SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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ERIKA OLEY-TROJANOWSKA, AS ADMINISTRATOR OF THE ESTATE OF BARBARA LUNDBERG, AND ERIKA OLEY-TROJANOWSKA, INDIVIDUALLY

Plaintiff,

- v -

KEVIN KELLEY, M.D.,

Defendant.

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INDEX NO. 805021/2019

MOTION DATE 08/10/2022

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53

were read on this motion to/for JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and for wrongful death, the defendant moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendant is awarded summary judgment striking any claim to recover for lack of informed consent, as set forth solely in the plaintiff's bill of particulars, and the motion is otherwise denied.

II. FACTUAL BACKGROUND

The plaintiff's decedent, Barbara Lundberg, was the plaintiff's mother. The crux of the plaintiff's claim is that the defendant psychiatrist failed properly and timely to recognize the severity of her decedent's major depression and thereupon treat it appropriately, contributing to the decedent's suicide. The defendant denies that he departed from good and accepted practice or that anything that he did or failed to do in treating the plaintiff's decedent caused or contributed to her suicide.

Prior to commencing treatment with the defendant, the plaintiff's decedent had treated with psychiatrist Jeorg Bose, M.D., on May 25, 2016, June 7, 2016, June 22, 2016, and October 31, 2016, and continuing until November 7, 2016, by which time she had already commenced treatment with the defendant. Dr. Bose prescribed the decedent the sleep aids Ambien and Lunesta, as well as the anxiolytic Klonopin. According to the defendant, there is no documentation that Dr. Bose ever asked the decedent if she had experienced or was then experiencing suicidal thoughts. Prior to commencing treatment with the defendant, the decedent had also treated with psychiatrist Henry Schwarz, M.D., on August 22, 2016. At this visit, Dr. Schwarz prescribed the decedent the selective serotonin reuptake inhibitor (SSRI) Zoloft, an antidepressant. The defendant asserted that Dr. Schwartz documented that the decedent evinced no suicidal ideology. In addition, prior to her commencement of treatment with the defendant, the decedent began treating with psychiatrist Mikyum Kim, M.D., on August 23, 2016, and continued that treatment through January 16, 2017, by which time she had also begun treating with the defendant. During the early stages of treating the decedent, Dr. Kim prescribed her Klonopin, as well as the anxiolytic Ativan, the antidepressant Lexapro, and the serotonin agonist and reuptake inhibitor (SARI) Trazodone, also an antidepressant. As the defendant characterized it, Dr. Kim also documented that the decedent evinced no suicidal ideology.

The decedent initially treated with the defendant from November 1, 2016 through November 2, 2016, upon which the defendant diagnosed her with Major Depressive Episode, although he never memorialized that diagnosis in his records. From November 3, 2016 through November 18, 2016, the decedent was an inpatient at New York Presbyterian-Westchester (NYPW). During her admission, the decedent was continued on Klonopin, Lexapro, and Trazodone, and was provided with trial dosages of the tetracyclic antidepressant Remeron, the dopamine and serotonin antagonist Risperidone, also an antidepressant, and the antipsychotic Zyprexa. Upon discharge, she continued taking Remeron and Zyprexa. According to the

defendant, NYPW's records documented that, on numerous occasions during her admission, the decedent denied having experienced or currently experiencing suicidal ideation. The plaintiff, however, contended that certain portions of NYPW's records reflected that there was a reason for medical personnel to have been concerned about suicide. The decedent resumed treatment with the defendant on November 22, 2016, and thereafter treated with him on November 30, 2016, December 1, 2016, December 7, 2016, December 12, 2016, December 13, 2016, December 14, 2016, December 19, 2016, December 20, 2016, December 21, 2016, December 22, 2016, December 23, 2016, December 27, 2016, December 30, 2016, December 31, 2016, January 2, 2017, January 12, 2017, January 13, 2017, January 14, 2017, January 17, 2017, January 18, 2017, January 19, 2017, January 20, 2017, and January 21, 2017. The defendant apparently discontinued the administration of Zyprexa.

The defendant contended that, during his sessions with the decedent, he documented that she expressly denied having had, or was then currently experiencing, suicidal ideation. According to the plaintiff, however, the defendant only inquired about suicidal ideation during the decedent's first and second meetings on November 1, 2016 and November 2, 2016, and otherwise failed consistently or appropriately to ask the decedent about her ideation. She thus contended that the decedent's denials were an incomplete reflection of her decedent's psychiatric condition during the period in which she treated with the defendant. The plaintiff further asserted that, despite the defendant's knowledge that the decedent had been treating with other psychiatrists, he did not seek to obtain their records and, thus, was not fully or completely aware of the medications that the decedent was on, let alone their dosages.

During the 2016 Christmas holiday season, the plaintiff and her family flew to New York from Poland and visited with the decedent in New York. The decedent then travelled to Florida to visit her sister in January 2017. According to the plaintiff, her decedent underwent a change in mental status on January 12, 2017 and that, although she appeared for an appointment with the defendant on that day, the defendant did not inquire about suicidal ideation despite his

concession that a change in mental status required such an inquiry. As the plaintiff described it, this change in status manifested itself by the decedent's statements to the defendant emphasizing that she was depressed.

