DEFENSE PRACTICE UPDATE

MARTIN CLEARWATER & BELL LLP

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Understanding Telehealth and Related Medical Malpractice Considerations in a COVID-19 World

By: Rosaleen T. McCrory and Michelle A. Frankel

The use of technology in daily life has exponentially increased in recent decades and has been increasingly incorporated in healthcare. Developments in technology and artificial intelligence continue to change the practice of medicine and increase the use of "telehealth," defined as "the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient" under NY Public Health Law Section 2999-CC.[1] Telehealth represents a broad group of modalities to provide healthcare services from afar but is merely a progression of older concepts such as the use of on-call beepers and telephonic systems to communicate with patients outside of typical business hours. The development of video technology has enhanced the ability of medical providers to assess and treat patients from afar. The mandated use of electronic medical records (EMR) pushed the healthcare system into a new era of documentation and communication that can be shared more efficiently and effectively. Most recently, the COVID-19 pandemic thrust the healthcare system to quickly incorporate and rely on telehealth more than ever. It is likely

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1. *New York Consolidated Laws, Public Health Law* § 2999-cc, Definitions, *available at* https://codes.findlaw.com/ny/public-health-law/pbh-sect-2999-cc.html.

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that the increased acceptance and use of telehealth will remain after the pandemic subsides. It is therefore important for medical providers to understand what constitutes telehealth, how it may be used and consider associated medical malpractice risks.

Telemedicine refers to the use of "two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site."[2] This is the most well-known concept of telehealth and involves presenting to a physician without leaving one's home, for instance, by logging into a secure video conferencing system and relaying complaints virtually. This has obvious convenience and safety benefits but has been slow to be extensively implemented. Elderly patients may have difficulty accessing telehealth technology but could benefit from the convenience of not having to travel to the doctor. They could also benefit from the reduced risk of falling in transit or otherwise contracting an illness via public exposure. Patients with chronic medical conditions could yield similar benefits. Younger populations have been more enthusiastic about the ability to squeeze in a virtual appointment at their convenience and are less likely to need in-person examinations given their general good health. Until the pandemic, telehealth was most ideal for routine checkups and prescription refills or orders—needs which could be met from afar with limited risk to the patient.

When engaging in telehealth services, medical providers must be cognizant of where the patient is located (to ensure that he/she, the provider, is licensed and certified to treat the patient) and ensure adherence with all applicable standards of care.

The pandemic changed the landscape for all population groups and made it more beneficial for as many patients as possible to engage in telehealth. More than ever, telehealth is a favorable alternative to presenting to a doctor's office or the emergency room.

When engaging in telehealth services, medical providers must be cognizant of where the patient is located (to ensure that he/she, the provider, is licensed and certified to treat the patient) and ensure adherence with all applicable standards of care. Traditionally, a physician must be licensed in the state where the patient is located when services are rendered. Changes to interstate licensing have been developing state-by-state to ease the practice of medicine across state lines. The Interstate Medical Licensure Compact (the Compact) is assisting states[3] in this regard by streamlining licensing procedures for physicians who want to practice in multiple states. The Federation of State Medical Boards (a group of state medical board executives, administrators and attorneys) developed the Compact around 2014. One function of the Compact is to enable a state in which a physician is already licensed to share previously submitted information with a state where he/she seeks to become licensed. Each state may choose to join the Compact by enacting its own bill authorizing its participation and developing consistent policies. The Compact leaves state medical boards in charge of regulating providers in their states. New York (NY) introduced a bill to the state Senate on February 11, 2020[4] to allow NY to become a member of the Compact and amend the Education Law to include the streamlined provisions of the Compact to make it easier to become licensed in other states. It is unclear at this time if NY will pass and enact the bill, and until then NY physicians should adhere to ensuring that they are licensed where their remote patients are located.

Organizations such as the American Medical Association have developed informational resources for the implementation of telehealth.[5] While this guidance can be practical and helpful, the way that patient care may play out from a safety and legal perspective is ever-changing, especially as telehealth becomes more widely used at this time. Therefore, it is important to defer to the tried and true standards of a specific medical specialty and critically assess if and when a follow-up examination in person is necessary, for example, or consultation with a specialist or presentation to the hospital.

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2. *Id.* Notably, in NY, telehealth "shall not include the delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology or remote patient monitoring."
3. *Interstate Medical Licensure Compact*, Introduction, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/#WhoDevelopedTheCompact.
4. *Senate Bill S7732*, THE NEW YORK STATE SENATE, https://www.nysenate.gov/legislation/bills/2019/S7732.
5. *AMA Telehealth quick guide*, AMA, updated June 22, 2020, https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice.

