MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

SPRING 2014

Excluding Inadmissible Hearsay from Medical Records in Evidence

BY JOHN L.A. LYDDANE & BARBARA D. GOLDBERG

It is familiar law that, ordinarily, physicians' office records or hospital records are admissible pursuant to the "business records" exception to the hearsay rule codified at CPLR 4518(a) to the extent they are germane to diagnosis and treatment. This includes medical opinions.[1] Where, however, details of how a particular injury allegedly occurred are not relevant to diagnosis and treatment, they are not considered to have been recorded in the regular course of a hospital's or physician's business and are therefore inadmissible and subject to redaction. As explained by the Court of Appeals in the leading case of *Williams v. Alexander*[2]:

> [i]n some instances, perhaps, the patient's explanation as to how he was hurt may be helpful to an understanding of the medical aspects of his case; it might, for instance, assist the doctors if they were to know that the injured man had been struck by an automobile. However, whether the patient was hit by car A or car B, by car A under its own power or propelled forward by car B, or whether the injuries were caused by the negligence of the defendant or another, cannot possibly bear on diagnosis or aid in determining treatment. That being so, entries of this sort, purporting to give particulars of the accident, which serve no medical purpose, may not be regarded as having been made in the regular course of the hospital's business (emphasis in original) (citations omitted).

Thus, in *Williams* the portion of a hospital record containing the plaintiff's statement to a physician that he was hit after a car that had been stopped at an intersection was propelled into him by another vehicle was inadmissible.

Admission of such statements can also constitute reversible error where they do not support the patient's account of how the accident occurred and they bear on the ultimate issue to be decided by the jury. This is demonstrated by *Cuevas v. Alexander's, Inc.*,[3] where the Appellate Division, Second Department held that portions of a hospital record which the trial court permitted the defendants' counsel to read to the jury constituted inadmissible hearsay, as they related to the manner of an accident and were not germane to diagnosis and treatment. "The statements in the hospital record directly contradicted the plaintiff's account as to how the accident occurred. Under the circumstances, the erroneous admission of these statements contained in the hospital record cannot be deemed harmless, as the entries related to the very issue to be deter-

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1 *See, e.g., People v. Ortega*, 15 N.Y.3d 610 (2010); *Williams v. Alexander*, 309 N.Y. 283, 287 (1955); *Wilson v. Bodian*, 130 A.D.2d 221, 231 (2nd Dept. 1987).

2 309 N.Y.2d at 288.

3 23 A.D.3d 428 (2nd Dept. 2005).

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mined by the jury, i.e., how the accident happened."[4] Accordingly, a new trial was ordered.

To the same effect is *Carcamo v. Stein*.[5] There, the Second Department held that statements in hospital and ambulance records which the trial court read to the jury constituted inadmissible hearsay, as they related to the manner of an accident and were not germane to diagnosis and treatment. As in *Cuevas*, the error could not be deemed harmless, since the statements directly contradicted the defendant's account as to how the accident occurred and as such bore on the ultimate issue to be decided by the jury. Under these circumstances "the admission of the statements may have prejudiced the defendant by lending undue credence to the plaintiff's testimony."[6]

In *Stewart v. Manhattan and Bronx Surface Transit Operating Authority*, the Appellate Division, First Department held that it was reversible error to admit into evidence a "disclaimer" contained in a toxicology report.[7] The plaintiff in *Stewart* was hit by defendants' bus and was taken to the hospital, where blood was drawn for laboratory analysis, generating, among other things, a toxicology report showing a high level of alcohol content consistent with intoxication. At the end of the toxicology report, beneath the data, appeared the following language: "comment: specimen analysis was performed without chain-of-custody. These results are to be used for clinical evaluation only (and not for any legal or employment evaluative purposes). Confirmation testing was not performed."

With an underlying fact pattern which is complex, and a close nexus between the author of the hearsay and the parties to the lawsuit, the issues surrounding hearsay in medical records can become complicated...

The Appellate Division stated that "the limiting language contained in the 'disclaimer' had absolutely no bearing on plaintiff's treatment and diagnosis and, consequently, should not have been admitted."[8] Once again, the inadmissible statement bore on the ultimate issue to be decided by the jury and the error could not be considered harmless. The defendants' primary defense was that the plaintiff's high level of intoxication resulted in a loss of visual acuity, balance and judgment, and that accordingly the plaintiff's intoxication was the sole proximate cause of her accident. "Allowing the disclaimer into evidence permitted the jury to speculate on the validity of the blood alcohol contents, thereby unduly prejudicing defendants' defense."[9]