The decedent died by suicide on January 21, 2017, when she placed a plastic bag over her head, causing asphyxia due to displacement of oxygen by carbon dioxide. According to the defendant, on January 21, 2017, the plaintiff reported to Derry Chow of the Office of the Chief Medical Examiner (OCME) that the decedent had been treating for depression for approximately six months prior to her death, and that her decedent had expressed suicidal thoughts to the plaintiff during a telephone communication two days prior to her death. According to the defendant, the records from the New York City Police Department (NYPD) and Lenox Hill Hospital also reflected that that the plaintiff reported that the decedent made references to thoughts of suicide during the two days prior to her death. The plaintiff vigorously denied that she made these statements to these governmental officials or hospital representatives, asserting that the decedent had never indicated to her that she was suicidal.

III. THE PLAINTIFF'S ALLEGATIONS

In her complaint, the plaintiff simply asserted that, from on or about November 2, 2016, and thereafter, her decedent sought professional care from the defendant in connection with certain medical complaints, including complaints from which she then was suffering, and that the defendant carelessly, unskillfully, and negligently rendered medical care, diagnosis, treatment, and services to her that were not in accordance with accepted standards of medical care, diagnosis, treatment, and services in the relevant medical community. The plaintiff averred that, as a consequence, her decedent sustained "great pain, agony, injury, suffering, disability, hospitalization, as well as mental anguish and emotional distress, all of which caused, precipitated, and contributed to, her death on January 21, 2017." The plaintiff thus asserted a "survival action" to recover for the conscious pain and suffering or other compensable damages sustained by the decedent while she remained alive. In addition, the plaintiff asserted a cause

of action to recover for wrongful death, encompassing the pecuniary loss to the decedent's estate that was proximately caused by her death.

In her bill of particulars, the plaintiff asserted that the defendant departed from good and accepted medical practice in failing to request, obtain, and record a thorough, proper, and complete evaluation of her decedent's relevant medical history and relevant family history, including, but not limited to, the decedent's allergies and the medications she had been and was currently taking, as well as the reactions and intolerances to such medications. The plaintiff faulted the defendant for prescribing medications to her decedent that possessed the clear potential to cause harm, prematurely prescribing medications prior to attempting psychotherapy for a period of time, and prematurely prescribing medications prior to adequately assessing whether the decedent exhibited signs of a major depressive disorder. In addition, the plaintiff asserted that the defendant negligently prescribed inappropriate medications concurrently and, in this regard, failed to recognize or appreciate the toxic interaction of several of the medications that had been prescribed and concurrently administered to the decedent. She further contended that the defendant inappropriately increased and decreased the dosages of the medications, failed to recognize her decedent's adverse response to those medications that had previously been prescribed by other physicians, and negligently prescribed medications, both individually and concurrently with those prescribed by those other physicians, prior to ascertaining whether psychotherapy alone would yield positive results. In this regard, the plaintiff alleged that the defendant failed to adjust the medication dosage to reflect her decedent's signs, symptoms, and physical conditions, including her body weight.

The plaintiff additionally averred in her bill of particulars that the defendant failed clearly to advise her decedent of the risks, complications, and advantages of, and alternatives to, the medications that he prescribed, and that he allowed an undue and ultimately fatal delay in the decedent's maintenance and care. Specifically, the plaintiff asserted that the defendant failed to advise her decedent that the medications prescribed to her or removed from her regimen, most

particularly antipsychotic drugs, had the potential to cause impaired judgment, hypersensitivity syndrome, and suicidal ideation. She further asserted that the defendant failed to advise both the decedent and her family members to monitor any mood changes while the decedent remained on the medications, and to recommend that those family members keep each other informed of those changes, including any onset of suicidal ideation.

Moreover, the plaintiff claimed that the defendant departed from good and accepted medical practice in failing to discontinue those medications that he ordered and prescribed, in failing to recognize and appreciate a potential for serious injury by virtue of the decedent's medical history, and in failing to obtain greater knowledge of the adverse effects of the prescribed medications. In addition, she asserted that the defendant prescribed a contraindicated and unnecessary drug. The plaintiff also contended that the defendant should have referred her decedent to a qualified physician for required treatment and care and should have considered conservative or standard treatment prior to the administration of the medications that he did prescribe, or refer the decedent for proper evaluations and laboratory testing before prescribing and administering, or discontinuing, antipsychotic medications.

The bill of particulars also set forth allegations that the defendant departed from good and accepted care in failing to order the decedent's re-hospitalization, in failing to maintain his own proper and complete medical charts, and in failing to obtain the decedent's hospital and medical charts from her hospitalization at NYPW and her prior treatment by other psychiatrists.

The plaintiff alleged that, as a proximate result of the defendant's negligence, her decedent was caused to sustain medication-induced torment, pain and suffering, crippling mood disorder, depression, intense sadness, suicidal ideation, asphyxia injury, hypoxic respiratory failure, and death.

IV. THE SUMMARY JUDGMENT MOTION

In support of his summary judgment motion, the defendant submitted the pleadings, the plaintiff's bill of particulars, the parties' deposition transcripts, relevant hospital and medical records, a statement of allegedly undisputed material facts, and the expert affirmation of psychiatrist Anthony J. Rothschild, M.D.

Dr. Rothschild set forth, in detail, the contents of the notes and records of the psychiatrists who treated the decedent in the months leading up to her suicide, as well as the contents of the NYPW hospital records. He concluded that the defendant did not depart from good and accepted practice in treating the decedent, and that nothing that the defendant did or failed to do caused or contributed to the decedent's worsening mental health condition or her suicide.

