MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

FALL 2011

THE ROLE OF THE NON-PARTY PHYSICIAN WITNESS IN PERSONAL INJURY LITIGATION

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

Physicians who have treated a personal injury plaintiff before, during or after the events in issue, often have a unique perspective which can be helpful to the finder of fact at trial. The purpose of this article is to explore how such non-party treating physicians can be identified, interviewed, and brought to the assistance of the litigants in their search for the truth.

THE VALUE OF NON-PARTY PHYSICIAN WITNESSES

Non-party treating physicians are frequently unaware that their patients are litigating issues which involve their physical condition. Hospital records and even the doctor's office records may be secured by parties to the litigation without the knowledge of the treating physician, who does not participate in that aspect of medical record management. The patient presumably reports symptoms, history, and treatment outcome in a correct and truthful fashion, oriented to the medical complaints which need to be addressed. The result can be that there is a contemporaneous and accurate record of the plaintiff's complaints, history, interventions, and outcome which is unaffected by the ongoing litigation and helpful to one or more litigating parties well after the fact. The records are generally preserved by custom or pursuant to law, and can furnish an accurate record of the various aspects of the plaintiff's injuries or disability which does not depend on the memory of a potentially biased party to the lawsuit.

The assistance such evidence can provide to the litigants is without bounds and can extend to any aspect of liability, causation, or damages. The carefully documented records of prior care can give insight into the extent and trajectory of prior disability or underlying disease. Where the accepted standards of testing or examination are in issue, contemporaneous records of treatment can yield valuable insight which is not affected by retrospective "expert" analysis. Where there is an issue as to the extent of treatment, monitoring, therapy, or assistance needed as a consequence of an injury or condition, what better way to find the truth than to see what the physi-

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cian responsible for the litigant's care did to discharge the responsibility to a compliant patient whose objective was to regain or preserve good health? Likewise, the treating physician may be in the best possible position to give sound evidence on the prognosis of the particular patient, the residual effects of the injury or condition given the patient's other medical issues, and the extent of any disability expected to have lasting effects.

IDENTIFYING NON-PARTY PHYSICIAN WITNESSES

The identification of the treating non-party physician who is in a position to provide supporting evidence can be difficult. Since patient confidentiality issues, poor patient recollection of past treatment, handwriting and record-keeping issues, and complex medicine may in combination obscure valuable evidence, a careful approach to discovery is required. The search expands from the records of treatment for the injury which is the subject of the lawsuit, and may not end before thousands of pages of hospital and medical records have been secured and carefully reviewed. Since the scope of discovery is more comprehensive than the scope of evidence admitted at trial, both plaintiff and defendant are obligated to search out any record of medical care which could reasonably lead to admissible evidence, and no attorney or judge should presume to know that a record yet to be secured or reviewed will not lead to important and necessary evidence.

Life insurance applications, job applications, pharmacy records, employment physical examination reports and other ancillary records have often led to the discovery of highly relevant records of other injuries or ostensibly unrelated medical conditions which may still be relevant to issues of damages, prognosis, disability, or life expectancy. The attorney who restricts or allows others to restrict the scope of record discovery may be creating problems for the trial court and jury when the case is tried, and depriving one or more of the parties of effective representation by counsel.

THE USE OF *ARONS* AUTHORIZATIONS

In *Arons v. Jutkowitz*,[1] the Court of Appeals held that an attorney may privately interview an adverse party's treating physician, when the adverse party has placed his or her medical condition in controversy, and that the adverse party may be compelled to provide HIPAA-compliant authorization permitting such interviews. It is now settled law that *Arons* authorizations are available during discovery and are not just a trial preparation tool. Obtaining *Arons* authorizations in discovery is an important task because all too frequently a treating physician has not recorded all that is important, has made records in shorthand or handwriting which defies interpretation, or has not provided a complete copy of the patient's chart when it was requested. If *Arons* interviews are left to the trial preparation phase, it may be too late to follow up in important areas, and the attorney may be committed to a trial strategy which is based on erroneous or incomplete information.

It can be a challenge to explain to the non-party treating physician that the *Arons* authorization does in fact permit her to speak to an attorney who does not represent her patient. However difficult it may be, in the appropriate case it is the obligation of the attorneys to follow up on their efforts to secure the appropriate and necessary information needed to advance the interests of their clients. The interview does not need to be formal or even in person, and can be limited to obtaining answers from the witness which have been submitted in writing prior to the interview.