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Documentation (whether written and/or video recorded) will be critical to the defense of medical malpractice claims that may arise months or years later. A patient's complaints, the sound of his/her voice and the way he/she appears may be worthy of documenting in detail. It may be similarly helpful to correlate relevant visualized or audible details to the medical decisions. Notably, the physician should verbally confirm with the patient whether the interaction is being recorded and document the response. Physicians engaging in telehealth may want to be mindful of best practices and only refill medications, for instance, once via telemedicine visit and then require an in-person physical exam. This practice may improve patient safety and reduce the risk of complications. It may be beneficial to follow office practices such as incorporating multiple levels of care in a single patient presentation. For example, a telemedicine presentation may include an initial assessment by a nurse and then an evaluation and assessment by a physician. Engaging in the presentation as similarly as possible to a typical in-person office visit may help ensure a proper diagnosis and yield a stronger defense since two qualified professionals were involved.

Insurance carriers may also question medical judgments when determining if telehealth visits should be covered. Whether patient visits are covered depends on specific health insurance policies and programs. Federal and state regulations must be followed to ensure proper cybersecurity and the protection of patient health information. The Telehealth Parity Law became effective in NY on January 1, 2016 to require commercial insurers and Medicaid to reimburse telehealth services if the services would have been covered during an in-person presentation. There were some restrictions and reimbursement issues under this law, which limited its use. Given this and the realities of the pandemic, on March 7, 2020, NY Governor Andrew Cuomo issued Executive Order No. 202, which declared a disaster emergency in the State of New York.[6] Certain provisions expired on April 6, 2020 but the Order remains in effect until September 7, 2020 and may again be extended. Governor Cuomo adopted an emergency regulation on March 14, 2020 that the Department of Financial Services (DFS) must require insurance companies to waive co-pays for telehealth visits, whether or not related to coronavirus (COVID-19).[7] This regulatory action was taken to encourage New Yorkers to seek medical attention from their homes and reduce the spread of COVID-19 as well as the strain on the healthcare system. The NY State Department of Health (DOH) similarly expanded Medicaid coverage to reimburse telehealth evaluations and services for established patients for whom face-to-face presentations may not be recommended.[8] The expansions and changes to such coverage continue to be changed and updated with the continued goal of facilitating "access to services through telemedicine and telephonic means where necessary" by relaxing some rules about the "types of clinicians, facilities, and services eligible for billing under telehealth rules."[9] These types of changes are supposed to remain in effect for the remainder of the disaster emergency declared by Executive Order No. 202 or until other subsequent guidance by the DOH is issued.[10] The extent to which such changes will be extended and/or made permanent remains to be seen.

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The use of telehealth and artificial intelligence technology has also been recognized for enhancing physicians' ability to understand patients' medical

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6. Executive Order No. 202, Declaring a Disaster Emergency in the State of New York, *available at* https://www.governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york.
7. *Department of Financial Services Adopts New Emergency Regulation Requiring Insurance Companies to Waive Cost-Sharing for In-Network Telehealth Visits*, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, Press Release, March 17, 2020, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr20203171.
8. *2020 DOH Medicaid Updates – Volume 36*, NEW YORK STATE DEPARTMENT OF HEALTH, *available at* https://www.health.ny.gov/health_care/medicaid/program/update/2020/index.htm.
9. *Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-19 State of Emergency*, MEDICAID UPDATE, Volume 36, Number 9, May 1, 2020, *available at* https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no05_2020-03-21_covid-19_telehealth.pdf.
10. *Id*.

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conditions and enable second opinions (whether by other experts near or far, or via computer programs that can make their own assessments). Physicians may be able to assess patients with less routine complaints and conditions from afar with the assistance of "store and focus technology", which refers to the electronic transmission of "digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site."[11] Remote patient monitoring may also be used to assess on-going conditions and collect related personal health information and data to facilitate providers understanding of patient ailments and alter treatment recommendations as necessary. Remote cardiac monitoring has been in use for some time and tracking technology designed by companies such as Apple, Google and/or Microsoft may be useful. However, since the reliability of such technology is far from perfect at this time, medical providers must be aware of its drawbacks, especially since the providers face potential legal exposure for any related poor outcomes.