Dr. Rothschild described the decedent's work background, noting that she was a high-achieving business executive, with an M.B.A. degree from the Wharton School of Business and extensive experience as an officer or director for several large corporations. He noted that, only two years prior to the decedent's death, she accepted a position with a business consulting firm in New York after she had returned from Poland, where she had worked as a business consultant for several years. He further noted that the decedent had encountered legal difficulties in Poland.

The defendant's expert asserted that, according to the NYPD's post-mortem records, the decedent's two closest friends did not report during their post-suicide interviews with the NYPD that the decedent expressed suicidal thoughts to them, or that her physical affect was such that she appeared suicidal. As Dr. Rothschild interpreted the NYPD records, the decedent had made plans for a friend, Eileen Hanford, to accompany her to a visit with Dr. Bose on January 23, 2016, only two days after her date of death. According to Dr. Rothschild, "the records show that the only person the decedent confided to about any thoughts of suicide was plaintiff, her daughter," and he asserted that that he came to this conclusion because the "police, Medical

Examiner, and Lenox Hill Hospital records all documented that upon inquiry plaintiff reported that in the couple of days prior to taking her life, the decedent made reference to thoughts of suicide to her." He further noted that "[t]here is no indication that plaintiff acted" on this information.

Dr. Rothschild went on to assert that, based on his review of the relevant psychiatric and hospital records, the decedent, despite her reports of depression and anxiety, demonstrated "forward- or goal-oriented-thinking, which signifies hope and/or optimism about future prospects," and that she evinced such thinking throughout her treatment period, both with the defendant and her other treating psychiatrists. As an example, Dr. Rothchild pointed to the decedent's statements to Dr. Bose that, despite her fears and feelings of inability to perform at work, she planned to move forward with applications for positions on the boards of directors of several corporations. In this regard, he noted that the decedent's calendar entries for the month January 2017 showed that she had numerous psychiatric and medical appointments scheduled, including appointments with the defendant, Drs. Kim and Bose, her primary care physician, an audiologist, a dermatologist, and a psychoanalyst, as well as appointments to attend yoga class, have her nails done, pick up pants at Saks, and attend a work-related function.

As Dr. Rothschild explained it, "[w]hen treating anxiety and depression, changes in medications, including combinations of medications and dosages of medications, is common, necessary, and within the standard of care," particularly when a patient presents with multiple disorders such as anxiety and depression. According to Dr. Rothschild, this is because "comorbid anxiety and depression is often more resistant to pharmacologic treatment, and patients with co-existing disorders have a poorer medical prognosis than do patients with either disorder alone." He stated that the decedent's records clearly showed that she presented to her treating psychiatrists with symptoms of both anxiety and depression, but that, even had she presented with only one of those two disorders, "she would have been a difficult patient to treat with medications because of the numerous reported side effects she experienced."

Dr. Rothschild averred that the decedent's treatment difficulties were exacerbated by her resistance to concurrent psychotherapy, as evidenced throughout the records. As an example, he noted that, although Dr. Bose recommended regular psychotherapy sessions, as well as an antidepressant in combination with tranquilizers, the decedent did not comply with this recommendation. He quoted from Dr. Bose's records, in which Dr. Bose noted that it was "difficult to get a sense of traction" with the decedent and engage her in serious self-reflection, as she was externally focused. In interpreting Dr. Bose's notes, Dr. Rothschild averred that the decedent was reluctant to engage Dr. Bose, preferring to rely only on herself. As a further example, Dr. Rothschild noted that, throughout the decedent's interview upon her admission to NYPW, she had difficulty describing her depressive symptoms other than decreased sleep. He asserted that the decedent, when asked to describe her symptoms, kept referring to situations in which she became nervous or panicked, such as when she had to give a speech at the New York Stock Exchange, and that the NYPW chart indicated that the decedent needed constant re-direction in order properly to describe her condition and need for hospitalization.

With respect to the actual care and treatment that the defendant provided to the decedent, Dr. Rothschild concluded that the defendant "obtained a thorough, proper, and complete history from the decedent relative to the care and treatment he provided," including an appropriate personal and treatment history, "the latter of which included an appropriate history of trials of medications, their effectiveness or lack of effectiveness for the decedent, and the decedent's reactions to them." He asserted that the defendant's charting with respect to the decedent's personal and medical history was essentially the same as that undertaken by the decedent's other treating providers, inasmuch as when discussing her history, the decedent focused on her family, her initial career success, her subsequent work-related issues in Poland, and her current work and financial problems. As Dr. Rothschild characterized it, the decedent's primary focus of her treatment with the defendant was to resolve her reported difficulty in sleeping. He stated that the records also showed that the decedent consistently complained to

all of her treating psychiatrists of actual or perceived side effects of prescribed medications, and either frequently made requests to change medications or their dosages, or sought treatment with a different provider.

Dr. Rothschild concluded that the defendant conducted an in-depth assessment and evaluation of the decedent at each session, noting her conversation style, thought processes, and preoccupations. He opined that there was no deviation from the standard of care in relation to these assessments, and that the assessments allowed the defendant properly to prepare a plan of treatment for the decedent, as evidenced by the medications that he prescribed. Dr. Rothschild further opined that

> "[a]ny omission of some of the details of these assessments was not the reason the decedent decided to take her life. Any omission by Dr. Kelly of a specific diagnosis in the decedent's chart at any time had no causal connection to her death, as the medications prescribed were appropriate based on her presentation.
>
> "Dr. Kelly appropriately documented the general subject matter of each session with the decedent, as well as the telephone communications in between sessions. He also appropriately documented the decedent's description of her symptoms, any change in mental status, and any change in medication. The medications prescribed by Dr. Kelly, including their combinations and doses, were appropriate given the decedent's presentation and described symptoms."

