MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

JUNE 2016

"Authoritative" Medical Literature in New York State Courts

BY: ANTHONY M. SOLA & KATHRYN R. BAXTER

Recently we successfully defended an obstetrician during a trial in New York State Supreme Court, Queens County. During the trial, we succeeded in introducing into evidence portions of a "*Practice Bulletin*"© published by the American College of Obstetricians and Gynecologists (ACOG) which played a crucial role in the defense of the case. This case highlighted the tricky evidentiary issues in New York State courts involving the use of so called "authoritative" medical literature. Importantly, there are legitimate differences of opinion as to how best to handle the issue of "authoritative" works. The use of "authoritative" medical literature in this particular case provides an illustrative guideline of one particularly successful method of admitting such literature into evidence.

First, let's provide some legal background. While the Federal Courts and most other state courts allow, in varying degrees, medical literature into evidence[1], New York State Courts generally still adhere to the old prohibition against the introduction into evidence of medical literature. This general prohibition is based on the hearsay rule. For the purposes of this article, hearsay is a statement – which would include any literature – made out of court and offered for the truth of the statement asserted. In such a situation, the author of the literature is not on the witness stand and subject to cross-examination by the adverse party and, as hearsay, it is thus inadmissible. The rationale for the hearsay rule is that if such literature is permitted into evidence, it deprives the party against whom it is introduced the opportunity to cross-examine the author of the article to test the reliability of the article.

There is, however, a qualified exception to New York's hearsay rule as it pertains to the use of medical literature. Specifically, if an adverse witness recognizes a medical article as "authoritative", then that witness can be read parts, or all, of the article in an attempt to discredit the witness[2]. If they agree with the statement, then it becomes evidence in chief. The reason this is permissible in such a situation is the adverse witness has essentially vouched for the reliability of the "authoritative" article. We emphasize that this comes into play only when an *adverse* witness agrees that it is authoritative. So, for example, we, as defense lawyers, cannot put our own expert on the stand, ask them if a work is authoritative, and then read from it. That is because we are both on the same side and we are prohibited from doing indirectly that which we cannot do directly.

This begs the question as to what is meant by "authoritative". In theory, it basically means a respectable work of the type commonly relied upon in the profession for use in the practice of medicine.

But what happens during a trial? Almost invariably, plaintiffs' experts cynically refuse to recognize *anything* as authoritative. The usual result is medical literature and scientific studies are deemed hearsay and *do not come into evidence for the jury's consideration*. Unfortunately,

"AUTHORITATIVE" MEDICAL LITERATURE
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1 See, Fed. R. Evid. 803(18).

2 See, N.Y. Pattern Jury Instr. - Civil. 1:90.1 (3d ed.) 2016.

"Authoritative" Medical Literature in

that means that the defense lawyers are often deprived of a major tool with which to cross-examine the plaintiffs' expert witnesses and expose their testimony as invalid. From the jury's perspective, such deprivation means they will not have the benefit of the relevant medical literature to assist them in evaluating plaintiffs' medical experts' testimony. Consequently, the jury decides which expert to believe based upon the experts' personality and demeanor. That is a less than reliable method to ascertain the validity of medical opinions.

So what can defendant physicians and their experts do? How should they handle cross-examination by plaintiffs' attorneys as to whether to recognize medical literature as "authoritative"? First of all, we assume that plaintiffs will only seek to cross-examine a defense witness with literature if that literature contains statements helpful to the plaintiffs' claims. Consequently, under the theory of "what's good for the goose is good for the gander," some experienced defense attorneys explain the situation to the defense witnesses and the result is, since plaintiffs' experts won't acknowledge anything as authoritative, then the defense witnesses frequently won't either.