A party seeking to establish the applicability of a hearsay exception must establish that the evidence in question is reliable.[10] Entries in records regarding the manner of causation of an injury that might otherwise be germane to diagnosis and treatment are nevertheless inadmissible where the source of the information is unknown, or might have been part of the history provided by an interested party such as the patient.[11] For example, in *Ginsberg* the Appellate Division, Second Department approved the trial court's redaction of certain portions of the infant plaintiff's medical records stating that her condition was attributable to kernicterus, where the authoring physician was not present at birth and there was no reference to kernicterus in the labor and delivery records. The Second Department noted that ". . . the references to the diagnoses appear to have come from other unknown charts or records, and may have been part of the history relayed by the plaintiff herself or her counsel. As such, the trial court properly redacted these references."[12]

With an underlying fact pattern which is complex, and a close nexus between the author of the hearsay and the parties to the lawsuit, the issues surrounding hearsay in medical records can become complicated for the Court and counsel. The point is illustrated by a recent non-reported trial in which the patient's primary care physician referred him to a treating urologist for a large kidney stone. The treating urologist discussed the treatment options with the patient, and although the stone was large, they agreed on a course of lithotripsy to break up the stone into fragments which would presumably pass, rather than more invasive treatment.

The treating urologist performed three shock wave lithotripsy procedures which were moderately successful in breaking up the kidney stone, but the patient ultimately had a large fragment of the stone lodge in his ureter, and became septic. At the same time he had multiple comorbidities which precipitated him into renal failure and required hospitalization. The patient was unhappy about the situation and the primary care physician transferred his care to the consulting urologist at another facility. The consulting urologist performed a five-hour procedure to remove the stone fragment from the patient's ureter with arguably serious sequelae.

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4 *Id.* at 429.

5 53 A.D.3d 520 (2nd Dept. 2008).

6 *Id.* at 521 (citation omitted).

7 30 A.D.3d 283 (1st Dept. 2006).

8 *Id.* at 283-284 (citation omitted).

9 *Id.* at 284.

10 *See Nucci v. Proper*, 95 N.Y.2d 597, 602 (2001).

11 *See, e.g., Lessoff v. 26 Court Street Associates, LLC*, 58 A.D.3d 610 (2nd Dept. 2009); *Dickson v. Queens Long Island Medical Group, P.C.*, 289 A.D.2d 193 (2nd Dept. 2001); *Jajoute v. New York City Health & Hospitals Corporation*, 242 A.D.2d 674 (2nd Dept. 1997); *Ginsberg v. North Shore Hospital*, 213 A.D.2d 592 (2nd Dept. 1995).

12 *Id.* at 592 (emphasis added).

Expert Disclosure in The Context of Summary Judgment Motions

By Michael A. Sonkin & Bryn N. Fuller

Summary judgment motions are an effective tool to both resolve litigations in advance of a costly and uncertain trial, as well as to force the opposing party to clearly articulate its theory of the case. Recent decisions from both the First and Second Departments of the Appellate Division requiring pre-note of issue disclosure of expert witness responses has implications for both moving for, and opposing, a grant of summary judgment that must be considered early and often during the litigation.

Summary judgment motions have been recognized as the functional equivalent of a trial and serve to dispose of cases for which there are no material issues of fact. An integral part of a motion for summary judgment is the expert's affirmation or affidavit attesting to, or criticizing, the medical care rendered. A summary judgment motion in a medical malpractice case cannot be granted or successfully opposed without the submission of such an affirmation or affidavit.

CPLR 3101(d)(1)(i), which governs expert disclosure, states in pertinent part that:

> *"upon request, each party shall identify each person whom the party expects to call as an expert witness at trial and shall disclose in reasonable detail the subject matter on which each expert is expected to testify, the substance of the facts and opinions on which each expert is expected to testify, the qualifications of each expert witness and a summary of the grounds for each expert's opinion." CPLR § 3101(d)(1)(i).*

Significantly, this statute does not set forth a time frame for issuance of the demand or the response, and actually states that where good cause is shown for the retention of an expert an insufficient time before trial to give appropriate notice thereof, that expert's testimony shall not be precluded solely on the grounds of insufficient notice.

Notwithstanding the lack of statutory language as to when expert disclosures must be served in advance of trial, appellate courts have recently held that the failure to provide expert disclosure prior to the filing of the note of issue in response to a demand for same may lead to preclusion of the expert's affirmation in support of, or in opposition to, a motion for summary judgment.

In 2008, the Appellate Division, Second Department in *Singletree v. Lowe, et al.*, 55 A.D.3d 861 (2d Dept. 2008) affirmed the preclusion of defendant's expert for lack of pre-note of issue disclosure in response to the parties' demands. In that case, a defendant moved for summary judgment in a commercial litigation action and a co-defendant was precluded from opposing this motion for failing to identify their own experts during the discovery phase of the case. Although it was argued that 3101(d)(1)(i) governed disclosure of **trial** expert witnesses, and did not mandate disclosure of experts during the discovery phase of the case, the majority nonetheless held that the trial court had the discretion to preclude the affirmation of an expert who had not been disclosed during discovery. The net effect of this decision was to essentially mandate the disclosure of expert witnesses before the filing of the note of issue or else risk preclusion of expert affirmations or affidavits in connection with a summary judgment motion.