Moreover, smart watches, Fitbits and other monitors that claim to be able to detect irregular heartbeats and blood sugar levels may not be reliable at this time. If patients choose to use such technologies and share their results with physicians, the patient should be informed about potential drawbacks including possible inaccuracies. Physicians should be careful not to offer to review or rely on the data collected. The latter could unintentionally create new duties for the physician and create new areas of medical malpractice risk.

Nonetheless, there may be subtle benefits to some patients using health tracking devices or applications. Menstrual cycle tracking applications, for instance, may help patients more easily monitor changes and patterns with limited risk to the patient. Physicians may consider this information when making medical decisions, but if relied on, the information should be well documented along with other history and information shared. Patients should be well informed about the types of situations and changes in symptoms that may warrant evaluation by a physician. Similarly, fitness tracking applications pose little risk to patients (medically cleared to engage in exercise) and general information about changes in a patient's weight and level of physical engagement may be helpful to physicians when assessing a patient's overall health condition. Physicians should once again document any such information shared with them. This type of information may be relevant to medical malpractice litigation because it may discredit a plaintiff/patient's claims that he/she cannot engage in physical activity meanwhile he/she reported or was tracked running five miles per day.

The healthcare arena is ever changing with continued advances in technology and while they can be beneficial, it is imperative for medical providers to be cognizant of current standards of care and embrace telehealth developments with caution and proper knowledge. Medical providers can best safeguard themselves by being well informed and documenting their sources of information and other factors contributing to their medical judgments. ■

Rosaleen T. McCrory is a Senior Trial Partner with over 25 years of experience at the Firm. Her legal practice primarily encompasses medical malpractice defense and nursing home litigation in which she defends individual doctors, nurses, aides and technicians, along with hospitals, nursing homes and dialysis centers in professional liability matters.

Michelle A. Frankel is an Associate at Martin Clearwater & Bell LLP. Her practice encompasses all areas of medical malpractice, dental malpractice, podiatric malpractice, nursing home defense, general liability and professional liability.

11. *New York Consolidated Laws, Public Health Law* § 2999-cc, Definitions, *available at* https://codes.findlaw.com/ny/public-health-law/pbh-sect-2999-cc.html.

The Evolution of NYS DOH Guidelines/ Regulations Amid the COVID-19 Pandemic and its Impact Upon the Inevitable Litigation Against Nursing Homes

By: Yuko A. Nakahara and Karen B. Corbett

As our knowledge and understanding of COVID-19 and its reach on society continues to grow, we are able to see an evolution of orders, regulations, guidelines and/or advisories issued in New York: starting with Executive Order 202[1] by Governor Andrew M. Cuomo ("the Governor") on March 7, 2020, in which he declared a Disaster Emergency in the State of New York in response to the threat of COVID-19. The issuance of further orders, regulations, guidelines and/or advisories thereafter followed by the Governor, as well as the New York State Department of Health ("NYS DOH") and the New York State Senate – including those directed towards healthcare providers, in their dealings with this global pandemic.

Recognizing early on, and even still, that the elderly are among those at highest risk for death with the spread of COVID-19, NYS DOH issued a guidance letter[2] to all nursing homes in the State, as early as March 11, 2020 (i.e. prior to the State-wide mandatory closure of all non-essential businesses). The guidance letter included basic information concerning symptoms of COVID-19, as well as mandatory measures to prevent the exposure and spread of the disease. One such measure required the nursing homes to screen visitors for, and perhaps restrict visitation based upon, their symptoms and potential exposure to COVID-19. Other mandates addressed issues including staff screening, the use of personal protective equipment ("PPE") and the handling of residents and/or staff suspected of having COVID-19. Significantly, the letter did not set forth any guidance as to resident and/or staff testing for the virus, and further, it set forth a focus on the conservation of PPE, by not requiring *all* staff to wear the most basic PPE, a face mask, unless they were within 6 feet of a resident. The letter was also worded in such a way as to lead the facility to reasonably believe that a resident would be transferred upon a confirmed and/or suspected diagnosis of COVID-19, by language such as "[w]hile awaiting transfer …" and "… until they are transferred."