DEPOSITIONS OF NON-PARTY PHYSICIANS

Where records of treatment and *Arons* interviews have identified treating professionals who possess important evidence beyond what is available from admissible documents, thought must be given to how that evidence is to be preserved and presented to the trier of fact. Fortunately, the deposition of a licensed physician may be read to the jury at trial without proving that the witness is otherwise unavailable (CPLR 3117[a][4]), so physicians who may be difficult to schedule for court appearances may be deposed without inconvenience to their patients or themselves. If for reasons of infirmity, age, medical condition, career changes, or other factors, a physician witness may not be available at the time of trial, the deposition transcript will always remain available. With all of the factual foundation testimony in admissible form (the executed deposition transcript), there is far less uncertainty as to whether the basis for expert testimony will be available to support the contentions of a party at trial. The death or unavailability of a key witness prior to trial could have a profound effect on the outcome of the case at trial, as many trial attorneys know from personal experience.

[1] *Arons v. Jutkowitz*, 9 N.Y. 3d 393(2007).

SECURING THE NON-PARTY DEPOSITION

Most non-party treating physicians have plenty to occupy their time and cannot be expected to be anxious to spend an afternoon with several strangers from the legal profession whose divergent interests and probing questions do not make for the most pleasant of social interactions. Although the CPLR's subpoena power provides a tool to overcome the reticence of witnesses, the physician can usually be convinced that submitting to a deposition in familiar surroundings at a convenient time is preferable to the vagaries of a live appearance at trial, where travel, delays, and scheduling issues can create far more inconvenience. If the non-party witness comprehends the difference between changing a suddenly inconvenient deposition date and changing a scheduled court appearance for a jury trial, cooperation can be obtained more easily. Paying the witness a reasonable amount to compensate for lost time from work would also help secure cooperation, provided it does not provide a basis for an argument that the payment biased the witness in favor of the proponent of the testimony.[2]

FOREGOING THE DEPOSITION

Where there is reason to expect that the witness will be available for trial, and the party which is favored by the testimony feels that for tactical reasons it is preferable to produce a live witness, it may be counterproductive to secure the deposition of that witness prior to trial. This scenario prompts the question as to what disclosure has to be made in advance of trial with regard to the witness, to ensure that the witness can testify in all contemplated areas at trial. The non-party physician is a hybrid between a fact witness who testifies based upon personal observation, and an expert witness who is permitted to state opinions because of training and experience in an area which is beyond the knowledge of the average juror. Although CPLR 3101(d) requires fairly explicit disclosure in advance of an expert's testimony, the courts have made it very clear that the testimony of a treating physician is not to be precluded due to the absence of an expert response for that witness.[3]

Trial courts have differed, however, on the extent to which the treating physician may testify in the absence of an expert response, some precluding any opinion testimony whatsoever, and some permitting only that opinion testimony which was incidental to the treatment rendered by the witness. It is settled law that a subpoenaed expert cannot be forced to give expert testimony for which the expert is not compensated.[4] To remove all doubt, and prevent lengthy argument and *ad hoc* rulings at trial, a party could arrange to compensate the non-party witness and prepare a detailed CPLR 3101(d) response for the witness.

Where there is reason to expect that the witness will be available for trial, and the party which is favored by the testimony feels that for tactical reasons it is preferable to produce a live witness, it may be counterproductive to secure the deposition of that witness prior to trial.

The litigant has to weigh the options carefully in this area before deciding how to proceed. A non-party treating physician makes an attractive witness because she is presented as one who has the perspective of an independent professional whose sole focus has been upon rendering care to the injured party. If that witness becomes a paid expert for any of the parties to the case, there is a chance that the jury will see her as having less of the desired independence and attractiveness. Furthermore, if the non-party treating physician does the job of the party's expert witness thoroughly enough, there could be an argument that the subsequent expert's testimony would be cumulative and should be precluded.

PRODUCING THE NON-PARTY PHYSICIAN AT TRIAL

Most non-party physician witnesses who receive a subpoena for trial consult an attorney regarding compliance. More often than should be the case, this conversation results in the attorney for the witness calling the attorney who served the subpoena and suggesting that the witness has no information helpful to the litigant, the attorney for the litigant will not be happy with the witness's testimony, the witness will not speak with the litigant's attorney prior to trial, and the witness will only answer those questions which he is directed to answer by the trial court, making it very obvious that the witness is testifying against his will. There are legitimate limits to

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[2] See New York Code of Professional Responsibility, Rule 3.4(b)

[3] See e.g., *Andrew v. Hurh*, 34 A.D. 3d 1331 (4th Dept. 2006) lv den 8 N.Y. 3d 808 (2007).