In this regard, Dr. Rothschild asserted that the defendant made very few changes to the decedent's medication regimen during the period of time that he treated her, as he continued her on the anti-depressant Remeron (mirtazapine) that she had commenced taking at NYPW. Dr. Rothschild noted that, while the defendant lowered the dose from 45 milligrams (mg) to 30 mg upon the decedent's request during the week before her death, "such a change was not significant, was within the standard of care and would not have caused the decedent to take her life." He further concluded that, although the defendant increased the dose of the anti-depressant Celexa from 10 mg to 20 mg, that also was not a significant change, was within the standard of care, and would not have caused the decedent to take her life. According to Dr.

Rothschild, relevant studies had demonstrated that there is no evidence of increased suicidality in patients of the decedent's age who took SSRI antidepressants like Celexa.

As Dr. Rothschild explained it, the defendant recommenced the decedent on the anxiolytic Klonopin during the month prior to her death, and prescribed it at her request as her preferred anti-anxiety medication. He noted that the decedent had taken this medication in the past, and its recommencement by the defendant was within the standard of care and would not have caused the decedent to take her life. Dr. Rothschild further opined that it was within the standard of care for the defendant to have tapered the decedent off of the anti-psychotic Zyprexa (olanzapine) at the rate that he recommended. He explained that this determination was properly predicated on the decedent's reported symptoms of restlessness, which Dr. Rothschild averred was a common side effect of Zyprexa, as well as the absence of any presentation of psychosis, which Dr. Rothschild concluded could be inferred from the notes of Drs. Bose and Kim that described the decedent as rational, goal-oriented, logically thinking, and free of delusional or psychotic content. Dr. Rothschild noted that the defendant had testified at his deposition that the decedent was logical, could tell a coherent story, and demonstrated logical ideas, and that this presentation did not change over the course of her treatment with the defendant.

In Dr. Rothschild's opinion, none of the medications prescribed by the defendant increased the decedent's risk of suicide, and there was no risk of a toxic interaction of the medications that she took concurrently. Based on his review of the defendant's records, Dr. Rothschild concluded that the defendant considered each of the decedent's actual and/or perceived side effects of the medications that she was taking, and adjusted the medications appropriately. He opined that it was not a deviation from the standard of care for the defendant to have maintained the decedent on a medication, merely because she believed that it was causing a symptom, when there was a medical basis to support its continuation.

Dr. Rothschild further concluded that it was not a deviation from the standard of care for the defendant to have failed to ask the decedent during each and every treatment session if she had suicidal thoughts. As Dr. Rothschild noted, the defendant asked the decedent if she had suicidal ideation during their initial telephone communication and during their first in-person treatment session, and that the decedent answered that question in the negative on both occasions. Hence, Dr. Rothschild concluded that there was no need to continue asking this question of the decedent, particularly because the defendant conducted a detailed mental status check of the decedent during every session, as described in his deposition testimony. Nor, Dr. Rothschild concluded, was there any change in the decedent's presentation that would prompt the defendant to continue to inquire of the decedent with respect to this issue. As such, Dr. Rothschild further concluded that it was reasonable for the defendant to reach the conclusion that the decedent was not at risk for suicide.

In addition, Dr. Rothschild opined that the defendant did not deviate from the standard of care by continuing telephone sessions with the decedent while the plaintiff was visiting her mother in New York, while the decedent was travelling to Florida, and upon the decedent's return from Florida. He also opined that it was not a deviation from the standard of care for the defendant to have made changes to the decedent's medications during the time periods when he was not seeing her in person, as the defendant had met with the decedent in person several times and had taken a thorough history from her by the time he and the decedent engaged in these telephone sessions. As Dr. Rothschild recounted it,

> "[t]he records show that during phone sessions the decedent continued to express and describe her symptoms in the same way she had during in person sessions. There was no impediment to the decedent's care and treatment by the continuation of phone sessions that would have caused the decedent's death."

Moreover, Dr. Rothschild concluded that it was not a deviation from the standard of care for the defendant to have charted only the changes in the decedent's medication protocol, as it was not mandated by any standard of care for a psychiatrist to ask patients at each session what

medications they were taking or to document those medications. In this regard, Dr. Rothschild asserted that it is expected that patients will take their medications as prescribed, "and there is no evidence to indicate that the decedent was not doing so" but, rather, that the decedent "consistently reported with regard to what medications she was taking and how much of the same."

Dr. Rothschild opined that

> "the decedent was deliberate in the planning of her suicide. For example, she sent a very specific text message to a friend with the clear intent of having the friend check on her so that it would not be long before her body was found. There is no indication in the records that at the time of her death she was anything but well related and well oriented, with intact cognitive function and without psychosis. Additionally, the medication regimen the decedent was following would not and could not have resulted in a change in the decedent's mental or physical health such that it would cause her to take her life. None of the medications prescribed by Dr. Kelly have the potential to cause suicidal ideation."

