fuzhou. He reports mood is "ok" "alright": Denies [suicidal ideation/homicidal ideation]. Thinking more clearly. States he is ready to return home, reported that he spoke with wife yesterday and today who confirmed he could return home."
>
> [Patient] is stable for discharge. He has been compliant with meds, in good behavioral control. Discharge Home with outpatient follow up. Cont. current meds

(*id.* at 133).

At her deposition, Dr. Coram testified, among other things, that she was made aware of Wang's prior attack on his brother-in-law as a result of her direct interview of Wang. During Wang's admission, Dr. Coram further questioned Wang as to any other acts of violence or

aggression. According to Dr. Coram, Wang specifically denied any attempt to hit his wife or any other family members prior to his admission. Dr. Coram testified that, during his treatment at LHH, she tried to contact Liu to discuss treatment of Wang, but was unable to talk to Liu.

Specifically, Dr. Coram, testified as follows:

> Q: Now did you have any concerns that Miss Liu, Kang Wang's wife, was still in fear of Mr. Kang Wang?
>
> A: I did not, and we contacted her twice on the 21st. Messages were left both in English and Chinese with the interpreter telling her that Mr. Wang we felt was ready for discharge and that he would be discharged the following day.
>
> Q: Do you know whether she -
>
> A: And if she had any concerns, to contact the hospital, and, in fact, on the 21st we felt [Wang] had stabilized and he was ready for discharge on the 21st, but we decided to hold him one more day to give [Liu] an opportunity to contact us if she had any concerns at all regarding his discharge. [...]
>
> A: She never contacted the hospital with any questions or concerns about his discharge, and in the past, when we had attempted to call her, I mean, she was able to call us back, so you know, that in combination with the patient saying that he spoke with his wife on the 21st and he again spoke with her on the 22nd and she said that he could come home and felt that it was safe for him to return.

(Stone aff, exhibit G at 82-83).

Dr. Coram further testified as to Wang's improvement and readiness for discharge:

> Q: So now on Monday after a weekend, what changed that made now discharge the plan rather than continued monitoring and treatment?
>
> A: It appeared that his mood had improved, that his thinking was clearer. He was no longer having suicidal thinking, and he was expressing that he was feeling ready to return home"

(*id.* at 81).

Dr. Deringer also testified as to her knowledge of certain safety concerns voiced by Liu, including Wang previously "grabbing two family members." (Stone aff, exhibit H at 57). Dr. Deringer testified that the entire team at LHH was aware of the potential for

violence and had evaluated Wang for this. Dr. Deringer also confirmed that there were plans to conduct family meetings on several occasions but they did not occur. As a result, Dr. Deringer and the rest of the medical team were unable to discuss the patient's condition with the family in any substantive manner and were unable to obtain any additional information from the family.

Dr. Deringer testified:

> A: [...] I tried twice today [May 21] to contact the patient's wife, left messages via the phone interpreter service but messages were not returned. It's customary when somebody's being discharged, to make a good effort to try to talk with the family to confirm that the patient has a safe home and a safe plan to go to and that was what we were trying to do.
>
> Q: All right. It's also customary to make sure that the family itself is safe if he's discharged? [...]
>
> A: If we had concerns about risk to anybody, we would not have discharged the patient

(*id.* at 111).

According to the hospital notes of May 20, 2012, Wang had no overt symptoms of suspiciousness or paranoia, denied suicidal ideation/homicidal ideation, auditory hallucinations/visual hallucinations and exhibited good impulse control, was alert, attentive and lucid. On May 21, 2012, the nursing notes confirmed continued cooperation and calm affect. Wang continued to be compliant with medication. On that day, Dr. Coram and Dr. Deringer both evaluated and examined Wang. Wang reported feeling much better and wanting to go home. It was determined by the hospital staff that Wang would return to his home with his spouse and continue treatment with his private psychiatrist, Dr. Liu, from whom Wang had been receiving treatment for 10 years. An appointment was scheduled for Saturday, May 27 at 10 am, and Wang agreed to this and to be compliant with his medication. According to the hospital

notes, Wang's mood and affect at discharge were appropriate. Wang declined to wait for his wife and was discharged on his own account with follow-up instructions at or around 5 pm on May 22, 2012.