This case demonstrates the successful use of a different approach. As the defendant physician is usually called as one of the first witnesses by the plaintiff, and testifies before plaintiff's expert, often the first time the jury will observe an attempt to cross-examine a medical witness with medical literature will be with the defendant physician.[3] If the defendant physician takes a position when confronted with medical literature that "nothing is authoritative," the jury's critical first impression of the defendant might well be that he or she is "hiding" from the medical literature. That is ***not*** a first impression we want the jury to have. Moreover, when we subsequently cross-examine the plaintiffs' expert who then refuses to acknowledge anything as authoritative, it denies us the opportunity to argue plaintiff's expert is "hiding" from the medicine since our own witness did likewise.

In this case, the preferred procedure starts with our preparation for the trial. First, we carefully scrutinize the medical literature with our witnesses. In this particular case, some literature was useful to the defense, and some we felt was not authoritative for several reasons. Our client was therefore prepared to testify that some carefully selected literature was authoritative[4], and he had good reasons to say some was not authoritative. Most importantly, he would not make a blanket statement that "nothing was authoritative."

If the defendant physician takes a position when confronted with medical literature that "nothing is authoritative," the jury's critical first impression of the defendant might well be that he or she is "hiding" from the medical literature.

Here is how it played out in our case. The lawsuit involved a young woman who developed gestational hypertension during pregnancy. Shortly after delivering she developed severe hypertension. This was followed by an eclamptic seizure and a stroke resulting in significant injuries. Central issues to the case involved the definition of preeclampsia, and when to employ magnesium sulfate in an attempt to prevent an eclamptic seizure. Plaintiff's counsel subpoenaed our client, an experienced and highly regarded obstetrician, as a witness on the plaintiff's case. Before attempting to cross him with medical literature, plaintiff's counsel had to first "lay a foundation" by asking if our client agreed that a particular work was authoritative. Plaintiff's counsel began with a number of reference works inquiring as to whether our client considered, for example, *Williams Obstetrics,* 23rd edition©, authoritative. The client's response was that he could not say whether the textbook was authoritative because each chapter is written by a different person so he would have to know who the author was in the particular chapter being considered. Plaintiff's counsel moved on to another article, written by Dr. Sibai. Our client responded he was familiar with the author, but he did not consider him to be an authority in the field. She went through a few other articles and the client offered different reasons as to why he could not say if someone was authoritative or not. She ended by asking our client whether the ACOG *Practice Bulletin* #33© was authoritative. Having carefully reviewed this document as part of pre-trial preparation, we knew that it was, in fact, authoritative. Most importantly, it did not contain anything of significance that would be detrimental to our case. So he replied that it

3 Sometimes we are able to convince the trial judge based on a technical objection that the plaintiff should be precluded from attempting to cross a defendant they call as their witness with authoritative articles. Not so in this case.

4 One also must keep in mind that recognition of authorities can have an impact in future cases.

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was an authority. Plaintiff's counsel's expression was one of pleasant surprise. She proceeded to read a sentence from the *Practice Bulletin*©, which stated that one of the main goals of labor management was prevention of eclampsia. Of course, he agreed with that.

Now that our client had recognized that *Practice Bulletin*© as authoritative and plaintiff's counsel had read from it, she opened the door to our being able to read from other parts of the article which were relevant. To make it much more persuasive, while reading from it we also projected onto a screen[5] the actual *Practice Bulletin*© to enable the jury to read along with it as I read the key portions which completely supported the defense[6]. **Most importantly, the client's acknowledgment that the *Practice Bulletin*© was authoritative and his agreement with the portions read was the only way we were able to get this critical document into evidence for the jury's consideration.**

There was a significant further advantage to this information coming into evidence in addition to having it in front of the jury during our client's testimony. Notably, now that portions of this *Practice Bulletin* © were in evidence, we were able to cross-examine plaintiff's expert with it when he subsequently came on the stand. An important point here is that since this document was already in evidence as part of the defendant's prior testimony, we did not need to have the plaintiff's expert first admit that the *Practice Bulletin*© was authoritative in order to use it against him.

There is no question that the ACOG *Practice Bulletin* © was a critical piece of evidence that played a major role in persuading the jury that our position on the medical issues was the credible one. We strongly suggest that the handling of authoritative literature be decided carefully on a case-by-case basis and that "nothing is authoritative" may actually hinder the defense.