Summary judgment motions have been recognized as the functional equivalent of a trial and serve to dispose of cases for which there are no material issues of fact.

In 2012, the Second Department attempted to clarify its *Singletree* decision in the medical malpractice case of *Rivers v. Birnbaum*, 102 A.D.3d 26 (2d Dept. 2012). In *Rivers*, plaintiff demanded expert disclosure three months after commencing suit, and filed a note of issue five months later. Plaintiff served its 3101(d) disclosure a week before filing the note of issue, and then argued that defendants should be precluded from utilizing expert affirmations or affidavits in support of their summary judgment motions for lack of their own pre-note of issue expert disclosure. The Appellate Division expressly recognized its earlier *Singletree* decision, but nonetheless would not preclude the defendants' expert affirmations. The Court clarified its position by confirming that CPLR 3101(d)(1)(i) does not require service of expert disclosure at any specific time and that it does not mandate preclusion for non-com-

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pliance with a demand. The Court held, however, that disclosure after the filing of the note of issue can still be a factor to determine whether the disclosure was timely and that preclusion or other appropriate sanctions could be imposed. Notably, the factors to be considered were not set forth.

Just after the *Rivers* decision was issued, the same Second Department affirmed the preclusion of an expert affirmation in the case of *Kozlowski v. Oana*, 102 A.D.3d 751 (2d Dept. 2013) where there was no excuse offered for the delay and the circumstances indicated the delay was willful. Although the Second Department acknowledged its decision in *Rivers* and the discretion that exists to accept a post-note of issue expert affirmation without prior disclosure, it declined to do so in this instance where the defendant had retained its expert several months before moving for summary judgment and had utilized the expert to perform a physical examination without including the expert's opinions in the subsequently issued report.

The appellate courts have issued decisions both for and against parties who seek to oppose or support summary judgment motions without having first disclosed their experts prior to the filing of the note of issue.[1] These decisions suggest that the specific criteria as to whether to preclude a non-disclosed expert's affirmation remain uncertain, but that prejudice and willfulness are to be considered.

In light of these recent decisions, a defendant intending to move for, or oppose, summary judgment who does not first serve an expert disclosure before the note of issue is filed for the specialty to be used to support that motion runs the risk of having its expert's affirmation or affidavit precluded. In order to avoid this precarious position, it is important that a case be analyzed early in the litigation for the potential for a motion for summary judgment, and that this analysis be updated throughout the life of the case. If the potential exists for such a motion, or if there is the potential that a plaintiff (or co-defendant) may so move and have to be opposed, then early expert retention is strongly recommended so that a review can be completed and a disclosure of that particular expert can be made in advance of the filing of the note of issue. It is presently unclear whether the disclosure has to be to the level of detail that would be utilized in advance of trial, but the most important feature of the aforementioned cases is that the disclosure be made for the specialty to be relied upon in support of, or in opposition to, a summary judgment motion.

A demand for expert disclosure is a standard discovery demand that accompanies our answers and is a common demand served by plaintiffs with their initial discovery responses. By serving a pre-note of issue expert disclosure where a summary judgment motion is anticipated, this will not only prevent plaintiff from using the timing of the disclosure as a grounds to oppose such a motion, but may serve to support a defense argument that plaintiff be precluded from opposing our motion if they have not similarly responded. Conversely, a court permitting late disclosure of the movant's expert will likely not preclude the opposing party who similarly has not responded.[2]

Recent case law on the subject of expert disclosures and summary judgment motions has created uncertainty given the lack of clear statutory guidance. Early analysis and proactive expert retention and disclosure in the appropriate situations increases the chances of a successful outcome whether moving for, or opposing, a summary judgment motion.

Michael A. Sonkin is a Senior Partner and the Firm's Managing Partner. His legal practice primarily encompasses medical malpractice matters in which he defends individual physicians and major teaching hospitals from inception through trial. Since joining MCB, Mr. Sonkin has defended cases at trial in a variety of areas. He is an invited faculty participant in Hofstra University Law School's annual Trial Training Program.

Bryn N. Fuller is an associate at Martin Clearwater & Bell LLP and focuses her practice on medical malpractice defense.

1 *See Martin v. Triborough Bridge and Tunnel Auth.*, 73 A.D.3d 481 (1st Dept. 2010)(denying preclusion of defendant's expert disclosure because delay not willful); *Williams v. C & M Auto Sales*, 105 A.D.3d 419 (1st Dept. 2013) (denying preclusion of plaintiff's expert affidavit as any prejudice to defendant was cured by vacating the note of issue and affording it the opportunity to conduct further discovery); and Garcia v. City of New York, 98 A.D.3d 857 (1st Dept. 2012) (supporting preclusion of plaintiff's expert affidavit for late disclosure after note of issue despite earlier demands for same).