On March 8, 2019, after the exchange of documents, including Wang's LHH medical chart, and several depositions, plaintiff filed her Note of Issue

LHH's Motion for Summary Judgment

LHH now moves for summary judgment, arguing that medical malpractice claim must be dismissed as there is no physician-patient relationship between LHH and Liu and, therefore, it owed no legal duty to Liu, and that Liu has failed to offer any evidence to support an expansion of that duty to her based upon any "special relationship" with LHH, or LHH having actual control over Wang.

LHH alternatively argues that it is entitled to summary judgment as its physicians did not depart from the standard of care in treating and discharging Wang, and that under the factual circumstances at issue, no duty arose to warn Liu of any danger posed by Wang. In support of this argument, LHH submits the expert affirmation of Dr. Philip R. Muskin, M.D., M.A. (Dr. Muskin), a board-certified Psychiatrist and Professor of Psychiatry, who is licensed to practice medicine in New York. Dr. Muskin states that his opinions and conclusions are based his education and training, including as it pertains to voluntary psychiatric admissions, and his review of relevant deposition testimony, medical records and pleadings, and that his opinions are stated within a reasonable degree of medical certainty.

Dr. Muskin notes that the LHH psychiatric team was able to speak with Dr. Liu, the patient's private treating psychiatrist on several occasions, who provided additional historical and collateral information and that according to Dr. Liu, Wang had never expressed suicidal ideation and did not have a history of violence.

Of Wang's treatment and improvement at LHH, Dr. Muskin opines:

> The psychiatric team in assessing the new onset of SI [suicidal ideation] with plan and Ms. Liu's concerns of potential for violence, noted that the patient had fair insight and judgement and understood he had a mental illness, which required medication to treat. In patients with schizoaffective disorder, when medication treatment is not followed, episodes can occur where the patient may experience drastic mood destabilization, become severely depressed and suicidal. This destabilization may also contribute to the patient's mood lability and increased agitation and potential for physical and/or violent outbursts. At this point, the patient had been on continuous medication management for approximately eleven (11) days. Although the anticipation is for continued improvement while on medication, it does take some time for the medication to reach therapeutic levels and the patient's concerns related to discharge and SI were not inconsistent with his disease and were fully appreciated by the psychiatric team in their recommendation for continued admission.

(Dr. Muskin affirmation at 9).

Dr. Muskin notes that Mr. Wang's admission for acute psychosis and suicidal ideation was voluntary and that "while acknowledging his need for help, [Wang] voluntarily sought medical treatment and consented to admission. Wang was free to leave at any time during this admission, although prior to May 22, it would have been formally against medical advice, 'AMA,' but he was legally within his rights to do so. This is in stark contrast to an involuntary admission" (*id.* at 14). Dr. Muskin states that under the circumstances where there is a voluntary admission for a patient like Wang, the plan of treatment and ultimate goal is to stabilize the patient, obtain therapeutic medication management and return the patient to baseline with a definitive plan for continued outpatient treatment and management. He opines that while "[d]uring the admission, the [Wang's] SI waned although it did recur half-way through treatment when the patient began to consider discharge, [t]his is consistent with treatment of a schizoaffective disorder patient in an acute episode when faced with the reality and anxiety of returning to normal life outside of the hospital and potentially indicative of the need for continued medical adjustment to reach desired therapeutic effect" (*id.* at 15).

With respect to the propriety of Wang's treatment and the determination that he was ready for discharge, Dr. Muskin opines:

> After continuous and proper evaluation and treatment during the 18-day admission, the psychiatric team responsible for the patient's care reported Wang as behaviorally stable and ready for discharge. This was a collective decision and exercise of medical and psychiatric judgment reached by cumulative analysis of the patient's initial symptoms, diagnosis, treatment and progress. Wang no longer expressed any SI, AH [auditory hallucinations] or VH [visual hallucinations]. He exhibited good impulse control, normal behavioral affect and maintained fair insight/judgment. Wang was in agreement and acknowledged his need for continued medication treatment and outpatient follow-up. The patient had never expressed HI [homicidal ideation], neither at the time of presentation, at any point during the admission, nor at the time of discharge. Per the patient's treating psychiatrist, the patient had never had any prior history of violence.

(*id.* at 15-16).