Just 2 days later, on March 13, 2020, the NYS DOH issued a "Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities,"[3] which was distributed to all nursing homes and adult care facilities. Significantly, this advisory substantively changed some of the directives set forth in the March 11, 2020 guidance letter – including, now, a complete prohibition of visitation except when medically necessary, or to family members of residents in "imminent end-of-life situations." It further expanded upon the prior directives concerning the use of PPE, as well as staff screening, staff/resident assignment and the handling of residents and/or staff confirmed or suspected of having COVID-19. While the advisory no longer set forth an expectation that a resident would be transferred if confirmed or suspected of having COVID-19, it continued to focus on the need for conservation of PPE and it made no recommendations for testing – other than performing basic screening which merely called for taking a resident and/or staff member's temperature and asking questions concerning their symptoms and exposure. On March 21, 2020, the NYS DOH issued a "Health Advisory: Respiratory Illness in Nursing Homes and Adult Care Facilities in Areas of Sustained Community Transmission of COVID-19." This advisory expanded upon the scope of what is to be considered "presumed" COVID-19 and how to proceed relative to testing and infection control.

The most controversial of these directives is the mandate that a long-term care facility had to readmit residents with a confirmed COVID-19 diagnosis. On March 25, 2020, "Advisory: Hospital Discharges and Admissions to Nursing Homes," in its relevant part, provided that "[n]o resident shall be denied re-admission or admission to the [nursing home] solely based on a confirmed or suspected diagnosis of COVID-19. [Nursing Homes] are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or

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1. https://www.governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york.
2. https://www.health.ny.gov/professionals/nursing_home_administrator/dal/docs/dal_nh_20-04.pdf.
3. https://coronavirus.health.ny.gov/protecting-public-health-all-new-yorkers.

THE EVOLUTION OF NYS DOH GUIDELINES/REGULATIONS

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readmission" [emphasis added]. Compliance with this regulation made contamination unavoidable in most long-term care facilities. Even though the COVID-19 positive patients coming back from the hospital were reportedly stable, there was no way to know what the impact of these readmissions would be. And, it was not until May 10, 2020, the Governor announced the reversal of the March 25, 2020 advisory – now prohibiting a hospital to discharge a patient to a nursing home unless they test for the virus and are confirmed to be negative. See Executive Order 202.30.[4]

Importantly, nursing homes are required to follow the ever changing and evolving guidelines and advisories, with noted consequences for non-compliance. The new mandates must be followed while continuing to comply with the long-standing State and Federal regulations protecting residents' rights which come with their own noted consequences for non-compliance. And despite compliance with the rules, the as of the date this article is being written, over 20,000 nursing home residents and employees have died from COVID-19. Families are angry about the loss of their loved ones which is compounded by not having been able to see them for the duration of the lock down leading up to it. It is anticipated that a major uptick in civil nursing home litigation is on the horizon.

In view of the challenges of limited space, equipment and other resources that the healthcare providers had been facing, on March 23, 2020, the Governor issued Executive Order 202.10,[5] granting immunity (from civil liability) to "all physicians, physician assistants, specialist assistants, nurse practitioners, licensed registered professional nurses and licensed practical nurses… for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the State's response to the COVID-19 outbreak, unless it is established that such injury or death was caused by the gross negligence[6] of such medical professional." This Order has been codified by the Senate resulting in an amendment of the NY Public Health Law to include Article 30-D, which extended the immunity to all health care professionals and facilities – including nursing homes.[7] See NY PHL §§3080 – 3082 (i.e. the Emergency Disaster Treatment Protection Act).[8]

While the Governor's Executive Order (202.10) and amendments to the Public Health Law were certainly intended to ease the burden (by creating an immunity against civil liability) on the healthcare providers who, in good faith, are treating their patients (with, or without COVID-19), all while maneuvering the challenges of this new/novel disease – increased litigation against them, and specifically, against nursing homes, is inevitable. As a result, plaintiffs will have an increased burden to show gross negligence, recklessness and/or intentional misconduct on the part of the nursing homes to recover in nursing home cases where the care in question was during the pandemic.

However, it is anticipated that there may be claims involving the violation of COVID-negative residents' rights to various therapies (which may have then resulted in a decline of their overall condition), the increased exposure to COVID-19 and the ramifications of same, and the actual exposure, pain and suffering and perhaps death due to COVID-19.

With the above, it would be prudent upon the nursing homes to gather and organize their potential defenses amid the pandemic – to be able to systematically demonstrate that their efforts to comply with the then prevailing requirements/directives were reasonable and appropriate such that they should be deemed immune from civil liability. ■

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Karen B. Corbett is a Partner at Martin Clearwater & Bell LLP. Her practice encompasses all areas of medical malpractice, dental malpractice, podiatric malpractice, nursing home defense, general liability and professional liability.