The case was tried by Senior Partner Anthony M. Sola, assisted by Partner Thomas J. Kroczynski and Associate Andrew G. Meier

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Kathryn R. Baxter is an Associate at Martin Clearwater & Bell LLP where she focuses her practice on the defense of medical malpractice matters.

5 Parenthetically, I and a number of my partners have been employing a software program called "Trial Director"® for quite a number of years and have found it very helpful in making persuasive arguments to a jury. "Trial Director"® is a program that allows us to scan any records or documents into our laptops. The pages are then printed out with a barcode at the bottom. During the trial we simply use a supermarket-style scanner to project on a screen the specific page we want to reference. It is well known that people, in this case jurors, learn better and understand more when they are able to simultaneously see evidence as well as hear it.

6 Specifically, we were able to read the definition of preeclampsia required a finding of proteinuria (which the patient did not have during the relevant time period) and further that magnesium sulfate was only recommended for "severe preeclampsia" including the definition of "severe preeclampsia." In our particular case, the patient did not meet the criteria for the employment of magnesium sulfate during the time period claimed by plaintiff's counsel.

PEDIATRIC EMERGENCY ROOM LIABILITY

BY BRUCE G. HABIAN

THE Pediatric Emergency Room ("E/R") can expose a hospital to claims of substandard care. When child assessments by private pediatric neighborhood clinics are involved, together with E/R presentations for the same condition, the potential for liability risks increases.

This author defended a case involving chronic otitis media ("O.M."), with both left and right-sided complaints of ear pain and variations in clinical status. This case should illustrate some of the liability topics described herein. The month long persistent condition, with assessments by both private clinic practitioners, as well as various E/R personnel, resulted in a devastating meningitis with severe neurologic injuries. Over this span of time, there existed confusion concerning the ear examinations per redness of the tissues, intermittent fevers and headache status. Initially, an E/R visit assessed right-sided ear pain. An antibiotic was prescribed (Zithromax), although it was not a first line treatment drug for O.M. In addition, the child's mother did not administer the drug for the complete duration as had been prescribed. Several weeks later, a private clinic practitioner examined the child who once again presented with right-sided ear pain. The antibiotic was changed to the appropriate first line drug (Augmentin), but the mother, once again, did not complete the dosage, obviously thinking that the acute process had resolved.

Shortly thereafter, at a third visit, the child presented to the clinic — now with left-sided pain — and was prescribed Zithromax again. A fourth visit to the E/R for persistent left-sided ear pain appreciated the prior clinic status assessment. The Zithromax was stopped as there was no clear O.M. clinical signs per examination. A complete blood count ("CBC") and blood culture were ordered for baseline purposes; however, there was no reporting to the family of the CBC results which indicated infection. Obviously the culture took time to provide results. Several days later at the final E/R visit, the child sustained a fulminant meningitis condition with seizure activity and necessity for intubation. Specialists opined that partial treatment of O.M. over a month's time was the cause of the meningitis.

Lack of coordination can occur at the private clinic during subsequent visits; this, particularly where a different pediatrician than the initial doctor assesses the child. Many times the clinic practitioners do not have admitting privileges at the E/R hospital; this further complicates the retrieval of the E/R chart data and allows disjointed assessments to continue.

PEDIATRIC NEIGHBORHOOD CLINICS:

Where these facilities maintain no evening hours and no on call physician protocols, the E/R then becomes the primary caregiver. Often, lack of coordinated care occurs concerning the accuracy of symptoms previously reported to the private clinic. Without access to that initial chart, the E/R physicians rely on the concerned parent to provide history and physician advices. Very often, without accurate specifics of the differential diagnoses entertained, the specific medication given, the duration of medicine taken and the overall response of the child to the treatment, a meaningful plan of action is lacking.