Further, Dr. Muskin opines that LHH could not have sought an involuntary admission for Wang as according to the information possessed by LHH on May 22, 2012, LHH did not believe that he was a danger to himself or others. Dr. Muskin notes that "Wang did not express any desire or indications for violence to others and certainly did not state in any fashion a desire to harm his wife" (*id.* at 18-19). He also states that Liu's knowledge of Wang's prior abuse was unknown to LHH despite every effort to obtain it (*id.* at 18). Further, with respect to any duty to warn Liu, Dr. Muskin opines that "if involuntary admission could not be achieved and the patient had indicated that he had an intent to harm his wife, then LHH would be permitted to disclose same to the wife, if possible, without breach of patient-physician confidentiality. However, this was simply and entirely not the circumstances presented to LHH in this case" (*id.*).

Dr. Muskin next opines that based on his review of the relevant medical records that, "there is no medical evidence to support a concern or potential for violent behavior where the patient had been successfully treated and stabilized" (*id.* at 19). Dr. Muskin notes that on many occasions Wang had been treated for schizoaffective disorder as an inpatient and then would "return home and resume his normal life. Wang's admission to LHH in May 2012 was only one

of multiple inpatient admissions for an acute episode of his mental disease likely caused in part by noncompliance with medication" (*id.* at 19). Dr. Muskin further opines that it would be "pure speculation" to presume that LHH could have prevented this attack, and that "[i]t would be wholly inequitable to charge LHH and its medical staff with the duty and responsibility to essentially be soothsayers in order to predict the patient's subsequent and otherwise unpredictable attempt to murder his wife with a meat clever [sic]" (*id.* at 20).

In opposition, plaintiff submits the affirmation of Jianping Chen, MD, PhD (Dr. Chen), a board-certified psychiatrist, licensed to practice medicine in the State of New York, who also has a PhD degree in Neuroscience and Neuropsychopharmacology. He states that his opinions, which are stated within a reasonable degree of medical certainty, are based on his training and experience, including evaluation of patients who require psychiatric admissions on a voluntary and involuntary basis, his review relevant medical records and pleadings, and Dr. Muskin's affirmation.

Dr. Chen opines that LHH departed from good medical practice in its assessment, care and treatment of Wang, and that LHH prematurely discharged him. Dr. Chen opines that it was a departure from good medical practice for LHH to have not pursued the option of involuntary admission. On this point, Dr. Chen opines:

> Even though Mr. Wang's condition was severe enough to have merited an involuntary admission, he was initially admitted on a voluntary basis. It was a departure for Defendant's staff to have failed to pursue this option. Wang was found to be depressed, manic, psychotic and suicidal with potential violence. His judgement was severely impaired. Involuntary admission was an obviously correct action that would give the treatment team more time to stabilize him. This would have avoided a so-called 72-hour request for discharge by Mr. Wang later during his admission who had a severely impaired judgement as evidenced by his severe psychotic, depressed and manic mental condition. His medical chart from Lenox Hill Hospital never documented that Mr. Wang ever demanded immediate release which would have prompted the 72-hour rule.

(Dr. Chen affirmation at 4).

He further opines that the language barrier between Chinese-speaking Wang, who spoke Fuzhou and Mandarin, and the English-speaking hospital staff,[2] who used a telephone translation service to communicate with Wang, created an obstacle in accurately assessing Wang's mental state. Dr. Chen states:

> I cannot emphasize enough that these telephone interpreters are not medically and psychiatrically trained. Many important psychiatric and emotional symptoms can be been lost during the interpretation. I treat many patients who can only speak Spanish, Korean, and Japanese over the years of my practice. It is based on my own clinical experience that a telephone translation service is often close to useless when it comes to assessing a psychiatric patient

(*id.* at 4).

Dr. Chen further opines on Wang's cultural isolation in this setting and how it "worsened his anxiety" (*id.* at 6). He talks of Wang's persistent requests to be transferred to Elmhurst hospital "which had Chinese-speaking psychiatrists," and opines that had the treatment team made greater efforts to transfer him to another facility, "he would have benefited from a more effective treatment with more accurate assessment of his psychiatric condition" (*id.* at 6). Additionally, LHH's lack of familiarity with Chinese cultural norms, "(women are generally submissive to their spouses) led the treatment team to overlook and underestimate the courage it finally took for Ms. Liu to disclose on May 15, 2012 that she was in fear for her life if her husband were released from the hospital. But her statement and fear were totally minimized during the treatment team's planning for discharge of Mr. Wang" (*id.* at 8-9).