4. https://www.governor.ny.gov/news/no-20230-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency.
5. https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency.
6. The immunity further does not apply to, among other things, willful or intentional criminal conduct, reckless misconduct and/or intentional infliction of harm.
7. The effective date(s) for the immunity is: March 7, 2020 to the end of the COVID-19 Emergency Declaration.
8. https://www.nysenate.gov/legislation/laws/PBH/A30-D.

Labor & Employment Focus

Legal Alert: Reopening the Right Way

By: Valerie K. Ferrier

With all regions of New York State having entered Phase IV of reopening, businesses have a lot to think about. Knowledge of the latest legal guidance, communication, and flexibility will be the keys to success.

Legal Guidance

Constantly changing information from an alphabet soup of federal agencies (CDC, OSHA, DOL, EEOC, among others) and state and local health officials presents a challenge. Employers need to be sure that they reopen in compliance with the latest public health information, both to ensure the safety of their workers and customers, and also to give a sense of security and comfort to people who may have concerns about physically returning to the business. Businesses also need to avoid exposing themselves to liability in the way they bring employees back to work.

Communication

Businesses should communicate their reopening plans to employees clearly, and with as much advanced notice as possible to enable their workers to make the plans that will be necessary to shift back to in-person work. Explain what you will do to help keep everyone safe. Be direct about what employees must do to help protect their colleagues. And be honest about what is still unknown. A well-crafted reopening statement, containing new policies, will make sure everyone is on the same page.

Flexibility

The workplace is very different than it was four months ago. No one knows what course the pandemic may take. Employees may have personal, health, or child care needs that prevent them from returning to in-person work. Employers should work with their employees to come up with solutions that accommodate individual circumstances as much as possible. This is not the time to enforce blanket policies for the sake of consistency.

Consulting with an employment lawyer can help businesses reopen the right way, ensuring safety, and avoiding lawsuits. Call Valerie K. Ferrier, Partner and head of MCB's Labor & Employment Practice Group, to get help with your reopening plan.

Valerie K. Ferrier is a Partner and the Head of Martin Clearwater & Bell LLP's Labor & Employment Practice Group. Ms. Ferrier is an experienced litigator and counselor who has been practicing in the field for over 12 years, including the healthcare, hospitality, staffing and retail industries.

What To Do When the Mental Capacity of a Party is In Question

By: Karen B. Corbett and Gregory A. Cascino

Sometimes, in the course of discovery, an issue concerning the mental capacity of a party may arise. While attorneys are not qualified to diagnose mental illness or to assess the mental capacity of either their client or any other party, it is important for lawyers to be aware of the parties' mental well-being since that may give rise to ethical and/or procedural issues. The Rules of Professional Conduct, statutes, and case law provide attorneys with guidance in navigating the representation of a potentially mentally diminished client. However, even when it is the adverse party's mental capacity which is in question; it is also in the best interests of your own client to take action to get a guardian ad litem appointed. This is because whether the attorney is prosecuting or defending an action, the adverse party's statements and testimony will be a critical part of the case, and is best addressed early on.

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WHEN THE MENTAL CAPACITY OF A PARTY IS IN QUESTION

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In New York, there are two avenues that can be taken to get a guardian ad litem appointed for a party litigant. An Article 81 Guardianship proceeding can be commenced to have a party declared judicially incompetent. An Article 81 guardianship proceeding is typically brought by a family member on behalf of an adult family member who has lost legal capacity to handle their medical and/or financial decisions due to a mental defect or due to a medical condition. An Article 81 proceeding is lengthy and can be expensive. Alternatively, there is a quicker and more streamlined option pursuant to New York Civil Practice Law and Rules (CPLR) §1201 for the appointment of a guardian ad litem to represent the party within the context of an individual lawsuit only. CPLR §1201 provides that a person shall appear by a guardian ad litem if "he is an adult incapable of adequately prosecuting or defending his rights." Courts have specifically held that this criteria is met where a party is in a coma;[1] suffering from dementia;[2] diagnosed with Down's Syndrome;[3] confined to a mental health institution;[4] suffering from physical impairments including a brain injury;[5] and suffering from a mental illness that severely impacts their insight and judgment and causes them to act in a self-destructive manner.[6]

CPLR §321 provides that persons who are deemed to be incapacitated under CPLR §1201 are precluded from appearing in civil actions by an attorney, rather they may only appear by their guardian. CPLR § 1201 provides that a guardian ad litem may be appointed by the court in which the action is tried at any stage of the proceeding upon the court's own initiative or the initiative of the party themselves, a relative, friend, or guardian, or any other party to the action. When the party whose capacity is in question is your own client, the attorney has an ethical obligation to take action to have a guardian ad litem appointed for them. New York Rule of Professional Discipline 1.14 directs an attorney who believes their own client has diminished capacity and is at risk for substantial physical, financial or other harm unless action is taken and they cannot adequately act in their own interest must move to appoint a guardian ad litem.