By way of explanation, he noted that the decedent had a long history of depressive episodes relating to her work and financial problems and that, despite the plaintiff's deposition testimony to the contrary, the decedent had in fact lost the ability to feel pleasure and enjoy life prior to the commencement of the defendant's management of the decedent's medications, "as demonstrated by the decedent's reports to her other treating providers." Dr. Rothschild further concluded that the decedent's tax and employment records suggested that, at the end of 2016, her work and financial problems had "reached a peak," and that she could no longer manage them, "as predicted by Dr. Kim's opinions about the decedent's poor judgment specifically as to managing her own expenses." He continued that "[t]he decedent very clearly could not cope with her inability to perform at work and maintain the lifestyle to which she had become accustomed prior to her legal problems in Poland and work-related issues in the U.S." Dr. Rothschild thus concluded that

> "no medication or combination of medications would have enabled the decedent to better deal with her financial and work-related issues in January 2017 such that her suicide would have been prevented. To suggest otherwise would be pure speculation . . .[T]he decedent's suicide was not foreseeable. There was nothing

> in her presentation or history that would alert a treating provider that the decedent had suicidal thoughts. Additionally, there was nothing in her presentation to indicate that the decedent needed to be hospitalized or otherwise referred to another treating provider. It was not a deviation from the standard of care for Dr. Kelly to fail to hospitalize or otherwise refer the decedent to another treating provider after her discharge from NYP. Up until at least the day prior to her death, the decedent was apprised of current events, was making plans, and was continuing to participate in her care and treatment with Dr. Kelly by further discussing her medication regimen."

Moreover, he asserted that any alleged deficiencies in the defendant's charting, record keeping, or assessments were of no consequence, as the charting and written assessments had no relation to the decedent's death.

In opposition to the defendant's motion, the plaintiff relied upon the documentation submitted by the defendant, and also submitted an attorney's affirmation, a counter-statement of material facts, and the affirmation of an expert board-certified psychiatrist.

According to the plaintiff's expert, the decedent had scheduled a phone conversation with the defendant for what turned out to be the date of her death. The expert noted that the decedent last saw the defendant in person on January 12, 2017, nine days before her death, at which time the defendant increased the dosage of her anti-depressant medications because she had reported that she was depressed. The plaintiff's expert faulted the defendant for failing to note or memorialize "in what way she was more depressed or the level of that depression." As the expert explained it, the defendant "concede[d] that it was a deviation from accepted standards of psychiatric treatment not to notate what the indication of depression was at that point." The expert continued that the defendant

> "claims that he diagnosed Ms. Lundberg at the first visit (but never notated it) with Major Depression Disorder *and indicates that this diagnosis does render the patient at an increased risk of suicide.* Notwithstanding that, he spoke to the patient about suicidal ideation at her first visit and at the second visit (after her hospitalization,) but never inquired about it again."

(emphasis added). The expert characterized the defendant's deposition testimony as including a proper and correct concession that, had there been a change in the decedent's mental status, there was "a need to inquire about suicidal ideation." The expert further asserted that the

defendant conceded that, on January 12, 2017---the decedent's eighth visit with the defendant---there was "a change in status," in that the decedent "was more depressed than she had previously been." As the expert interpreted the defendant's deposition testimony, the defendant

> "concedes that an inquiry with reference to suicidal ideation should have been done and it wasn't. A failure to inquire with reference [to] suicidal ideation at this point was a deviation from accepted standards of medical practice, as was a failure to do a suicide assessment and safety plan.
>
> "Although he knew the patient had seen at least one other psychiatrist before treating with him, he never reached out to the prior doctors or obtained their notes or records. Accordingly, he was unaware of the totality of medications she had been previously prescribed or at what dosages.
>
> "*He was aware of some of the medication she was on with prior doctors, but didn't know when she stopped taking these medications or the dosages*. He concedes it would have been 'useful' to know this information, but he never reached out to the other doctors to find out about the medication dates and dosages or general treatment regimen"

(emphasis added).

The plaintiff's expert opined that the defendant's record keeping was inadequate and that his treatment of the decedent was "equally poor," as there were no diagnoses identified in the defendant's chart and there were barely any indications in his records of any conversations between the decedent and him, except with respect to her subjective reactions to medications. He explicitly disagreed with Dr. Rothschild's opinion that decedent's suicide was not a function of the defendant's failure properly to treat her, as "the records are devoid of any reference to what Ms. Lundberg's problems were at these visits." Contrary to Dr. Rothschild's assertion that the defendant conducted a detailed mental status check of the decedent during every session, the plaintiff's expert noted that "[t]here is no reference at all to mental status exams" in the defendant's chart. As the expert explained it,

> "[m]ental status exams at each visit should include an assessment, and description of appearance (including grooming, dress, eye contact, and posture); level of consciousness (response to stimuli); attentiveness; motor and speech activity (spontaneous speech v halting v manic); mood and affect; thought and perception (rational response or exaggerated response to events); and attitude and insight (emotional tone displayed toward examiner). There is a

> requirement to check for a sense of hostility, anger, helplessness, pessimism, over dramatization and self-centeredness."

The expert characterized the defendant's deposition testimony as reflecting that he not only "minimally notated" his charts, but that these minimal notations represented the totality of the conversations between the decedent and the defendant on the relevant dates. As the expert phrased it, the defendant conceded that he generally didn't know if a patient were taking medication at any particular point, and, because his notes did not reflect whether the patient was taking any particular medicine at any time, the defendant didn't know whether a patient such as the decedent actually took any particular medications.