Dr. Chen opines that Wang was "depressed, manic and psychotic," and was not a reliable reporter of events or states of mind that took place to, or during, his admission. On this point, Dr. Chen states:

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[2] There was a second-year medical student on the team treating Wang, who spoke Mandarin, however, he was only there for one week of Wang's admission at LHH.

> The veracity of any statements attributed to him should have been interpreted with caution. It is my medical opinion that Wang was unreliable and inaccurate as a historian, and he was incapable in disclosing details about his psychiatric condition and symptoms, to say the least even if he wanted to be cooperative

(*id.* at 5).

According to Dr. Chen, this lack of understanding of Chinese cultural norms, as well as Wang's questionable reliability, support his conclusions that LHH's discharge of Wang was a deviation in that it was not safe. In this connection, he opines that based on "clearly documented in the emergency room notes on May 4, 2012 that his wife related that Mr. Wang had recently become agitated and violent towards his adult daughter…[and] history of past violence towards other family members… highlights the attention that should have been given that it was reasonably foreseeable without adequate and effective inpatient psychiatric treatment, that Mr. Wang's psychiatric condition posed an imminent danger to others." He also opines that "this safety concern has been clearly and prominently documented by the resident physician in her progress notes from May 15, 2012 during Mr. Wang's hospitalization [until] his discharge date on May 22, 2012" *(id.* at 5-6).

He states that LHH's discharge of Wang without notifying the family was a further departure, as it failed to warn Liu or allow to prepare resources for his return home. With respect to the discharge, Dr. Chen states:

> The treatment team tried but failed to communicate and confirm with Mr. Wang's outpatient psychiatrist Dr. Liu to see if Mr. Wang had returned to his baseline of mental state. Without this confirmation, the treatment team just presumed that Mr. Wang had stabilized to his "baseline", and unsafely discharged him

(*id.* at 9).

He further states:

> When the staff delayed his actual discharge until the following day, it was in the hope of still speaking to Ms. Liu. The fact that no one came to the hospital to meet Mr. Wang at the time of his discharge should have raised a red flag and alarmed the treatment team.

> But the treatment team failed to perceive this and still let Wang go (clearly documented in the discharge note)

(*id.* at 10).

Dr. Chen opines that Wang's "premature discharge" was further based on pressure from Mr. Wang's medical insurance company, and points out that LHH's expert "fails to address this improper basis for Mr. Wang's premature discharge" *(id.* at 12). He notes that "a letter from Mr. Wang's insurance company UnitedHealthcare dated May 23, 2012 stated that they would not cover payment for his care from May 22, 2012 forward. The dramatic change of the Defendant's staff's medical opinion and documentation discrepancy by the treatment team in my opinion should be questioned" (*id.* at 12).

Dr. Chen further opines that LHH should have provided a long acting medication for Wang due to his unreliability in taking his medications and his resulting decompensation. On this point, he opines that:

> [Wang's] duplicity in not taking his medicine was also clearly documented on May 21, 2012, the same day that Mr. Wang was further assessed and advocated by the resident physician for continued inpatient treatment. It is my medical opinion that the Defendant's treatment team failed to consider long acting injectable antipsychotic (biweekly or monthly) as part of his medication regimen to address his long-standing noncompliance issue which had led to his violent behaviors and multiple hospitalizations in the past

(id. at 13).

He also opines that LHH should have considered a partial hospital program as a step-down treatment, where Wang could go to be monitored until he was truly stabilized.

Dr. Chen also opines that above "departures were the proximate causes and a substantial factor in the severe personal injury suffered by …Liu" (*id* at 3).

In reply, LHH argues, *inter alia*, that plaintiff has not established that this case falls within the rare circumstances in which a physician would owe a duty to a non-patient family member, and that at the time at issue no duty to warn applied under New York law.