When the party whose capacity is in question is your own client, the attorney has an ethical obligation to take action to have a guardian ad litem appointed for them.

When the party whose capacity is in question is your adversary, you need to ensure a guardian ad litem is appointed for the adverse party since if you do not do so, you may be effectively deprived of any meaningful discovery. This is because a party whose capacity is at issue cannot testify. Additionally, any authorizations signed by a party without capacity are null and void. Further, without a guardian appointed, there is no way the party could agree to resolve the case by settlement, and any settlement or judgment remains vulnerable to attack.[7]

Attorneys who litigate on behalf of nursing homes and other medical professionals are often advised by their clients when they believe an adult defendant is incapable of defending him or herself in the litigation. The courts have held that when a party's de facto incapacity is perceived, an interested person should apply for appointment of a guardian ad litem. If this is the case, the attorney should make a motion to stay the action until a guardian can be appointed for the adverse party. An attorney for the nursing home or medical malpractice defendant has standing to make the motion, and should do so both to protect their own client's interests and to ensure the adverse party can adequately prosecute or defend his or her rights. ■

Karen B. Corbett is a Partner at Martin Clearwater & Bell LLP. Her practice encompasses all areas of medical malpractice, dental malpractice, podiatric malpractice, nursing home defense, general liability and professional liability.

Gregory A. Cascino is Of Counsel and a member of the Firm's Appellate Practice Group. He works on appellate matters involving all of the Firm's practice areas including medical malpractice, general liability and healthcare law.

1. *Weldon v. Long Island College Hospital*, 142 Misc.2d 61 (Kings Supreme 1988).
2. *Renton v Kirby*, 88 A.D.2d 979 (2d Dep't. 1982).
3. *Kushner v. Mollin*, 144 A.D.2d 649, (2nd Dep't 1988).
4. *Safarty v. Safarty*, 83 A.D.2d 748 (4th Dep't. 1981).
5. *Carrasqillo v. Holliswood*, 37 A.D.3d 509 (2d Dep't 2007).
6. *Shad v. Shad*, 167 A.D.2d 532 (2d Dep't 1990).
7. *See Mohrmann v. Lynch-Mohrmann*, 24 A.D.3d 735 (2d Dep't 2005).

MCB CASE RESULTS

January 2020: Summary Judgment Granted in Guillain-Barré Syndrome Case

Senior Partner William P. Brady obtained a dismissal on a summary judgment motion, or in the alternative, for a Frye hearing in a case involving a plaintiff with Guillain-Barré syndrome (GBS). The plaintiff alleged that our client doctor delayed the diagnosis and treatment by 24-36 hours. The Court found that our client doctor established that earlier diagnosis and treatment would not have changed the outcome. It was noted that plaintiff's Neurology expert disagreed and opined that the delay resulted in a substantial contribution to plaintiff's injuries. The Judge wrote that while conflicting expert opinions normally result in credibility determination to be decided at trial, in this case plaintiffs' expert failed to support his conclusions through competent medical literature. Further, the Judge concluded that although Courts have allowed issues of causation to be determined by a jury even where an expert cannot quantify the extent to which a defendant's conduct diminished the chances of a better outcome, those cases involve theories or opinions, unlike here, where the defendants opinion was supported by the medical literature. Accordingly, our motion for summary judgment was granted and the case dismissed, as plaintiff's Neurology expert failed to raise triable issues of fact in response to the motion.

January 2020: Summary Judgment Granted in Claimed Botched Hysterectomy - Suffolk County Supreme Court

Senior Partner Daniel L. Freidlin was granted summary judgment for our client obstetrician/gynecologists in Suffolk County Supreme Court. Plaintiff alleged that our three defendant obstetrician/gynecologists negligently performed a hysterectomy and then failed to diagnose a vesicovaginal fistula postoperatively. After conservative treatment with a pessary failed, plaintiff consented to undergo a vaginal hysterectomy as definitive treatment for a complete uterine prolapse. Plaintiff developed urinary incontinence over 4 1/2 months after the surgery and was diagnosed with a vesicovaginal fistula which she claimed was due to negligent intraoperative technique.

