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How to Litigate a Medical Malpractice Case – Part 1: The Initial Screening

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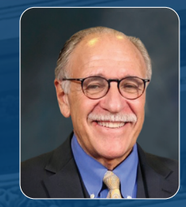

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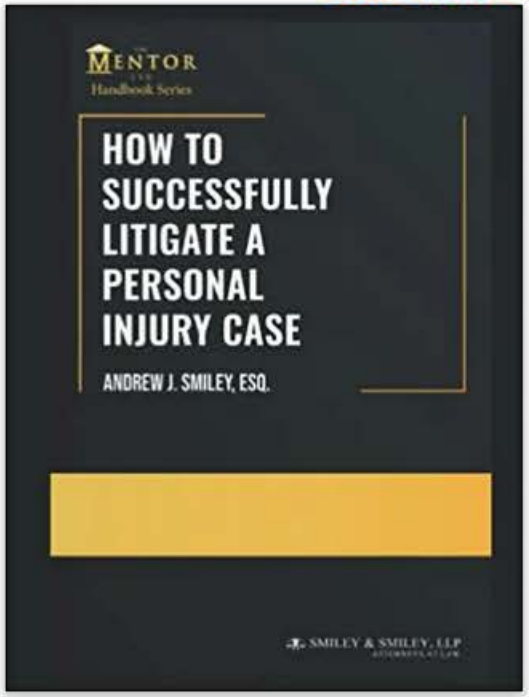


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How to Successfully Litigate a Personal Injury Case: A Practical Guide Hardcover – December 14, 2022

by Andrew J. Smiley Esq. (Author)

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Andrew J. Smiley, Esq is a leader in the field of personal injury law. He is a Past President of The New York State Academy of Trial Lawyers, Past President of The New York City Trial Lawyers Alliance, Master Continuing Legal Education (CLE) instructor, Lecturer, Trial Team Coach and Mentor. His podcast, *The Mentor Esq,* is listened to around the world.

In his debut book, *How to Successfully Litigate a Personal Injury Case - A Practical Guide*, Andrew shares how he has successfully litigated personal injury cases for the last few decades. This practical book is designed to break down to a granular level a plaintiff's personal injury case from start to finish. The chapters in this book outline each step in the litigation process from getting the client through settlement and trial.

If you are an attorney who wants to successfully litigate a personal injury case and obtain the best results for your clients, this step-by-step book is for you!

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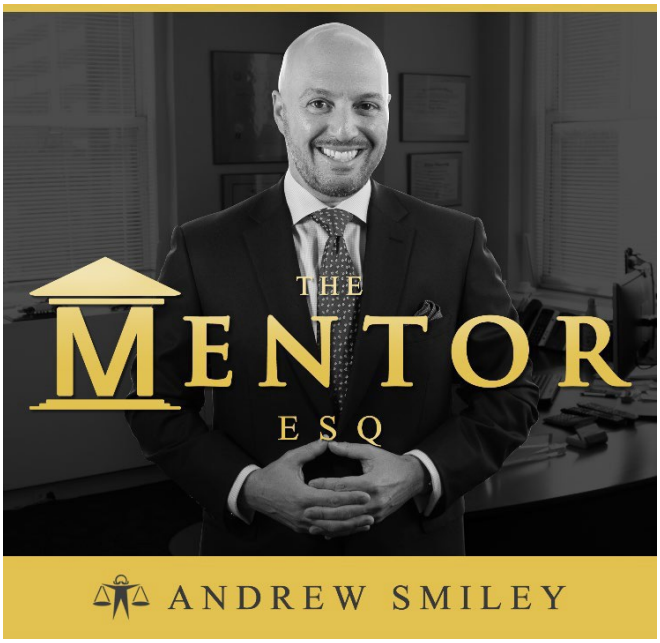

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CURRICULUM VITAE

Education:

·Brooklyn Law School - Juris Doctorate 1996

Moot Court Honor Society - Vice President/Executive Board (Chair of Trial Division)
Moot Court Honor Society - Competitor - National Appellate Trademark Competition
Moot Court Honor Society – Coach, National Trial Team – Regional Champions
CALI Excellence For The Future Award - Advanced Legal Research
Judge Edward and Doris A. Thompson Award for Excellence in Trial Advocacy

·Tulane University, New Orleans, LA - Bachelor of Arts (Honors, Psychology) 1993

Professional:

· *Smiley & Smiley, LLP*

Managing Partner & Senior Trial Attorney, January 2001 - present
Associate, June 1996 - December 2000
Law Clerk, September 1993 - June 1996
Major verdicts and settlements in plaintiffs' personal injury, medical malpractice and wrongful death litigation

· *Adjunct Clinical Instructor of Law - Brooklyn Law School*, Trial Advocacy Program (1998-2004)

· *The Mentor Esq. Podcast – A Podcast for Lawyers*

- Founder & Host (2019 – Present)

· *New York "Super Lawyer"*
2010, 2011,2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022

·Bar Admissions:
- The United States Supreme Court
- New York State Courts
- United States Eastern District, Southern District & Northern District of New York
- United State District Court of Vermont

Organizations/Affiliations:

·New York State Academy of Trial Lawyers
-Immediate Past President (May 2018- May 2019)
-President (May 2017 – May 2018)
-President-Elect – (April 2016- May 2017)
-Vice President – 1st Dept. (July 2013-May 2016)
-Executive Committee (May 2019 – present)
- Board of Directors (2013- present)
- Judicial Screening Committee (2013- present)
- Master CLE Instructor (2020 – present)
- CLE Instructor (2013 – present)

· New York City Trial Lawyers Alliance
-Chairman of Board of Governors (July 2017 – July 2019)
-President (July 2015 – July 2017)
-Vice President (June 2013 – July 2015)
-Treasurer (June 2011 – June 2013)
-Secretary (June 2009- June 2011)
-Board of Directors (2000-present)

- Judicial Screening Committee, Kings County Democratic Party (2013)
- New York State Bar Association
- Brooklyn Bar Association
  Medical Malpractice Committee
  Supreme Courts Committee
- American Bar Association
- The American Association for Justice

- Brooklyn Law School Alumni Association
- National Order of Barristers
- Porsche Club of America (Connecticut Valley Region)
- Porsche Sim Racing League
- Sports Car Driving Association (SCDA)
- Just Hands Racing Foundation – Board of Directors

Publications

Smiley, Andrew J. *How to Successfully Litigate a Personal Injury Case – A Practical Guide* (2022, The Mentor Esq. Handbook Series – Available on Amazon)

Continuing Legal Education (CLE) Presentations:

(58) *How to Litigate a Construction Accident Case – Part 4:* Motion Practice, New York State Academy of Trial Lawyers, December 7, 2022

(57) *Preparing for Depositions: Best Practices for Asking and Answering Questions,* Office of The NYS Attorney General, Legislature, 2022 Legislature Program, December 6, 2022

(56) *How to Litigate a Construction Accident Case – Part 3: Depositions*, New York State Academy of Trial Lawyers, November 2, 2022

(55) *How to Litigate a Construction Accident Case – Part 2: Commencing The Action*, New York State Academy of Trial Lawyers, October 3, 2022

(54) *Trial Series: Part 2 - Opening Statement Webinar,* Queens County Bar Association, September 22, 2022

(53) *How to Litigate a Construction Accident Case – Part 1: An Overview of New York Labor Law,* New York State Academy of Trial Lawyers, September 7, 2022

(52) *How to Litigate a Catastrophic Automobile Accident Case – Part 6: The Trial,* New York State Academy of Trial Lawyers, July 6, 2022

(51) *How to Litigate a Catastrophic Automobile Accident Case – Part 5: Mediation and Settlement,* New York State Academy of Trial Lawyers, June 2, 2022

(50) *How to Litigate a Catastrophic Automobile Accident Case – Part 4: Expert Depositions,* New York State Academy of Trial Lawyers, May 4, 2022

(49) *How to Litigate a Catastrophic Automobile Accident Case – Part 3: Liability and Damages Experts,* New York State Academy of Trial Lawyers, April 6, 2022

(48) *How to Litigate a Catastrophic Automobile Accident Case – Part 2: Commencing the Action,* New York State Academy of Trial Lawyers, March 2, 2022

Continuing Legal Education (CLE) Presentations Continued*:*

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(45) *Anatomy of a Trial, a Trial Skills Series – Part 4: Cross-Examination,* New York State Academy of Trial Lawyers, December 1, 2021

(44) *Anatomy of a Trial, a Trial Skills Series – Part 3: Direct Examination,* New York State Academy of Trial Lawyers, November 3, 2021

(43) *Anatomy of a Trial, a Trial Skills Series – Part 2: Opening Statements,* New York State Academy of Trial Lawyers, October 6, 2021

(42) *Anatomy of a Trial, a Trial Skills Series – Part 1: Jury Selection,* New York State Academy of Trial Lawyers, September 10, 2021

(41) *How to Successfully Litigate a Personal Injury Case Series - Part 7: It's a Wrap!,* New York State Academy of Trial Lawyers, July 7, 2021

(40) *How to Successfully Litigate a Personal Injury Case Series - Part 6: The Trial,* New York State Academy of Trial Lawyers, June 2, 2021

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(34) *Brick by Brick: Building a Personal Injury Practice,* New York State Academy of Trial Lawyers, December 10, 2020

(33) *Working with Experts to Build Your Case,* New York State Academy of Trial Lawyers, October 8, 2020

Continuing Legal Education (CLE) Presentations Continued:

(32) *Fitness Industry Liability: Gyms, Trainers and Waivers*, The Mentor Esq. Podcast, September 8, 2020

(31) *Let's Make a Federal Case Out of It: Litigating Personal Injury Cases in Federal Court,* New York State Academy of Trial Lawyers, June 9, 2020

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(24) *Punitive Damages – What to Plead, What to Prove: Medical Malpractice*, New York State Academy of Trial Lawyers, June 8, 2017 & June 21, 2017

(23) Presenter on Evidence, *2016 Annual Update, Precedents & Statutes for Personal Injury Litigators*, New York State Academy of Trial Lawyers, September 30, 2016

(22) *Medical Malpractice in New York: A View from All Sides: The Bench, The Bar and OCA,* New York State Bar Association, October 11, 2015

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(8) *Preparing the Construction Accident Case*, New York County Lawyers Association, March 26, 2012

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(5) *Trial Effectively Using Experts in Personal Injury Cases*, Lawline.com, May 4, 2011
Techniques: The Tricks of the Trade, Lawline.com, February 16, 2011

(4) *Practice Makes Perfect: Learn to Practice Like a Pro*, Lawline.com, January 18, 2011

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Television Appearances – Legal Commentary:

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-The O'Reilly Factor
-What's Happening Now with Martha McCallum
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- Fox & Friends
-Fox Business Channel
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-Money with Melissa Francis
CNN -Anderson Cooper 360
ET – Entertainment Tonight
Bloomberg TV
Headline News
Tru TV
Court TV
The Morning Show with Mike and Juliet

Interests, Hobbies:

Porsche Club, High Performance Driving Events, Sim Racing, Tennis, Yoga, Cooking

To: YOUR FIRM NAME AND ADDRESS

RETAINER

The undersigned, _____ ("Client"), residing at _____, hereby retains YOUR FIRM NAME ("You") to prosecute or adjust a claim for damages arising from personal injuries sustained by me on or about _____, through the negligence of _____ and/or third persons.

The Client hereby gives You the exclusive right to take all legal steps to enforce this claim through trial. The attorney shall have the right but not the obligation to represent the client on appeal.

In consideration of the services rendered by You, the undersigned hereby agree(s) to pay You and You are authorized to endorse on behalf of the undersigned any checks that may be paid in settlement of this action and to retain out of any funds that may come into your hand by reason of the above claim, subject to Court approval when required, whether recovered by suit, settlement or otherwise:

Thirty (30%) percent of the first $250,000.00 recovered;
Twenty-Five (25%) percent of the next $250,000.00 recovered;
Twenty (20%) percent of the next $500,000.00 recovered;
Fifteen (15%) percent of the next $250,000.00 recovered;
Ten (10%) percent of any amount recovered over $1,250,000.00.

In the event extraordinary services are required, You may apply to the Court for greater compensation pursuant to the Judiciary Law and the Special Rules of the Appellate Division regulating the conduct of Attorneys. In the event that the above fee schedule is no longer mandated by New York State Law, the undersigned agrees that You will be entitled to a 33 1/3% contingency fee or, in the alternative, the maximum fee allowable under New York State Law.

Such percentage shall be computed on the net sum recovered after deducting from the amount recovered expenses and disbursements for expert testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution of the action. In computing the fee, the costs as taxed, including interest upon a judgment, shall be deemed part of the amount recovered. For the following or similar items there shall be no deduction in computing such percentages: liens, assignments or claims in favor of hospitals, for medical care and treatment by doctors and nurses, or self-insurers or insurance carriers.

If the claim or case is settled by a structured settlement, the amount of the settlement shall be determined by ascertaining the present value of the settlement to the plaintiffs. The settlement shall be so structured that the full attorney's fee will be computed based upon said total settlement present value and shall be payable in full out of the initial cash payment.

The retainer agreement is effective only up until settlement or verdict after trial. This retainer agreement anticipates no appeal. If any appeal is required then a new retainer agreement covering the appeal will be negotiated.

Either party may terminate this Agreement but must do so in writing. If terminated, You have a lien for all work and disbursements to the time of termination.

The Client agrees and understands that You are agreeing to represent the Client on a conditional basis, **subject to investigation**, in that all relevant facts and circumstances have as yet not been discovered and evaluated. Client agrees that the attorney may withdraw from the matter for any purpose or reason, at their sole discretion. The attorney agrees to notify client in writing of any such withdrawal.

Dated: _____ Client _____(L.S.)

Witness: _____ Client _____(L.S.)

STATE OF NEW YORK COUNTY OF NEW YORK ss.:

On the__ day of _____, 2023, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
NOTARY PUBLIC

NY PJI 2:150

New York Pattern Jury Instructions - Civil > DIVISION 2. NEGLIGENCE ACTIONS > G. SPECIFIC NEGLIGENCE ACTIONS > 4. Malpractice

PJI 2:150. Malpractice--Physician

Malpractice is professional negligence and medical malpractice is the negligence of a doctor. Negligence is the failure to use reasonable care under the circumstances, doing something that a reasonably prudent doctor would not do under the circumstances, or failing to do something that a reasonably prudent doctor would do under the circumstances. It is a deviation or departure from accepted practice.

A doctor who renders medical service to a patient is obligated to have that reasonable degree of knowledge and skill that is expected of an (average doctor, average specialist) who (performs, provides) that (operation, treatment, medical service) in the medical community in which the doctor practices. ([*If there is evidence that the doctor should have complied with standards that exceed the standards of the medical community in which the doctor practices, the following should be charged*:] **The doctor must also comply with minimum (statewide, national) standards of care.)**

The law recognizes that there are differences in the abilities of doctors, just as there are differences in the abilities of people engaged in other activities. To practice medicine a doctor is not required to have the extraordinary knowledge and ability that belongs to a few doctors of exceptional ability. However every doctor is required to keep reasonably informed of new developments in (his, her) field and to practice (medicine, surgery) in accordance with approved methods and means of treatment in general use. A doctor must also use his or her best judgment and whatever superior knowledge and skill (he, she) possesses, even if the knowledge and skill exceeds that possessed by the (average doctor, average specialist) in the medical community where the doctor practices.

By undertaking to perform a medical service, a doctor does not guarantee a good result. The fact that there was a bad result to the patient, by itself, does not make the doctor liable. The doctor is liable only if (he, she) was negligent. Whether the doctor was negligent is to be decided on the basis of the facts and conditions existing at the time of the claimed negligence.

[This paragraph should only be charged when there is evidence that the doctor made a choice among medically acceptable alternatives. See Caveat 2 below:] **A doctor is not liable for an error in judgment if (he, she) does what (he, she) decides is best after careful evaluation if it is a judgment that a reasonably prudent doctor could have made under the circumstances. In other words, a doctor is not liable for malpractice if he or she chooses one of two or more medically acceptable courses of action**.

If the doctor is negligent, that is, lacks the skill or knowledge required of (him, her) in providing a medical service, or fails to use reasonable care in providing the service, or fails to exercise his or her best judgment, and such failure is a substantial factor in causing harm to the patient, then the doctor is responsible for the injury or harm caused.

[*Where appropriate, add*:]

A doctor's responsibility is the same regardless of whether (he, she) was paid.

Comment

The charge should be preceded by a separate charge defining negligence, see PJI 2:10, and followed by a charge on proximate cause, see PJI 2:70. It can be adapted for use with respect to claims against other health care providers such as dentists, podiatrists, nurses, chiropractors, physical therapists, etc.

Caveat 1: Each claimed departure from accepted medical practice should be the subject of a separate jury question, *Steidel v Nassau, 182 AD2d 809, 582 NYS2d 805 (2d Dept 1992)*; see *Davis v Caldwell, 54 NY2d 176, 445 NYS2d 63, 429 NE2d 741 (1981)*; see also *Harris v Parwez, 13 AD3d 675, 785 NYS2d 781 (3d Dept 2004)*.