Discussion

The threshold issue on this motion is whether LHH owes a duty to Liu, who was not a patient, based on its care and treatment of her husband, Wang. The question of whether and to whom a duty is owed "is a legal one for the courts to resolve, taking into account common concepts of morality, logic and consideration of the social consequences of imposing the duty" (*Tenuto v Lederle Labs., Div. of Am. Cyanamid Co.*, 90 NY2d 606, 612 [1997]). "It has long been recognized that, as a general rule, the sine qua non of a medical malpractice claim is the existence of a doctor-patient relationship. Indeed, it is this relationship which gives rise to the duty imposed upon the doctor to properly treat his or her patient" (*Fox v. Marshall*, 88 AD3d 131, 138 [2d Dept. 2011]). Thus, the courts have been reluctant to expand the doctor's duty to nonpatients, since there is a danger that this would "render doctors liable to a prohibitive number of possible plaintiffs . . . a doctor's duty can, in limited circumstances, encompass nonpatients who have a special relationship with either the physician or the patient" (*McNulty v City of New York*, 100 NY2d 227, 232-233 [2003]; *see also*, *Eisenman v. State of New York, 70 NY2d 175, 180-182* (1987) [holding that prison physician who erroneously reported that ex-convict seeking college admission was not emotionally unstable did not owe a duty to accurately report prisoner's condition to the community at large]).

At the same time, however, the courts have recognized that "under certain circumstances, the law is flexible enough to imply a duty of care by a doctor, in a medical malpractice context, to those who are not patients." *Fox v. Marshall*, 88 AD3d at 130. For example, a doctor can "'owe[ ] a duty of care [not only] to his patient [but also] to [those] persons he knew or reasonably should have known were relying on him for [a particular] service to his patient'" Thus, the Court of Appeals has found that a physician's duty can extend to non-

patients, including members of a patient's household, "when the service performed on behalf of the patient necessarily implicates protection of household members or other identified persons foreseeably at risk because of a relationship with the patient, whom the doctor knows or should know may suffer harm by relying on prudent performance of that medical service" *(Tenuto v Lederle Labs., Div. of Am. Cyanamid Co.*, 90 NY2d at 613; *see also, Davis v South. Nassau Communities Hosp.*, 26 NY3d 563, 574 [2015] [noting that New York law recognizes that "members of a patient's immediate family or household who may suffer harm as a result of the medical care a physician renders to that patient benefit from a duty of care running to them from the physician"]).

In *Tenuto*, the court held that a physician had a duty of reasonable care to the parents of a child to whom he administered an oral polio vaccine to warn them of the risk of exposure to polio. In *Davis*, a bus driver was injured when a former patient of the defendant hospital was "negligently" administered opioids prior to the non-party patient injuring the plaintiff/bus driver. The patient drove across the double yellow line and struck plaintiff while the patient was under the influence of the medication. In reinstating the complaint, the Court of Appeals stated: "A critical consideration in determining whether a duty exists is whether "the defendant's relationship with either the tortfeasor or the plaintiff places the defendant in the best position to protect against the risk of harm" (id.).

The First Department has also held that where the plaintiff has no doctor-patient relationship with the defendant, can be imposed on behalf of a plaintiff who was harmed when the defendant released a mental patient from an inpatient facility (*Winters v New York City Health & Hosps. Corp.*, 223 AD2d 405 [1st Dept 1996]). This duty is based upon the facility's authority to restrain dangerous or potentially dangerous persons under its control (*see Schrempf v*

State of New York, 66 NY2d 289, 294 [1985]; *Stewart v. Brookdale Hospital and Medical Center*, 62 AD3d 860 (2d Dept 2009)[issue of fact existed as to whether defendant committed malpractice in discharging decedent's son from its psychiatric facility]; *compare Pingtella v Jones,* 305 AD2d 38, 43 [4th Dept], *lv dismissed* 100 NY2d 640 [2003][finding no special relationship between the mother's treating psychiatrist and child injured by his mother where defendant "had no control over [the mother] and the record establishe[d] that [the mother] had no history of violence]).

In *Winters,* a hospital released a psychiatric patient who later killed a third party. The trial court denied summary judgment to the defendant hospital and the First Department affirmed, finding that issues of fact existed as to whether the hospital's decision to release the patient was based on an error in the exercise of professional medical judgment or whether the hospital had failed to make the inquiries that it should have made. The court wrote:

> Given that a resident psychiatrist apparently failed to inquire into the nature of the patient's auditory hallucinations and the phrase the patient kept repeating to himself, it is not clear whether there was a careful psychiatric examination of the patient. Nor is it clear whether the patient's records from prior psychiatric hospitalizations at the same institution were read prior to the patient's release

(*Winters*, 223 AD2d at 405 [citation omitted]).