2 *See LeMaire v. Kuncham,* 102 A.D.3d 659 (2d Dept. 2013).

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The hearsay problem arose as a result of notes in the records of both the subsequent treating hospital and the consulting urologist which included statements to the following effect.

1. The patient was transferred with a history of kidney failure and urosepsis secondary to an improperly handled kidney stone by an outside urologist.
2. The patient was "completely improperly cared for" with multiple lithotripsies. He was septic, in renal failure, and obstructed.
3. The transfer was effected at the request of the primary care physician who had interceded in the treating urologist's care to avoid a contemplated fourth lithotripsy.
4. The patient had hydronephrosis and urosepsis secondary to the lodged fragment, and the treating urologist had failed to recognize that there was a retained fragment and that the patient was in renal failure.

For obvious reasons, the attorney for the plaintiff argued that the records should be admitted in their entirety, whereas defense counsel objected to the cited entries as inadmissible hearsay. A number of arguments were advanced, and additional information was developed before the issue was resolved.

The information did not seem to come from an "unidentified source." The primary care physician and the patient had spoken to the consulting urologist, and somewhat after the fact, he had received at least some of the records of the prior treatment. The patient's argument was that the information was collected by the consulting urologist and recorded to assist him in the diagnosis and management of a complex situation with iatrogenic origins.

The defense argument approached the hearsay material under *Williams*, supra as information which was unnecessary to diagnosis or treatment of the patient. How the patient had been managed previously had no bearing on the diagnosis at the time of transfer. Either the patient had a fragment of a stone in his ureter, urosepsis, and renal failure, or he did not. Those conditions were each diagnosed by either imaging studies or laboratory testing, and not by prior history.

However, the defense argument was strengthened by the accusatory nature of the entries in the consulting urologist's notes. The record before the Court reflected that there was some discussion prior to and during the treating urologist's course of management as to treatment alternatives, but the patient stated a preference for the less invasive lithotripsy as opposed to the more invasive alternatives. Whether the consulting urologist had a fair basis for reaching a conclusion on the propriety of the prior treatment was a genuine issue, as was his conclusion that the treating urologist failed to recognize that there was a retained fragment, and planned a fourth lithotripsy procedure.

Given these genuine issues, and their proximity to the ultimate question before the jury (whether the patient's alleged injuries were the result of complications or substandard care) it was argued that these opinions should not be placed before the jury without the opportunity to have them tested by cross-examination. Only then would it be known what they were based upon or whether they were held with a "reasonable degree of medical certainty", the foundation necessary for the admission of medical opinions.

The Court ultimately excluded all of the contested material and the case was resolved in favor of the treating urologist on the basis of the testimony of experts, including the testimony of the consulting urologist which was far less incendiary than his notes would have predicted.

While not every case will involve such clear examples of inadmissible hearsay in medical records, this example highlights the strategic importance of carefully scrutinizing medical records for sometimes occult entries that are not germane to diagnosis and treatment but, as in this example and the *Ginsberg* case, may have been a one-sided version of the events provided by the patient or someone on his behalf. Moreover, as the reported cases demonstrate, the distinctions between inadmissible hearsay and the admissible portions of medical records are ignored by both plaintiffs and defendants at their peril. If the hearsay portion of a medical record bears on a central issue in the case, and is prejudicial to the losing party at trial, its admission will likely constitute reversible error, but only if timely objection is interposed.

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John L.A. Lyddane is a Senior Partner and trial attorney at Martin Clearwater & Bell LLP. With over 30 year's legal experience, he focuses his practice on the defense of technical personal injury and professional liability actions in state and federal trial courts. He has tried over 200 cases to verdict and has represented corporate defendants, insurance carriers, product manufactures, self-insured hospitals, universities, municipalities and individual physicians, attorneys, architects and engineers.

Barbara DeCrow Goldberg is a Partner and Head of the Firm's Appellate Department. Ms. Goldberg is well known for her appellate expertise in high exposure and complex cases and has handled hundreds of significant motions and appeals in State and Federal Courts. She is noted for several important decisions in the areas of medical malpractice, negligence, workers compensation and labor law.

