At an IAS Term, Part MMESP-7 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 24th day of May 2021.

P R E S E N T:
HON. PAMELA L. FISHER,
J.S.C.

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AMANDA SCOTT, as Administratrix of the Goods, Chattels and Credits of THOMAS SCOTT, JR., deceased,

Plaintiff,

DECISION/ORDER

- against -

Index No: 512549/2018

DAVID MARSH, M.D., ZLATIN IVANOV, M.D., YARA BONET-PAGAN, M.D., OSMOND QUIAH, M.D., and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.

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Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

	Papers Numbered
Notice of Motion/Cross Motion/Order to Show Cause and Affidavits (Affirmations) Annexed	1, 2
Opposing Affidavits (Affirmations)	3
Reply Affidavits (Affirmations)	4

Upon the foregoing papers in this medical malpractice action, defendants, David Marsh, M.D., Zlatin Ivanov, M.D., Osmond Quiah, M.D., and New York City Health and Hospitals Corporation, move, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff's complaint with prejudice.

Plaintiff served a Notice of Claim upon defendants on or about September 6, 2017 (Defendants' Affirmation in Support ¶ 6; Notice of Claim, annexed as Exhibit B to defendants' motion papers). Plaintiff commenced this action by filing a summons and complaint on June 18, 2018 (Summons & Complaint, annexed as Exhibit C to defendants' motion papers; Plaintiff's Affirmation in Opposition ¶ 4). By October 5, 2018, "issue had been joined as to all defendants" (Defendants'

Affirmation in Support ¶ 8; Answers annexed as Exhibit D to defendants' motion papers). Plaintiff served a bill of particulars upon defendants on or about October 30, 2018 (Defendants' Affirmation in Support ¶ 9; Bill of Particulars annexed as Exhibit E to defendants' motion papers). In her complaint and bill of particulars, plaintiff alleges that defendants departed from good and acceptable medical practice in their treatment of decedent from May 24, 2017 through June 11, 2017 by "prescribing medications which were not indicated," "prescribing and administering excessive amounts of medications and" "improper[ly] combin[ing]" them, and "failing to timely and properly diagnose and treat" decedent's condition (Complaint ¶ 29; Verified Bill of Particulars ¶¶ 1, 3). Plaintiff asserts that the combination of medications prescribed to decedent caused a "change in [his] breathing pattern and cardiac dysrhythmia," ultimately resulting in his death (*Id.*). As a result of defendants' alleged malpractice, plaintiff is claiming that decedent sustained the following injuries: "serious adverse reactions to administration of excessive, combined, contraindicated medications," "prolonged progressively increasing agitation, confusion, weakness and distress," "changes in breathing pattern," "unresponsiveness," "cardiac dysrhythmia resulting from pharmacologic therapy," "therapeutic complication," "elevated CPK levels," "unsuccessful resuscitation with parasternal fractures [of] right 5-7 ribs," "multiple contusions and abrasions," "prolonged excruciating pain, suffering, terror, torment, agony, fear and realization of his progressively deteriorating condition and impending demise, and catastrophic wrongful death" (*Id.* at ¶ 4).

The following facts are not in dispute. Plaintiff's decedent, Thomas Scott, JR., a 52-year-old autistic man, had a long history of mental illness, and had resided in institutions for the majority of his childhood and his entire adult life (Defendants' Affirmation in Support ¶¶ 3, 11). Although Mr. Scott was cognitively impaired, he was able to feed and dress himself, and use the bathroom independently (*Id.*). He was "minimally verbal," and behaved in a violent and aggressive manner on multiple occasions (*Id.*). He also had the following medical conditions: seizures, hypertension, cataracts,