[4] See e.g., *Gilly v. City of New York*, 69 N.Y. 2d 509 (1987); *McDermott v. Manhattan Eye, Ear & Throat Hospital*, 15 N.Y. 2d 20 (1964).

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what can be required of a subpoenaed witness, but the attorney for the witness has ethical duties which should preclude this type of telephone call. The Code of Professional Responsbility provides that an attorney, among other things, shall not suppress any evidence that the lawyer or the client has a legal obligation to reveal or produce.[5]

Although it is not easy to find clearly written precedent on what has occurred to attorneys for witnesses who place their obligation to the witness above the interests of the tribunal, it does not strain the imagination to see where this might be sanctionable conduct. Rarely would the attorney for the witness know the litigant's case well enough to correctly conclude that the testimony would be less than helpful to the litigant. The trial of a lawsuit is expensive and often unpredictable, and it should be a rare trial attorney who subpoenas a witness to give testimony where that witness will not provide material evidence on the points in issue. The ends of justice are not served by the witness who attempts to evade the responsibility to testify, and worse can be said of the attorney who gives legal assistance to that evasion.

The Role of the Trial Witness

Only in an unusual case would the non-party physician's testimony supplant the need for expert medical testimony on the part of the litigant. That being the case, careful attention is needed to define the roles of the treating physician and the expert witness. There is a spectrum of possibility, but in each situation the distinctions remain important to preserve.

The non-party physician may be needed to provide solely factual testimony where there is a dispute among the parties on one or more subjects, and the history taken by the witness or some aspect of her observations or treatment helps to resolve the conflict. Examples include history, medications, diagnoses, and treatments which are denied at trial but documented in the records and memory of the witness. There may be a mixed issue of factual observation and medical expertise where the non-party treating doctor has acted in a manner which supports the litigant's contention. Examples include decisions (and their basis) by contemporaneous treating physicians who did not perform testing which the defendant was allegedly obligated to perform. There may also be circumstances in which the standard of care at the time and place of treatment is in issue, and the director of the hospital service testifies on a pure standard of care issue with marginal connection to the patient.

The testimony of physician witnesses from differing specialties is not cumulative even where it touches upon the same subject matter, since each can bring a different perspective to bear on the issues. However, the trial court and jury are all presumably intelligent people who do not need multiple witnesses to make the same points. Here it is useful to orient the non-party physician witness to what occurred in the course of the treatment in which she participated, and allow the expert witness to speak to the standard of care and give the causation opinions. This allows the non-party physician to draw on the strength of her knowledge of the patient and the precise environment in which the treatment was rendered. The expert witnesses have less insight here, and their strength lies in their qualifications as experts and the impartiality they can maintain precisely because they were not exposed to the precise environment in which the treatment was rendered.

A well balanced defense may require the participation of non-party treating physicians, and their presence and testimony at trial could communicate a legitimacy which is not conveyed by either the parties or their expert witnesses. Whether non-party physicians can advance the position of a litigant requires careful analysis by the trial attorney, who needs a solid basis for that analysis.

[5] See New York Code of Professional Responsibility, Rule 3.4 (a)(1).

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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

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.

The Responsibilites of the General Dentist to Screen for Oral Pharyngeal Cancers

BY: JEFFREY A. SHOR & RYAN M. DONIHUE

According to the Centers for Disease Control, more than 36,000 individuals in the United States will be diagnosed with oral cancers this year. Notwithstanding advances in chemotherapy, radiation therapy, and surgery, the five year survival rate has been estimated at 52%. While the number of people developing and dying (approximately 8,000 annually) from oral cancers continues to grow, the general dentist is the first line of defense in screening for and identifying potential oral cancers. This article will address the issues and defense in connection with dental malpractice cases involving claims of failure to diagnose oral cancer.

The American Dental Association reported that over 60% of the population visits the general dentist at least one time per year. Of that population, less than 15% reported having an oral cancer screening performed by their dentist. Since the patient is being seen in the office on a regular basis, it is the responsibility of the dentist to perform an oral cancer screening annually.