Caveat 2: The fifth paragraph of the Charge ("error in judgment") should not be charged unless there is a showing that defendant considered and chose among several medically acceptable alternatives, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; *Mancuso v Kaleida Health, 172 AD3d 1931, 100 NYS3d 469 (4th Dept 2019)*, aff'd, *34 NY3d 1020, 114 NYS3d 773, 138 NE3d 502 (2019)*; *Lacqua v Silich, 141 AD3d 690, 35 NYS3d 488 (2d Dept 2016)*; *Wulbrecht v Jehle, 89 AD3d 1470, 933 NYS2d 467 (4th Dept 2011)*; *Dumas v Adirondack Medical Center, 89 AD3d 1184, 932 NYS2d 230 (3d Dept 2011)* (citing PJI); *Anderson v House of Good Samaritan Hosp., 44 AD3d 135, 840 NYS2d 508 (4th Dept 2007)*; see Comment, infra. The fact that defendant physician's diagnosis or treatment involved the exercise of medical judgment does not by itself provide a basis for giving an "error in judgment" charge, *Anderson v House of Good Samaritan Hosp., supra.* Further, it is improper to give the "error in judgment" charge when the evidence simply raises the issue of whether defendant physician deviated from the degree of care that a reasonable physician would have exercised under the same circumstances, *Lacqua v Silich, supra*; *Rospierski v Haar, 59 AD3d 1048, 873 NYS2d 802 (4th Dept 2009)*; *Martin v Lattimore Road Surgicenter, Inc., 281 AD2d 866, 727 NYS2d 836 (4th Dept 2001)*. An error in giving the "error in judgment" charge when the case does not involve a physician's choice among medically acceptable alternatives is not harmless if the primary issue is whether the physician deviated from accepted standards of care, *Anderson v House of Good Samaritan Hosp., supra*; see *Lacqua v Silich, supra*; *Rospierski v Haar, supra.*

Caveat 3: In a medical malpractice action, a plaintiff may, under certain circumstances, pursue a theory of loss of chance. Although all four Departments recognize the loss of chance theory, the Court of Appeals has not squarely addressed the issue, see *Wild v Catholic Health System, 21 NY3d 951, 969 NYS2d 846, 991 NE2d 704 (2013)*. The contours of the theory are the subject of developing appellate case law and, therefore, there is no loss of chance pattern charge, see this Comment, infra.

The second paragraph of the charge is based on the analysis in *Toth v Community Hospital at Glen Cove, 22 NY2d 255, 292 NYS2d 440, 239 NE2d 368 (1968)*, which applied the locality rule as a minimum standard, and then added the further requirement that doctors use their "best judgment and whatever superior knowledge, skill and intelligence" they possess, see *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*.

The fifth paragraph of the charge ("error in judgment") is based on *Toth v Community Hospital at Glen Cove, 22 NY2d 255, 292 NYS2d 440, 239 NE2d 368 (1968)*; *Pike v Honsinger, 155 NY 201, 49 NE 760 (1898)*; *Wulbrecht v Jehle, 89 AD3d 1470, 933 NYS2d 467 (4th Dept 2011)*; *Dumas v Adirondack Medical Center, 89 AD3d 1184, 932 NYS2d 230 (3d Dept 2011)* (citing PJI); *Hale v State, 53 AD2d 1025, 386 NYS2d 151 (4th Dept 1976)*; see *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; *Lacqua v Silich, 141 AD3d 690, 35 NYS3d 488 (2d Dept 2016)*; *Scofield v Moreland, 23 AD3d 1082, 804 NYS2d 207 (4th Dept 2005)* (citing PJI). The use of the phrase "medical community" in the pattern charge is supported by Toth, as well as by such cases as *Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985)* ("[a] physician's duty is to provide the level of care acceptable in the professional community in which he practices"); *Bovay v Podolsky, 266 AD2d 843, 697 NYS2d 427 (4th Dept 1999)* (same); *Kelly v State, 259 AD2d 962, 687 NYS2d 843 (4th Dept 1999)* (same); *Ressis v Mactye, 108 AD2d 960, 485 NYS2d 132 (3d Dept 1985)* (psychologists must have skill of "the average member of their profession"); *Littlejohn v State, 87 AD2d 951, 451 NYS2d 225 (3d Dept 1982)* (physician must have skill of "the average member of the medical profession"); *Hale v State, supra* (doctor must have the skill of "the average member of the medical community"); see *Stuart by Stuart v Ellis Hosp., 198 AD2d 559, 603 NYS2d 212 (3d Dept 1993)*; *Schoch v Dougherty, 122 AD2d 467, 504 NYS2d 855 (3d Dept 1986)*.

As to the statute of limitations applicable to malpractice claims, see Introductory Statement, supra. As to itemized verdicts in malpractice cases, see PJI 2:151A(1) and PJI 2:151A(2); as to collateral source payments, see PJI 2:151B; as to fraudulent concealment of an act of malpractice, see PJI 2.151C; as to informed consent, see PJI 2:150A.

In *Alvarez v Prospect Hosp., 68 NY2d 320, 508 NYS2d 923, 501 NE2d 572 (1986)*, the Court of Appeals held that, in a medical malpractice action, once defendant has made a prima facie showing that he or she was not negligent, plaintiff must submit evidentiary facts in rebuttal to establish the existence of a triable question of fact, see *Pullman v Silverman, 28 NY3d 1060, 43 NYS3d 793, 66 NE3d 663 (2016)*. The First and Third Departments have held that, when defendant has moved for summary judgment and has made a prima facie showing that there was no deviation from accepted medical practice, plaintiff must meet that showing with evidence of both a departure from accepted practice and a proximate cause between the departure and plaintiff's injuries, *Anyie B. v Bronx Lebanon Hosp., 128 AD3d 1, 5 NYS3d 92 (1st Dept 2015)*; *Ramos v Weber, 118 AD3d 408, 987 NYS2d 51 (1st Dept 2014)*; *Kristal R. v Nichter, 115 AD3d 409, 981 NYS2d 399 (1st Dept 2014)*; *Bacani v Rosenberg, 74 AD3d 500, 903 NYS2d 30 (1st Dept 2010)*; *Chase v Cayuga Medical Center at Ithaca, Inc., 2 AD3d 990, 769 NYS2d 311 (3d Dept 2003)*; see *Park v Kovachevich, 116 AD3d 182, 982 NYS2d 75 (1st Dept 2014)*. In contrast, the Second and Fourth Departments held that a plaintiff opposing a motion for summary judgment dismissing the complaint need only adduce evidence rebutting the prima facie showing that the defendant has made, *Bubar v Brodman, 177 AD3d 1358, 111 NYS3d 483*

(4th Dept 2019) (disavowing *O'Shea v Buffalo Medical Group, P.C., 64 AD3d 1140, 882 NYS2d 619 (4th Dept 2009)*; *Guctas v Pessolano, 132 AD3d 632, 17 NYS3d 749 (2d Dept 2015)*; *Ahmed v Pannone, 116 AD3d 802, 984 NYS2d 104 (2d Dept 2014)*; *Makinen v Torelli, 106 AD3d 782, 965 NYS2d 529 (2d Dept 2013)*; *Stukas v Streiter, 83 AD3d 18, 918 NYS2d 176 (2d Dept 2011)* (disavowing *Amsler v Verrilli, 119 AD2d 786, 501 NYS2d 411 (2d Dept 1986)*. Under the Second and Fourth Departments' rule, where defendant has made a prima facie showing that there was no departure from accepted practice, plaintiff may defeat summary judgment with evidentiary proof that such a departure occurred and need not adduce evidence that the departure was a proximate cause of the alleged injuries, *Bubar v Brodman, supra*; *Stukas v Streiter, supra.* In *Pullman v Silverman, 28 NY3d 1060, 43 NYS3d 793, 66 NE3d 663 (2016)*, the Court noted that the issue of the proper medical malpractice summary judgment standard, which was discussed in a concurring opinion, was not before the Court, and the Court therefore did not address it.

The Court of Appeals' decision *Orsi v Haralabatos, 20 NY3d 1079, 965 NYS2d 71, 987 NE2d 631 (2013)*, indicates that the approach of the Second Department is proper. In Orsi, the Court reversed an order granting defendants' summary judgment motion, finding that triable issues of fact existed as to whether defendants departed from the applicable standard of medical care. The Court observed that summary judgment in defendants' favor on the issue of proximate cause was not warranted because defendants failed to make a prima facie showing that any alleged departure was not a proximate cause of plaintiff's injuries. The Orsi decision tacitly suggests that a plaintiff opposing a summary judgment motion need only rebut the prima facie showing a defendant has made, leaving without comment the Second Department's statement to that effect in the order under review, *89 AD3d 997, 934 NYS2d 195 (2d Dept 2011)*.

I. Elements Generally

The required elements of proof in a medical malpractice case are (1) a deviation or departure from accepted practice and (2) evidence that such departure was a proximate cause of injury or damage, *Donnelly v Parikh, 150 AD3d 820, 55 NYS3d 274 (2d Dept 2017)*; *Gallagher v Cayuga Medical Center, 151 AD3d 1349, 57 NYS3d 544 (3d Dept 2017)*; *Stukas v Streiter, 83 AD3d 18, 918 NYS2d 176 (2d Dept 2011)*; *Giambona v Stein, 265 AD2d 775, 697 NYS2d 399 (3d Dept 1999)*; *De Stefano v Immerman, 188 AD2d 448, 591 NYS2d 47 (2d Dept 1992)*; *Amsler v Verrilli, 119 AD2d 786, 501 NYS2d 411 (2d Dept 1986)*; see *Mazella v Beals, 27 NY3d 694, 37 NYS3d 46, 57 NE3d 1083 (2016)*; *Rivera v Kleinman, 16 NY3d 757, 919 NYS2d 480, 944 NE2d 1119 (2011)*. In addition to being held liable for conduct falling short of the generally accepted standards of care in the medical community, a doctor may be liable if the doctor's treatment decisions do not reflect his or her own best judgment, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*. Claims for medical malpractice should be distinguished from claims for breach of contract arising out of the rendering of medical care. The latter class of claims will be held legally sufficient only if they are based on an express special promise to effect a cure or accomplish a definite result, *Duquette v Oliva, 75 AD3d 727, 905 NYS2d 316 (3d Dept 2010)*; *Delaney v Krafte, 98 AD2d 128, 470 NYS2d 936 (3d Dept 1984)*. For a charge and comment on breach of contract claims based on the rendering of medical care, see PJI 4:35.

With respect to proximate cause, plaintiff must establish the requisite nexus between the malpractice allegedly committed by defendant and the injury, unless the causal relationship is readily apparent to the trier of fact, *Horth v Mansur, 243 AD2d 1041, 663 NYS2d 703 (3d Dept 1997)*. The mere offering of expert opinion on proximate cause does not suffice absent a showing of the requisite nexus between the malpractice allegedly committed and plaintiffs injuries, *Koeppel v Park, 228 AD2d 288, 644 NYS2d 210 (1st Dept 1996)*. Thus, where plaintiff's expert could not state with a reasonable degree of medical certainty that defendant's departures were a proximate cause of plaintiff's injuries, plaintiff's malpractice claim did not lie, *Giambona v Stein, 265 AD2d 775, 697 NYS2d 399 (3d Dept 1999)*; *Evans v Holleran, 198 AD2d 472, 604 NYS2d 958 (2d Dept 1993)*; see *Callistro ex rel. Rivera v Bebbington, 94 AD3d 408, 941 NYS2d 137 (1st Dept 2012)*, aff'd, *20 NY3d 945, 958 NYS2d 319, 982 NE2d 81 (2012)*; see also *Bossio v Fiorillo, 210 AD2d 836, 620 NYS2d 596 (3d Dept 1994)* (malpractice claim did not lie where plaintiff presented no evidence that plaintiff's physical condition would have been any different absent alleged malpractice).

A complaint sounds in medical malpractice rather than ordinary negligence where the challenged conduct constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician to a particular patient, *Davis v South Nassau Communities Hosp., 26 NY3d 563, 26 NYS3d 231, 46 NE3d 614 (2015)*; *Dupree v Giugliano, 20 NY3d 921, 958 NYS2d 312, 982 NE2d 74 (2012)* (citing PJI); *Weiner v Lenox Hill Hosp., 88 NY2d 784, 650 NYS2d 629, 673 NE2d 914 (1996)*; *Scott v Uljanov, 74 NY2d 673, 543 NYS2d 369, 541 NE2d 398 (1989)*; *Bleiler v Bodnar, 65 NY2d 65, 489 NYS2d 885, 479 NE2d 230 (1985)*; *Caso v St. Francis Hosp., 34 AD3d 714, 825 NYS2d 127 (2d Dept 2006)*; *Toepp v Myers Community Hosp., 280 AD2d 921, 721 NYS2d 177 (4th Dept 2001)*; *Cullinan v Pignataro, 266 AD2d 807, 698 NYS2d 381 (4th Dept 1999)*. While a cause of action based on medical malpractice must be predicated on an express or implied physician-patient relationship, *Lee v New York, 162 AD2d 34, 560 NYS2d 700 (2d Dept 1990)*; *Hickey v Travelers Ins. Co., 158 AD2d 112, 558 NYS2d 554 (2d Dept 1990)*, the absence of such a relationship does not preclude recovery in ordinary negligence where the physician's alleged negligence is readily determinable by the trier of fact based on common knowledge, *McKinney v Bellevue Hosp., 183 AD2d 563, 584 NYS2d 538 (1st Dept 1992)*. Thus, the failure to inform a prospective employee that his pre-employment physical revealed a serious medical condition constituted a basis for an action against the employer where the omission induced plaintiff to rely on his otherwise good health and resulted in his failure to seek treatment, *McKinney v Bellevue Hosp., supra*; see *Mosezhnik v Berenstein, 33 AD3d 895, 823 NYS2d 459 (2d Dept 2006)* (defendant may be liable in ordinary negligence for failing to communicate significant medical findings to patient or treating physician). For a detailed discussion of the distinction between actions sounding in medical malpractice and those sounding in ordinary negligence, see Malpractice, Introductory Statement, Malpractice Statute of Limitations.

II. Standard of Care

A. Generally

"A doctor is charged with the duty to exercise due care, as measured against the conduct of his or her own peers--the reasonably prudent doctor standard," *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; see *Pike v Honsinger, 155 NY 201, 49 NE 760*

(1898). Not every instance of failed treatment or diagnosis may be attributed to a doctor's failure to exercise due care, *Nestorowich v Ricotta, supra.*

The practice of chiropractic is distinct from the practice of medicine, and therefore a chiropractor is generally held to the standard of care that a reasonably prudent chiropractor would exercise under the circumstances, *Hoagland v Kamp, 155 AD2d 148, 552 NYS2d 978 (3d Dept 1990)*. A physician's standard of care applies only when a chiropractor exceeds the restrictions placed upon the practice of his or her profession, *Taormina v Goodman, 63 AD2d 1018, 406 NYS2d 350 (2d Dept 1978)*; see *Education Law § 6551*; *Annot: 58 ALR3d 590*; *77 ALR4th 273*; see also *73 ALR4th 24*. A physical therapist is generally held to the standard of care that a reasonably prudent physical therapist would exercise under the circumstances, and may be held liable for professional malpractice where he or she deviates from good and accepted standards of physical therapy practice, see *Shank v Mehling, 84 AD3d 776, 922 NYS2d 495 (2d Dept 2011)*.

The standard of care imposed on a pharmacist is generally described as ordinary care in the conduct of his or her business, *Burton v Sciano, 110 AD3d 1435, 972 NYS2d 755 (4th Dept 2013)*; see *Abrams v Bute, 138 AD3d 179, 27 NYS3d 58 (2d Dept 2016)*. The rule of ordinary care as applied to a pharmacist means the highest practicable degree of prudence, thoughtfulness and vigilance commensurate with the dangers involved and the consequences that may attend inattention, *Burton v Sciano, supra*; *Brumaghim v Eckel, 94 AD3d 1391, 944 NYS2d 329 (3d Dept 2012)*; *Eberle v Hughes, 77 AD3d 1398, 909 NYS2d 273 (4th Dept 2010)*; *Hand v Krakowski, 89 AD2d 650, 453 NYS2d 121 (3d Dept 1982)*. Generally, a pharmacist cannot be held liable for negligence in the absence of an allegation that he or she failed to fill a prescription precisely as directed by the physician or was aware that the customer had a condition that would render the prescription of the drug at issue contraindicated, *Burton v Sciano, supra*; *Brumaghim v Eckel, supra*; *Elliott v A.H. Robins Co., 262 AD2d 132, 691 NYS2d 501 (1st Dept 1999)*. In addition, liability or culpable conduct on the part of a pharmacy may be found where there was some active negligence on the part of the pharmacist, *Brumaghim v Eckel, supra* (holding that pharmacist had no duty to warn customer or contact customer's physician prior to filling a prescription that was not contraindicated on its face but which plaintiff alleged was inappropriate for her). In *Abrams v Bute, supra*, the Second Department concluded that when a pharmacist has demonstrated that he or she did not undertake to exercise any independent professional judgment in filling and dispensing prescription medication, he or she cannot be held liable for negligence unless he or she failed to fill the prescription precisely as directed by the prescribing physician or that the prescription was so clearly contraindicated that ordinary prudence required the pharmacist to take additional measures before dispensing the medication.

The courts have often evaluated medical malpractice claims by reference to the extent to which an exercise in judgment was involved. In this regard, a distinction must be made between an "error in judgment" and a doctor's failure to use his or her best judgment, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; see *Spadaccini v Dolan, 63 AD2d 110, 407 NYS2d 840 (1st Dept 1978)* (citing PJI) (failure to select any accepted method of treatment does not constitute an "error in judgment"). For a discussion of that distinction, see *Anderson v House of Good Samaritan Hosp., 44 AD3d 135, 840 NYS2d 508 (4th Dept 2007)*.