Recalling the case described above, many times blood workup results are often not provided for follow up to the private clinic, thereby further creating gaps in the care continuum. Blood work results are sometimes not timely reported to the family, as the hospital practitioner charged with this communication is typically different than the pediatrician who assessed the child during the evening hour shift. As in our case, blood cultures take time to identify the offending organism and the child's condition may significantly advance prior to culture results being obtained for specificity of antibiotic coverage.

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How Physicians and Physician Extenders Function Together

By Michael A. Sonkin & Michelle A. Frankel

Despite changes to and advancements within the healthcare system, healthcare demands continue to grow. Some patient needs continue to be unmet while others require more efficiency and improved quality. The use of physician extenders, such as physician assistants and nurse practitioners, can assist in making the healthcare delivery system more efficient. Physicians can focus on patient needs by utilizing physician extenders for more routine physical assessments and ongoing care. Recognizing and utilizing the capabilities of physician assistants and nurse practitioners to a greater extent will not only "offer [more] financial profitability [] [but also promote] efficiency, improved quality of care, enhanced flexibility for physicians and greater patient satisfaction."[1] Consequently, it is important to understand the legal responsibilities as well as the distinctive and collaborative roles of physicians, physician assistants, and nurse practitioners.

The use of physician extenders, such as physician assistants and nurse practitioners, can assist in making the healthcare delivery system more efficient.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) are dependent practitioners required to work under the supervision of licensed physicians. A supervising physician is "medically responsible" for the medical services provided by physicians assistants.[2] Such medical responsibility can translate into legal responsibility in that supervising physicians can be held liable for "acts of negligence and medical malpractice allegedly committed by a physician's assistant supervised or employed by the physician."[3] Therefore, physicians should be cognizant of their duties as supervisors.

Physician supervision must be continuous though physical presence is not required; rather a supervising physician must simply be in contact and/or available via telecommunication.[4] It should be clear which physician is supervising a physician assistant and it is advisable to consider documenting the relationship in writing, which can be made available upon request by a regulatory agency.[5] NY Education Law §6542 limits a single physician to supervising a maximum of four PAs. New York City Rules and Regulations further limit physicians to supervising two PAs.

It is important for supervising physicians to be aware of what duties can and cannot be delegated to physician assistants because a physician can be liable for negligent supervision even if the physician assistant is not liable.[6] Physician assistants can perform an array of medical services such as taking patient medical histories, performing physical examinations, and prescribing medications.[7] Physician assistants may assist supervising physicians on rounds, develop and execute patient care plans, review and interpret patient diagnostics for abnormal deviations, and record progress notes.[8] Physician assistants may also counsel patients regarding compliance with therapeutic regimens and general health maintenance.[9]

Physician assistants must be appropriately trained and qualified to perform the aforementioned services, which are routinely performed within the scope of physician practice. For instance, physician assistants may manage simple conditions, or assist in the management of more complex conditions. They can perform routine procedures such as injections, vaccinations, sutures and wound care, but they are prohibited from performing more specialized tasks, such as the practice of radiologic technology, optometry, and signing death certificates.[10] Physician assistants can write medical orders for controlled substances under NY Public Health Law §3702 if working within their scope of practice and to the extent assigned by a supervising physician. In New York, whether a countersignature is necessary is a deci-

Physicians and Physicians Extenders
Continued on page 6

1 Bill Lamers, *Physician Extenders = Key to Profitability*, ACTION FOR BETTER HEALTHCARE (January 29, 2014), http://www.actionforbetterhealthcare.com/physician-extenders-key-profitability/.
2 10 N.Y.C.R.R. §94.2(f).
3 *Marchisotto v. Williams*, 11 Misc.3d 1089(A) (N.Y. Sup. Ct. Kings County 2006).
4 American Academy of Physician Assistants, *Guidelines for State Regulation of Physician Assistants*, 3 (Adopted 1988, most recently amended 2011), https://www.aapa.org/Workarea/DownloadAsset.aspx?id=795.
5 *Id.* at 4.
6 Mirsade Markovic, Esq., *Physician Assistants: A Risk-Benefit Analysis*, 13 MLMIC DATELINE 2 (2014), http://c32df2bce85a57faecab-4eaa7697b-73b284591ad9c4a5284206b.r79.cf5.rackcdn.com/wp-content/uploads/2014/04/DatelineSpring14-1.pdf.
7 *Reference Information: Registered Physician Assistant*, NEW YORK STATE DEPARTMENT OF HEALTH, https://www.health.ny.gov/professionals/doctors/conduct/physician_assistant.htm (last revised February 2014).
8 *Id.*
9 *Id.*
10 *Id.*

sion within the discretion of a supervising physician or hospital but "in no event shall [] be required prior to execution."[11]