The oral cancer screen consists of a two part process: (i) obtaining and reviewing a detailed social and medical history, and (ii) performing a comprehensive physical examination. A practitioner's first step is to obtain and review a detailed social and medical history from the patient since there are several known risks factors that exist which increase the presence of oral cancers. These include: age (individuals over the age of 40); heavy consumption of alcohol; cannabis use; tobacco use; failure to consume a sufficient amount of fruits and vegetables; and not utilizing sun protection around the mouth and lips. Additionally, there has been a recent trend of younger individuals developing oropharyngeal squamous cell carcinoma due to high risk sexual behavior. A positive history of any of these risk factors must be documented in the office record. It should be mentioned that many of the generic "Dental/Medical" history forms do not specifically address all, if any, of these risks factors. As such, a dentist utilizing such a form must document that the social and medical history was discussed with the patient and note all positive and/or negative risk factors in the office record.

The next step for the practitioner is to proceed with her extensive physical examination of the patient. This will include a visual inspection and palpation of the head, neck, oral and pharyngeal regions, palpation of the nodes in the neck and palpation and observation of the floor of the mouth, tongue, and oral and pharyngeal mucosa. The tongue should be protracted with gauze to observe the posterior, lateral and base of the tongue.

A practitioner's first step is to obtain and review a detailed social and medical history from the patient since there are several known risks factors that exist which increase the presence of oral cancers. These include: age (individuals over the age of 40); heavy consumption of alcohol; cannabis use; tobacco use; failure to consume a sufficient amount of fruits and vegetables; and not utilizing sun protection around the mouth and lips.

Any abnormal finding observed during the course of the examination must be communicated to the patient and documented in the office record. The documentation of a normal exam should specifically state that. Similarly, should it be determined that the physical examination was found to be normal, it must also be noted that an oral cancer screening was performed and was found to be negative.

Once a suspicious area has been detected on exam a definitive diagnosis is achieved via biopsy. In light of the fact that over 90% of all oral cancers are squamous cell carcinomas, the dentist must advise the patient of the abnormal finding and provide an immediate referral to an oral pathologist or an oral and maxillofacial surgeon for further evaluation, diagnosis and treatment.

It should be noted that while there are a large number of abnormal tissues and lesions in the mouth, which when observed by the dentist, appear remarkably similar to an oral cancer (i.e., herpes simplex ulceration and aphthous ulcerations), any abnormal tissue or lesion present for fourteen days or more also warrants advising the patient as to the clinical finding and immediately referring to a specialist

Should the patient be non-compliant in following up with the recommended specialist, the practitioner must

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THE RESPONSIBILITES OF THE GENERAL DENTIST TO SCREEN FOR ORAL PHARYNGEAL CANCERS

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document this in her office record, noting that the patient was advised of the need to see the specialist as well as that the patient has chosen not to, or has delayed doing so, and that the importance of following up with the specialist was reinforced with the patient.

Since it is anticipated that the number of individuals developing oral cancer will continue to increase, the general dentist must take a more aggressive approach in performing yearly oral cancer screenings on patients. Furthermore, in order to avoid a potential dental malpractice based on a claim of failure to diagnose oral cancer, the practitioner must take affirmative action in documenting in the office records that the oral cancer screenings were performed and any abnormal findings were communicated to the patient with a recommendation to be seen by the appropriate specialist.

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Jeffrey A. Shor is a Senior Partner at Martin Clearwater & Bell LLP, whose practice encompasses all areas of medical malpractice and dental malpractice defense as well as the defense of professional liability actions. His case representation has been noted in *New York Magazine* and he is a member of the Litigation Counsel of America, a trial lawyer honorary society.

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MCB FALL CLE SAVE THE DATE

The Role of Non-Party Treating Physicians in the Defense of Personal Injury Claims
Thursday, October 20, 2011; 8:30 a.m. - 12:30 p.m.
Helmsley Hotel, Knickerbocker ABC

MCB Senior Partners John L.A. Lyddane, Michael F. Lynch and Michael A. Sonkin will present the Firm's Fall CLE, entitled "The Role of Non-party Treating Physicians in the Defense of Personal Injury Claims." The program will explore the potential benefits and pitfalls of the evidence provided by treating physicians who are not parties to the lawsuit. It will cover the manner in which witnesses can be identified, their records effectively used, their interviews obtained, and their testimony secured for the defense, or neutralized where necessary. This program is approved for 3.5 New York State CLE credits. This program is also being offered as a webinar for our clients. For more information or to register, please contact Lauren Rogers, Marketing Manager, at 212-471-1235 or rogerl@mcblaw.com