Clinical practice guidelines are sometimes used to inform a medical expert's opinion as to the standard of care, *Ellis v Eng, 70 AD3d 887, 895 NYS2d 462 (2d Dept 2010)*. However, practice guidelines are not conclusive and are not necessary elements of plaintiffs proof in a medical malpractice case, id.

In some situations, the courts have limited the scope of a medical practitioner's duty based on the type and expected level of care. For example, an attending physician who had been consulted for the purpose of treating a patient for fractures following the patient's discharge from the emergency room had no duty to scan the patient's chart for irregularities outside the scope of the treatment, *Dombroski v Samaritan Hosp., 47 AD3d 80, 846 NYS2d 430 (3d Dept 2007)*; *Donnelly v Parikh, 150 AD3d 820, 55 NYS3d 274 (2d Dept 2017)*. The failure to investigate a condition that would have led to an incidental discovery of an unindicated condition does not constitute malpractice, *Brooks v April, 154 AD3d 564, 63 NYS3d 331 (1st Dept 2017)*; *David v Hutchinson, 114 AD3d 412, 980 NYS2d 38 (1st Dept 2014)*; see *Curry v Dr. Elena Vezza Physician, P.C., 106 AD3d 413, 963 NYS2d 661 (1st Dept 2013)*; *Rivera v Greenstein, 79 AD3d 564, 914 NYS2d 94 (1st Dept 2010)*. Similarly, an emergency room physician has no duty to follow up on the results of all of the tests performed on a patient while he or she was in the emergency room, since a contrary rule would be inconsistent with the limited purpose of the emergency-room service, id; see *Ellis v Eng, 70 AD3d 887, 895 NYS2d 462 (2d Dept 2010)*. Thus, there was no liability for the emergency-room physician's failure to follow up on a patient's elevated glucose level, which was revealed by a test he had ordered. In concluding that the emergency room physician could not be held liable, the Dombrowski court stressed that he had noted the condition on of patient's chart before discharging him to the inpatient attending physician, there were a number of possible non-serious explanations for the condition, a urinalysis had not yet been performed, there was no immediate threat to the patient, and the condition was in no way related to the trauma for which the patient had sought emergency-room treatment, id.

B. Best Judgment

Implicit in the concept of due care is the principle that doctors must employ their best judgment in exercising skill and applying their knowledge, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*. This principle assures conformity to the prevailing standard of care and accepted medical practice, id. A cause of action for medical malpractice may be premised on a physician's failure to use his or her best judgment, as well as lack of knowledge or lack of ability, see *Brazie v Williams, 221 AD2d 993, 634 NYS2d 274 (4th Dept 1995)* (citing PJI). A doctor may be liable if his or her treatment decisions do not reflect the doctor's best judgment, *Nestorowich v Ricotta, supra*; *Pike v Honsinger, 155 NY 201, 49 NE 760 (1898)*. In other words, liability may be predicated upon a failure to exercise any professional judgment, *Pigno v Bunim, 43 AD2d 718, 350 NYS2d 438 (2d Dept 1973)*, aff'd, *35 NY2d 841, 362 NYS2d 865, 321 NE2d 785 (1974)*; *Larkin v State, 84 AD2d 438, 446 NYS2d 818 (4th Dept 1982)*.

C. Error in Judgment

When used in the context of medical malpractice litigation, the term "error in judgment" is something of a misnomer, as it is not properly used in a case where the issue involves a claimed

misjudgment by the defendant practitioner, see *Anderson v House of Good Samaritan Hosp., 44 AD3d 135, 840 NYS2d 508 (4th Dept 2007)*. Rather, the socalled "error in judgment" rule represents a narrow principle of law that protects medical practitioners from liability when they are sued for making non-negligent choices among medically acceptable alternatives, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; *Mancuso v Kaleida Health, 172 AD3d 1931, 100 NYS3d 469 (4th Dept 2019)*, aff'd, *34 NY3d 1020, 114 NYS3d 773, 138 NE3d 502 (2019)*; *Michalko v DeLuccia, 187 AD3d 1365, 133 NYS3d 122 (3d Dept 2020)*; *Anderson v House of Good Samaritan Hosp., supra*; see *Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985)*; *Weinreb v Rice, 266 AD2d 454, 698 NYS2d 862 (2d Dept 1999)*; *Ibguy v State, 261 AD2d 510, 690 NYS2d 604 (2d Dept 1999)*; *Darren v Safier, 207 AD2d 473, 615 NYS2d 926 (2d Dept 1994)*. Where alternative procedures are available to a physician, any one of which is medically acceptable and proper under the circumstances, there is no negligence in using one rather than another, *Koehler v Schwartz, 48 NY2d 807, 424 NYS2d 119, 399 NE2d 1140 (1979)*; *Henry v Bronx Lebanon Medical Center, 53 AD2d 476, 385 NYS2d 772 (1st Dept 1976)*; *Schreiber v Cestari, 40 AD2d 1025, 338 NYS2d 972 (2d Dept 1972)*; see *Gross v Friedman, 138 AD2d 571, 526 NYS2d 152 (2d Dept 1988)*, aff'd, *73 NY2d 721, 535 NYS2d 586, 532 NE2d 92 (1988)*; *Annot: 89 ALR4th 799*. To be distinguished from true "error in judgment" cases involving choices among medically acceptable alternatives are those in which the term "error in judgment" or a similar formulation is used but the real question is simply whether the practitioner's treatment represented a permissible exercise of medical judgment, see *Oelsner v State, 66 NY2d 636, 495 NYS2d 359, 485 NE2d 1024 (1985)*; *Johnson v Yeshiva University, 42 NY2d 818, 396 NYS2d 647, 364 NE2d 1340 (1977)*; *Davis v Patel, 287 AD2d 479, 731 NYS2d 204 (2d Dept 2001)*.

The "error in judgment" charge implies the exercise of some judgment in choosing from among two or more available, medically acceptable alternatives, *Lacqua v Silich, 141 AD3d 690, 35 NYS3d 488 (2d Dept 2016)*; *Martin v Lattimore Road Surgicenter, Inc., 281 AD2d 866, 727 NYS2d 836 (4th Dept 2001)*; *Spadaccini v Dolan, 63 AD2d 110, 407 NYS2d 840 (1st Dept 1978)* (citing PJI). Thus, it should not be given unless there is a showing that defendant considered and chose among several medically acceptable alternatives, *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)* (citing PJI) ("error in judgment" charge improper where neither party contended that ligation of renal artery was acceptable alternative means of treatment); *Mancuso v Kaleida Health, 172 AD3d 1931, 100 NYS3d 469 (4th Dept 2019)*, aff'd on other grounds, *34 NY3d 1020, 114 NYS3d 773, 138 NE3d 502 (2019)* (per Fourth Department's decision: "error in judgment" charge not warranted where there was no evidence hospital personnel exercised judgment or chose between medically acceptable treatment alternatives in administering statin at prescribed dose); *Michalko v DeLuccia, 187 AD3d 1365, 133 NYS3d 122 (3d Dept 2020)* (error in judgment charge should not have been given where there was no evidence that defendant chose between two or more medically accepted alternatives); *Lacqua v Silich, supra* ("error in judgment" charge appropriate only in narrow category of cases in which there is evidence that defendant physician considered and chose between or among several medically acceptable treatment alternatives); *Anderson v House of Good Samaritan Hosp., 44 AD3d 135, 840 NYS2d 508 (4th Dept 2007)* (citing PJI) ("error in judgment" charge improper where claim involved physician's alleged misdiagnosis and there was no issue as to whether physician had failed to use best judgment in choosing among medically acceptable alternatives); *Martin v Lattimore Road Surgicenter, Inc., supra* (citing PJI)

("error in judgment" charge appropriate only in narrow category of cases in which there is evidence that defendant physician considered and chose among several medically acceptable treatment alternatives); *Grasso v Capella, 260 AD2d 600, 688 NYS2d 666 (2d Dept 1999)* (where there was no evidence that defendant surgeon had to consider and choose among medically acceptable alternatives, trial court properly refused to give "error in judgment" charge); see *Capolino v New York City Health & Hospitals Corp., 199 AD2d 173, 605 NYS2d 87 (1st Dept 1993)* ("error in judgment" charge should have been given where it was possible for jury to determine that there was more than one course acceptable under medical standards at time of treatment); *Petko v Ghoorah, 178 AD2d 1013, 580 NYS2d 668 (4th Dept 1991)* (court did not err in giving "error in judgment" charge where each party's expert testified to acceptable methods of diagnosing and treating condition). It is improper to give the "error in judgment" charge when the evidence simply raises the issue of whether defendant physician deviated from the degree of care that a reasonable physician would have exercised under the same circumstances, *Martin v Lattimore Road Surgicenter, Inc., supra*; see *Lacqua v Silich, supra.*

A mere difference of opinion among medical providers is not, standing alone, sufficient to sustain a prima facie case of medical malpractice, *Weinreb v Rice, 266 AD2d 454, 698 NYS2d 862 (2d Dept 1999)*; *Ibguy v State, 261 AD2d 510, 690 NYS2d 604 (2d Dept 1999)*; *Darren v Safier, 207 AD2d 473, 615 NYS2d 926 (2d Dept 1994)*. The permissible exercise of medical judgment is measured by the state of medical knowledge at the time of the act or omission, *Johnson v Yeshiva University, 42 NY2d 818, 396 NYS2d 647, 364 NE2d 1340 (1977)*; *Fallon v Loree, 136 AD2d 956, 525 NYS2d 93 (4th Dept 1988)*; *Paradies v Benedictine Hospital, 77 AD2d 757, 431 NYS2d 175 (3d Dept 1980)*. Liability for malpractice must be based on the facts confronting defendant at the time of the occurrence and should not be subjected to "the second guess of a jury," *Topel v Long Island Jewish Medical Center, 55 NY2d 682, 685, 446 NYS2d 932, 431 NE2d 293 (1981)*; see *Krapivka v Maimonides Medical Center, 119 AD2d 801, 501 NYS2d 429 (2d Dept 1986)*; *Henry v Bronx Lebanon Medical Center, 53 AD2d 476, 385 NYS2d 772 (1st Dept 1976)*.

For the application of the "error in judgment" principle to actions against mental health professionals, see VII. Mental Health Professionals: B. Error in Judgment, infra.

D. The Locality Rule

Under the "locality rule," a physician or surgeon is held only to the degree of diligence, skill and learning that is possessed by physicians or surgeons in the particular locality where he or she practices, *Pike v Honsinger, 155 NY 201, 49 NE 760 (1898)*. New York has apparently not abandoned the locality rule, see *Toth v Community Hospital at Glen Cove, 22 NY2d 255, 292 NYS2d 440, 239 NE2d 368 (1968)*, as have some other jurisdictions, see *Brune v Belinkoff, 354 Mass 102, 235 NE2d 793 (1968)*; *Pederson v Dumouchel, 72 Wash 2d 73, 431 P2d 973 (1967)*. However, *Toth v Community Hospital at Glen Cove, supra*, recognized a two-tiered rule, holding that a specialist may be held liable where a general practitioner would not be and that a specialist must use whatever superior knowledge, skill and intelligence he or she has, see *Riley v Wieman, 137 AD2d 309, 528 NYS2d 925 (3d Dept 1988)*; see also *Darren v Safier, 207 AD2d 473, 615 NYS2d 926 (2d Dept 1994)* (defendant who was specialist in gastroenterology not subject to liability for failing to exercise that degree of skill and care expected of specialist in

psychiatry where defendant referred patient to appropriate specialist). For further discussion, see *Annot: 18 ALR4th 603*; *AmJur2d, Physicians, Surgeons, and Other Healers § 209*.

The two-tiered Toth approach applies the locality rule as a minimum standard and then adds the further requirement that doctors use their "best judgment and whatever superior knowledge, skill and intelligence" they possess, see *Nestorowich v Ricotta, 97 NY2d 393, 740 NYS2d 668, 767 NE2d 125 (2002)*; *McGinn v Sellitti, 150 AD2d 967, 541 NYS2d 648 (3d Dept 1989)* (oral surgeon subject to "higher standard of practice" than general dentist). Thus, as used in New York, the locality rule does not prohibit plaintiff from establishing that defendant failed to comply with a minimum local, state-wide or national standard of care, *McCullough v University of Rochester Strong Memorial Hosp., 17 AD3d 1063, 794 NYS2d 236 (4th Dept 2005)*; see *Payant v Imobersteg, 256 AD2d 702, 681 NYS2d 135 (3d Dept 1998)* (national); *Hoagland v Kamp, 155 AD2d 148, 552 NYS2d 978 (3d Dept 1990)* (state-wide). If the standard of care in a particular locality is less demanding than that which is necessary to attain and maintain licensure within the State, the local standard of care is unacceptably low, *Hoagland v Kamp, supra.* The Court of Appeals has declared that "[a] physician will usually be insulated from tort liability where there is evidence that he or she conformed to accepted community standards of practice," *Spensieri v Lasky, 94 NY2d 231, 701 NYS2d 689, 723 NE2d 544 (1999)*. Nevertheless, the Court approved the trial court's charge that the standard of care for the physician defendants was measured by "the degree of knowledge and ability of the average Board-certified obstetrician/gynecologist in good standing practicing that specialty in the State of New York." However, there is no rule setting up a separate standard or third analytical tier for specialists who are board-certified, *Mayer v Oswego County Ob-Gyn, P.C., 207 AD2d 985, 617 NYS2d 92 (4th Dept 1994)*. As to the statute of limitations applicable to malpractice claims, see Introductory Statement, supra.

III. Persons Who May Be Liable

One who holds himself or herself out as qualified to give treatment but who is not in fact licensed to practice medicine will be held to the professional standards of skill and care of those lawfully offering such treatment, *Brown v Shyne, 242 NY 176, 151 NE 197 (1926)*; *Monahan v Devinny, 223 App Div 547, 229 NYS 60 (3d Dept 1928)*. The fact that defendant practiced medicine without a license is prima facie evidence of negligence, *CPLR 4504(d)*; see also *Pagano v Massapequa General Hosp., 99 AD2d 769, 472 NYS2d 15 (2d Dept 1984)* (error to charge that defendant's qualifications were a question of fact and to refuse charge, as a matter of law, that defendant was not a licensed physician, where defendant had certificate from Educational Council for Foreign Medical Graduates); *Ellenberger v Pena, 88 AD2d 373, 453 NYS2d 436 (2d Dept 1982)* (certificate from Educational Council for Foreign Medical Graduates is not equivalent to permit from State Education Department; holder of the certificate is merely eligible to obtain permit). However, the failure of a licensed physician to obtain board certification before practicing in a specialized area does not constitute malpractice, and a hospital is not negligent in allowing a non-certified but licensed physician to practice a specialty, see *Thomas v Solon, 121 AD2d 165, 502 NYS2d 475 (1st Dept 1986)*. Additionally, treating a patient at a location other than the address registered with the Education Department does not give rise to a fraud cause of action by the patient, *Boothe v Weiss, 133 AD2d 603, 519 NYS2d 710 (2d Dept 1987)*.

A complaint sounds in medical malpractice rather than ordinary negligence where the challenged conduct constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician to a particular patient, *Davis v South Nassau Communities Hosp., 26 NY3d 563, 26 NYS3d 231, 46 NE3d 614 (2015)*; *Dupree v Giugliano, 20 NY3d 921, 958 NYS2d 312, 982 NE2d 74 (2012)*; *Weiner v Lenox Hill Hosp., 88 NY2d 784, 650 NYS2d 629, 673 NE2d 914 (1996)*; *Scott v Uljanov, 74 NY2d 673, 543 NYS2d 369, 541 NE2d 398 (1989)*; *Bleiler v Bodnar, 65 NY2d 65, 489 NYS2d 885, 479 NE2d 230 (1985)*; *Rabinovich v Maimonides Medical Center, 179 AD3d 88, 113 NYS3d 198 (2d Dept 2019)*; *Jeter v New York Presbyterian Hospital, 172 AD3d 1338, 101 NYS3d 411 (2d Dept 2019)*; *Levinson v Health South Manhattan, 17 AD3d 247, 793 NYS2d 401 (1st Dept 2005)*; *Toepp v Myers Community Hosp., 280 AD2d 921, 721 NYS2d 177 (4th Dept 2001)*; *Cullinan v Pignataro, 266 AD2d 807, 698 NYS2d 381 (4th Dept 1999)*. In distinguishing whether conduct should be deemed medical malpractice or ordinary negligence, the critical factor is the nature of the duty owed to the plaintiff that the defendant is alleged to have breached, *Rabinovich v Maimonides Medical Center, supra*; *Jeter v New York Presbyterian Hospital, supra.* The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of the facts, *Rabinovich v Maimonides Medical Center, supra*; *Jeter v New York Presbyterian Hospital, supra.* Therefore, a nurse performing a medical service is subject to a claim for medical malpractice, *Bleiler v Bodnar, supra.* As to the duty of care a nurse owes to a patient, see *Applewhite v Accuhealth, Inc., 81 AD3d 94, 915 NYS2d 223 (1st Dept 2010)*. The allegations sounded in medical malpractice where a hospital inadequately provided for the treatment and supervision of a patient with memory loss who disappeared from the hospital for five days, *Rabinovich v Maimonides Medical Center, supra*; see *Jeter v New York Presbyterian Hospital, supra.* However, a resident who assists a doctor during a medical procedure cannot be held liable so long as he or she did not exercise any independent medical judgment and the doctor's directions did not so greatly deviate from normal practice that the resident had a duty to intervene, *Tsocanos v Zaidman, 180 AD3d 841, 118 NYS3d 219 (2d Dept 2020)*; *Hatch v St. Joseph's Hospital Health Center, 174 AD3d 1404, 105 NYS3d 742 (4th Dept 2019)*; *Soto v Andaz, 8 AD3d 470, 779 NYS2d 104 (2d Dept 2004)*; see *Macancela v Wyckoff Heights Medical Center, 176 AD3d 795, 109 NYS3d 411 (2d Dept 2019)* (question of fact as to whether resident was obligated to intervene in attending physician's treatment of decedent).