Revised Diagnostic to Take Effect in Ju

By Thomas A. Mobilia & Melanie G. Gelfand

The Joint Commission has recently announced new and revised diagnostic standards for accredited hospitals, critical access hospitals, and ambulatory health care organizations that provide diagnostic imaging services.[1]

Medical experts have emphasized the importance of facilities utilizing diagnostic imaging to take necessary precautions to minimize the risk of radiation exposure. While experts may have differing views on the risks of cancer from diagnostic imaging, there is agreement that care should be taken in weighing the necessity of a given level of radiation against those risks, and steps that should be taken to eliminate avoidable radiation exposure and long-term damage.[2] The fact that diagnostic imaging has become increasingly available to patients has also meant that the country's exposure to ionizing radiation has almost doubled in the past 20 years.[3] In light of these statistics, many health care providers have worked to restructure their radiation safety standards by focusing on areas such as CT protocols, development of incident management policies and procedures, and procurement of new technologies and software to track and monitor radiation dosage.[4] The Joint Commission's new imaging standards will target those states and/or health care providers who have yet to adopt such safety measures.

After recognizing the need to more heavily regulate quality and safety issues in radiology, the Joint Commission met with and took recommendations from diagnostic imaging experts, professional associations, and accredited organizations, to devise these new standards which not only expand upon the already existing requirements, but also ensure that imaging protocols remain current.[5] This was achieved by focusing on patient safety, including radiation safety, oversight of imaging services, overall staff competency, and equipment maintenance.[6] According to Joint Commission Executive Vice President, Margaret VanAmringe, the intended goal is to "ensure that organizations providing imaging services have the requisite infrastructure and safety culture to minimize radiation exposure to patients and staff and provide safe and effective care."

Hospitals and other imaging facilities will have until July 1, 2014 to meet the newly revised radiation safety rules, or risk losing Joint Commission accreditation, as well as Medicare and Medicaid participation.

The safety standards addressed in the prepublication requirements include: (i) managing safety and security risks involving patients with special circumstances, such as claustrophobia or medical implants; (ii) risk management related to hazardous materials and waste, including assessment of staff radiation exposure levels by a radiation safety officer or medical physicist; (iii) annual performance evaluations of all imaging equipment by a diagnostic medical physicist; (iv) mandatory ongoing education for radiologic technologists, including training in radiation dose reduction techniques; (v) minimum competency for radiology technicians, including registration and certification by July 1, 2015, by either the American Registry of Radiologic Technologists or the Nuclear Medicine Technology Certification Board; (vi) documentation of CT radiation doses in the patient's clinical record; and (vii) continuing collection of data on radiology incidents and injuries.[7] These changes will be implemented in phases. The first phase, which will take effect July 1, 2014, will focus on computed tomography, nuclear medicine, positron emission tomography, and magnetic resonance imaging. The second phase is to be implemented by July 1, 2015, and will focus on fluoroscopy, required qualifications for imaging clinicians, and cone beam CT used in dental offices and oral-maxillary surgery practices.

1 The Joint Commission, is an independent, non-profit organization which accredits and certifies more than 20,000 health care organizations and programs in the United States, with the goal of improving health care by evaluating and educating organizations so that they can provide safe, effective and high quality care to the public; http://www.jointcommission.org.

2 *Radiation Risks of Diagnostic Imaging,* 47 The Joint Commission Sentinel Event Alert 1, (2011) (hereinafter "Sentinel Event Alert").

3 Neomi Mullens, *Are you ready to Comply with New Radiation Safety Rules?*, AuntMillie.com (February 6, 2014); http://www.auntmillie.com.

4 *Id.*

5 Elizabeth Eaken Zhani, *Joint Commission Announces New and Revised Diagnostic Imaging Standards,* The Joint Commission (February 6, 2014); http://www.jointcommission.org.

6 Zhani, *supra* note 6.

7 See, The Joint Commission Prepublication Requirements, at http://www.jointcommission.org.

Imaging Standards ly 2014

While compliance with these new standards is important for all facilities seeking to maintain Joint Commission accreditation, it is equally as important for the facilities and hospitals that intend on continued participation in Medicare and Medicaid reimbursement programs. Since January 1, 2012, Medicare has required that advanced diagnostic imaging, including MRI, CT, PET, and nuclear medicine imaging, be billed by those providers which are accredited by one of the Centers for Medicare & Medicaid Services approved accrediting organizations.[8] Hospitals and other imaging facilities will have until July 1, 2014 to meet the newly revised radiation safety rules, or risk losing Joint Commission accreditation, as well as Medicare and Medicaid participation. It is recommended that the new requirements in the *2014 Ambulatory Care, Critical Access Hospitals, and Hospital Comprehensive Accreditation Manual*, published this month, be carefully reviewed in order to ensure up-to-date compliance.[9]

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Thomas A. Mobilia is a Senior Partner and trial attorney at Martin Clearwater & Bell LLP who has defended the firm's hospital clients, medical practices and physicians in high-exposure malpractice cases in state and federal courts for more than 20 years. Mr. Mobilia also represents physicians and health care professionals in disciplinary proceedings brought by the New York State Department of Health, Office of Professional Medical Conduct and Office of Professional Discipline.