GERD, and abnormal TSH (*Id.*). From 1995 to 2017, "Mr. Scott resided at Bernard Fineson Development Center (BFDC), a supportive housing facility in Queens" (*Id.*). In January 2017, plaintiff's decedent was being prescribed "Depakote 1500 mg and 250 mg at bedtime, Lithium 450 mg, and Clozapine (brand name is Clozaril) 300 mg daily and 12.5 mg at bedtime" (*Id.* at ¶ 12). In late March or early April 2017, Mr. Scott was relocated from BDFC to a "group home maintained by Services for the Underserved (S:US) located on Bushwick Avenue in Brooklyn" (*Id.* at ¶ 13). At his annual physical on April 4, 2017, it was documented that Mr. Scott had a "history of hypertension, hyperlipidemia, constipation, seizure disorder, GERD, and psychiatric illness" (*Id.* at ¶ 14; SUS Chart Excerpts, Summary View for Scott, Thomas at 1 of 2; annexed as Exhibit H to defendants' motion papers). The notes indicate that Mr. Scott was taking "Clozapine 50 mg three times daily and Lithium 150 mg once daily in the morning," for his psychiatric conditions (Defendants' Affirmation in Support ¶ 14; SUS Chart Excerpts, Summary View for Scott, Thomas at 1 of 2). Bloodwork was performed, and the EKG "revealed normal QT/QT_c of 390/441" (Defendants' Affirmation in Support ¶ 14; SUS Chart Excerpts, Summary View for Scott, Thomas at 2 of 2; EKG Report in SUS Chart Excerpts). The Clozapine dosage was increased by adding 12.5 mg before bed, and Lithium was increased to 300 mg (SUS Chart Excerpts, Summary View for Scott, Thomas at 2 of 2; Defendants' Affirmation in Support ¶ 14). On April 12, 2017, Mr. Scott was "seen for a psychiatric follow up," and the notes state that he appeared to "be presently stable on current medications" (Plaintiff's Affirmation in Opposition ¶ 8). The dosage for Clozapine was increased to 150 mg twice daily and 12.5 mg at bedtime, and the Lithium dosage was increased to 300 mg once daily and 150 mg at bedtime (*Id.*).

On April 16, 2017, Mr. Scott was transported to Woodhull Medical and Mental Health Center (Woodhull) after he hit another resident at S:US over the head with a coffee table, causing a laceration (Defendants' Affirmation in Support ¶ 16; Woodhull Chart Excepts at 4 of 172; annexed as Exhibit G to defendants' motion papers). He was admitted to Woodhull as a psychiatric inpatient from April 16,

2017 to April 26, 2017 (Defendants' Affirmation in Support ¶ 17). The attending physician was Dr. David Marsh (Woodhull Chart Excerpts at 4 of 172; Defendants' Affirmation in Support ¶ 17). The records indicate that Mr. Scott "was experiencing command hallucinations;" "he [held] his hands over his ears, and stated that voices were telling him to hurt himself and others" (*Id.*; Woodhull Chart Excerpts at 29 of 172). He was "found to have sub therapeutic Clozaril levels" (Defendants' Affirmation in Support ¶ 17). A Transthoracic Echocardiogram (TTE) was performed, "reveal[ing] mild concentric left ventricular hypertrophy with an ejection fraction of 65-70%" (*Id.*; Woodhull Chart Excerpts at HHC 148-49). The EKG showed "left atrial abnormality and nonspecific T abnormalities and QT/QT_c of 396/428, which was within normal limits" (*Id.* at HHC 199; Defendants' Affirmation in Support ¶ 17). Mr. Scott's behavior improved during the course of his admission to Woodhull, and he was discharged to S:US on April 26, 2017 with prescriptions for Clozaril 50 mg at bedtime, Prolixin 2.5 mg twice daily, Lithium 300 mg three times daily, and Depakene 1500 mg at bedtime (*Id.*; Woodhull Chart Excerpts at HHC 234-35).

On May 15, 2017, Mr. Scott presented to the psychiatric emergency room at Interfaith Hospital due to a violent outburst (Defendants' Affirmation in Support ¶ 19; Interfaith Chart Excerpts at 1 of 4; annexed as Exhibit I to defendants' motion papers). He was discharged the same day with an increase in his Clozapine dosage to 50 mg twice daily (Interfaith Chart Excerpts, Discharge Instructions). On May 24, 2017, Mr. Scott was transported to the emergency room at Woodhull for psychiatric evaluation (Defendants' Affirmation in Support ¶ 20). A S:US social worker accompanied him, reporting that plaintiff's decedent "had thrown a metal chair at a housemate, hitting her in the head causing a gash that required stitches" (*Id.*). The progress notes indicate that the decedent "demonstrated involutional and negativistic behavior, repeating the same words for every question," and a mental status exam "revealed blunted affect, irritable mood, incoherent speech, and significant cognitive impairment" (*Id.*; Woodhull Chart Excerpts at HHC 28-29). The notes document that the