Thus, physician assistants can improve healthcare access by performing medical tasks that are within physician scope of practice while leaving physicians to perform other more complex tasks that physician assistants are not trained to address.

NURSES

Physician liability for nurses differs from the liability and responsibility associated with physician assistants because each profession is governed by different regulations. The nursing field is comprised of tiered nurses with distinctive qualifications and some nurses are treated as independent practitioners who do not require supervision.[12] It is important to understand the different levels of nursing degrees to understand the role of nurse practitioners within the healthcare system at large.

Licensed Practical Nurses (LPN) perform tasks related to case finding, health teaching, health counseling, and supportive and restorative care under the direction of a registered nurse, clinical nurse specialist, nurse practitioner, licensed midwife, physician, PA, special assistant, dentist, or podiatrist.[13] As with the supervision of a physician assistant, a practitioner directing an LPN does not have to be physically present, but must be readily available and able to intervene.[14] Examples of tasks that can be performed by an LPN are medication and immunization administration, blood drawing, bedside nursing care, clinical procedures (catheterizations, suctioning, sterile dressing changes, starting peripheral IV), supervision of unlicensed care staff such as certified nurse aides, and identification of patient goals for consideration by registered nurses to include in care plans.[15]

A Nurse Practitioner (NP) can diagnose illnesses and perform therapeutic and corrective measures within a certified specialty area, which may be Adult Health, Family Health, Gerontology, Neonatology, Obstetrics, Oncology, Pediatrics, Perinatology, Psychiatry, School Health, Women's Health, Holistics, and Palliative Care.[16] Traditionally, NPs practiced pursuant to written practice protocols and agreements with collaborating physicians. Collaborating physicians were required to co-sign NP orders and to review their charts at least once every three months.[17] Such collaborative requirements were intended to maintain the distinct practice areas of physicians and nurse practitioners based on their respective training. However, many states have begun to acknowledge that such laws are "…keeping nurses from practicing to the full extent of their education and training, making it harder for patients to get the care they need."[18]

As of 2014, seventeen states (including Maryland[19] and Connecticut[20]) and the District of Colombia passed laws to provide greater independence to NPs by maximizing the use of their training to improve access to care. Such laws were intended to modernize NP scope of practice by eliminating the need for written collaborative agreements if other state specific requirements are met. The New York Nurse Practitioner Modernization Act, which went into effect on January 1, 2015, modernized the scope of NP practice by eliminating hurdles, such as co-signature requirements and written collaborative agreements (which largely serve financial functions[21]) for NPs who performed over 3,600 hours of clinical practice. The goal of this law was to enable NPs to better meet public health needs.[22] Now NPs must simply "communicate with collaborating physicians to provide comprehensive care or to make referrals, as necessary," and otherwise they can "diagnose, treat and prescribe exclusively and autonomously"[23] given their additional clinical nursing education and certification.[24]