PRACTICE SPOTLIGHT: NURSING HOME LAW

MCB's extensive experience in defending traditional medical malpractice claims has led to its prominence in the defense of nursing homes and other long-term care facilities. Our background provides MCB attorneys with the ability to analyze and defend the medical issues in nursing home cases, while at the same time recognizing the aspects of nursing home cases which differ from those presented in traditional malpractice cases. The Firm currently defends nursing homes and long-term care facilities, both through insurers and on a self-insured basis. The Firm's experience includes the defense of claims involving:

- Pressure ulcers
- Resident falls
- Alleged neglect and abuse
- Alleged assaults upon residents
- Nutrition and hydration
- Medication errors

The Firm works to anticipate aggressive discovery tactics employed by plaintiffs' attorneys and formulates a proactive defense in each case. We realize that nursing home defense cases require early and exhaustive investigation and work-up in multiple areas, and we seek to identify problems and obtain and preserve helpful information.

As in other areas of practice, the Firm believes communication is an integral part of its long-term relationship with its clients. At the outset of a case, the attorney meets with appropriate personnel at the facility to discuss each case, and keep them informed of developments. MCB attorneys follow new developments in nursing home law, so that clients are provided with proactive solutions to potential legal problems.

MCB is well versed in the medical issues involved in these cases, including geriatric medicine, pressure ulcer care and prevention, nutrition and hydration, and wound care. The Firm has extensive experience in dealing with statutory claims brought under New York's Public Health Law. MCB's attorneys are fully familiar with the various Federal and State statutes and regulations pertaining to nursing homes, enabling them to defend claims involving violations of such statutes and regulations. The Firm has also developed a library of legal and medical materials dealing specifically with nursing home issues, and maintains a panel of experts in the field, including medical, nursing and administrative experts with actual "hands-on" experience in nursing homes.

MCB is actively involved in alternative dispute resolution, including mediation of nursing home cases, where appropriate. Please contact Joseph L. DeMarzo with any questions at demarj@mcblaw.com or 212-916-0911.

CASE IN POINT

BY: JOSEPH L. DEMARZO AND CHARLES S. SCHECHTER

A long term care case was recently tried to verdict in Supreme Court, Nassau County. The case involved treatment rendered to a then 56 year old married woman with a history of progressive dementia. The decedent resided at the defendant facility until her death 5 1/2 years later. During the admission, her condition deteriorated as her dementia progressed. In the last year of the decedent's life, she lost the ability to ambulate and was wheelchair bound. Although the decedent was not yet bed immobile, a care plan required routine turning and positioning. However, turning and positioning was not implemented until several months later.

Five months after the decent became wheelchair bound, blisters were noted on the left hip and right shoulder, and a lesion was observed on the right buttocks. A physician was consulted and determined that the buttocks lesion was an abscess. Treatment of the abscess was started immediately, and a turning and positioning schedule was also implemented. Over the next few weeks the abscess opened and became infected. The decedent was treated at a local hospital for what was diagnosed there as an infected Stage IV pressure ulcer and sepsis. The ulcer was debrided and the decedent returned to the nursing home, where she expired several months later.

At trial, plaintiff alleged nursing home abuse, negligence and violations of Public Health Law 2801-d. Plaintiff alleged that defendant facility violated seven federal regulations governing nursing home care, and sought both compensatory and punitive damages. Plaintiff focused on wound care management and alleged improper record keeping. MCB contended that the overall management of the resident's care was appropriate, her entire course was dictated by the progressive nature of her disease and that there was no evidence of any abuse. We further contended that the buttock ulcer was an abscess, and not a pressure ulcer, so that any allegations in respect to turning and positioning were immaterial.

After approximately four weeks of trial, the jury returned a defense verdict on all twelve liability questions which were presented for its consideration.

Social Media Policies and to Protect Social Network

BY: STEVEN M. BERLIN

As the phenomenon of social networking continues to expand into the work place, employers have been drafting social media policies to exercise some control over employees' use of such media to make undesirable, unflattering and sometimes defamatory statements about their employer and to protect against other unlawful or inappropriate disclosures. In response, the National Labor Relations Board ("NLRB") has focused on ensuring such employer activity does not discourage or retaliate against workers from engaging in protected concerted activity. Recently, the NLRB, through its Office of Acting General Counsel, has issued a Report Concerning Social Media (the "Report"), which summarizes some of this activity, providing guidance as to what it considers protected activity and in particular, for drafting a social networking policy that will withstand NLRB scrutiny.