staff's impression was that Mr. Scott had autism spectrum disorder and an unspecified intellectual disability (*Id.* at HHC 29; Defendants' Affirmation in Support ¶ 20). He was diagnosed with schizophrenia and admitted to the inpatient psychiatric floor for one-to-one observation and testing, including EKG, labs, urinalysis, and toxicology (*Id.*). The admitting psychiatrist wrote prescriptions for Clozapine, 50 mg at bedtime, Prolixin, 2.5 mg twice daily, Ramipril, 2.5 mg daily for hypertension, Lithium, 300 mg three times daily, and Metformin, 500 mg daily for pre-diabetes (*Id.*). The blood work indicated that Mr. Scott had sub therapeutic Clozapine, Lithium and VPA (Depakote) levels (*Id.*). During the next two weeks, Mr. Scott "was restrained and sedated on multiple occasions for aggressive behavior" (Plaintiff's Affirmation in Opposition ¶ 19). On May 31, 2017, Dr. Marsh prescribed Klonopin for agitation (Woodhull Chart Excerpts at HHC 357; Defendants' Affirmation in Support ¶ 21). On June 2, 2017, Dr. Marsh "discontinued Prolixin and started Thorazine 100 mg twice daily" (*Id.* at ¶ 22). An EKG was performed four days later on June 6, 2017 (*Id.*). The EKG "revealed left atrial abnormality and nonspecific T abnormalities;" the QT/QT_c was 368/433, which is normal (*Id.*; Woodhull Chart Excerpts at HHC 102). On June 7, 2017, Dr. Marsh wrote that the patient was in "better control" (*Id.* at HHC 388; Defendants' Affirmation in Support ¶ 23). He noted that he was increasing the Klonopin dosage to 1 mg in the morning and evening, and 2 mg twice during the day (Woodhull Chart Excerpts at HHC 388; Defendants' Affirmation in Support ¶ 23). He increased the Thorazine dosage to 100 mg every 12 hours and "every six hours for agitation as needed" (*Id.*). The "VPA blood level was therapeutic," and the Clozaril dosage was increased to 100 mg every six hours (*Id.*). Mr. Scott's CPK level was "elevated at 1650, which Dr. Marsh noted was indicative of acute inflammation probably secondary to restraints and IMs" (*Id.*). Two liters of fluids were ordered, resulting in a decrease in the CPK level (*Id.*).

On June 11, 2017, at 6:00 a.m., Mr. Scott was administered phenylephrine nasal spray (*Id.* at ¶ 24). At 7:00 a.m., he received insulin, Klonopin and Metformin (*Id.*). At 11:00 a.m., he took Ramipril,

heparin, ranitidine, Thorazine 100 mg, Klonopin 2 mg, Metoprolol, and phenylephrine nasal spray (*Id.*). His blood pressure was 118/79, and he had not been in restraints for the past two days (*Id.*). The log sheet documents that Mr. Scott was awake for 15 minutes from 11:00 to 11:15 am, and was asleep at 11:30 am, 11:45 am, 12:00 PM, and 12:15 PM (*Id.*). His respirations were 18 at each of these times, which is normal (*Id.*). Mr. Scott was found unresponsive at 12:24 PM (*Id.* at ¶ 25). The Rapid Response Team was called, and then a code blue was called one minute later (*Id.*). The staff attempted to resuscitate him, but were unsuccessful, and he was pronounced dead at 1:29 PM (*Id.*).

In support of their motion for summary judgment, defendants submit an expert affirmation from Dr. Philip R. Muskin, M.D., a physician board certified in psychiatry, contending that the treatment rendered at Woodhull "conformed in all respects to accepted medical practice," and that the decedent's injuries were not proximately caused by any act or omission of the defendants (Defendants' Expert Affirmation ¶¶ 1, 3, annexed as Exhibit A to defendants' motion papers). Dr. Muskin's opinion is based on review of the pleadings, bill of particulars, medical records, deposition testimony, and his own training and experience in the field of psychiatry (*Id.* at ¶ 4). Dr. Muskin disagrees with plaintiff's contention that Mr. Scott was misdiagnosed with schizophrenia, and overmedicated, resulting in his death (*Id.* at ¶ 46). Dr. Muskin maintains that the medications that were prescribed to Mr. Scott during his last admission to Woodhull "were appropriate in dosage, timing and duration" (*Id.* at ¶ 5). He affirms that the diagnosis of schizophrenia was appropriate given Mr. Scott's symptoms, including "his exhibiting of delusions, hearing voices, and responding to command hallucinations" (*Id.* at ¶ 47). Further, he attests that the medications, sedation and restraints were necessary based on Mr. Scott's repeated violent outbursts (*Id.* at ¶ 46). He states that Mr. Scott was being prescribed Clozaril long before he was ever admitted to Woodhull, and claims that defendants properly monitored decedent for cardiac complications from this medication (*Id.* at ¶ 48). Defendants performed "a full cardiac workup and regular blood testing" during his first admission to Woodhull, and "regular blood testing and an