The expert concluded that, because the defendant's notes did not reflect all of the medications that the decedent was taking in early January 2017, or her level of depression at that time, he was not able, and would not have been able, to ascertain what her condition was in the few days leading up to her suicide on January 21, 2017. According to the plaintiff's expert, the defendant conceded that his notes did not reflect the decedent's level of depression during a telephone conversation on January 18, 2017, and that he also conceded that it was a deviation not to memorialize her level of depression as of that date. Similarly, with respect to the defendant's notes in connection with a telephone conference on January 19, 2017, the plaintiff's expert asserted that the defendant did not know, and failed to memorialize, which medications the decedent was then taking, or what the severity of her depressive state was at that time. The expert asserted that, on January 20, 2017---one day before the suicide, and the last time that the defendant spoke with the decedent---the defendant and decedent only spoke about travel plans, and that the defendant did not know, nor did he memorialize, the extent or severity of the decedent's depressive state.

The plaintiff's expert concluded that the defendant thus departed from good and accepted medical practice in negligently failing to assess, diagnose, and treat the decedent, inasmuch as he failed to perform careful, comprehensive psychological examinations and failed

properly and adequately to care for the decedent's worsening depressive state. The expert also opined that the defendant negligently monitored and prescribed medications, without having full knowledge of the medications that the decedent had previously taken or was then currently taking, let alone the dosages thereof. The expert asserted that the defendant further departed from good and accepted medical practice in failing to reach out to the other psychiatrists with whom the decedent was then treating, even though he knew that she was treating with at least one other psychiatrist at that time. The plaintiff's expert averred that the standard of care required the defendant to ascertain the other psychiatrists' impressions of the decedent's medical status, their diagnoses, and the medications that they were prescribing and had previously prescribed to her, along with the dosages thereof.

As the plaintiff's expert characterized it,

> "[d]efendant concedes at his deposition that he departed from accepted standards of medical practice when, on January 12, 2017, he failed to notate what the indication of depression was at that point. His deviations, with reference [to] that date further include his failure to notate the circumstances surrounding the increase in depression, the nature of that depression and further failure to perform a careful and complete suicide risk assessment at that time."

The expert concluded that, as a consequence of those departures, the decedent's suicidal ideation or tendencies "may well have gone undetected as a result of inadequate examinations," and that the defendant's acts of malpractice "resulted in a worsening psychiatric/mental state, worsening depression to the point that Ms. Lundberg committed suicide," and "were a substantial factor in causing the worsening of Ms. Lundberg's mental state progression to the point of suicide."

In reply, the defendant submitted his attorney's affirmation. As set forth in that affirmation, the defendant argued that the court should not consider the plaintiff's expert affirmation because it was served and filed seven days beyond a stipulated deadline, because the plaintiff's attorney redacted the name of the retained expert, and because the expert's affidavit did not establish a foundation upon which the expert could render an opinion. In

addition, the defendant asserted that the expert misrepresented the facts, inasmuch as the defendant never conceded to having departed from good and accepted practice.

Moreover, the defendant argued that his alleged failure to memorialize the decedent's level of depression on January 18, 2017, January 19, 2017, and January 20, 2017 could not have constituted a departure from good practice because those dates only involved telephone conversations or voicemail messages. The defendant further contended that it was not necessary for him to make a specific, documented diagnosis, and that the failure to memorialize such a diagnosis was not a proximate cause of the decedent's suicide in any event. He also asserted that it was sufficient that he only documented any *changes* in medication, and that it was unnecessary for him to document all of the medications that the decedent already had been prescribed prior to her commencement of treatment with him. In addition, he claimed that the plaintiff's expert relied on conclusions contrary to the "record," explaining that he had testified at his deposition that he conducted the necessary mental status examinations, and that he had done so notwithstanding the fact that he did not memorialize them in writing in his charts.

A. SUMMARY JUDGMENT STANDARDS

The court exercises its discretion and considers the affirmation of the plaintiff's expert. Although that affirmation was served and filed seven days after a stipulated briefing deadline, there would be no prejudice to the defendant were the court to consider the plaintiff's expert affirmation, as the defendant had a full 20 days after service of that affirmation within which to serve and file a reply.

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR

3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

B. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Where a physician fails properly to diagnose or improperly diagnoses a patient's

condition, thus providing less than optimal treatment or delaying appropriate treatment, thus proximately causing injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview*, 190 AD3d 790, 795 [2d Dept 2021]; *see Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must

address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Thus, the affirmation of a plaintiff's expert should not be credited where it completely "is contradicted by the record" (*Mulroe v New York-Presbyt. Hosp*., 203 AD3d 665, 665 [1st Dept 2022]). The term "record," in this context, refers to medical records, charts, test results, and notes, or party admissions by the plaintiff (*see Wong v Goldbaum*, 23 AD3d 277, 280 [1st Dept 2005] [plaintiff's expert's opinion contradicted by defendant's notes and plaintiff's own testimony]). Where, however, no written

notations concerning relevant or necessary assessments or evaluations have been entered into the appropriate medical or other records, a triable issue of fact is presented as to whether those assessments or evaluations were actually made or conducted (*see Rappaport v Correctional Med. Care, Inc.,* 200 AD3d 1150, 1153 [3d Dept 2021]).