Where full-time psychiatric, psychological and social work personnel were employed at a center for the emotionally disturbed to provide clinical as well as educational services, and where plaintiff was referred to the facility for treatment, she was entitled to assert a claim for medical malpractice against the center based on allegations that the staff failed to exercise reasonable care in their initial evaluation and in the administration of a deleterious course of treatment, *Cantone by Cantone v Rosenblum, 186 AD2d 167, 587 NYS2d 743 (2d Dept 1992)*. In contrast, non-professional staff members who provide supportive and oversight services but not treatment and make daily visits to a residential facility maintained for individuals receiving psychiatric care elsewhere are not engaged in an activity that bears a substantial relationship to the rendition of medical treatment, *Avins v Federation Employment and Guidance Service, Inc.,*

52 AD3d 30, 857 NYS2d 550 (1st Dept 2008). Thus, a cause of action for medical malpractice cannot be sustained against such staff members, id.

An individual who is trained in first aid techniques, but is not a member of the medical profession, is not subject to suit for medical malpractice, *Lazzaro v Nassau, 245 AD2d 342, 665 NYS2d 441 (2d Dept 1997)*. A physician may also be liable for breach of contract, if there is an express contract with the patient to effect a cure or to accomplish some definite result, Nicoleau v Brookhaven Memorial Hosp. Center, 201 AD2d 544, 607 NYS2d 703 (2d Dept 1994); see PJI 4:35.

IV. Physician-Patient Relationship

A. Gratuitously Provided Services

That the physician's services are rendered gratuitously does not affect the physician's liability, Du Bois v Decker, 130 NY 325, 332, 29 NE 313 (1891), except in cases to which the so-called Good Samaritan statute applies, Education Law §§ 6527(2) (physicians); 6611 (dentists); 6909(1) (nurses), 6537 (licensed physical therapist); 6457 (physician's assistant); Public Health Law § 3013 ("certified emergency medical technician," "voluntary ambulance service," and "advanced emergency medical technician"); Public Authorities Law § 1266-b (emergency first aid treatment by employees of LIRR). However, the Good Samaritan statute applicable to voluntary ambulance services does not protect against claims of gross negligence, see *Kowal v Deer Park Fire Dist., 13 AD3d 489, 787 NYS2d 352 (2d Dept 2004)*, or claims of negligence based on an alleged failure to provide qualified, competent personnel, Estate of Klinger v Corona Community Ambulance Corps., Inc., 301 AD2d 495, 753 NYS2d 126 (2d Dept 2003). Medical personnel requested by a police officer to take blood samples pursuant to VTL § 1194(4) are immune from liability, VTL § 1194(4)(a)(2).

General Business Law § 627-a imposes a duty on certain health clubs to have on the premises both automated external defibrillators and individuals trained to use those devices. That provision, however, does not create a duty running from a health club to its members to use that device, Miglino v Bally Total Fitness of Greater New York, Inc., 20 NY3d 342, 961 NYS2d 364, 985 NE2d 128 (2013); Digiulio v Gran, Inc., 74 AD3d 450, 903 NYS2d 359 (1st Dept 2010), aff'd, 17 NY3d 765, 929 NYS2d 71, 952 NE2d 1064 (2011). When an employee of a club certified to use the device does so to render emergency medical treatment or first aid to a stricken individual, the employee is only liable for gross negligence, *General Business Law § 627-a(3)*; Public Health Law § 3000-a. The club that provided the device is insulated from liability except for its own negligence, gross negligence or intentional misconduct, *General Business Law § 627-a(3)*; Public Health Law § 3000-a(2). Thus, *General Business Law § 627-a*, in conjunction with Public Health Law §§ 3000-a and 3000-b, protects health clubs and their employees from the risk of liability for ordinary negligence with respect to those devices, Miglino v Bally Total Fitness of Greater New York, Inc., supra. A health club does owe a limited, common law duty of care to a patron struck down by a heart attack or cardiac arrest while engaged in athletic activities on the club's premises, id (club owes common law duty to employ proper lifesaving measures to patron who suffered cardiac arrest at club).

B. Physician's Undertaking to Provide Services

Generally, whether a physician owed a duty of care to plaintiff is a legal question, not a question of medical expertise, *Burtman v Brown, 97 AD3d 156, 945 NYS2d 673 (1st Dept 2012)*; *Koeppel v Park, 228 AD2d 288, 644 NYS2d 210 (1st Dept 1996)*; *Sawh v Schoen, 215 AD2d 291, 627 NYS2d 7 (1st Dept 1995)*; *Lipton by Lipton v Kaye, 214 AD2d 319, 624 NYS2d 590 (1st Dept 1995)*. Thus, an affidavit by plaintiffs medical expert on the subject intrudes upon the exclusive province of the court and will not defeat summary judgment, *Kamhi v Tay, 244 AD2d 266, 664 NYS2d 288 (1st Dept 1997)*; *Sawh v Schoen, supra*; *Lipton by Lipton v Kaye, supra.* However, whether a physician's giving of advice furnishes a sufficient basis upon which to conclude that an implied physician-patient relationship has arisen has been deemed to be a question of fact for the jury, *Marshall v Rosenberg, 196 AD3d 817, 151 NYS3d 240 (3d Dept 2021)*; *Campbell v Haber, 274 AD2d 946, 710 NYS2d 495 (4th Dept 2000)*; *Cogswell by Cogswell v Chapman, 249 AD2d 865, 672 NYS2d 460 (3d Dept 1998)*.

A physician-patient relationship is created when the professional services of a physician are rendered to and accepted by another person for the purposes of medical or surgical treatment, *Pizzo-Juliano v Southside Hosp., 129 AD3d 695, 10 NYS3d 572 (2d Dept 2015)*; *Cygan v Kaleida Health, 51 AD3d 1373, 857 NYS2d 869 (4th Dept 2008)*; *Garofalo v State, 17 AD3d 1109, 794 NYS2d 269 (4th Dept 2005)*. To overcome a motion to dismiss based on the question whether a physician-patient relationship existed, it is not necessary to show that the physician saw, examined, took a history or treated the patient, *Pizzo-Juliano v Southside Hosp., supra* (dismissal denied where plaintiffs alleged that defendant physician, in his role as on-call plastic surgeon for hospital, made medical determination over telephone that infant plaintiff's laceration was not an emergency requiring defendant's expertise); *Tom v Sundaresan, 107 AD3d 479, 966 NYS2d 434 (1st Dept 2013)* (summary judgment dismissing complaint denied where defendant physician had consulted by telephone with neurosurgeon and both physicians planned to treat plaintiff as surgical team); see *Scalisi v Oberlander, 96 AD3d 106, 943 NYS2d 23 (1st Dept 2012)* (summary judgment denied where physician had formulated plans with other medical professionals who later relied on those recommendations); *Santos v Rosing, 60 AD3d 500, 875 NYS2d 59 (1st Dept 2009)* (summary judgment denied where evidence that physician consulted with nurse midwife concerning plaintiff's treatment). Whether there was in fact an undertaking to provide medical attention may be a question for the jury, *Dillon v Silver, 134 AD2d 159, 520 NYS2d 751 (1st Dept 1987)*; *O'Neill v Montefiore Hospital, 11 AD2d 132, 202 NYS2d 436 (1st Dept 1960)*. If there is such an undertaking, the physician will be liable if he or she abandons treatment prematurely, *Meiselman v Crown Heights Hospital, 285 NY 389, 34 NE2d 367 (1941)*; *Lewis v Capalbo, 280 AD2d 257, 720 NYS2d 455 (1st Dept 2001)*; *O'Neill v Montefiore Hospital, supra*; see *Shapira v United Medical Service, Inc., 15 NY2d 200, 257 NYS2d 150, 205 NE2d 293 (1965)*; *AmJur2d, Physicians, Surgeons, and Other Healers § 218*; *Annot: 57 ALR2d 432*, unless the patient consents or the physician gives the patient sufficient notice so that another physician can be employed, *Becker v Janinski, 15 NYS 675 (CP Ct 1891)*.

The duty owed by a physician may, however, be limited to those medical functions undertaken by the physician and relied upon by the patient, *Mann v Okere, 195 AD3d 910, 150 NYS3d 306 (2d Dept 2021)*; *Mosezhnik v Berenstein, 33 AD3d 895, 823 NYS2d 459 (2d Dept 2006)*; *Wasserman v Staten Island Radiological Associates, 2 AD3d 713, 770 NYS2d 108 (2d Dept 2003)*; *Markley by Markley v Albany Medical Center Hosp., 163 AD2d 639, 558 NYS2d 688 (3d Dept 1990)*. Thus, a radiologist to whom the decedent was referred for a routine

mammogram did not assume any duty of care beyond that of reading the mammography images and reporting his findings, despite the fact that the decedent indicated on the intake worksheet that she experienced pain and/or soreness in her breast and allegedly told the radiologist's employee that she felt a lump in her breast, *Mann v Okere, supra.* A primary care physician has no independent duty to supervise or override a course of treatment initiated by another physician actively treating a patient, *Burtman v Brown, 97 AD3d 156, 945 NYS2d 673 (1st Dept 2012)*. Moreover, a physician's participation in surgery did not give rise to a duty to supervise or participate in the patient's postoperative care where the physician did not undertake to supervise the case and the patient had a primary care physician, *Bettencourt v Long Island College Hosp., Inc., 306 AD2d 425, 762 NYS2d 261 (2d Dept 2003)*. Similarly, a physician group that deferred to orthopedic specialists for the assessment and treatment of plaintiff's ankle condition was not chargeable with the failure to properly diagnose that condition, *Wasserman v Staten Island Radiological Associates, supra.*

C. Medical Examinations Conducted on Referral of Employers and Insurance Carriers

Ordinarily, a physician conducting an independent medical examination for a workers' compensation carrier cannot be held liable in negligence or malpractice to the examinee for a misdiagnosis or failure to report a proper diagnosis to the carrier, *Zajac v Wilson, 2 AD3d 1410, 768 NYS2d 889 (4th Dept 2003)*; *Lee v New York, 162 AD2d 34, 560 NYS2d 700 (2d Dept 1990)*; *LoDico v Caputi, 129 AD2d 361, 517 NYS2d 640 (4th Dept 1987)*; see *Bazakos v Lewis, 12 NY3d 631, 883 NYS2d 785, 911 NE2d 847 (2009)*; *Savarese v Allstate Ins. Co., 287 AD2d 492, 731 NYS2d 226 (2d Dept 2001)*; see also *White v Southside Hosp., 281 AD2d 474, 721 NYS2d 678 (2d Dept 2001)* (physician-patient relationship not established where doctor who performed pre-employment physical advised decedent of positive tuberculosis test and advised her to obtain second opinion); but see *McKinney v Bellevue Hosp., 183 AD2d 563, 584 NYS2d 538 (1st Dept 1992)*.

A person referred to a physician by a third party such as an employer or workers' compensation carrier is deemed to have a "limited physician-patient relationship." In such a relationship, the physician will ordinarily not be liable for damages resulting from the conclusions he or she reaches or reports, but he or she may be held be liable in malpractice for performing the examination in a manner that causes physical harm, *Bazakos v Lewis, 12 NY3d 631, 883 NYS2d 785, 911 NE2d 847 (2009)*; see *Smith v Pasquarella, 201 AD2d 782, 607 NYS2d 489 (3d Dept 1994)*; *Twitchell v MacKay, 78 AD2d 125, 434 NYS2d 516 (4th Dept 1980)*. Additionally, in such situations, the examinee may maintain a medical malpractice action against the physician based on the physician's providing negligent treatment or rendering negligent medical advice, *Badolato v Rosenberg, 67 AD3d 937, 890 NYS2d 85 (2d Dept 2009)*; *Lawliss v Quellman, 38 AD3d 1123, 832 NYS2d 328 (3d Dept 2007)*; *Hickey v Travelers Ins. Co., 158 AD2d 112, 558 NYS2d 554 (2d Dept 1990)* (physician who conducted examination for the purpose of evaluating an injury for workers' compensation carrier may be held liable for alleged malpractice in advising examinee that surgery was not necessary); see *Rojas v McDonald, 267 AD2d 130, 701 NYS2d 21 (1st Dept 1999)*; *Heller v Peekskill Community Hosp., 198 AD2d 265, 603 NYS2d 548 (2d Dept 1993)*. To establish such liability, plaintiff must show: (1) the advice was incorrect, (2) the issuance of such advice constituted medical malpractice, (3) it was foreseeable that the examinee would rely upon the advice, and (4) the examinee did, in fact, rely

upon the advice to the his or her detriment, *Hickey v Travelers Ins. Co., supra*; *Badolato v Rosenberg, supra*; see also *Violandi v New York, 184 AD2d 364, 584 NYS2d 842 (1st Dept 1992)* (physician who examined plaintiff solely for convenience of plaintiff's employer not liable for advice in which plaintiffs personal physician independently concurred, since lack of reliance established as matter of law); but see *Durso v New York, 251 AD2d 8, 673 NYS2d 651 (1st Dept 1998)* (examining doctor's recommendation to plaintiff that he stop taking prescribed pain medication that made him nauseous did not take case out of "wellestablished rule" that, absent "something more," physician-patient relationship does not exist where examination was conducted solely for the purpose, convenience or on behalf of employer).

D. Relationship Arising From Physician's Providing Medical Advice or Consultation Services

Liability may be imposed on non-treating physicians in situations of joint action in diagnosis or treatment or some control over the course of treatment of one by the other, *Cygan v Kaleida Health, 51 AD3d 1373, 857 NYS2d 869 (4th Dept 2008)*. For example, a question of fact existed as to the involvement of a non-treating physician where there was evidence that the physician, as director of cardiac surgery, affirmatively directed the cancellation of the decedent's previously scheduled surgery, id. Such evidence may have indicated more than an informal interest and involvement on the part of the non-treating physician, id; see *Campbell v Haber, 274 AD2d 946, 710 NYS2d 495 (4th Dept 2000)*. However, a referring physician is not liable if he or she did not undertake to monitor the patient's condition and, in fact, left that function to the physician to whom the patient was referred, *Ellis v Eng, 70 AD3d 887, 895 NYS2d 462 (2d Dept 2010)*.

An implied physician-patient relationship may arise when a physician gives advice to a patient, even where the advice was communicated though another health care professional, *Marshall v Rosenberg, 196 AD3d 817, 151 NYS3d 240 (3d Dept 2021)*; *Campbell v Haber, 274 AD2d 946, 710 NYS2d 495 (4th Dept 2000)*; *Cogswell by Cogswell v Chapman, 249 AD2d 865, 672 NYS2d 460 (3d Dept 1998)*. A doctor-patient relationship can be established by a telephone call when the doctor affirmatively advises a prospective patient as to a course of treatment, it is foreseeable that the patient will rely on the advice, and the patient did in fact rely on the advice, *Marshall v Rosenberg, supra*; *Cogswell by Cogswell v Chapman, supra*; *Miller v Sullivan, 214 AD2d 822, 625 NYS2d 102 (3d Dept 1995)*; see *Campbell v Haber, supra.* An implied physician-patient relationship can arise with a specialist if the patient's treating physician reasonably and foreseeably relied upon the specialist's advice to the patient's detriment, *Marshall v Rosenberg, supra.*

The exposure of a non-treating physician engaged in a consulting capacity is limited, *Alvarez v Prospect Hosp., 68 NY2d 320, 508 NYS2d 923, 501 NE2d 572 (1986)*; *Lipton by Lipton v Kaye, 214 AD2d 319, 624 NYS2d 590 (1st Dept 1995)*. A non-treating physician is not responsible for the future treatment of a patient for whom the doctor has made an accurate diagnosis, *Lipton by Lipton v Kaye, supra.* Although physicians ordinarily owe a general duty of care to their patients, that duty may be limited to those medical functions undertaken by the physicians and relied on by the patient, *Mosezhnik v Berenstein, 33 AD3d 895, 823 NYS2d 459 (2d Dept 2006)*; *Chulla v DiStefano, 242 AD2d 657, 662 NYS2d 570 (2d Dept 1997)*. Similarly, radiologists who had the limited role of interpreting mammography films and documenting their findings had no duty to schedule or urge further testing or diagnose plaintiff's medical conditions, *Mosezhnik v Berenstein, supra.* However, a fertility specialist who performed in vitro fertilization

and embryo implantation on referral from the patient's treating physician had an obligation to ensure that the patient was fully informed of the risks attendant to a potential pregnancy in view of the patient's personal health and circumstances, even though the treating physician had "medically cleared" the patient for the procedure and was responsible for monitoring her pregnancy, *Nieves v Montefiore Medical Center, 305 AD2d 161, 760 NYS2d 419 (1st Dept 2003)*. Further, a non-treating physician's failure to communicate significant medical findings to a patient or his treating physician may constitute ordinary negligence, see *Yaniv v Taub, 256 AD2d 273, 683 NYS2d 35 (1st Dept 1998)*; *McKinney v Bellevue Hosp., 183 AD2d 563, 584 NYS2d 538 (1st Dept 1992)* (failure to disclose a potentially life threatening condition detected in a pre-employment physical examination may give rise to liability by employer based on ordinary negligence); see also *Glasheen v Long Island Diagnostic Imaging, 303 AD2d 365, 756 NYS2d 589 (2d Dept 2003)*.