EKG on June 6, 2017" during his last admission to Woodhull (*Id.*). Dr. Muskin notes that the bloodwork and QT_c were normal on June 6, 2017, indicating that Mr. Scott was not at "an elevated risk of a cardiac arrhythmia" at that time (*Id.*). Dr. Muskin suggests that the risk of developing an arrhythmia in the future was "not improbable, but was unpreventable under the circumstances" (*Id.*). He contends that the staff at Woodhull "timely and appropriately responded to Mr. Scott's cardiopulmonary arrest," based on the fact that he was on one-to-one observation when he arrested, and the documentation in the medical records indicating that the physicians were informed immediately (*Id.* at ¶ 49). Dr. Muskin opines that the staff could not resuscitate Mr. Scott despite diligent efforts, as it is "extremely difficult to resuscitate obese patients that suffer cardiac arrest" (*Id.*). He explains that in the case of an obese patient, "[c]hest compressions are unable to establish a shockable rhythm and the patient's heart cannot be restarted" (*Id.*). Dr. Muskin concludes that plaintiff's claims lack merit (*Id.* at ¶ 50).

In opposition to defendants' motion for summary judgment, plaintiff submits a redacted expert affirmation from a physician board certified in psychiatry, who opines that defendants deviated from the standard of care by "inappropriately diagnosing Mr. Scott with schizophrenia," "prescribing and administering medications which were not indicated," and "administering sedative medications despite symptoms consisting of difficulty breathing" (Plaintiff's Expert Affirmation ¶¶ 1, 57, annexed as Exhibit 1 to plaintiff's opposition papers). Plaintiff's expert opinion is based on review of the medical records, Dr. Muskin's affirmation, and deposition transcripts (*Id.* at ¶ 2). Plaintiff's expert maintains that the diagnosis of schizophrenia was inappropriate, since the decedent "had not suffered from symptoms consistent with schizophrenia" for at least six months, as required by the Diagnostic and Statistical Manual of Mental Disorders (DSM) (*Id.* at ¶¶ 9, 58). Further, even if the diagnosis of schizophrenia was correct, defendants departed from the standard of care by prescribing Clozaril, as "Clozaril is only approved for usage in patients with schizophrenia after attempting other

antipsychotics," such as Risperdal and Abilify (*Id.*). Plaintiff's psychiatrist cites to American Psychological Association (APA) treatment guidelines, which "recommend attempting two antipsychotics, such as two atypicals or one typical and one atypical, prior to declaring treatment-resistant schizophrenia for which Clozaril is needed" (*Id.*). He/she criticizes Dr. Marsh's decision to administer Clozaril at a subtherapeutic level, since it "produced sedative and respiratory suppressive side effects without the benefits of the medication" (*Id.*). Plaintiff's expert also claims that defendants deviated from acceptable medical practice by prescribing too many antipsychotic drugs (Clozapine, Thorazine, Haldol, and Geodon) and benzodiazepines (Klonopin, Ativan) at one time, increasing the likelihood that decedent would suffer from respiratory distress and cardiac dysrhythmia (*Id.* at ¶¶ 58, 60). He/she affirms that it would have been safer to treat decedent only with Clozaril rather than using multiple medications at one time (*Id.* at ¶ 58). The psychiatrist contends that defendants negligently prescribed phenylephrine with metoprolol, a beta blocker, making Mr. Scott more susceptible to "constriction of [his] blood vessels and an increase in blood pressure" (*Id.* at ¶ 59). Further, he/she states that a "hold for sedation" order "should have been placed on all standing sedative medications including Thorazine, Klonapin, and Clozapine," since Mr. Scott was at an increased risk for respiratory distress and had poor communication skills (*Id.* at ¶ 60). Plaintiff's expert suggests that Mr. Scott should have been treated with Risperdal and Abilify for his condition of "irritability in autism," and that defendants deviated from the standard of care by not trying behavioral interventions, such as music therapy before administering benzodiazepines and antipsychotics (*Id.* at ¶¶ 61, 63). He/she concludes that Mr. Scott's death could have been prevented had defendants diagnosed him appropriately and given him the proper medications (*Id.* at ¶ 64).