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" (*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 399). Although a plaintiff's expert may have chosen a different course of treatment, this, "without more, 'represents, at most, a difference of opinion among [medical providers], which is not sufficient to sustain a prima facie case of malpractice'" (*Ibguy v State of New York*, 261 AD2d 510, 510 [2d Dept 1999], quoting *Darren v Safier,* 207 AD2d 473, 474 [2d Dept 1994]).

In the context of mental health providers, the Appellate Division, First Department, has explained that, "[w]hen 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] [internal quotation marks omitted]; *see Toth v Community Hosp.,* 22 NY2d 255, *Park v Kovachevich*, 116 AD3d 182, 190-191 [1st Dept 2014]; *Centeno v City of New York*, 48 AD2d 812 [1st Dept 1975], *affd* 40 NY2d 932 [1976]; *Betty v City of New York*, 65 AD3d 507 [2d Dept 2009]). Thus, for example, where a psychiatrist fails to predict that a patient will harm himself or herself if released from treatment, liability will not attach for a mere error in professional judgment (*see Schrempf v State of New York*, 66 NY2d 289, 295 [1985]; *Ozugowski v City of New York*, 90 AD3d 875, 876 [2d Dept 2011]). While it is true that "the line between medical judgment and deviation from good medical practice is not easy to draw" (*Topel*

v Long Is. Jewish Med. Ctr., 55 NY2d 682, 684 [1981]; *see O'Sullivan v Presbyterian Hosp. in City of N.Y. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 100 [1st Dept 1995]), the

> "prediction of the future course of a mental illness is a professional judgment of high responsibility and in some instances it involves a measure of calculated risk. If a liability were imposed on the physician . . . each time the prediction of future course of mental disease was wrong, few releases would ever be made and the hope of recovery and rehabilitations of a vast number of patients would be impeded and frustrated"

(*Centeno v City of New York*, 48 AD2d at 813). Nonetheless, if a decision to release a patient from oversight and treatment constituted less than a professional medical determination, liability may attach (*see O'Sullivan v Presbyterian Hosp. in City of N.Y. at Columbia Presbyterian Med. Ctr.*, 217 AD2d at 100). Crucially, a psychiatric decision will not be insulated by the medical judgment rule if it is not based upon a careful examination (*see Park v Kovachevich*, 116 AD3d at 190-191; *Thomas v Reddy*, 86 AD3d 602, 604 [2d Dept 2011]; *Bell v New York City Health & Hosps. Corp.*, 90 AD2d 270, 280-281 [2d Dept 1982]).

Here, the discharge of a mental health patient is not involved. Instead, the issue presented include whether a psychiatrist failed properly to assess a patient's condition, failed to perform a full and careful examination, failed to monitor the effects of current medication, failed to document a potential risk of suicide, and failed appropriately to assess the prospective effectiveness and adverse side effects of new medications, alone or in conjunction with previously prescribed medications. Under these circumstances, a plaintiff's expert's non-conclusory opinion, as set forth in an affirmation or trial testimony, is sufficient to permit a jury to determine whether the psychiatrist deviated from accepted practice, and whether that deviation caused or contributed to the patient's conscious distress and, ultimately, suicide (*see Mazella v Beals*, 27 NY3d 694, 707-708 [2016] [triable issue raised by expert testimony that defendant prescribed the SSRI antidepressant Paxil to the patient for more than 10 years, but improperly failed to monitor it or taper it off during withdrawal, causing a "horrific" reaction when the drug was withdrawn, then improperly prescribed the anti-psychotic Zyprexa without referring to

medical records, and thereafter resumed the patient on a double dose of Paxil several days later]; *Tkacheff v Roberts*, 147 AD3d 1271, 1274-1275 [3d Dept 2017] [expert affirmation asserting that defendant deviated from proper care by placing a medication review on hold and failing to conduct and document a suicide risk]; *O'Sullivan v Presbyterian Hosp. in City of N.Y. at Columbia Presbyterian Med. Ctr*., 217 AD2d at 101 [expert affirmation asserting that defendant deviated from proper care by failing to diagnose a major depression, formulate a comprehensive and interdisciplinary treatment plan for the patient, detect the severity and acuteness of his presenting problem, have him undergo a physical examination, contact his treating physician about his weight problem, assign the patient a primary therapist, and refer him for appropriate psychotropic medication]).

Contrary to the defendant's contention, it is perfectly appropriate for the plaintiff to redact the name of her retained medical expert from the copy uploaded to the New York State Court Electronic Filing system, while submitting an unredacted copy to the court, as she did here (*see* CPLR 3101[d][1][i]; *Vega v Mount Sinai-NYU Med. Ctr. & Health Sys*., 13 AD3d 62, 63 [1st Dept 2004]; *Wilcox v Winter*, 282 AD2d 862, 863 [2d Dept 2001]). Moreover, the court rejects the defendant's contention that a board-certified psychiatrist is not qualified to render an opinion as to the standard of care applicable in the field of psychiatry merely because he or she did not assert, in explicit detail, that he or she had specific knowledge and experience "in treating and prescribing medication to patients with depression and anxiety who ultimately commit suicide." An expert affidavit employed to oppose a summary judgment motion in a medical malpractice action need only "be by a qualified expert who 'profess[es] personal knowledge of the standard of care in *the field of . . . medicine* [at issue], whether acquired through his practice or studies or in some other way'" (*Bartolacci-Meir v Sassoon*, 149 AD3d 567, 571 [1st Dept 2017] [emphasis added], quoting *Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015]). A psychiatrist would necessarily have knowledge or experience in the diagnosis and treatment of depression and anxiety, and the prescription of medications with respect thereto, whether or not he or she ever

had a patient who committed suicide. Depression is a leading cause of suicide, and an expert need not have experienced an unsuccessful attempt in preventing a suicide to be able to render an expert opinion as to the relevant standards of care.