In our summary judgment motion, we established that the surgical technique utilized during the surgery was appropriate and that there was no evidence of an intraoperative injury. We argued that vesicovaginal fistula is a known complication of surgery, and that the injury could not have been caused intraoperatively as the plaintiff had multiple normal examinations over the 4 1/2 months before the injury presented. In granting our motion and dismissing the case, the Court agreed with our position that the plaintiff's opposition and expert's opinion was speculative and unsupported by the evidence.

February 2020: MCB Labor & Employment Result: Doctor's Three Discrimination Claims Against Hospital Dismissed

Head of MCB Labor & Employment practice, Partner Valerie K. Ferrier, obtained a favorable result for our client hospital in Queens County. MCB moved to dismiss this action involving three claims of age discrimination by a retired doctor, based on a signed release of all such claims, as well as a claim for breach of contract, and for an award of attorney's fees, pursuant to the release. In opposition, the doctor argued that he never signed a release, only a three page "agreement," which he annexed to the opposition. The three pages were, in fact, pages numbered 1, 2, and 7 of the release.

The court declined to dismiss the breach of contract claim, but dismissed all the three discrimination claims. The court held that "[W]hat plaintiff seeks in this instance is an implausible finding that an educated doctor, such as plaintiff, would sign a contract that, facially, was missing four out of seven pages. 'A plaintiff is expected to exercise ordinary diligence and may not claim to have reasonably relied on a defendant's representations where he has means available to him of knowing, by the exercise of ordinary intelligence, the truth or the real quality of the subject of the representation.'" The court held that the plaintiff failed to show there was fraud, duress or other facts sufficient to void the release.

Further, the court held that the hospital is entitled to its attorney fees under the release, but that it was premature to determine the amount of fees owed by the doctor at this stage of the proceedings.

February 2020: MCB Successfully Blocks Plaintiff's Motion for Summary Judgment

Partner Gregory J. Radomisli and Associates Emma B. Glazer and Yusuf Sattar successfully blocked plaintiff's motion for partial summary judgment in Kings County.

In this case, it was alleged that the defendant physician misdiagnosed the plaintiff as suffering from ADHD, and that he therefore improperly prescribed a the Schedule II drug Methylphenidate, a/k/a Ritalin. Plaintiff also alleged that the physician prescribed Ritalin in excessive doses, causing the plaintiff to become addicted. Plaintiff claims that he lost his job and his marriage, and incurred physical injuries, as a result of his addiction.

Plaintiff's counsel moved for partial summary judgment, arguing that the Court should find that the defendant physician was negligent per se because he violated Section 3332 of the New York Public Health Law, which allegedly imposed a duty upon him not to write a new

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CASE RESULTS

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prescription if the patient had more than a 23-day supply of medication remaining from the prior prescription. MCB argued, among other things, that Section 3332 of the Public Health Law did not create a private right of action and, as such, plaintiff could not bring a negligence per se claim based upon the alleged violation of the statute. The Court agreed with our arguments and denied plaintiff counsel's motion for partial summary judgment.

March 2020: Defense Verdict in Crush Injury Victim Claims Rehabilitation Doctor Caused Injury

MCB Partner Jayne L. Brayer, Esq. assisted by Partner Aryeh S. Klonsky, Esq. obtained a unanimous defense verdict on all questions of liability in a case involving a crush injury victim in Richmond Supreme Court.

The 46-year-old female plaintiff was struck by a motor vehicle while walking in a parking lot, pinning her between two cars. She was diagnosed with a large closed hematoma, status post crush injury, and was admitted to the hospital for inpatient care. The plaintiff developed blisters over the area of the closed hematoma which were left open to the air. A week later the plaintiff was medically cleared and transferred to inpatient rehabilitation under the care of our client, an attending rehabilitation medicine physician. During her rehabilitation stay, the plaintiff's blisters ruptured and were treated with daily dressing changes, sterile saline and bacitracin. The plaintiff was discharged with a referral for visiting nurses for daily wound care.

Plaintiff claimed that our client failed to recognize signs and symptoms of infection prior to discharging the plaintiff, resulting in sepsis four days after discharge. Damages claimed included subsequent debridement and skin graft surgeries as well as nerve and tissue damage. The Defense successfully argued that the plaintiff did not have an infection at the time of discharge and the infection resulted from her dressing change at home, two days after discharge. Further, a blood culture taken at the time of the subsequent debridement surgery revealed that the plaintiff had a Group B *Streptococcus* infection, the symptoms of which would manifest within 36 hours of exposure. Using the culture's result, the defense successfully argued that the plaintiff's infection began two days after discharge and not while under the care of our rehabilitation physician.