In reply, defendants reiterate that they did not deviate from the standard of care in their treatment of Mr. Scott, and that no act or omission on their part proximately caused his injuries and death (Defendants' Reply Affirmation ¶ 3). Defendants argue that plaintiff's complaint should be

dismissed against Dr. Quiah and Dr. Ivanov, as plaintiff's expert opinion did not include any specific allegations that these physicians departed from the standard of care (*Id.* at ¶ 4). Defendants claim that plaintiff's expert opinion is "speculative, conclusory, contradictory, and not based on evidence in the record" (*Id.* at ¶ 5). Specifically, defendants contend that their decision to diagnose Mr. Scott with schizophrenia is immaterial, as both Dr. Marsh and Dr. Muskin have established that the treatment would have been the same regardless of the diagnosis (*Id.* at ¶ 6). Further, defendants indicate that plaintiff's expert opinion fails to account for certain facts, including that Mr. Scott had been taking Clozaril for many years before he was admitted to Woodhull, and defendants were increasing the Clozaril dosage to "obtain therapeutic blood levels" (*Id.* at ¶¶ 7-8). Defendants maintain that plaintiff's references to APA guidelines, the DSM, and "FDA black box warnings" are insufficient to demonstrate that defendants deviated from the standard of care, since plaintiff's expert has failed "to establish how this hearsay evidence impacted the treatment in this case, and how and why these guidelines/diagnostic manuals/federal regulations influence the standard of care" (*Id.* at ¶ 5). Defendants suggest that the combination of medications and sedation/restraints were necessary due to decedent's violent behavior, and allege that prescribing a drug for an "off-label use" "is not evidence of malpractice" (*Id.* at ¶¶ 8, 9).

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant "deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v. Streiter*, 83 AD3d 18, 23 [2d. Dept. 2011]). On a motion for summary judgment, defendant must "make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Iulo v. Staten Is. Univ. Hosp.*, 106 AD3d 696, 697 [2d. Dept. 2013]). Once the defendant meets its burden, the burden then shifts to the plaintiff to "raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing"

(*Stukas*, 83 AD3d at 24). If the defendant "makes only a prima facie showing that he or she did not deviate or depart from accepted medical practice, the plaintiff, in order to defeat summary judgment, need only raise a triable issue of fact as to the alleged deviation or departure, and need not address the issue of proximate cause" (*Hayden v. Gordon*, 91 AD3d 819, 821 [2d. Dept. 2012]). Conclusory allegations that are "unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat defendant physician's summary judgment motion" (*Deutsch v. Chaglassian*, 71 AD3d 718, 719 [2d. Dept. 2010]). Where the parties have submitted conflicting expert reports, summary judgment should not be granted; "[s]uch credibility issues can only be resolved by a jury" (*Id.*).

Here, defendants met their prima facie burden. Defendants' expert, Dr. Muskin, affirmed that the practice and procedures by the treating physicians were within acceptable standards of medical practice, and that no act or omission of defendants proximately caused any injury to the decedent. Dr. Muskin described and explained the significance of the tests that were performed to monitor the decedent for cardiac complications, and opined that Mr. Scott's cardiac arrythmia was "unpreventable under the circumstances" (Defendants' Expert Affirmation ¶ 48). Dr. Muskin's affirmation constitutes competent evidence, in that it is based on the pleadings, bill of particulars, medical records, deposition testimony, and his own training and experience.

In opposition, plaintiff produced an affidavit of merit from a board-certified psychiatrist attesting to departures from accepted standards of medical practice, and that these departures were a competent producing cause of the decedent's injuries. Plaintiff's expert opinion, based on review of the medical records, Dr. Muskin's affirmation, and deposition transcripts, raises triable issues of fact. Due to the conflicting expert reports, defendants' motion for summary judgment is denied (*See Deutsch*, 71 AD3d at 719).

This constitutes the decision and order of the Court.

ENTER,

Hon. Pamela L. Fisher, J.S.C.