Social media includes websites and other technology tools that allow individuals to create public and semi-public profiles and to share information, or as it is more commonly known, to engage in social networking. Some of the more prominent social networking sites include Facebook.com, Linkedin.com and Twitter.com, but social media can also include blogs, texts, e-mail, posts of audio and posting pictures and video. Social networking offers unprecedented opportunities for a business to get its message out and for conversations about the business. When the latter involves conversations by workers about their employers, however, issues of concern to the business as well as to the protected rights of the employees can arise.

There are no laws dealing with social networking specifically. Nevertheless, use of social media may implicate a variety of legitimate concerns, such as privacy rights, unlawful discrimination and harassment, protection of trade secrets, an employer's desire to control or monitor communications about its company, any employer rights to control and monitor employees' activity during and/or outside of work, and, as the NLRB suggests in the Report, employees' rights to engage in protected concerted activity.

By now, most employers probably have workplace privacy, data and electronic communication policies which govern employees' use of such technology. Many have probably reviewed and updated these policies to account for new social media. However, as the Report indicates, whether well intended or not, many of these social media policies run afoul of the current NLRB's interpretations of employees' protected rights.

Even before social networking, legitimate concerns existed as to employees making inappropriate or defamatory statements about their employer, a co-worker or customer, disclosing private, confidential or trade secret information, or engaging in harassing or discriminatory conduct. These and other concerns have been exemplified by the proliferation of social media in our society, including the workplace. More recently the ability with which employees can post work related messages and images on their employers' or their own devices, during or after work hours, to a select or broad audience, and with a much more lasting effect is significantly easier than it has been in the past. As the Report suggests, however, in their eagerness to protect their businesses from this unprecedented potential onslaught of employee communication, employers must also be cognizant of drafting and enforcing policies that do not run afoul of legitimate employee rights.

The Report primarily focuses on the rights of workers provided for in Section 7 of the National Labor Relations Act (the "Act"), which gives union and non-union employees the right to engage in concerted activities for the purpose of "mutual aid or protection."[1] The Report relies on established, pre-social media case law providing that an activity is concerted when an employee acts "with or on the authority of other employees, and not solely by and on behalf of the employee himself."[2] Concerted activity also includes "circumstances where individual employees seek to ini-

1 29 U.S.C. § 157.

2 "Report of the Acting General Counsel Concerning Social Media Cases," Office of the General Counsel, National Labor Relations Board, Division of Operations-Management, Memorandum OM 11-74 (Aug. 18, 2011) at ¶ 11 (citing Meyers Industries (Meyers I), 268 NLRB 493 (1984), *revd. sub nom.* Prill v. NLRB, 766 F.2d 941 (D.C. Cir. 1985), *cert. denied* 474 U.S. 948 (1985), *on remand* Meyers Industries (Meyers II), 281 NLRB 982 (1986), *affd. sub nom.* Prill v. NLRB, 835 F.2d 1481 (D.C. Cir. 1987), *cert. denied* 487 U.S. 1205 (1988).

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tiate or to induce or to prepare for group action" and where individual employees bring "truly group complaints" to management's attention.[3]

Further, the Report provides that an employer commits an unfair labor practice in violation of Section 8 (a) (1) of the Act through the maintenance of a work rule that would "reasonably tend to chill employees in the exercise of their Section 7 rights."[4] In determining if a policy would have such an effect, the NLRB uses a two-step inquiry which is set forth in *Lutheran Heritage Village-Livonia*.[5] First, a rule that explicitly restricts Section 7 activities is unlawful. Second, if the rule does not explicitly restrict protected activities, it may still be unlawful, but only upon a showing that: (1) employees would reasonably construe the language to prohibit Section 7 activity; (2) the rule was promulgated in response to union activity; or (3) the rule has been applied to restrict the exercise of Section 7 rights.

Clearly, the NLRB considers a social media policy that outright prohibits discussion of terms and conditions of employment, such as wages, scheduling or safety concerns, to violate its *Lutheran* test and such policies should be avoided. The question of whether a policy was promulgated in response to union activity and is therefore unlawful goes to a unique set of circumstances that likely does not arise with great frequency.

The Report, however, focuses on policies that were not facially inappropriate but presented the question of whether those social media policies reasonably tended to chill the exercise of Section 7 rights. To that purpose, the Report contains several examples of policy language that it finds acceptable and many more examples of policies that it finds to be overbroad. A review of some of these provides useful guidance to employers.