Here, the court finds that LHH owed a duty to Liu Wang's spouse and a member of his household based on evidence that Liu was not only known to LHH, but that his violence towards Liu and other family members and Liu's fear of Wang was known by LHH as reflected in LHH's chart for Wang. Specifically, the chart under "reason for hospitalization," "[t]here was … a report of him becoming agitated at home, during which time he grabbed 2 family members and tried to harm them," and "collateral from wife . . . She became scared that he might become violent as he has in the past" (Stone aff, exhibit N (Certified Chart from LHH) at 6). Further, on

May 15, 2012, there is an entry in the chart that reads: "Wife refused to come to the hospital for family meeting. She doesn't feel he is at his baseline "'Not talking normally'" She doesn't feel it's safe as he "'beat people'" was violent prior to hosp." (*id.* at 95).

Moreover, it is indicated in several places in Wang's hospital chart that LHH continued treatment of Wang in part because of Liu's concerns of Wang's violence. In an entry on May 10th, six days into Wang's admission at LHH, the chart states:

> Continued hospitalization is warranted due to the severity of patient's psychosis, as well as concerns of safety raised by the wife, including her not feeling safe, and his prior history of violence during a decompensated state

(*id.* at 73).

This language regarding the need for Wang's continued hospitalization because of Liu's safety concerns is repeated in several places in Wang's chart, including in entries on May 18, 2012 (*id.* at 111), and on May 21, 2012 (*id.* at 132). The entry on May 21, 2012, one day prior to Wang's discharge reflects the hospital's continued attention to Liu's concerns about Wang's violence and the delay in his discharge in order to contact Liu with respect to that plan:

> Continued hospitalization is warranted due to the severity of the patient's psychosis, as well as due to concerns of safety raised by the wife, including prior history of violence when he has been in a decompensated state. While patient's symptoms are showing improvement, continued hospitalization is warranted for at least one more day to confirm a safe discharge plan, including giving wife reasonable time to respond to message left today informing her of the discharge and to confirm she is comfortable with him going back home

(*id.* at 132).

Thus, LHH held Wang an extra day, until May 22, 2012, to try to get in touch with Liu to let her know of the discharge and communicate with her with respect to her concerns about his coming home. The May 22nd note in Wang's chart indicates that that Wang "states that he is ready to return home, reported that he spoke with wife yesterday and today who confirmed he could return home" (*id.* at 133). Despite having no contact with Liu on May 21st or May 22nd to

confirm a safe discharge plan or give her time to respond, LHH discharged Wang to the home he shared with Liu, even though it was aware of Liu's concerns of safety and the severity of Wang's psychosis. Wang attacked Liu within 12 hours of this discharge from LHH.

Under these circumstances, the court finds that LHH owed a duty to Liu based on her status as Wang's spouse and a member of Wang's household, and LHH's knowledge of the foreseeable risk of harm to Liu. Nor can it be said that Wang was not under LHH's control as the record shows that LHH made the decision to discharge Wang, and that he did not leave against medical advice (*see Clark v. State*, 99 AD2d 616 [3d Dept 1984][rejecting defendant's argument that physician had no control over patient with history of mental illness who physician decided not to hospitalize and who subsequently stabbed the claimant]; *compare Oddo v. Queens Village Committee of Mental Health for Jamaica Community Adolescent Program, Inc.*, 28 NY3d 731 [2017][residential substance abuse treatment facility owed no duty of care to victim who was assaulted by discharged former resident who decided to leave facility]).

With regard to the next basis for LHH's summary judgment motion, which is that it did not depart from the applicable standard of care in its care, treatment and discharge of Wang, the court notes that "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 demonstrate the absence of any material issues of fact" (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). "Failure to make such prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers" *(id.* [internal citation omitted]). "Once this showing has been made, however, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" *(id.* [internal citation omitted]).

> "In a medical malpractice action, a plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact" (*id.*).

"'The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted community standards of practice and evidence that such departure was a proximate cause of injury or damage'" (*Korszun v Winthrop Univ. Hosp.*, 172 AD3d 1343, 1344 [2d Dept 2019] [internal citations omitted]; *see also Cadichon v Facelle*, 154 AD3d 461, 462 [1st Dept 2017]).