A doctor's participation in weekly group staff meetings of a professional corporation at which a patient's care was discussed does not, without more, give rise to a physician-patient relationship between the doctor and the patient discussed, *Sawh v Schoen, 215 AD2d 291, 627 NYS2d 7 (1st Dept 1995)*; but see *Tom v Sundaresan, 107 AD3d 479, 966 NYS2d 434 (1st Dept 2013)* (distinguishing *Sawh* where defendant physician had detailed conversation with neurosurgeon and both physicians planned for surgery to be jointly performed). Similarly, a physician-patient relationship did not arise between a patient and members of a team to assess impaired physicians whose involvement with the patient-doctor terminated after they concluded that he did not suffer from a psychological or psychiatric illness, *Gedon v Bry-Lin Hospitals, Inc., 286 AD2d 892, 730 NYS2d 641 (4th Dept 2001)*.

V. Persons to Whom Duty of Care is Owed

A. Duty to General Public

A physician's duty of care is ordinarily owed to the patient and not the general public, *Purdy v Public Adm'r of Westchester County, 72 NY2d 1, 530 NYS2d 513, 526 NE2d 4 (1988)*; *Fox v Marshall, 88 AD3d 131, 928 NYS2d 317 (2d Dept 2011)*; *Adams v Elgart, 213 AD2d 436, 623 NYS2d 637 (2d Dept 1995)* (nursing home and its admitting physician owe no duty to general public to prevent voluntary patient from driving or to warn of dangers presented by such driving); *Cartier v Long Island College Hosp., 111 AD2d 894, 490 NYS2d 602 (2d Dept 1985)* (physicians practicing in alcoholism clinic do not owe duty to public at large to control behavior of out-patients and are not liable for failing to prevent out-patient from driving while intoxicated); see *Davis v South Nassau Communities Hosp., 26 NY3d 563, 26 NYS3d 231, 46 NE3d 614 (2015)*. A physician who completes a health report on a patient owes a duty of care only to the patient and those persons the physician knew or reasonably should have known were relying upon the report, *Eiseman v State, 70 NY2d 175, 518 NYS2d 608, 511 NE2d 1128 (1987)* (prison physician, who erroneously reported that ex-convict seeking college admission was not emotionally unstable, was not liable when ex-convict murdered another student). For a discussion of mental health professionals' duty to third persons for claimed negligence in releasing mentally ill patients, see VII. Mental Health Professionals: A. Duty to Persons Other Than Patient, infra.

B. Duty to Family Members and Others in Contact with Patient

A doctor does not owe a duty of care to a nonpatient who is caring for the patient, even where the nonpatient's role and identity are known to the doctor, unless the physician's treatment of the patient is the cause of the injury to the nonpatient, *Candelario v Teperman, 15 AD3d 204, 789 NYS2d 133 (1st Dept 2005)*. Thus, a doctor does not owe a duty of care to a friend of a patient treated for infectious meningitis based on the doctor's negative answer to the friend's question whether she needed treatment after being in close contact with the patient, *McNulty v New York, 100 NY2d 227, 762 NYS2d 12, 792 NE2d 162 (2003)*. In McNulty, there was no allegation that plaintiff's injury arose from the doctors' treatment of the primary patient. The principle that a doctor ordinarily owes no duty of care to a nonpatient who is caring for the patient applies even though the nonpatient caregiver is a close relative of the patient and the action is cast as one for ordinary negligence rather than medical malpractice, *Candelario v Teperman, supra.*

In *Tenuto v Lederle Laboratories, Div. of American Cyanamid Co., 90 NY2d 606, 665 NYS2d 17, 687 NE2d 1300 (1997)*, the Court held that a doctor treating an infant patient with an oral polio vaccine had a duty to warn the infant's parents to take precautions against contracting polio from exposure to the infant's feces or saliva, see *Doe v Lai-Yet Lam, 268 AD2d 206, 701 NYS2d 347 (1st Dept 2000)*. The Tenuto Court stressed that a special relationship existed sufficient to supply the predicate for extending a duty to warn and advise plaintiffs of the danger and the need to use precautions, especially since the physician was a pediatrician engaged by the parents to provide medical services to their infant and the physician's role necessarily required advising the patient's parents. However, courts that have analyzed Tenuto suggest that the more significant consideration was the fact that the physician's treatment of the patient was the cause of the nonpatient's injury, *Davis v South Nassau Communities Hosp., 26 NY3d 563, 26 NYS3d 231, 46 NE3d 614 (2015)*; *McNulty v New York, 100 NY2d 227, 762 NYS2d 12, 792 NE2d 162 (2003)*; *Candelario v Teperman, 15 AD3d 204, 789 NYS2d 133 (1st Dept 2005)*.

A company that provided nursing services for a ventilatordependent child requiring 24-hour nursing care did not owe a duty of care to a non-patient parent who allegedly suffered emotional distress when she observed her child in a state of suffocation, hypoxia and/or apoxia as a result of the alleged negligence of a nurse the company provided, *Shaw v QC-Medi New York, Inc., 10 AD3d 120, 778 NYS2d 791 (4th Dept 2004)*; see also *Landon by Landon v New York Hosp., 65 NY2d 639, 491 NYS2d 607, 481 NE2d 239 (1985)*, aff'g for reasons stated in opinion below, *101 AD2d 489, 476 NYS2d 303* (doctor owed no duty to parents to prevent emotional harm from either their witnessing child's deterioration from meningitis or their fear that they might have contracted meningitis where doctor failed to make timely diagnosis of child's meningitis). Although the Court of Appeals allowed a mother to recover emotional-distress damages because of medical malpractice resulting in a stillbirth, *Broadnax v Gonzalez, 2 NY3d 148, 777 NYS2d 416, 809 NE2d 645 (2004)*, the court in *Shaw v QC-Medi New York, Inc., supra*, reasoned that the Court of Appeals' holding was limited to the physical and psychological injuries suffered by reason of the mother's pregnancy. The fact that the parents in Shaw sent the defendant a letter giving written notice of their concerns did not create an independent duty running from the defendant to the non-patient parents, id.

Where a medical provider has administered medication that impairs or could impair the patient's ability to operate an automobile, the medical provider has a duty to third parties to warn

the patient of that danger, *Davis v South Nassau Communities Hosp., 26 NY3d 563, 26 NYS3d 231, 46 NE3d 614 (2015)*. The imposition of such a duty in Davis was appropriate because the medical provider administered the medication without warning the patient about the effects of it, thereby creating a peril affecting every motorist in the vicinity of the automobile operated by the patient; the medical provider was the only one who could have provided a proper warning; and the cost imposed on the medical provider by the obligation to warn the patient was small, id.

VI. Malpractice Relating to Fetuses and Newborns

A. "Wrongful Life" and "Wrongful Birth" Claims

A negligent failure to test for or advise prospective parents of the potential for the birth of a disabled child is not actionable by the child as "wrongful life" or "wrongful conception," *Becker v Schwartz, 46 NY2d 401, 413 NYS2d 895, 386 NE2d 807 (1978)* (Down's Syndrome); *Howard v Lecher, 42 NY2d 109, 397 NYS2d 363, 366 NE2d 64 (1977)* (Tay-Sachs disease); *Stewart v Long Island College Hospital, 35 AD2d 531, 313 NYS2d 502 (2d Dept 1970)*, aff'd, *30 NY2d 695, 332 NYS2d 640, 283 NE2d 616 (1972)* (effect on fetus of mother's measles during pregnancy); *John v De Vivo, 179 AD3d 597, 117 NYS3d 230 (1st Dept 2020)*; *Weed v Meyers, 251 AD2d 1062, 674 NYS2d 242 (4th Dept 1998)* (cause of action on behalf of children cannot be maintained against defendant doctor based on alleged failure to provide genetic counseling to father for retinoblastoma, a hereditary form of eye cancer); see *Williams v State, 18 NY2d 481, 276 NYS2d 885, 223 NE2d 343 (1966)* (no cause of action for plaintiff born out of wedlock to mentally deficient mother who conceived while patient in State hospital). Likewise, negligence in performing an amniocentesis test and in issuing an erroneous report that a normal child should be expected does not give rise to a "wrongful life" claim on the part of an infant who was born with birth defects, *Alquijay by Alquijay v St. Luke's-Roosevelt Hosp. Center, 63 NY2d 978, 483 NYS2d 994, 473 NE2d 244 (1984)* (Down's Syndrome). An infant plaintiff born with a genetic condition may not recover under the theory that the doctor's advice led to a delayed diagnosis and treatment of the condition, since he did not owe the infant plaintiff a duty before he was conceived or born, *John v De Vivo, supra.* The parents of such a child are not entitled to recover damages for emotional distress occasioned by the birth and premature death of the child, *Becker v Schwartz, supra*; *Howard v Lecher, supra*; *Weed v Meyers, supra*; PJI 2:280. The parents may, however, recover damages measured by the cost of care and treatment of the child under a "wrongful birth" theory, *Becker v Schwartz, supra*; see *B.F. v Reproductive Medicine Associates of New York, LLP, 30 NY3d 608, 69 NYS3d 543, 92 NE3d 766 (2017)*; *Foote v Albany Medical Center Hosp., 16 NY3d 211, 919 NYS2d 472, 944 NE2d 1111 (2011)*; *Mayzel v Moretti, 105 AD3d 816, 962 NYS2d 656 (2d Dept 2013)*. Since parents have no legal obligation to support children who attain age 21, see *Family Court Act, § 413*; *Domestic Relations Law, § 32*; *Social Services Law, § 101*, such recovery is limited to the extraordinary expenses incurred or to be incurred prior to the child's 21st birthday, *Bani-Esraili v Lerman, 69 NY2d 807, 513 NYS2d 382, 505 NE2d 947 (1987)*. The existence of government programs that provide resources to a disabled child will not, as a matter of law, eliminate the parents' financial obligation for their child's extraordinary medical and educational expenses during the child's minority, *Foote v Albany Medical Center Hosp., supra.* Therefore, the existence of such programs is not necessarily fatal to the parents' claim, id. The parents, however, must demonstrate that they have incurred or will incur some extraordinary expenses in caring for the child; conclusory or speculative assertions that such expenses have been or will be incurred are

insufficient, see *Mayzel v Moretti, supra* (parents failed to raise triable issue of fact regarding whether they sustained damages as a result of child's "wrongful birth"; child's care was provided by a residential care facility and paid for by Medicaid, and parents offered no evidence that resources provided by government were insufficient or that they actually intended to care for child in future).

Where a normal child is conceived and born after an ineffective sterilization procedure upon one of the parents, the claim sounds in "wrongful life" or "wrongful conception" and there can be no recovery for the future maintenance and support of the child, *O'Toole v Greenberg, 64 NY2d 427, 488 NYS2d 143, 477 NE2d 445 (1985)* (tubal ligation); *Miller v Rivard, 180 AD2d 331, 585 NYS2d 523 (3d Dept 1992)* (vasectomy); *Abbariao v Blumenthal, 107 AD2d 556, 483 NYS2d 296 (1st Dept 1985)* (tubal ligation); *Weintraub v Brown, 98 AD2d 339, 470 NYS2d 634 (2d Dept 1983)* (vasectomy); see *Mears v Alhadeff, 88 AD2d 827, 451 NYS2d 133 (1st Dept 1982)* (negligently performed abortion). However, there can be recovery for medical expenses, including the expenses of the unsuccessful sterilization procedure and costs of delivery, loss of services and consortium, and physical pain and suffering arising from the unanticipated pregnancy, *Miller v Rivard, supra*; *Weintraub v Brown, supra*; *Sorkin v Lee, 78 AD2d 180, 434 NYS2d 300 (4th Dept 1980)*; *Sala v Tomlinson, 73 AD2d 724, 422 NYS2d 506 (3d Dept 1979)*.

B. Birth Defects

A claim for malpractice may be asserted on behalf of a child who sustained injuries in utero or as a result of premature birth because of defendant physician's failure to advise the mother of the special risks involved in her pregnancy and the need for special monitoring to prevent such occurrences, *Nieves v Montefiore Medical Center, 305 AD2d 161, 760 NYS2d 419 (1st Dept 2003)*.

Neither the parent nor the malformed child may recover for failure to perform an abortion, *Stewart v Long Island College Hospital, 35 AD2d 531, 313 NYS2d 502 (2d Dept 1970)*, aff'd, *30 NY2d 695, 332 NYS2d 640, 283 NE2d 616 (1972)*.

C. Emotional Injury

The circumstances under which recovery may be had for purely emotional injury are limited, see *Nadal v Jaramillo, 102 AD3d 843, 959 NYS2d 505 (2d Dept 2013)* (woman not informed of pregnancy could not recover for emotional distress arising from fear that unborn child might be harmed by CT-scan); *Lancellotti v Howard, 155 AD2d 588, 547 NYS2d 654 (2d Dept 1989)* (woman erroneously advised that she was pregnant and treated for that condition for months limited to recovery for pecuniary loss and may not, absent physical trauma, recover for emotional distress); see *Creed v United Hosp., 190 AD2d 489, 600 NYS2d 151 (2d Dept 1993)* (plaintiffs suing for alleged negligent implanting of wife's fertilized ova in another woman may not recover for emotional injury where there was no allegation of negligence or physical injury from initial physical intrusion into wife's body). One such circumstance arises when a pregnant woman generally opposed to abortion decides to submit to one only because of negligent medical advice that the fetus was grossly abnormal. In such circumstances the woman may recover for the emotional distress resulting from the abortion and the death of the fetus, which was in fact normal, *Martinez v Long Island Jewish Hillside Medical Center, 70 NY2d 697, 518*

NYS2d 955, 512 NE2d 538 (1987). The Martinez Court reasoned that, unlike cases such as *Tebbutt v Virostek, 65 NY2d 931, 493 NYS2d 1010, 483 NE2d 1142 (1985)*, and Becker v Schwartz, 46 NY2d 401, 413 NYS2d 895, 386 NE2d 807 (1978), Martinez did not involve the claim of a bystander seeking to recover for emotional harm caused by observing or learning of injury or death to a third person (the fetus). Instead, the mother's mental distress was the direct result of the breach of a duty owed directly to her. Similarly, recovery was allowed where defendant negligently failed to advise plaintiff that she could still be pregnant due to an incomplete abortion and plaintiff miscarried, *Ferrara v Bernstein, 81 NY2d 895, 597 NYS2d 636, 613 NE2d 542 (1993)*. Likewise, where a physician negligently failed to detect plaintiff's pregnancy before prescribing a drug potentially harmful to the fetus and plaintiff, fearful that the fetus was harmed, underwent an abortion, plaintiff could recover for the physical and emotional injuries resulting from the abortion and the decision to have the abortion, Lynch v Bay Ridge Obstetrical and Gynecological Associates, P.C., 72 NY2d 632, 536 NYS2d 11, 532 NE2d 1239 (1988). Lynch held that, unlike *Tebbutt v Virostek, supra*, and Vaccaro v Squibb Corp., 52 NY2d 809, 436 NYS2d 871, 418 NE2d 386 (1980), plaintiff was not seeking to recover for an injury to the fetus itself or for emotional distress in witnessing or knowing of an injury to the fetus, but rather for her own physical and emotional injuries.

In Broadnax v Gonzalez, 2 NY3d 148, 777 NYS2d 416, 809 NE2d 645 (2004), the Court of Appeals overruled *Tebbutt v Virostek, 65 NY2d 931, 493 NYS2d 1010, 483 NE2d 1142 (1985)*, and held that an expectant mother may recover damages for emotional distress resulting from a miscarriage or stillbirth that was caused by medical malpractice, even in the absence of independent physical injury. Further, although the physician owes no duty of care to an expectant father, the father may maintain a derivative cause of action for loss of services and consortium where the mother has a cause of action for emotional distress and the facts support such a derivative claim, see Brashaw v Cohen, 154 AD3d 1327, 62 NYS3d 251 (4th Dept 2017). Broadnax appears to have overruled or at least undermined the analyses in such cases as Bauch v Verrilli, 146 AD2d 835, 536 NYS2d 240 (3d Dept 1989) (no recovery for emotional distress suffered by mother when baby died after birth where only injury to mother was episiotomy), and Sceusa v Mastor, 135 AD2d 117, 525 NYS2d 101 (4th Dept 1988) (mother may not recover for emotional distress resulting from loss of twins after emergency caesarean section where no physical injury in addition to those inherent in surgery was sustained); see also Arroyo v New York City Health and Hospitals Corp., 163 AD2d 9, 558 NYS2d 8 (1st Dept 1990) (where two siblings underwent similar hospital treatment, surviving sibling cannot recover for emotional harm resulting from other sibling's death since surviving sibling was not in physical danger).