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8 *Medicare Coverage of Imaging Services*, Department of Health and Human Services: Centers for Medicare & Medicaid Services, June 2013, available at: http://www.cms.gov/

9 Zhani, *supra* note 6.

Client Advisory:
Physician Profile Requirements

The Partners at MCB believe that it is a primary responsibility to keep clients advised of developments in health care law to prevent regulatory exposure.

Recently, the Office of Professional Medical Conduct (OPMC) has advised that the failure of a New York Physician to update his or her Physician Profile may lead to disciplinary action. Physicians have been required to update their Profiles pursuant to New York State Public Heath Law 2995 previously, but the change is that now physicians may be disciplined for not keeping their profiles up to date.

Our attorneys have extensive experience in representing physicians and other health care professionals in investigations and disciplinary proceedings brought by the OPMC and OPD. If you have any questions regarding regulatory matters, please contact our Managing Partner, Michael A. Sonkin at sonkim@mcblaw.com.

The Employment Lawyer's Prescription:

Is a Request for an Indefinite Leave of Absence a Request for a Reasonable Accommodation?

BY STEVEN M. BERLIN

What if you have an employee who is on a medical leave of absence and unable to provide a return-to-work date? Do employers have to hold the position open in case the employee might be able to resume his or her duties sometime in the future? In New York, the answer may depend on whether the employee works in New York City.

Recently, in the matter of *Romanello v. Intesa Sanpaolo, S.p.A.*, the New York Court of Appeals addressed the issue of whether a request for an indefinite leave of absence is a reasonable accommodation. When a bank executive did not return from a medical leave after expiration of his three months of protected leave under the Family and Medical Leave Act, the bank's attorney sent a letter inquiring as to the executive's intentions. The executive's lawyer responded that his client's return-to-work date was "indeterminate" but that the executive had no intention of abandoning his position. Faced with what it interpreted as a request for an indefinite leave of absence, the bank terminated the executive.

The executive sued, claiming disability discrimination under both the New York State and City Human Rights laws. The bank successfully moved to have the lawsuit dismissed. Eventually the case was appealed to New York's highest court, the Court of Appeals, which considered whether the executive can pursue a claim against the bank for firing him after he indicated his desire to continue working but because of his condition could not provide a return-to-work date.

Under the State Human Rights Law, a protected disability exists if the employee is able to perform in a reasonable manner the activities involved in the job or occupation with a reasonable accommodation that does not impose an undue hardship on the business. To prevail on a disability discrimination claim, the employee must request a reasonable accommodation and show that the employer unreasonably failed to provide it. The court found the state law claim was properly dismissed. By never offering any indication as to when he would return to work, the executive failed to establish that he requested a reasonable accommodation to enable him to perform his essential functions, which the employer could be held responsible for failing to provide.

On the other hand, the court recognized the City Human Rights Law requires that it be broadly interpreted to protect rights of employees. That law broadly defines disability as a physical or mental impairment and places the burden on the employer to prove as a defense that either: (1) the employee could not, with a reasonable accommodation, satisfy the essential requisites of the job, or (2) the accommodation would place an undue hardship on the company. Because the employer had not met its obligation to plead and prove that the executive could not perform his essential job functions with a reasonable accommodation that would not cause undue hardship, the court reinstated the New York City claim.

So, what is the employment lawyer's prescription when an employee seeks an indeterminate leave of absence from work due to a disability? The answer, obviously, depends on the laws under which the employee is seeking the accommodation. Under the state law, such a request is not a reasonable accommodation. Under the city law, such a request may or may not be a reasonable accommodation; it is up to the employer to plead and prove it is not. In addition, be mindful that an employee working for a company with more than 25 employees may also seek a claim under the federal Americans with Disabilities Act (ADA). Under the ADA, while indefinite leave would usually not be considered a reasonable accommodation, it may be under the specific facts and circumstances at issue. Therefore, when faced with this issue, an employer should perform a thorough and careful analysis with the help of its employment lawyer before responding to such a request.

Reprinted from January 2014 *MD News

Partner Steven M. Berlin is the head of Martin Clearwater & Bell LLP's Employment and Labor Practice Group. For more information, visit www.mcblaw.com.

MCB News

Dana L. Brubaker and Yuko A. Nakahara Named Partners as of January 2014

Dana L. Brubaker joined Martin Clearwater & Bell LLP as an associate in June 2009. Ms. Brubaker's practice encompasses all areas of medical malpractice litigation and personal injury defense. Ms. Brubaker defends doctors and hospitals in professional liability matters and has assisted physicians in OPMC proceedings. Ms. Brubaker received her J.D. in 2004 from Syracuse University College of Law and her B.A. from Syracuse University. Prior to joining MCB, Ms. Brubaker was an Assistant District Attorney at Queens County District Attorney's Office. Ms. Brubaker is admitted to practice before the state courts of New York as well as the United States District Courts for the Southern and Eastern Districts of New York.