With many of these policies, the NLRB's concern was that the polices were overbroad and did not contain examples as to what was precluded or specifically exclude Section 7 activity. For example, the NLRB has reasoned that a policy prohibiting employees from making disparaging comments when discussing the company or superiors, coworkers, and/or competitors was unlawful because it contained no limiting language to inform employees that it did not apply to Section 7 activity.[6]

The NLRB similarly disapproved of a policy that emphasized the employer's support of the free exchange of information and camaraderie among employees, but still cautioned that when internet blogging, or engaging in chat room discussions, e-mail, text messages, or other forms of communication employees could not reveal confidential and proprietary information or engage in inappropriate discussions about the company, management, and/or coworkers. According to the Report, that policy unlawfully utilized broad terms that would commonly apply to protected criticism of the employer's labor policies, treatment of employees, and terms and conditions of employment. The policy also did not define "inappropriate discussions" by specific examples or limit it in any way that would exclude Section 7 activity. As a result, an employee could reasonably interpret the policy to prohibit discussion of terms and conditions of employment.

The Report even found overly broad a hospital's social networking policy despite the heightened concerns in a health care setting for patient privacy.

The Report even found a hospital's social networking policy to be overbroad despite the heightened concerns in a health care setting for patient privacy. That policy prohibited employees from using any social media that may violate, compromise, or disregard the rights and reasonable expectations as to privacy or confidentiality of any person or entity. However, it failed to provide a definition or guidance as to what the employer considered to be private or confidential and could be understood by employees to apply, for example, to Facebook postings that are concerted and

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3 *Id.* at ¶ 11 (citing Meyers II, 281 NLRB at 887).
4 *Id.* at ¶ 52, (citing Lafayette Park Hotel, 326 NLRB 824, 835 (1988), *enfd.* 203 F.3d 52 (D.C. Cir. 1999).
5 *Id.* at ¶ 61 (citing Lutheran Heritage Village-Livonia, 343 NLRB 646, 647 (2004)).
6 *Id.* at ¶ 23 (citing University Medical Center, 335 NLRB 1318, 1320-22 (2001)).

Social Media Policies and The NLRB's Quest to Protect Social Networking as Concerted Activity

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relate to working conditions—such as wages.

A policy which prohibited employees from posting pictures of themselves in any media, including the internet, which depict the company in any way, including a company uniform or corporate logo, was also considered by the NLRB to be unlawful because it would prohibit an employee from posting a picture of employees carrying a picket sign depicting the company's name, or wearing a t-shirt portraying the company's logo in connection with a protest involving terms and conditions of employment.

Not all policies addressing these types of employer concerns failed the NLRB's test. A media relations procedure that provided the employer's public affairs office was responsible for all official external communications in support of its policy that one person should speak for the employer to deliver an appropriate message and was found to support a legitimate business interest in limiting who can make official statements for the company and was not so broadly worded that employees would reasonably think they were prohibited from exercising their Section 7 right to speak with reporters about working conditions.

The same policy also prohibited employees from using cameras in the store or parking lot without prior approval from the corporate office. The NLRB stated in the context of the policy, that limitation was not unlawfully overbroad since the only reasonable interpretation was that the cameras referred to are news cameras, not employees' own personal cameras, and therefore, would not chill Section 7 conduct.

These NLRB enforcement actions have not yet been tested in the courts. Nevertheless, the Report underscores the need to be mindful of employees' rights, in particular, Section 7 rights, in revising or drafting social media policies. As with any such policy, employers should determine the legitimate goals and objectives of the policy before drafting. Once potential policies are developed, they should be subject to legal review to ensure they do not intentionally or inadvertently run afoul of employees' rights.

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Steven M. Berlin is a partner at Martin Clearwater & Bell LLP and head of the Firm's Employment and Labor Practice Group. Mr. Berlin has over 25 years of litigation experience and is a frequent author and lecturer in New York and New Jersey on employment law.

MCB Case Analysis & Strategy:
FAILURE TO DIAGNOSE

BY: JOHN L.A. LYDDANE

A claimed delay in diagnosis of cancer is a frequently seen malpractice case. The claim on behalf of a patient with a poor outcome is that the doctor's delay deprived them of an opportunity to be cured. Such was the case in a recent MCB trial that was ultimately tried to a defense verdict after less than two hours of deliberations.