April 2020: Dismissal of Abdominal Perforation Case: Tackling Overbroad Bills of Particulars and Circumstantial Evidence

MCB Senior Partner, Anthony M. Sola, and Associates, Amy E. Korn and Alexander C. Cooper, recently obtained dismissal of all claims against our hospital and gastroenterologist in a wrongful death case involving a patient with inoperable pancreatic cancer. The decedent was admitted with severe abdominal pain. She was prepped and intubated for an ERCP, but prior to inserting the scope, a scout film revealed free air under the diaphragm and our gastroenterologist decided to abort the procedure.

Plaintiffs' alleged a failure to diagnose a pre-existing perforation and document the time of the scout film. Plaintiffs questioned whether the scout film occurred before the ERCP and claimed res ipsa loquitur.

MCB moved for summary judgment contending that, prior to the ERCP, the decedent's diagnostic imaging studies revealed no evidence of an abdominal perforation and an ERCP was appropriately recommended to potentially treat the decedent's abdominal pain. In addition, the scout film occurred before the ERCP and any failure to record the time of the film did not proximately cause any injury to the decedent. Furthermore, the decedent's abdominal perforation was not caused by intubation.

An intra-abdominal perforation can and does usually occur in the absence of negligence and, in our case, could have been induced by the decedent's chemotherapy or tumor burden on adjacent abdominal structures.

Plaintiff voluntarily dismissed all claims against the Hospital and our gastroenterologist.

April 2020: Summary Judgment Motion Forces Plaintiff to Discontinue Case

Partner Christopher A. Terzian obtained a discontinuance for our clients in this diagnostic septic shock matter in Supreme Court, Ontario County. In this matter, the plaintiff alleged the defendant physician's assistant and clinic failed to diagnose septic shock in an elderly patient the day before she died. Our summary judgment motion on behalf of our clients was supported by affidavits of two experts who refuted 23 allegations of malpractice. The experts cited extensive and conclusive evidence showing the decedent was not in septic shock the day before her death, when she was last treated by the defendants. By refuting each allegation with detailed reference to the records and testimony, MCB's motion for summary judgment was overpoweringly convincing, and forced plaintiff's counsel to discontinue his case rather than oppose the motion. The outcome shows that when every allegation is refuted with in depth reference to the medical records, this increases the possibility a plaintiff's attorney will be convinced his case is without merit. ■

What's New at MCB?

MCB
MARTIN CLEARWATER & BELL LLP

Congratulations to Our Senior Partner, Laurie A. Annunziato, and Partner, Karen B. Corbett for Receiving Martindale-Hubbell's® Highest Rating: AV Preeminent®!


Laurie A. Annunziato


Karen B. Corbett

Martindale-Hubbell® conducts a thorough review of attorneys who wish to receive a Martindale-Hubbell® Peer Review Rating, through a secure online peer review survey where a lawyer's ethical standards and legal ability in a specific area of practice are assessed by their peers.

Ms. Annunziato and Ms. Corbett received Martindale-Hubbell's® highest peer rating standard: AV Preeminent.® This is given to attorneys who are ranked at the highest level of professional excellence for their legal expertise, communication skills, and ethical standards by their peers.

MCB, MLMIC and Fager Amsler Present for Physicians on Guidelines for Reopening Practices


Kenneth R. Larywon


Thomas A. Mobilia

MCB On Wednesday, June 10, 2020, MCB's Partners, Kenneth R. Larywon and Thomas A. Mobilia joined MLMIC Insurance Company and Fager Amsler Keller & Schoppmann, LLP in a presentation developed for physicians on guidelines for safely reopening physician practices during COVID-19. The presenters discussed the evolving changes to state and federal law associated with the pandemic, and provided a strategic roadmap towards safely resuming previously suspended operations.

Michael C. Clarke Presents at Dominican College


Michael C. Clarke

On Thursday, June 25, 2020, Martin Clearwater & Bell LLP's Michael C. Clarke returned as a guest lecturer for Dominican College's Graduate Division's Family Nurse Practitioner program. The students in this program are registered nurses who are candidates for post-graduate Master of Science in Nursing (MSN) degrees at Dominican College. Mr. Clarke discussed a variety of medical, legal, ethical and risk management issues – clinical and non-clinical – that impact health care professionals, and particularly those in the field of nursing. This year, the lecture was presented online via Zoom.

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