Other states, including Michigan and Kansas, have

11 N.Y. PUB. HEALTH LAW § 3702 (2013).
12 *Marchisotto,* 11 Misc. 3d 1089 (A), *supra* note 3.
13 *Nursing Practice Information Frequently Asked Practice Questions,* New York State Education Department, Office of the Professions
14 *Id.*
15 *Id.*
16 N.Y. Educ. Law§6902 (2015). *Practice Requirements for Nurse Practitioners, available at* http://www.op.nysed.gov/prof/nurse/np-prfnp.pdf.
17 *Nursing Practice Information Frequently Asked Practice Questions, supra* note 13.
18 *More States Removing Barriers to Nursing Practice and Care,* CAMPAIGN FOR ACTION (March 20, 2014), http://campaignforaction.org/news/more-states-removing-barriers-nursing-practice-and-care.
19 Adam Rubenfire, *Maryland Allows Nurse Practitioners to Practice Independently of a Physician,* MODERN HEALTHCARE (May 14, 2015), http://www.modernhealthcare.com/article/20150514/news/150519928.
20 Laura Ungar, *Nurse Practitioners Fight for More Independence,* USA TODAY (August 19, 2014, 1:57pm), http://www.usatoday.com/story/news/nation/2014/08/18/nurse-practitioner-independence-laws/13470733/.
21 *See* Alexandra Wilson Pecci, *NY Abolishes Written Practice Agreement for NPs,* HEALTHLEADERS MEDIA (April 22, 2014), http://www.healthleadersmedia.com/nurse-leaders/ny-abolishes-written-practice-agreement-nps#.
22 Joy Elwell, DNP, FNP-BC, FAANP and Stephen Ferrara, DNP, FNP-BC, FAANP, *The Elimination of Practice Barriers for Nurse Practitioners in New York: An Historical Perspective, available at* https://c.ymcdn.com/sites/www.thenpa.org/resource/resmgr/Headline_News/EliminationofPracticeBarrier.pdf.
23 *Nurse Practitioner,* NEW YORK STATE DEPARTMENT OF LABOR, https://labor.ny.gov/stats/olcny/nurse-practitioner.shtm (last updated December 3, 2014).
24 *Nursing,* New York State Education Department, Office of the Professions,, http://www.op.nysed.gov/prof/nurse/ (last updated August 13, 2014).
25 Jay Greene, *Doctors Wary of Bill to Expand Nurse Practitioners' Role,* CRAIN'S DETROIT BUSINESS (June 9, 2013, 8 AM) http://www.crainsdetroit.com/article/20130609/NEWS/306099991/doctors-wary-of-bill-to-expand-nurse-practitioners-role (last updated June 10, 2013).
26 Kelsey Ryan, *Advance Practice Registered Nurses Seek to Practice Independently from Physicians,* The Wichita Eagle (May 29, 2014, 12:00 AM), http://www.kansas.com/news/business/health-care/article1144498.html.

ENDERS FUNCTION TOGETHER *Continued from page 5*

not enacted legal reforms that will facilitate NP independence over concerns with the scope of NP practice which may result from eliminating the team approach[25] and risk leaving patient health "…in the hands of people perhaps not as able as physicians."[26] Legal reforms to alter the degree of NP independence are part of an on-going debate. The debate highlights the specific medical services that each type of practitioner can provide and how each role may be maximized to potentially improve the provision of healthcare as a whole.

Conclusion

Cognizance of the distinctive roles that physicians, physician assistants and nurse practitioners play can improve each practice and better meet healthcare demands since each practitioner has unique training and skills to fulfill patient needs, which can also facilitate a more efficient and effective healthcare system.

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Michelle A. Frankel is an Associate at Martin Clearwater & Bell LLP where she focuses her practice on the defense of medical malpractice matters.

PEDIATRIC EMERGENCY ROOM LIABILITY *Continued from page 4*

SERIAL E/R VISITS:

Independent of the private clinical assessments, multiple E/R visits can fail to appreciate the chronicity of a presenting complaint. The triage status is many times not influenced by the historical chronic status; a nurse may simply assess the child based on the immediate presentation with a lower risk factor. The current clinical status can be temporarily masked by recent medication, as occurred in the case described herein.