The holding in Broadnax v Gonzalez, 2 NY3d 148, 777 NYS2d 416, 809 NE2d 645 (2004) was intended to remedy an anomaly in tort jurisprudence that exposed medical caregivers to malpractice liability for in utero injuries when the fetus survived but immunized them when their malpractice caused miscarriage or still birth, see Sheppard-Mobley ex rel. Mobley v King, 4 NY3d 627, 797 NYS2d 403, 830 NE2d 301 (2005); Brashaw v Cohen, 154 AD3d 1327, 62 NYS3d 251 (4th Dept 2017); Ward v Safajou, 145 AD3d 836, 43 NYS3d 447 (2d Dept 2016). Thus, the holding is a narrow one intended to permit recovery where none would otherwise be available and, as such, does not apply in situations where a fetus injured in utero was carried to term and born alive, see Sheppard-Mobley ex rel. Mobley v King, supra; Ward v Safajou, supra;

Levin v New York City Health and Hospitals Corp., 119 AD3d 480, 990 NYS2d 490 (1st Dept 2014). In Sheppard-Mobley, for example, a mother was not permitted to recover for emotional distress resulting from the birth of an impaired child where she allegedly was negligently advised to terminate her pregnancy through a chemical abortion and the chemical abortion was incomplete. However, the mother in Sheppard-Mobley could recover for the emotional injuries she suffered independent of the birth of an impaired child, specifically the injuries she suffered because she had to decide whether to seek an out-of-state late-term abortion or risk the birth of a child with congenital defects. The Broadnax holding does not extend to a non-patient parent's emotional distress resulting from allegedly negligent medical treatment of a child, *Shaw v QC-Medi New York, Inc., 10 AD3d 120, 778 NYS2d 791 (4th Dept 2004)*.

A woman may not normally recover for the physical pain and suffering that are natural accompaniments of the childbirth process, *Fahey v Canino, 304 AD2d 1069, 758 NYS2d 708 (3d Dept 2003)*, rev'd on other grounds, *2 NY3d 148, 777 NYS2d 416, 809 NE2d 645 (2004)*; *Parsons v Chenango Memorial Hosp., 210 AD2d 847, 620 NYS2d 604 (3d Dept 1994)*; *Guialdo v Allen, 171 AD2d 535, 567 NYS2d 255 (1st Dept 1991)*; *Prado v Catholic Medical Center of Brooklyn and Queens, Inc., 145 AD2d 614, 536 NYS2d 474 (2d Dept 1988)*; *Wittrock v Maimonides Medical Center-Maimonides Hosp., 119 AD2d 748, 501 NYS2d 684 (2d Dept 1986)*; see *Kakoullis v Harri H. Janssen M.D. P.C., 188 AD2d 769, 591 NYS2d 224 (3d Dept 1992)*. However, recovery may be had for pain and suffering experienced during a miscarriage resulting from the negligent failure to notify a pregnant woman of her incomplete abortion and to secure her prompt return to the abortion facility, *Ferrara v Bernstein, 81 NY2d 895, 597 NYS2d 636, 613 NE2d 542 (1993)*.

Damages may be recoverable for emotional injuries suffered by a couple whose embryo was mistakenly placed in another woman, *Perry-Rogers v Obasaju, 282 AD2d 231, 723 NYS2d 28 (1st Dept 2001)*. In Perry-Rogers v Obasaju, the couple suffered emotional harm, established through medical affidavits attesting to objective manifestations of their trauma, because of their having been deprived of the opportunity of experiencing pregnancy, prenatal bonding and the birth of their own child, and by their separation from the child for more than four months after his birth.

D. Sterility

Where sterility results from medical malpractice, there can be no recovery for the loss of offspring as such or the deprivation of the companionship of children, but recovery may be had for any physical injuries sustained by the patient, the loss of fertility and any mental and emotional distress attending those injuries, *Hahn v Taefi, 115 AD2d 946, 497 NYS2d 522 (4th Dept 1985)*; see *Stewart v New York City Health and Hospitals Corp., 207 AD2d 703, 616 NYS2d 499 (1st Dept 1994)*. The spouse of a patient being treated for male infertility may not maintain a cause of action against the doctor based on the alleged treatment failure, *Cohen v Cabrini Medical Center, 94 NY2d 639, 709 NYS2d 151, 730 NE2d 949 (2000)*.

E. In Utero Injuries

Becker v Schwartz, 46 NY2d 401, 413 NYS2d 895, 386 NE2d 807 (1978), recognizes the continued vitality of the rule that an infant injured in utero by the tort of another "should, when

born, be allowed to sue," *Woods v Lancet, 303 NY 349, 353, 102 NE2d 691 (1951)*; *Brashaw v Cohen, 154 AD3d 1327, 62 NYS3d 251 (4th Dept 2017)*. Thus, in *Sheppard-Mobley ex rel. Mobley v King, 4 NY3d 627, 797 NYS2d 403, 830 NE2d 301 (2005)*, an infant plaintiff with congenital defects resulting from an incomplete chemical abortion was permitted to sue for injuries caused by defendants' erroneous advice to his pregnant mother that she would not be able to carry the fetus to term and should have a chemical abortion. Physicians who discontinued plaintiff's mother's tuberculosis medication while she was pregnant with plaintiff, resulting in his contracting tuberculosis meningitis from his mother shortly after his birth, owed a duty of care to plaintiff at the time of the alleged act of malpractice, *Moreta v New York City Health and Hospitals Corp., 238 AD2d 149, 655 NYS2d 517 (1st Dept 1997)*. The fact that the fetus was not viable at the time the in utero injury occurred does not preclude recovery if the child was ultimately born alive, *Leighton v New York, 39 AD3d 84, 830 NYS2d 749 (2d Dept 2007)*.

1. Accrual of Cause of Action for In Utero Injury

An infant plaintiff's medical malpractice cause of action premised on alleged injurious acts or omissions occurring prior to birth accrues on the infant's date of birth, *LaBello v Albany Medical Center Hosp., 85 NY2d 701, 628 NYS2d 40, 651 NE2d 908 (1995)*.

F. Pre-conception Torts

A child has no cause of action for injuries sustained as a result of a preconception tort committed against the mother, *Albala v New York, 54 NY2d 269, 445 NYS2d 108, 429 NE2d 786 (1981)*; see *Enright by Enright v Eli Lilly & Co., 77 NY2d 377, 568 NYS2d 550, 570 NE2d 198 (1991)*; *Weed v Meyers, 251 AD2d 1062, 674 NYS2d 242 (4th Dept 1998)* (defendant doctor owed no duty to children prior to their birth independent of duty owed to the father).

VII. Mental Health Professionals

A. Duty to Persons Other Than Patient

While there is no bright-line rule regarding whether a mental health care provider treating a patient on a voluntary basis owes a duty of care to the general public, a member of the general public may have a cognizable cause of action for negligence against the mental health care provider where that defendant has the necessary authority or ability to exercise control over a patient's conduct, *Fox v Marshall, 88 AD3d 131, 928 NYS2d 317 (2d Dept 2011)*; see *Purdy v Public Adm'r of Westchester County, 72 NY2d 1, 530 NYS2d 513, 526 NE2d 4 (1988)*; *Winters v New York City Health & Hospitals Corp., 223 AD2d 405, 636 NYS2d 320 (1st Dept 1996)*.

In *Pingtella v Jones, 305 AD2d 38, 758 NYS2d 717 (4th Dept 2003)*, the court held that a psychiatrist owed no duty of care to the child of his patient, who was stabbed by the patient during a psychotic episode, see *Cardenas v Rochester Regional Health, 192 AD3d 1543, 144 NYS3d 774 (4th Dept 2021)* (in the absence of specific threat, mental health care providers did not owe duty to patient's son, who was killed by patient after she was discharged from in-patient facility and was being treated on an outpatient basis); see also *Engelhart v Orange, 16 AD3d 369, 790 NYS2d 704 (2d Dept 2005)* (doctor who failed to advocate for hospitalization of psychiatric out-patient not liable to person injured in car accident with patient). It has also been

held that a physician who prescribed a sedative for a parent was not liable for injuries sustained by her children when the parent lost consciousness while driving an automobile, since there was no indication that the physician knew the children were relying upon the advice he had given the parent, *Conboy v Mogeloff, 172 AD2d 912, 567 NYS2d 960 (3d Dept 1991)*; see *Adams v Elgart, 213 AD2d 436, 623 NYS2d 637 (2d Dept 1995)* (doctor treating patient for delirium tremens in surgical unit and who knew of patient's propensities owed no duty to nurse working in the hospital who was injured by patient). With respect to psychiatric institutions operated by the State, the Court of Appeals has held that a third person injured as a result of a negligent release decision is not required to establish a special relationship between himself and the State as a condition to maintaining the claim, *Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985)*.

The California state legislature has enacted a statute protecting psychotherapists from "failing to warn of or protect from" a patient's violent behavior except where the patient (or a member of the patient's family) has communicated to the psychotherapist a "serious threat of physical violence against a reasonably identified victim or victims," *Cal Civ Code § 43.92(a)* (modifying holding in *Tarasoff v Regents of University of California, 17 Cal 3d 425, 131 Cal Rptr 14, 551 P2d 334 (1976)*); see *Ewing v Goldstein, 120 Cal App 4th 807, 15 Cal Rptr 3d 864 (2nd Dist 2004)*. There are no cases in New York indicating whether this State's courts will follow that rule.

B. Error in Judgment

When a mental health provider conducts a proper examination and evaluation and chooses a course of treatment within a range of medically accepted choices, the professional judgment doctrine will insulate the provider from liability, *Park v Kovachevich, 116 AD3d 182, 982 NYS2d 75 (1st Dept 2014)*; see *Tkacheff v Roberts, 147 AD3d 1271, 47 NYS3d 782 (3d Dept 2017)*. Thus, the decision by physicians to release a psychiatric patient from an institutional setting does not give rise to liability on the part of the physicians for harm done by the released patient where the decision to release the patient constituted an exercise of professional judgment, *Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985)*; *St. George v State, 283 App Div 245, 127 NYS2d 147 (3d Dept 1954)*, aff'd, *308 NY 681, 124 NE2d 320 (1954)*; *Ozugowski v New York, 90 AD3d 875, 935 NYS2d 613 (2d Dept 2011)*; *Vera v Beth Israel Medical Hosp., 214 AD2d 384, 625 NYS2d 499 (1st Dept 1995)*; *Smith v Fishkill Health-Related Center, Inc., 169 AD2d 309, 572 NYS2d 762 (3d Dept 1991)*. In order for liability to attach, it must be shown that the decision to release the patient was "something less than a professional medical determination," *Gallagher v Cayuga Medical Center, 151 AD3d 1349, 57 NYS3d 544 (3d Dept 2017)*; *Ozugowski v New York, supra*; *Darren v Safier, 207 AD2d 473, 615 NYS2d 926 (2d Dept 1994)*; *Bell v New York City Health & Hospitals Corp., 90 AD2d 270, 456 NYS2d 787 (2d Dept 1982)*; see *Huntley v State, 62 NY2d 134, 476 NYS2d 99, 464 NE2d 467 (1984)*; *Vera v Beth Israel Medical Hosp., supra*; *Wilson v State, 112 AD2d 366, 491 NYS2d 818 (2d Dept 1985)*, or that the psychiatrist's decisions were not the product of a careful evaluation, *Tkacheff v Roberts, supra*; *Gallagher v Cayuga Medical Center, supra*; *Ozugowski v New York, supra*, or a careful examination, *Park v Kovachevich, supra.* A conclusory claim that the release decision constituted a departure from accepted standards of practice is not enough to present a triable issue, *Smith v Fishkill Health-Related Center, Inc., supra*; *Mohan v Westchester County Medical*

Center, 145 AD2d 474, 535 NYS2d 431 (2d Dept 1988); see *Weinreb v Rice, 266 AD2d 454, 698 NYS2d 862 (2d Dept 1999)*.

Likewise, with respect to the failure to hospitalize voluntary outpatients, a doctor generally does not have sufficient control over the patient to justify imposition of liability, Engelhart v Orange, 16 AD3d 369, 790 NYS2d 704 (2d Dept 2005). The medical decision to treat a mentally ill person as an outpatient, rather than as an inpatient, necessarily involves calculated risks and disagreements among experts and is not actionable if made consistent with accepted standards of practice. Likewise, where the treating physician learns that a mental outpatient is not taking prescribed medication, a medical decision not to intervene is not negligence where made as an exercise of professional judgment, Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985); Killeen v State, 66 NY2d 850, 498 NYS2d 358, 489 NE2d 245 (1985). However, a physician's decision to change an existing course of medication for a mentally retarded patient may be found to be malpractice where expert testimony supported a finding that the physician had deviated from accepted practices, Leal v Simon, 147 AD2d 198, 542 NYS2d 328 (2d Dept 1989). An attempted suicide by the patient may give rise to a claim against the psychiatrist if the decision to discharge the patient was not a mere "error in judgment" but the result of a failure to make a decision based upon a careful examination of the patient, Bell v New York City Health & Hospitals Corp., 90 AD2d 270, 456 NYS2d 787 (2d Dept 1982); see *D'Avolio v Prado, 277 AD2d 877, 715 NYS2d 827 (4th Dept 2000)* (reinstating claim based on defendant's failure to remove mentally ill patient from her home); Wilson v State, 112 AD2d 366, 491 NYS2d 818 (2d Dept 1985).

VIII. Negligence in Prescribing Medication

The Physicians' Desk Reference (PDR) is an annual encyclopedia of medications and their side effects, written and compiled by drug manufacturers, Spensieri v Lasky, 94 NY2d 231, 701 NYS2d 689, 723 NE2d 544 (1999); Martin v Hacker, 83 NY2d 1, 607 NYS2d 598, 628 NE2d 1308 (1993). The PDR is hearsay if offered into evidence to establish, by itself, the standard of care for a doctor in prescribing and monitoring a drug, Spensieri v Lasky, supra. The PDR may have some significance in identifying a doctor's standard of care in the administration and use of prescription drugs, but it is not the sole determinant. The information contained in the PDR can only be analyzed in the context of the medical condition of the patient. The testimony of an expert is necessary to interpret whether the drug in question presented an unacceptable risk for the patient in either its administration or the monitoring of its use. Therefore, a plaintiff may offer testimony concerning her expert's professional evaluation of defendant's conduct based, in part, on reliance on the PDR. However, the contents of the PDR may not be offered as the sole evidence of the standard of care in a medical malpractice action.

IX. Other Specific Instances of Malpractice

A physician may be liable for failure to terminate treatment upon discovery that it was adversely affecting the patient, Eisele v Malone, 2 AD2d 550, 157 NYS2d 155 (1st Dept 1956). If the physician has reason to doubt that he or she has sufficient competence to handle the case, the physician may be liable for failure to advise the patient to consult a more skillful physician or surgeon, Benson v Dean, 232 NY 52, 133 NE 125 (1921); see Annot: 35 ALR3d 349.

The physician's obligation includes not only diagnosis and treatment, but also the giving of proper instructions to the patient, *Pike v Honsinger, 155 NY 201, 49 NE 760 (1898)*; *Carpenter v Blake, 75 NY 12 (1878)*, and to hospital staff nurses and physicians who treat or care for the patient, *Hollant v North Shore Hospital, Inc., 24 Misc2d 892, 206 NYS2d 177 (Sup 1960)*, aff'd, *17 AD2d 974, 235 NYS2d 372 (2d Dept 1962)*. The physician's duty also includes seeing to it that the physician's orders to hospital personnel are carried out, *Toth v Community Hospital at Glen Cove, 22 NY2d 255, 292 NYS2d 440, 239 NE2d 368 (1968)*; *Kless v Paul T.S. Lee, M.D., P.C., 19 AD3d 1083, 796 NYS2d 502 (4th Dept 2005)*. On the other hand, a hospital that has followed the physician's instructions as set forth in the pre-operative paperwork may not be shielded from liability if the patient has expressed doubts to a hospital nurse about the site of the planned surgery. Thus, in *Muskopf v Maron, 309 AD2d 1232, 764 NYS2d 741 (4th Dept 2003)*, the court held that a triable issue of fact as to the hospital's liability was raised where a hospital nurse gave deposition testimony that she would customarily speak to the treating physician if the patient raised such doubts and plaintiff's expert testified, based in part on the nurse's statement, that the failure to follow that practice in plaintiff's case was a departure from accepted standards of care.

Although the federal Food and Drug Administration (FDA) has not approved the marketing and promotion of a prosthetic device for a particular condition, the off-label use of the device is not precluded and does not necessarily constitute malpractice, *Sita v Long Island Jewish-Hillside Medical Center, 22 AD3d 743, 803 NYS2d 112 (2d Dept 2005)*. Thus, where there was evidence that the use of a pedicle screw system to treat plaintiffs back condition was considered the standard of care in the medical community, the off-label use of the product for that purpose was not actionable as malpractice. Further, since plaintiff was not participating in a clinical study, FDA regulations requiring disclosure of the product's regulatory status, see *21 USC § 360j(g)*; *21 CFR 50.25*, were inapplicable, see *Sita v Long Island Jewish-Hillside Medical Center, supra.*

The physician's duty with respect to organ transplants runs to the patient; therefore, the donor of an organ has no claim against the doctor whose negligence necessitated the transplant, *Moore v Shah, 90 AD2d 389, 458 NYS2d 33 (3d Dept 1982)*. For the same reason, a physician has no duty to a person holding the patient's health care proxy, and Public Health Law article 29-C, which authorizes such proxies, does not confer an independent right to recover, *DeCintio v Lawrence Hosp., 299 AD2d 165, 753 NYS2d 26 (1st Dept 2002)*.

Where defendant-physician prescribed a course of treatment for plaintiff-patient's mental health problems, including medication and counseling, plaintiff may assert a cause of action for medical malpractice stemming from a sexual relationship between plaintiff and defendant on the theory, supported by expert evidence, that defendant failed to manage the "transference" phenomenon, i.e., phenomenon in which patient experiences near-psychotic attraction to treating physician, *Dupree v Giugliano, 20 NY3d 921, 958 NYS2d 312, 982 NE2d 74 (2012)*.

For further specific examples of medical malpractice, see Comment to PJI 2:149(I)(A).