This case involved a 54 year-old patient who was diagnosed with a Stage IIIC high-grade serous carcinoma of the ovaries in the Fall of 2007, after she had been under the care of the defendant-doctor and her colleagues for almost 11 years. The patient had undergone surveillance for a variety of ovarian issues, primarily between 2002 and 2005, followed by a fairly benign interval between 2005 and 2007. The pathologist who studied her tumor at a leading cancer hospital described it as a high-grade serous carcinoma of the ovary with sarcomatoid and dedifferentiated components, placing the histology at the most aggressive end of the spectrum of ovarian malignancies. Although it was claimed that there was a delay in diagnosis of the ovarian malignancy and that the condition was incurable, it appears that this was a very fast-growing malignancy which is generally diagnosed at Stage III or Stage IV.

During opening remarks, the defense stressed the fact that the practice, the equipment, the technologist, and the doctors interpreting ultrasounds in the practice were all certified by the American Institute of Ultrasound in Medicine. It was further stated that the technician was in fact a highly trained sonographic technician who spent 100% of her time performing obstetrical and gynecological sonograms. She was extremely reliable, obtained excellent images, and gave our client gynecologist images and information which were far more reliable than the reports of a randomly selected outside radiologist. After the patient reported symptoms to her primary care doctor and an issue was raised on outside films, the ultrasound study performed in the office in September 2002, essentially eliminated the possibility of ovarian cancer at that point because the findings in the ovary did not have the characteristics of malignancy. Two months later when the patient returned for a repeat study, the cystic changes in the left ovary had resolved and there remained a calcification which was referred to as a "dermoid" that was ultimately shown to be a benign Brenner cell tumor. Several subsequent sonograms showed simple cysts which were never in the same location, consistent with a patient who was still having her menstrual cycle. The patient's initial complaints had resolved by the time she saw our defendant-doctor in 2002, and the patient had no more abdominal symptoms until August of 2007 when she returned to the defendant doctor and the diagnosis was made. Had this been ovarian cancer in September of 2002, the patient would have continued to be symptomatic and the intervening sonograms would not have shown normal findings. By May of 2003, the patient's sonogram was normal, and when it was repeated on March 16, 2005, because of the patient's lengthening menstrual periods, the study was likewise normal.

It was the position of the defense that offering a prophylactic oophorectomy to this patient would not have been in accord with the standard of care and the monitoring performed by the defendant-doctor was in conformity with the good and accepted practice. It was also our position that if the patient had an ovarian malignancy in September of 2002, the issue would have become more prominent with each successive ultrasound and the patient would not have survived until 2007. It was not the standard of care, as the attorney for the patient claimed, to follow a patient such as this one with CA-125 readings and transvaginal sonography every six months, and even if they had been performed, it would not have averted this patient's unfortunate outcome.

The patient who had a very aggressive form of ovarian cancer which in and of itself has a poor prognosis. Ovarian carcinoma and especially this patient's variant form are generally diagnosed at Stage III and the prognosis is never "excellent" as claimed by the opposing experts. Because this was an aggressive form of a cancer which is known to metastasize when it is microscopic, it becomes Stage III before it is clinically

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FAILURE TO DIAGNOSE

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evident. Because it takes a certain amount of tumor bulk to show on serial ultrasound or CA-125 studies, and by the time those studies show that the patient has ovarian cancer, it is almost always Stage III or greater, with prognosis that is fixed by the nature of the malignancy itself. Consequently, it was the position of the defense that there was no opportunity for the defendant to intervene and give this patient a better prognosis than she had from the very aggressive form of ovarian cancer which occurred in her case.

The jury retired to deliberate at 2:37 p.m. At approximately 4:25 p.m., the jury reported that it had reached a verdict. The jury decided all four liability questions in favor of the defense by a vote of 5 to 1.

The verdict was completely appropriate based upon the evidence at trial. At the conclusion of the proof, and again after the verdict was reported, the plaintiff's attorney moved for a directed verdict, and both times his motion was denied without discussion.

JOHN L.A. LYDDANE

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.

MCB Welcomes the Class of 2011

The Partners of Martin Clearwater & Bell LLP are pleased to welcome the eight new attorneys who joined the Firm on September 1st.

Kimberly Ayer	St. John's University School of Law
Kara Eyre	Benjamin N. Cardozo School of Law
Katie Harrison	St. John's University School of Law
Orrie Levy	Benjamin N. Cardozo School of Law
Megan Lynch	Hofstra Law School
Brian Osterman	Notre Dame Law School
Meg Panzer	University of Colorado Law School
Sarah Sellers	New York Law School

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