As resident staff and attendings examine the child, many times prior E/R charts concerning the same complaints are not directly assessed; this, even with current computer retrieval methods. On a day-to-day basis, given the different work schedule shifts, different physicians are seeing the patient who their colleagues saw recently. Many times this lack of continuity may not adequately focus on the current specialist treatment called for. In the case described herein, infectious disease consultation was absolutely necessary, and the persistent ear pain together with on and off fever status, as well as headaches, mandated spinal tap analysis together with CT and MRI considerations of the ear and mastoid bones. Obviously, with changing work shifts, correct and timely reporting among staff members is crucial so as to avoid delay in required medical treatments.

PRACTICE POINTS:

As much as practicable, private clinic visit information should be investigated in detail per the child's parents. If possible, calls should be made to the clinic during their working hours to assess the child's physical condition. Prior E/R visit data, particularly at the same institution, should be obtained. The resident and attending assessments should be complete as chart notations - even to the extent of recording negative signs and symptoms if germane to the differential workup. Our case had no listings per the absence of photophobia, severity of the headaches and temperature fluctuations. Certainly pertinent lab data must be reported to the family so additional follow up visits can be had.

In the scenario described herein an E/R visit may not be an isolated occurrence, but a continued bridge in relationship to prior clinic visits. The defense of liability claims requires documented coordinated care; this to avoid the "deep-pocketed" status of the hospital defendant as the litigation target.

Bruce G. Habian is a Senior Trial Partner at Martin Clearwater & Bell LLP and has represented the Firm's core clients in medical malpractice and professional liability defense litigation for more than 35 years. Mr. Habian specializes in the defense of severe infant neurological injuries, with their attendant high financial exposure and risk. Mr. Habian is a Fellow of the American College of Trial Lawyers.

Recent Case Verdicts

April 2016: Defense Verdict in Queens — 26-Year Old Mother of Twins Who Sustained Eclamptic Stroke After Delivery

Senior Trial Partner Anthony M. Sola, assisted by Partner Thomas J.Kroczynski and Associate Andrew G. Meier, obtained a defense verdict in Supreme Court, Queens County, following a three week trial. The case was tried before Justice Timothy Dufficy. The matter involved a 26-year old woman who had just delivered twins at 34 weeks gestation and shortly after birth developed severe preeclampsia, sustained a grand mal seizure (eclampsia) and had an intracranial hemorrhage. The central claim was that, when the patient developed hypertension post-delivery and complained of a severe headache with a pain scale of 10 out of 10, the severe preeclampsia was not immediately recognized, and magnesium sulfate to prevent the eclampsia was not started for a full hour. Our client, the private attending physician, had already left the teaching hospital and was managing the care by phone with the residents during the critical hour. We were fortunate to get into evidence the ACOG Practice Bulletin relevant to the time period and demonstrate that at that time the standard was not to employ magnesium sulfate unless one had a diagnosis of severe preeclampsia, which included proteinuria which was not present, and blood pressures more severe than what she had at the critical time. We successfully demonstrated that the patient had an unusual, atypical presentation of preeclampsia and our care was within the standards as they existed at the time and the jury returned a verdict for the defense.

Employment & Labor Case Result: Court Grants MCB's Motion Dismissing Disability Claims

A New York State Supreme Court judge in Queens County recently granted MCB's motion for summary judgment in favor of an MCB hospital client. In granting the motion shortly before trial, the judge dismissed a lawsuit filed by a former staff pharmacist who claimed she was the victim of disability discrimination.

The dispute arose after the hospital decided that for patient care needs it was making full-time employment an essential function for the position of pharmacist. Plaintiff, who had historically worked a part-time schedule, initially accepted a full-time pharmacist position. However, she subsequently changed her mind and claimed that due to a disability, she was able to work only two days per week. MCB established that the employee's demand was not a reasonable accommodation of her disability. Moreover, MCB established that the employee failed to engage in the legally required interactive process to help find a reasonable accommodation.

The court's decision creates a potentially useful precedent because it demonstrates that patient care improvements can be made by hospitals (and other healthcare providers) without running afoul of employment anti-discrimination laws.

MCB partners Greg Reilly and Adam Guttell were assisted by Associates Aisling McAllister and Melanie Ghaw in obtaining this positive result.

MCB Welcomes New Attorneys

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