"'Claims. for psychiatric malpractice often involve the soundness of the decision to release a patient who had been confined for treatment'" *(Vera v Beth Israel Med. Hosp.* 214 AD2d 384, 385 [1st Dept 1995] quoting *Bell v NYC Health and Hosps.*, 90 AD2d 270, 279 [2d Dept 1982]). "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" (*Bell*, 90 AD2d at 280-281 [internal citations omitted]). "Stated otherwise, '[p]hysicians are not liable for mistakes in professional judgment, provided that they do what they think best after careful examination . . . However, liability can ensue if their judgment is not based upon intelligence and thus there is a failure to exercise any professional judgment'" (*id.* at 281 [internal citations omitted]). "However, in the application of the rule it has been observed that 'the line between medical judgment and deviation from good medical practice is not easy to draw'" (*id.* [internal citations omitted]). "When the claimed malpractice concerns the wrongful release of a patient, courts have refused to impose liability unless there was 'something more' than an error of judgment" (*id.* [internal citations omitted]).

Here, to satisfy its burden of showing that it did not depart from the standard of care in discharging Wang, LHH relies on Dr. Muskin's opinion that by May 22, 2012, LHH had no grounds to hold Wang any longer as his condition had improved, he was not a danger to himself or others, that Wang was admitted on a voluntary basis, and that there was no basis for having Wang involuntarily committed, and that LHH had no specific information that Wang posed a danger to Liu or other family members. Further, with respect to any duty to warn Liu, LHH cites Dr. Muskin opinion that in the absence of an indication by Wang that he intended to harm Liu, LHH acted within the standard of care as there was no basis for breaching patient-physician confidentiality to warn Liu before discharge of any potential danger posed by Wang to her safety. Notably, however, Dr. Muskin's opinion does not take into account the repeated references in the LHH Chart of safety concerns raised by Liu, or Wang's history of violence.

In any event, even assuming *arguendo* that LHH has met its burden, it is not entitled to summary judgment as Liu has controverted any prima facie showing made by LHH based on the opinion of her expert, Dr. Chen that Wang was improperly discharged despite the LHH treatment team's knowledge and understanding that Mr. Wang was a potential danger to himself, to Ms. Liu and other family members, that further confinement of Mr. Wang for psychiatric treatment was medically necessary to prevent him from continuing to be a danger to Liu and others, and that LHH deviated from good practice by failing to take the steps necessary to admit Wang involuntarily or in getting him admitting to an in-patient step down program. Moreover, Dr. Chen opines that LHH departed from the standard of care in its care and treatment of Wang based on the treating doctors' reliance on Wang's statements as to his mental state in determining that Wang was not a danger to himself or others, given that Wang was depressed, manic and psychotic during his hospitalization, LHH's lack of understanding of Chinese cultural

norms, and Wang's history of not taking his medication, and under these circumstances, LHH also departed in failing to treat Wang with long acting medication.

With respect to the duty to warn, to the extent defendant argues that the warning Liu would have been improper as it would have required LHH to disclose privileged information about Wang's treatment and condition, at the very least, Dr. Chen's opinion raises questions of fact concerning whether Wang posed a danger to Liu and other family members, such as would have given rise to LHH's duty to report these threats to Liu and other family members (*see Juric v. Bergstraesser*, 44 AD3d 1186 [3d Dept 2007][noting that plaintiff's medical records "indicating that plaintiff was experiencing a 'major psych pathology,' had checked out of the hospital against medical advice, was carrying a large 'stack of gun magazines,' had recently been left by his wife and had a history of verbally abusing and intimidating his wife—may very well provide justification for [defendant physician's] attempt to alert plaintiff's wife of the potential danger to her safety"]; *MacDonald v Clinger*, 84 AD2d 482, 488 [4th Dept 1982][[d]isclosure of confidential information by a psychiatrist to a spouse will be justified whenever there is a danger to the patient, the spouse or another person]; *Oringer v. Rotkin*, 162 AD3d 113 [1st Dept 1990][holding that psychologist was justified in warning individual and his family that his patient had threatened the individual's life during a therapy session]).[3]

Accordingly, LHH's motion for summary judgment is denied.

Conclusion

In view of the above, it is

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[3] Contrary to LHH's apparent argument, New York law recognized a physician's duty to warn a third person where a patient posed a threat to such person, before the passage of Mental Hygiene Law §9.46 which codified the duty warn in connection with the passage of the NY Secure Ammunition of Firearms Enforcement (SAFE) Act.

ORDERED that LHH's motion for summary judgment is denied; and it is further

ORDERED that the pre-trial conference shall be held remotely on August 20, 2020, at noon, and the parties shall email the court at SFC-PART11@nycourts.gov for call in information.

Dated: August 11, 2020

J.S.C.

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