The following annotations are pertinent: *41 ALR2d 329* (X-ray); *54 ALR2d 200* (treatment of a fracture or dislocation); *54 ALR2d 273* (diagnosis of a fracture or dislocation); *55 ALR2d 461* (treating cancer); *57 ALR2d 379* (failure to attend diligently); *76 ALR2d 783* (surgery of the ear); *97 ALR2d 473* (burn cases); *99 ALR2d 599* (mental disease generally); *10 ALR3d 9* (foreign

object left in patient); *10 ALR3d 1071* (liability of physician hired by employer or insurer); *14 ALR3d 967* (insertion of prosthetic device); *17 ALR3d 796* (heart attack while undergoing unrelated procedure); *19 ALR3d 825* (heart disease and diseases of the vascular system); *23 ALR3d 1334* (mistakenly administering drug); *27 ALR3d 906* (sterilization or birth control procedures); *28 ALR3d 1364* (diagnosis and treatment of tetanus); *30 ALR3d 988* (diagnosis and treatment of epilepsy); *63 ALR3d 1020* (doctor's duty to warn nurse or attendant); *76 ALR3d 890* (organ or tissue transplants); *79 ALR3d 915* (cancer diagnosis); *80 ALR3d 583* (secs. 3-7 superseded in part by *26 ALR5th 245*) (limitation of recovery and submission of claim to pretrial panel); *89 ALR3d 32* (conditions of sexual or urinary organs); *94 ALR3d 317* (electroshock treatment); *8 ALR4th 464* (physical measures in treatment of mental disease); *19 ALR5th 563* (treatment of skin diseases); *30 ALR5th 571* (eyes); *48 ALR5th 575* (male urinary tract and related organs). As to malpractice by others than physicians, see *Annot: 51 ALR2d 970* (nurse); *53 ALR2d 142* (sec. 2(c) superseded by *49 ALR4th 63*) (anesthetist); *80 ALR2d 1278* (chiropodist); *83 ALR2d 7* (sec. 10 superseded in part by *11 ALR4th 748*) (dentist); *58 ALR3d 590* (chiropractor's liability for failure to refer patient to medical practitioner); *58 ALR3d 828* (druggist's liability for suicide); 71 ALR4th 811 (veterinarian); *77 ALR4th 273* (chiropractors and other drugless practitioners); see *6 ALR3d 704* (validity of exculpatory contract); see also *73 ALR4th 24* (osteopath).

X. Expert Opinion Evidence

A. When Expert Opinion is Required

Ordinarily, expert medical opinion evidence is necessary to make out a prima facie case of malpractice, *Koehler v Schwartz, 48 NY2d 807, 424 NYS2d 119, 399 NE2d 1140 (1979)*; *Meiselman v Crown Heights Hospital, 285 NY 389, 34 NE2d 367 (1941)*; *Gross v Friedman, 138 AD2d 571, 526 NYS2d 152 (2d Dept 1988)*, aff'd, *73 NY2d 721, 535 NYS2d 586, 532 NE2d 92 (1988)*; *McGinn v Sellitti, 150 AD2d 967, **541** NYS2d 648 (3d Dept 1989)* (alleged inadequate communication between dentist and oral surgeon); Mertsaris v 73rd *Corp., 105 AD2d 67, 482 NYS2d 792 (2d Dept 1984)* (failure of house physician to examine patient, while patient's own physician was en route); *Gibson v D'Amico, 97 AD2d 905, 470 NYS2d 739 (3d Dept 1983)*; *Annot: 81 ALR2d 597*; see also *Elliott v Fay, 105 AD2d 512, 481 NYS2d 462 (3d Dept 1984)* (proper to instruct jury to find for defendant if it rejected plaintiff's claim that operation was unnecessary since no expert opinion supported any alternative theory).

Notably, the rule in informed-consent actions is unequivocal. Under *CPLR 4401-a*, which applies to "cause[s] of action for medical malpractice based solely on lack of informed consent," such causes must be dismissed "if the plaintiff has failed to adduce expert medical testimony in support of the alleged qualitative insufficiency of the consent," see also *McDermott v Manhattan Eye, Ear and Throat Hospital, 15 NY2d 20, 255 NYS2d 65, 203 NE2d 469 (1964)*; *Gardner v Wider, 32 AD3d 728, 821 NYS2d 74 (1st Dept 2006)*; *Evans v Holleran, 198 AD2d 472, 604 NYS2d 958 (2d Dept 1993)*; *Keane v Sloan-Kettering Institute for Cancer Research, 96 AD2d 505, 464 NYS2d 548 (2d Dept 1983)*. This threshold requirement could not be satisfied by using defendant doctor as plaintiffs expert witness, *Gardner v Wider, 32 AD3d 728, 821 NYS2d 74 (1st Dept 2006)*; see *McDermott v Manhattan Eye, Ear and Throat Hospital, 15 NY2d 20, 255 NYS2d 65, 203 NE2d 469 (1964)*, since it was unlikely that defendant doctor would testify, in direct contradiction of his deposition testimony, that he knowingly acted without having obtained

the patient's informed consent, *Gardner v Wider, supra.* Expert testimony concerning what a reasonable person would have done is not necessary to maintain a malpractice claim premised upon lack of informed consent, *Hugh v Ofodile, 87 AD3d 508, 929 NYS2d 122 (1st Dept 2011)*; *Andersen v Delaney, 269 AD2d 193, 703 NYS2d 714 (1st Dept 2000)*; *Osorio v Brauner, 242 AD2d 511, 662 NYS2d 488 (1st Dept 1997)*; see *James v Greenberg, 57 AD3d 849, 870 NYS2d 100 (2d Dept 2008)*.

The negligent failure to diagnose cancer is not a matter within the ken of a layperson and requires expert testimony, *Fiore v Galang, 64 NY2d 999, 489 NYS2d 47, 478 NE2d 188 (1985)*; *Lyons v McCauley, 252 AD2d 516, 675 NYS2d 375 (2d Dept 1998)*. Expert testimony is also required on the issue of causal relation unless the matter is within the experience and observation of the ordinary juror, *Tatta v State, 19 AD3d 817, 797 NYS2d 588 (3d Dept 2005)* (whether and to what extent lack of nutritional supplement contributed to deterioration of plaintiff's health and immune system is outside the ordinary experience and knowledge of layperson); *Giambona v Stein, 265 AD2d 775, 697 NYS2d 399 (3d Dept 1999)* (expert failed to demonstrate that defendant's alleged deviation delayed diagnosis of Hodgkin's disease, resulted in different treatment for plaintiff, or adversely affected his physical condition or ultimate prognosis); *Duffen v State, 245 AD2d 653, 665 NYS2d 978 (3d Dept 1997)* (whether and to what extent medications contributed to claimant's condition is not matter of common knowledge that fact finder can decide in absence of expert testimony); *Prete v Rafla-Demetrious, 224 AD2d 674, 638 NYS2d 700 (2d Dept 1996)*; see *Zak v Brookhaven Memorial Hosp. Medical Center, 54 AD3d 852, 863 NYS2d 821 (2d Dept 2008)* (although registered nurse qualified to give expert opinion that administration of heparin was departure from accepted standards of care, nurse not qualified to opine that negligent act was substantial cause of patient's injury).

Failure to adduce expert testimony as to causation may result in the failure to make out a prima facie case, see *Park v Kovachevich, 116 AD3d 182, 982 NYS2d 75 (1st Dept 2014)* (conclusions that are speculative or unsupported by evidentiary foundation insufficient to withstand summary judgment); *Prete v Rafla-Demetrious, 224 AD2d 674, 638 NYS2d 700 (2d Dept 1996)*; *Guillari v Gormley, 142 AD2d 927, 530 NYS2d 353 (4th Dept 1988)*; *Kennedy v Peninsula Hosp. Center, 135 AD2d 788, 522 NYS2d 671 (2d Dept 1987)*. On the other hand, the mere offering of expert opinion on proximate cause does not suffice absent a showing of the requisite nexus between the malpractice allegedly committed and plaintiffs injuries, *Koeppel v Park, 228 AD2d 288, 644 NYS2d 210 (1st Dept 1996)*; see *Kaffka v New York Hosp., 228 AD2d 332, 644 NYS2d 243 (1st Dept 1996)*. Where causation is not an issue, testimony by a medical expert called by plaintiff that provides a basis for a finding that defendant's doctors deviated from accepted medical practice establishes a prima facie case, *Brown v New York, 47 NY2d 927, 419 NYS2d 491, 393 NE2d 486 (1979)*; however, expert opinion that there was an error of professional medical judgment does not, *Centeno v New York, 48 AD2d 812, 369 NYS2d 710 (1st Dept 1975)*, aff'd, *40 NY2d 932, 389 NYS2d 837, 358 NE2d 520 (1976)*.

In dealing with a motion to dismiss based on the fact that the testimony of plaintiffs experts is insufficient to establish causation, the court should, in the absence of prejudice, allow plaintiff to reopen and offer further expert testimony, see *Harding v Noble Taxi Corp., 182 AD2d 365, 582 NYS2d 1003 (1st Dept 1992)*; see also *Benjamin v Desai, 228 AD2d 764, 643 NYS2d 717 (3d*

Dept 1996); Lagana v French, 145 AD2d 541, 536 NYS2d 95 (2d Dept 1988); Kennedy v Peninsula Hosp. Center, 135 AD2d 788, 522 NYS2d 671 (2d Dept 1987).

While, as a general rule, expert medical evidence is necessary in an action to recover damages for negligent medical treatment, Martuscello v Jensen, 134 AD3d 4, 18 NYS3d 463 (3d Dept 2015) (expert evidence is necessary part of medical malpractice action), such evidence is not required where the allegations of lack of due care can be determined by the trier of fact on the basis of common knowledge or the action sounds in ordinary negligence, *Reardon v Presbyterian Hosp. in City of New York, 292 AD2d 235, 739 NYS2d 65 (1st Dept 2002)*. Thus, where plaintiff alleged that the physician was negligent in helping plaintiff alight from an examination table, the crux of the allegations were the physician's failure to exercise ordinary and reasonable care to insure that no unnecessary harm befell plaintiff, and, consequently, no expert medical evidence was required to establish plaintiffs prima facie case, id; see Kerker by Kerker v Hurwitz, 163 AD2d 859, 558 NYS2d 388 (4th Dept 1990).

Opinion evidence is also not necessary when common sense and ordinary experience demonstrate that the condition is incompatible with competent treatment. Thus, opinion testimony is not necessary where a psychiatrist beats his patient in the course of treatment, Hammer v Rosen, 7 NY2d 376, 198 NYS2d 65, 165 NE2d 756 (1960), or engages in sexual intercourse with the patient as part of "therapy," Roy v Hartogs, 85 Misc2d 891, 381 NYS2d 587 (AppT 1976), or a patient with known suicidal tendencies is left alone near an opened unscreened window, Wright v State, 31 AD2d 421, 300 NYS2d 153 (4th Dept 1969), or a dentist extracts the wrong tooth, Griffin v Norman, 192 NYS 322 (AppT 1922), (nor), or a part of a broken needle is left at the operative site, Benson v Dean, 232 NY 52, 133 NE 125 (1921), or a young boy is sent home from the hospital, over the protest of his parents, with both legs in casts, pus draining through windows in the casts, the boy running a high temperature and suffering intense pain, Meiselman v Crown Heights Hospital, 285 NY 389, 34 NE2d 367 (1941). However, where the defendant physician has presented expert evidence to rebut the inference thus arising, plaintiff may be required to come forward with expert evidence, Benson v Dean, supra; see Morwin v Albany Hospital, 7 AD2d 582, 185 NYS2d 85 (3d Dept 1959); see also Shaw v Tague, 257 NY 193, 177 NE 417 (1931); *Miller by Miller v Albany Medical Center Hosp., 95 AD2d 977, 464 NYS2d 297 (3d Dept 1983)*.

With respect to other forms of evidence aimed at establishing what constitutes due care and accepted practice, it is improper to allow the jury to view a videotape of defendant performing a surgical procedure similar to the one at issue upon a different patient, Glusaskas v John E. Hutchinson, III, M.D., P.C., 148 AD2d 203, 544 NYS2d 323 (1st Dept 1989).

Regarding the use of habit evidence in medical malpractice actions, see PJI 1:71.

In Spensieri v Lasky, 94 NY2d 231, 701 NYS2d 689, 723 NE2d 544 (1999), the Court of Appeals stated that the Physician's Desk Reference (PDR) "may have some significance in identifying a doctor's standard of care in the administration and use of prescription drugs, but is not the sole determinant." Thus, the PDR is inadmissible as hearsay and the testimony of an expert is necessary to interpret whether the drug in question presented an unacceptable risk for the patient in either its administration or the monitoring of its use. Other reliable medical reference materials may be admissible if used to explain a physician's decision-making process

and not as per se evidence of the standard of care, *Hinlicky v Dreyfuss, 6 NY3d 636, 815 NYS2d 908, 848 NE2d 1285 (2006)* (approving use of algorithm, table and chart indicating cardiac risk "stratification" for non-cardiac surgical procedures, which were published by American College of Cardiology, where material offered to illustrate physician's decision-making methodology); see *Halls v Kiyici, 104 AD3d 502, 960 NYS2d 423 (1st Dept 2013)* (clinical guidelines of American Gastroenterological Association regarding recommended frequency of colonoscopies for patients were admissible as mere recommendations regarding treatment; trial court erred in not giving specific instruction to jury that guidelines were not the same as standards of care and that jury was to make its determination on the appropriate standard of care based on particular circumstances of case, not guidelines alone). Whether such out-of-court statements may become admissible evidence solely because of their use as a basis for an expert's testimony remains an open question in New York, id. In *Ellis v Eng, 70 AD3d 887, 895 NYS2d 462 (2d Dept 2010)*, the court held that clinical practice guidelines may inform an expert's opinion, although they are generally not themselves conclusive.

B. Who May Testify As an Expert

An expert witness in a medical malpractice case must possess the requisite skill, training, knowledge, or experience to insure that an opinion rendered is reliable, see *LaMarque v North Shore University Hosp., 227 AD2d 594, 643 NYS2d 221 (2d Dept 1996)* (plaintiffs witness, who was not medical doctor, failed to show her qualifications to render expert opinion as to appropriate standards of medical and psychiatric care). For a comprehensive discussion of this subject, see Comment to PJI 1:90(I)(B).

A medical expert, if sufficiently knowledgeable, does not have to be a specialist in the relevant field to testify as an expert in a malpractice action against a specialist, *Michalko v DeLuccia, 187 AD3d 1365, 133 NYS3d 122 (3d Dept 2020)*; *Leavy v Merriam, 133 AD3d 636, 20 NYS3d 117 (2d Dept 2015)*; *Frank v Smith, 127 AD3d 1301, 6 NYS3d 754 (3d Dept 2015)*; *Williams v Halpern, 25 AD3d 467, 808 NYS2d 68 (1st Dept 2006)*; *Bodensiek v Schwartz, 292 AD2d 411, 739 NYS2d 405 (2d Dept 2002)*; *Forte v Weiner, 200 AD2d 421, 606 NYS2d 220 (1st Dept 1994)*; *Farkas v Saary, 191 AD2d 178, 594 NYS2d 195 (1st Dept 1993)*; *Annot: 31 ALR3d 1163*. The fact that two doctors do not practice in the same specialty goes to the weight to be accorded to the testimony, not its admissibility, *Michalko v DeLuccia, supra.* Thus, an expert with board certification in internal medicine may be qualified to testify even if the expert does not expressly state that he or she possesses the requisite background and knowledge regarding emergency-room medicine, *Ocasio-Gary v Lawrence Hosp., 69 AD3d 403, 894 NYS2d 11 (1st Dept 2010)*, and a cardiologist may be qualified to offer expert opinion on the standards of care of a general surgeon and an anesthesiologist, *Leavy v Merriam, supra.* An oncologist board certified in internal medicine was qualified to render an opinion as to the standard of care for a primary care physician regarding an alleged failure to diagnose cancer, *Goldschmidt v Cortland Regional Medical Center, Inc., 190 AD3d 1212, 141 NYS3d 522 (3d Dept 2021)*. However, where a physician gives an opinion outside of his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion, see *Keane v Dayani, 178 AD3d 797, 114 NYS3d 93 (2d Dept 2019)* (although radiologist was qualified to render opinion as to whether fracture was detectable on X-ray, he failed to lay foundation to render orthopedic opinion as to whether defendant's failure to diagnose fracture caused plaintiff's subsequent

injuries); *Ozugowski v New York, 90 AD3d 875, 935 NYS2d 613 (2d Dept 2011)* (absent proper foundation, internist and cardiologist failed to raise triable issue of fact as to psychiatric treatment); *Mustello v Berg, 44 AD3d 1018, 845 NYS2d 86 (2d Dept 2007)* (general surgeon failed to raise a triable issue of fact as to gastroenterological treatment administered to plaintiff); *Behar v Coren, 21 AD3d 1045, 803 NYS2d 629 (2d Dept 2005)* (opinion of plaintiffs' expert, a pathologist, submitted in opposition to defendants' motion for summary judgment insufficient to raise issue of fact regarding efficacy of surgical and gastroenterological treatment where expert failed to lay foundation for his asserted familiarity with applicable standards of care); *Postlethwaite v United Health Services Hospitals, Inc., 5 AD3d 892, 773 NYS2d 480 (3d Dept 2004)* (physician whose expertise was confined to anesthesiology and pharmacology was properly precluded from testifying as to whether surgeon and gastroenterologist correctly diagnosed and treated decedent based upon accepted diagnostic practices in their respective fields). A physiatrist may render an opinion with respect to a plaintiffs need for surgery, *Pares v La Prade, 266 AD2d 852, 697 NYS2d 413 (4th Dept 1999)*. However, a chiropractor is not licensed to interpret X-rays for the detection of fractures and is not competent to render an opinion in that regard, *Machac v Anderson, 261 AD2d 811, 690 NYS2d 762 (3d Dept 1999)*; see *Education Law § 6551(2)(a)*. Nor is a chiropractor qualified to render an opinion regarding the standard of care applicable to spinal fusion surgery, *Young v Sethi, 188 AD3d 1339, 134 NYS3d 571 (3d Dept 2020)*.