Yuko A. Nakahara joined Martin Clearwater & Bell LLP in June 2008. Ms. Nakahara's Practice encompasses all areas of medical malpractice. Ms. Nakahara defends individual doctors, nurses, aides and technicians, along with hospitals, nursing homes and dialysis centers in professional liability matters. Ms. Nakahara received her J.D. from St. John's University School of Law in 2004 and her B.A. from the State University of New York at Stony Brook in 2001. Prior to joining MCB, Ms. Nakahara was a Litigation Attorney at Brand, Glick & Brand P.C.. She is admitted to practice before the New York State Courts and the United States District Courts for the Southern and Eastern Districts of New York.

MCB Announces the Opening of Its Rochester Office

The Firm has recently expanded to upstate New York. In January 2014, MCB opened an office in Rochester, New York. The office is located in the historic Powers Building at 16 West Main Street, Suite 728, Rochester, NY 14614. For additional information, please contact Michael A. Sonkin, Managing Partner, at sonkim@mcblaw.com

Kenneth R. Larywon Named Chair-Elect of NYSBA Health Law Section

MCB is pleased to announce that Senior Partner Kenneth R. Larywon is the Chair-Elect of the Health Law Section of the New York State Bar Association with his term beginning June 1, 2014. Mr. Larywon previously served as the Vice Chair of the Health Law Section.

SAVE THE DATE

Summer 2014: Webinar CLE
Employment & Labor Law Update

Wednesday, June 18, 2014
9:30 am - 11:30 am

2 NY State CLE Credits

Recent Defense

October 2013

Premature Discharge Not the Cause of Death

Senior Partner John L.A. Lyddane, with the assistance of Partner Steven A. Lavietes, produced a defendant's verdict in Supreme Court, Richmond County. In this case, an adult male patient was treated for abdominal pain over the course of a week in the hospital, but died as a result of mesenteric ischemia shortly after discharge. The defense pathologist showed that showers of microembolic from the aorta caused an inoperable occlusion of the mesenteric arteries, from which the patient's death was inevitable.

Conservative Treatment and Post-Operative Injuries Disproved at Trial

Senior Partner Jeffrey A. Shor recently received a defense verdict in Supreme Court, Nassau County in a case involving a 46 year-old federal air marshal, who underwent a surgical excision of the plantar heal spur and plantar fascia tenotomy performed by the defendant-podiatrist. Post-operatively, plaintiff continued to complain of pain and was subsequently diagnosed with an incomplete stress fracture at the operative site and Reflex Sympathetic Dystrophy ("RSD") and with associated pain resulting in his inability to work and substantial lost earnings. Plaintiff claimed that conservative modalities should have been utilized for a longer period of time before attempting surgical treatment. The defense maintained that following a proper informed consent, plaintiff declined conservative measures and opted for surgery. The defense's neurologist testified that the plaintiff did not possess any of the sign and symptoms commonly associated with RSD.

November 2013

Unavoidable Extreme Prematurity

Senior Partner Bruce G. Habian obtained a defense verdict in Supreme Court, Queens County in a case involving a patient with 22 3/7 gestation pregnancy who presented with contraction activity, and severe dilated membranes; with an appreciation of the non-viable status of the fetus, the mother was counseled for potential termination and refused. Careful observation was undertaken, after amniocentesis failed to identify an offending organism. Plaintiff argued for antibiotics, consideration for cerclage, and tocolytics, so as to extend the labor. These modalities were not indicated in consideration of the lack of identification of infection, and the progressive membrane status. The mother delivered a viable infant at 23 weeks; extensive cerebral palsy insued. A defense verdict was obtained in this complicated obstetrical case. Any meaningful extension of the gestational age was not accepted by the jury. The dangers of maintaining the pregnancy - given the infectious trigger of the contractions - were most apparent. In this clinical setting, the mother's health concerning systemic infection was the focus of the defense.

Save the Date

MCB's Biennial Fall Ethics CLE

Thursday, October 23, 2014
9:00 am - 1:00 pm

Presented by: John L.A. Lyddane, Esq. and Anthony E. Davis, Esq.

4 NY State Ethics CLE Credits

Verdicts

Renal Failure Attributed to Visicol Prep

Senior Partner John L.A. Lyddane received a defense verdict in Supreme Court, Nassau County in a case involving an adult male who claimed that his gastroenterologist negligently prescribed a phosphosoda colonoscopy preparation which caused renal failure requiring a kidney transplant. Although the patient's treating nephrologist testified at trial that the Visicol caused the renal failure and should not have been used, the defense proved that the patient had idiopathic kidney failure and the defendant physician was exonerated.