The defendant established, with relevant medical records, his own testimony, and Dr. Rothschild's expert affirmation, that he did not depart from good and accepted practice in treating the decedent between November 2, 2016 and January 21, 2017, and that nothing that he did or failed to do caused or contributed to the decedent's worsening psychiatric condition and ultimate suicide. The plaintiff, however, raised triable issues of fact with respect to these elements of her medical malpractice claim both by referring to the gaps and absences in the defendant's chart and relying upon her expert's affirmation. Her expert's opinion was sufficient to raise triable issues of fact as to whether the defendant departed from good and accepted practice in failing to obtain the decedent's full medical history, including prior prescriptions for and continuations of various psychotropic drugs, in failing to undertake appropriate mental status examinations, as reflected by his failure to memorialize any such assessments, in failing to recognize and respond to the decedent's change in affect and mood on January 12, 2017, and, in light of this change, in failing to be sensitive to the possibility of increased susceptibility to suicidal ideation and responding thereto. The expert affirmation also was sufficient to raise a triable issue of fact as to whether the defendant obtained sufficient knowledge of the decedent's prescription history to determine whether any of the drugs that she was taking when she first presented to him would result in an adverse reaction when the defendant prescribed additional drugs or discontinued the administration of other drugs.

It is immaterial that the decedent never explicitly communicated to the defendant or any other psychiatrist or health-care provider that she was suicidal. In light of all of the circumstances pertaining to the decedent, including her diagnosis of major depressive episode, a two-week mental health hospitalization, her inability to work and function, her determination to consult and treat with four different psychiatrists over a six-month period, the prescription and

administration of a variety of tricyclic, SARI, and SSRI antidepressants, anxiolytics, sleep aids, and anti-psychotic drugs, and her change in affect and mood only nine days before her suicide, the affirmation of the plaintiff's expert was sufficient to permit a jury to infer that the defendant should have been more vigilant in considering the likelihood that the decedent's condition was worsening and that she might attempt or succeed at suicide.

Hence, that branch of the defendant's motion seeking summary judgment dismissing the medical malpractice cause of action must be denied.

The court notes that there is a sharp dispute as to whether the plaintiff first learned during the last two days of her mother's life that her mother was suicidal and reported that to the NYPD, OCME, and Lenox Hill Hospital immediately after her mother's death, or whether the plaintiff never learned of her mother's suicidal tendencies at any time before her death. This dispute, however, is immaterial to whether the defendant should have intuited that suicide was a possibility and, hence, whether he departed from accepted practice, thus contributing to that tragic outcome.

C. LACK OF INFORMED CONSENT

The elements of a cause of action for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). As the

Appellate Division, First Department, has recognized, a lack of informed consent cause of action thus may be predicated on a physician's failure to obtain a patient's fully informed consent to the administration of drugs or medications by virtue of the physician's failure to reveal all of the anticipated adverse side effects of such administration (*see Halloran v Kiri*, 173 AD3d 509, 510 [1st Dept 2019]; *Farkas v Saary*, 191 AD2d 178, 178-179 [1st Dept 1993]).

Nonetheless, "[i]t is well settled that lack of informed consent is a distinct cause of action requiring proof of facts not contemplated by an action based merely on allegations of negligence" (*Jolly v Russell*, 203 AD2d 527, 528 [2d Dept 1994]; *see Dodes v North Shore Univ. Hosp.*, 149 AD2d 455, 456 [2d Dept 1989]; *Culkin v Nassau Hosp. Assn.*, 143 AD2d 973, 974 [2d Dept 1988]). "In creating the cause of action, the Legislature not only established the unique factual allegations which support such a cause of action, but also established equally unique defenses to liability, and placed specific limitations on the types of cases in which the cause of action may be asserted" (*Jolly v Russell*, 203 AD2d at 528-529; *see* Public Health Law § 2805-d). Given the nature of a lack of informed consent cause of action, as well as the distinctions to be made between allegations of lack of informed consent and those pertaining to general negligence, where, as here, the original pleading did not provide the defendant with notice of the series of transactions or occurrences underpinning the lack of informed consent claim (*see* CPLR 203[f]), the court must conclude that the complaint fails to state a cause of action to recover for lack of informed consent. Consequently, any claim premised upon that theory may not be considered in this action (*see Jolly v Russell*, 203 AD2d at 529; *see also Parese v Shankman*, 300 AD2d 1087, 1088 [4th Dept 2002]; *Clark v Ferzli*, 284 AD2d 425, 425 [2d Dept 2001]; *Smith v Bessen*, 161 AD2d 847, 849 [3d Dept 1990]), and the defendant is awarded summary judgment striking that claim from the plaintiff's bill of particulars.

V. CONCLUSION

In light of the foregoing, it is

ORDERED that the defendant's motion is granted to the extent that he is awarded summary judgment striking any claim asserted by the plaintiff to recover for lack of informed consent, as set forth in the plaintiff's bill of particulars, the allegations referable to lack of informed consent are stricken from the plaintiff's bill of particulars, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

11/23/2022
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:	[ ]	CASE DISPOSED		[X]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[ ] DENIED	[X]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[ ]	REFERENCE