Femoral Neuropathy Unrelated to Surgery

Senior Partner Rosaleen T. McCrory received a defense verdict in a case involving a patient who underwent an exploratory laparotomy, extensive lysis of adhesions, and a completion proctectomy/abdominoperineal resection. Plaintiff alleged that during the the completion of the proctectomy, the defendant-physician negligently positioned plaintiff, allowed him to remain the lithotomy position for an extended period of time and/or failed to move the self-retained retractors during the procedure allowing unrelenting pressure on the femoral nerve. As a result, plaintiff alleged that as a result, he sustained a femoral nerve injury resulting in a permanent femoral neuropathy. The jury returned a unanimous verdict finding that a femoral neuropathy was clearly a known risk of the surgery and that plaintiff's expert failed to set forth any legitimate theory of negligence regarding the surgery.

December 2013

Renal Failure Attributed to Negligent Lithotripsy

Senior Partner John L.A. Lyddane, with the assistance of Partner Scott Frycek, produced a defendant's verdict in Supreme Court, Suffolk County. The case involved an elderly male patient who claimed that his urosepsis and kidney failure were due to his urologist's three attempts to break up a stone too large to have been treated with lithotripsy. The subsequent treating urologist had stated in the subsequent hospital records that the patient was "completely improperly treated," but this portion of the record was excluded from evidence.

January 2014

Postoperative Hemorrhage Not Fault of Surgeon

Senior Partner John L.A. Lyddane and Partner Scott Frycek received a defendant's verdict in Supreme Court, Nassau County. The case involved a 46 year old father of two underwent resection of a sphenoid wing meningioma by the defendant neurosurgeon and suffered a fatal subarachnoid hemorrhage on the tenth postoperative day. Two days before the fatal event an angiogram showed a possible pseudoaneurysm at the site where a small vessel had been avulsed from the carotid artery at surgery. At trial, it was claimed that intervention was mandated, but the jury accepted the defense position that conservative management was an option within the standard of care.

Trial Judge Strikes Plaintiff's Expert's Testimony

Partner Erik Kapner recently received a unanimous defense verdict in Supreme Court, Kings County in a case involving a diabetic patient who underwent a drainage of a foot ulcer. Plaintiff's foot was found to be stable and the defendant-podiatrist was not called back into the case by the attending physician. Plaintiff went on to develop gangrene, resulting in amputation of the toes at another hospital. Plaintiff claimed that the defendant podiatrist should have continued to follow him. The defense claimed that the care of the plaintiff's foot was taken over by the co-defendants, the attending physician and the infectious disease specialist, who settled before trial. Plaintiff's expert disclosure for expert podiatrist made claims against settling co-defendants. On cross-examination, plaintiff's expert denied that he ever held those opinions and his expert testimony was stricken as inconsistent with expert disclosure. Plaintiff then called a treating podiatrist as his expert, but the jury returned a verdict in favor of the defendant podiatrist.

RECENT DEFENSE VERDICTS... *Continued on page 12*

Recent Defense Verdicts *Continued from page 11*

Osteoporosis Patient Attemps to Hold Gynecologist Responsible for Fractures

Partner Thomas J. Kroczynski recently received a unanimous defense verdict in Supreme Court, Suffolk County, in a case involving a 56-year old woman with a history of left leg fractures who was taking Premarin, Calcium supplements and multivitamins (MVI). After a bone mineral density study showed worsening osteopenia, plaintiff decided to stop taking Premarin because of its potential risks. The defendant-gynecologist offered the option of taking a Bisphosphonate, or continuing osteopenia treatment with only Calcium and MVI; the patient chose the latter. The patient developed osteoporosis of the spine and fell and fractured her right tibia and fibula. Plaintiff claimed she should have been prescribed both Premarin and a Bisphosphonate when her osteopenia worsened, and had this been done, it would have reduced the risk of osteoporosis developing and the fractures of the right tibia and fibula from occurring. The defense was able to show that it was acceptable practice to treat plaintiff's osteopenia with Calcium and MVI and that osteoporosis did not cause or contribute to the fractures of the right tibia and fibula.

A Life Saved Yet, with Significant Gynecologic Complications

Senior Partner Bruce G. Habian received a defense verdict in Supreme Court, New York County in a case involving a patient who presented to the emergency room with significant hemorrhage (clinically noted, as well as, with low lab values) 10 days after a normal spontaneous vaginal delivery. In an attempt to avoid an indicated hysterectomy, the attending obstetrician performed a D&C and packed the uterus, with a plan to embolize the arteries in the future. During the course of the packing, significant lacerations of the bladder, cervix and vaginal wall occurred, ultimately necessitating a hysterectomy and significant bladder repair. Notwithstanding these complications, the jury returned a defense verdict. This indicated an appreciation for the temporizing nature of the conservative - packing - approach in light of the severe bleeding. The ultimate hysterectomy was argued as a potential procedure at the outset, essentially, unavoidable under the circumstances.

Defense Practice Update is a publication of Martin Clearwater & Bell LLP.

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