Accepted standards of practice for the defendant in question are properly the subject of expert testimony, but, where there is a conflict in testimony with regard to acceptable medical standards, the jury must be left to decide what that standard is, see *Ward v Kovacs, 55 AD2d 391, 390 NYS2d 931 (2d Dept 1977)*.

The deposition of one authorized to practice medicine may be offered by any party for all purposes, including as evidence in chief, without the necessity of showing unavailability or special circumstances, *CPLR 3117(a)(4)*.

Plaintiff may compel defendant doctor to testify as an expert at trial, *McDermott v Manhattan Eye, Ear and Throat Hospital, 15 NY2d 20, 255 NYS2d 65, 203 NE2d 469 (1964)*; *Braun v Ahmed, 127 AD2d 418, 515 NYS2d 473 (2d Dept 1987)*, and at an examination before trial, *Johnson v New York City Health & Hospitals Corp., 49 AD2d 234, 374 NYS2d 343 (2d Dept 1975)*; see *Hardter v Semel, 197 AD2d 846, 602 NYS2d 259 (4th Dept 1993)*; *Lingener v State Farm Mut. Auto. Ins. Co., 195 AD2d 838, 600 NYS2d 395 (3d Dept 1993)*, even though plaintiff has other expert witnesses available, *Segreti v Putnam Community Hospital, 88 AD2d 590, 449 NYS2d 785 (2d Dept 1982)*. A number of early cases held that use of an opponent's expert is not permitted, *Maglione v Cunard S.S. Co., 30 AD2d 784, 291 NYS2d 604 (1st Dept 1968)*; *Gnoj v New York, 29 AD2d 404, 288 NYS2d 368 (1st Dept 1968)*; *Gugliano v Levi, 24 AD2d 591, 262 NYS2d 372 (2d Dept 1965)*. However, an expert who examines a party during pretrial proceedings and whose report is disclosed to all parties may be called by any adverse party to testify to the substance of the report, *Gilly v New York, 69 NY2d 509, 516 NYS2d 166, 508 NE2d 901 (1987)*; see also *Onondaga v Hiawatha Plaza Associates, 195 AD2d 1009, 600 NYS2d 573 (4th Dept 1993)*; *Liddy v Frome, 85 AD2d 716, 445 NYS2d 841 (2d Dept 1981)*.

As a general rule, when the proposed opinion testimony of a witness who is not a medical doctor is offered against a defendant who is a medical doctor, the question of the course of treatment the defendant should have undertaken is beyond the witness's professional and educational experience and is not competent opinion evidence on the issue of negligence, *Parese v Shankman, 300 AD2d 1087, 752 NYS2d 503 (4th Dept 2002)*; *Jordan v Glens Falls Hosp., 261 AD2d 666, 689 NYS2d 538 (3d Dept 1999)*; see *Elliot v Long Island Home, Ltd., 12 AD3d 481, 784 NYS2d 615 (2d Dept 2004)*; *LaMarque v North Shore University Hosp., 227 AD2d 594, 643 NYS2d 221 (2d Dept 1996)*. However, where the defendant physician and a non-medical practitioner such as a podiatrist are both licensed to treat the type of injury sustained by the plaintiff, the podiatrist's opinion testimony should not be precluded without consideration of his or her professional and educational experience, *Escobar v Allen, 5 AD3d 242, 774 NYS2d 28 (1st Dept 2004)*; *Parese v Shankman, supra.*

C. Required Content of Expert Testimony

The expert's opinion, as a whole, must reflect an acceptable level of professional certainty, *Matott v Ward, 48 NY2d 455, 423 NYS2d 645, 399 NE2d 532 (1979)*; *Gross v Friedman, 138 AD2d 571, 526 NYS2d 152 (2d Dept 1988)*, aff'd, *73 NY2d 721, 535 NYS2d 586, 532 NE2d 92 (1988)*; see *Callistro ex rel. Rivera v Bebbington, 94 AD3d 408, 941 NYS2d 137 (1st Dept 2012)*, aff'd, *20 NY3d 945, 958 NYS2d 319, 982 NE2d 81 (2012)*; *Duffen v State, 245 AD2d 653, 665 NYS2d 978 (3d Dept 1997)*. Although experts often employ the phrase "reasonable degree of medical certainty" to describe the strength of their conclusions, use of that formula is not required as long as the witness's "whole opinion" reflects a degree of confidence sufficient to satisfy accepted standards of reliability, *Matott v Ward, supra*; *Jones v Davis, 307 AD2d 494, 763 NYS2d 136 (3d Dept 2003)*; see *Rosario v Our Lady of Consolation Nursing and Rehabilitation Care Center, 186 AD3d 1426, 128 NYS3d 906 (2d Dept 2020)* (expert's opinion rendered with "fair" degree of medical certainty sufficient to raise issue of fact); see *Viera v Khasdan, 185 AD3d 405, 126 NYS3d 462 (1st Dept 2020)* (where dentist did not provide accepted standards of practice, opinion concluding no deviation was insufficient). If an expert's testimony on direct is somewhat general, the problem may be cured if the expert's testimony on cross-examination and re-direct is more specific and sufficient to establish the requisite certainty, *Nicholas v Reason, 84 AD2d 915, 447 NYS2d 55 (4th Dept 1981)*; *Ward v Kovacs, 55 AD2d 391, 390 NYS2d 931 (2d Dept 1977)*.

In contrast to the flexible approach reflected in *Matott v Ward, 48 NY2d 455, 423 NYS2d 645, 399 NE2d 532 (1979)*, it has been held that, in order to establish a prima facie case based solely upon expert testimony, the expert must expressly state that defendant's conduct deviated from the required standard of care; merely reciting the areas of defendant's treatment with which the expert disagrees is insufficient, *Salzman v Alan S. Rosell, D.D.S., P.C., 129 AD2d 833, 132 AD2d 807, 513 NYS2d 846 (3d Dept 1987)*; see *Sohn v Sand, 180 AD2d 789, 580 NYS2d 458 (2d Dept 1992)*; see also *Stuart by Stuart v Ellis Hosp., 198 AD2d 559, 603 NYS2d 212 (3d Dept 1993)*. However, in *Knutson v Sand, 282 AD2d 42, 725 NYS2d 350*, the court held the expert testimony sufficient although the expert did not use particular or special combination of words or phrases because an inference could be drawn from the expert's testimony, without the need for jury speculation, that defendant's conduct was a deviation from the requisite standard of care.

Generally, as to expert testimony, see PJI 1:90. For a discussion of the disclosure requirements of CPLR 3101(d)(l)(i), see the Comment to PJI 1:90, IIIA.

XI. Res Ipsa Loquitur

Where the actual cause of an accident is unknown, the doctrine of res ipsa loquitur permits the inference of negligence to be drawn, in a proper case, from the happening of the event and defendant's relationship to it, *Kambat v St. Francis Hosp., 89 NY2d 489, 655 NYS2d 844, 678 NE2d 456 (1997)*; see *States v Lourdes Hosp., 100 NY2d 208, 762 NYS2d 1, 792 NE2d 151 (2003)*. The inference arises from "our everyday experience" and a recognition that "some accidents by their very nature would ordinarily not happen without negligence," *Dermatossian v New York City Transit Authority, 67 NY2d 219, 501 NYS2d 784, 492 NE2d 1200 (1986)*. For a discussion of the elements of the res ipsa doctrine, see PJI 2:65.

Res ipsa loquitur is particularly applicable in medical malpractice cases in which an injury to anesthetized patient occurs during surgery in an area remote from the operative site, *States v Lourdes Hosp., 100 NY2d 208, 762 NYS2d 1, 792 NE2d 151 (2003)*; *Rosales-Rosario v Brookdale University Hosp. and Medical Center, 1 AD3d 496, 767 NYS2d 122 (2d Dept 2003)*; *Ceresa v Karakousis, 210 AD2d 884, 620 NYS2d 646 (4th Dept 1994)*; *Hill v Highland Hosp., 142 AD2d 955, 530 NYS2d 381 (4th Dept 1988)*; *Mack v Lydia E. Hall Hosp., 121 AD2d 431, 503 NYS2d 131 (2d Dept 1986)*; *Fogal v Genesee Hospital, 41 AD2d 468, 344 NYS2d 552 (4th Dept 1973)*; see *Martinez v Adelphi Hospital, 21 AD2d 675, 249 NYS2d 1001 (2d Dept 1964)* (because plaintiff did not have to prove exact cause, it was error to charge that verdict must be for defendant if jury was "in doubt as to the exact way in which plaintiff contracted" disease). Nonetheless, the application of the res ipsa doctrine is somewhat different in medical malpractice cases, where the common knowledge and everyday experience of lay jurors may not be sufficient to support the inference of negligence, *Kambat v St. Francis Hosp., 89 NY2d 489, 655 NYS2d 844, 678 NE2d 456 (1997)*. There are some medical and surgical errors, such as when an physician leaves a sponge or implement inside the patient, that may give rise to an inference of negligence based solely on the common experience of lay persons, *Kambat v St. Francis Hosp., supra.* However, there are also situations in which expert testimony is necessary to provide the basis for concluding that the event would not have occurred in the absence of negligence, *States v Lourdes Hosp., supra.* In such cases, New York, like the majority of states that have considered the question, permit the use of expert testimony to bridge the gap, *States v Lourdes Hosp., supra* (plaintiffs right arm injured, allegedly as a result of anesthesiologist's procedure, during course of surgery to remove ovarian cyst); *Mattison v OrthopedicsNY, LLP, 189 AD3d 2025, 137 NYS3d 814 (3d Dept 2020)* (injury to distal sciatic nerve following total knee revision); *Smith v Sommer, 189 AD3d 906, 137 NYS3d 99 (2d Dept 2020)* (res ipsa charge properly given to jury where plaintiffs expert testified that, in first time fundoplication procedure, injury to vagus nerve does not normally occur if physician performs the proper surgical sequence).

For examples of the application of res ipsa in medical malpractice cases, see *Benson v Dean, 232 NY 52, 133 NE 125 (1921)*; *George v New York, 22 AD2d 70, 253 NYS2d 550 (1st Dept 1964)*, aff'd, *17 NY2d 561, 268 NYS2d 325, 215 NE2d 507 (1966)*; *Mattison v OrthopedicsNY, LLP, 189 AD3d 2025, 137 NYS3d 814 (3d Dept 2020)*; *Smith v Sommer, 189 AD3d 906, 137 NYS3d 99 (2d Dept 2020)*; *Hawkins v Brooklyn-Caledonian Hosp., 239 AD2d*

549, 658 NYS2d 375 (2d Dept 1997); *Schoch v Dougherty, 122 AD2d 467, 504 NYS2d 855 (3d Dept 1986)*; *Cornacchia v Mount Vernon Hosp., 93 AD2d 851, 461 NYS2d 348 (2d Dept 1983)*; *Pipers v Rosenow, 39 AD2d 240, 333 NYS2d 480 (2d Dept 1972)*; *Matlick v Long Island Jewish Hospital, 25 AD2d 538, 267 NYS2d 631 (2d Dept 1966)*; *Robbins v Nathan, 189 App Div 827, 179 NYS 281 (2d Dept 1919)*; PJI 2:65; *Annot: 82 ALR2d 1262*; see also *Kuhns v Millard Fillmore Hospitals, 296 AD2d 839, 744 NYS2d 787 (4th Dept 2002)* (application of res ipsa loquitur in support of negligence claim against hospital).

XII. Causation

The physician's act must be a substantial factor in bringing about the injury for there to be liability, *Wild v Catholic Health System, 21 NY3d 951, 969 NYS2d 846, 991 NE2d 704 (2013)* (citing PJL (medical malpractice plaintiff must generally show that defendant's negligence was a substantial factor in producing the injury); *Oakes v Patel, 20 NY3d 633, 965 NYS2d 752, 988 NE2d 488 (2013)*; *Clune v Moore, 142 AD3d 1330, 38 NYS3d 852 (4th Dept 2016)*; *Goldberg v Horowitz, 73 AD3d 691, 901 NYS2d 95 (2d Dept 2010)* (plaintiff must offer sufficient evidence from which reasonable person might conclude that it was more probable than not that defendant's deviation was a substantial factor in causing injury); *Candia v Estepan, 289 AD2d 38, 734 NYS2d 37 (1st Dept 2001)* (plaintiff must demonstrate that, absent defendant's malpractice, there was a substantial possibility that decedent could have been cured or that life could have been prolonged); *Kenigsberg v Cohn, 117 AD2d 652, 498 NYS2d 390 (2d Dept 1986)* (plaintiff must show that the conduct depriving plaintiff of a better chance of success more probably than not resulted in injury); see *Koehler v Schwartz, 48 NY2d 807, 424 NYS2d 119, 399 NE2d 1140 (1979)* (no issue of fact on causation where no evidence that doctor's omission caused or enhanced alleged injury). In a medical malpractice action, causation is relevant both to liability and to damages, *Oakes v Patel, 20 NY3d 633, 965 NYS2d 752, 988 NE2d 488 (2013)*. In such an action, liability cannot be established unless it is shown that the defendant's malpractice was a substantial factor in causing the plaintiff's injury, id. Even where liability is established, the plaintiff may recover only for those injuries and related damages proximately caused by the malpractice, id. Where the plaintiff had a pre-existing condition, the plaintiff is not entitled to recover for injuries that the pre-existing condition would have caused even in the absence of malpractice, id.

For a charge and comment on proximate cause, see PJI 2:70; for a charge and comment on concurrent causes (i.e., where two or more independent, negligent acts or omissions of two or more parties are alleged to have caused the same injury to plaintiff), see PJI 2:71; for a charge and comment on intervening causes (i.e., where defendant is negligent, but it is alleged that the act or omission of plaintiff or a third-party caused plaintiffs injury), see PJI 2:72.

A. Loss of Chance

In a medical malpractice action, a plaintiff may, under certain circumstances, pursue a theory of loss of chance. Although all four Departments recognize the loss of chance theory, the Court of Appeals has not squarely addressed the issue, see *Wild v Catholic Health System, 21 NY3d 951, 969 NYS2d 846, 991 NE2d 704 (2013)*. The contours of the theory are the subject of developing appellate case law and, therefore, there is no loss of chance pattern charge.

In *Kallenberg v Beth Israel Hospital, 45 AD2d 177, 357 NYS2d 508 (1st Dept 1974)*, aff'd, *37 NY2d 719, 374 NYS2d 615, 337 NE2d 128 (1975)*, regarded as one of the first loss of chance cases in New York, there was expert testimony that decedent's chance of survival, absent the malpractice, was as much as 20 to 40%. The record on appeal indicates that the trial court charged the jury to "decide whether there was a substantial possibility that [decedent] would have survived if she received proper treatment." The Appellate Division upheld a verdict for plaintiff, finding that, on the issue of proximate cause, such evidence was sufficient to support the verdict. The Court of Appeals affirmed without opinion, id.

Under the loss of chance doctrine, a plaintiff may establish that a defendant's negligence was a substantial factor in bringing about injury, where the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury, *Flaherty v Fromberg, 46 AD3d 743, 849 NYS2d 278 (2d Dept 2007)*; see *Mortensen v Memorial Hosp., 105 AD2d 151, 483 NYS2d 264 (1st Dept 1984)*. The plaintiff must demonstrate that the possibility or chance of a better outcome or a decreased injury was substantial, *Mortensen v Memorial Hosp., supra.* A plaintiff need not quantify the extent to which the defendant's negligence decreased the chance of a better outcome, *Hernandez v New York City Health and Hosp. Corp., 129 AD3d 532, 11 NYS3d 588 (1st Dept 2015)*; *King v St. Barnabas Hosp., 87 AD3d 238, 927 NYS2d 34 (1st Dept 2011)*; *Semel v Guzman, 84 AD3d 1054, 924 NYS2d 414 (2d Dept 2011)*. The mere possibility that the plaintiff would have had a better chance for a better outcome or a decreased injury is insufficient to establish proximate cause, *Mortensen v Memorial Hosp., supra*; see *Kimball v Scors, 59 AD2d 984, 399 NYS2d 350 (3d Dept 1977)*. In *Neyman v Doshi Diagnostic Imaging Services, P.C., 153 AD3d 538, 59 NYS3d 456 (2d Dept 2017)*, the court held that a plaintiff need not establish that, but for a defendant doctor's malpractice, the patient would have been cured. Rather, a plaintiff need only show a diminished chance at a better outcome or an increased injury, such as a substantially improved chance for a prolonged life or reduced suffering, id.

Cases where the evidence at trial regarding loss of chance was legally sufficient for the jury to find proximate cause include: *Daniele v Pain Management Center of Long Island, 168 AD3d 672, 91 NYS3d 496 (2d Dept 2019)* (evidence was legally sufficient to establish defendants' failure to timely diagnose and treat infection and resulting abscesses deprived plaintiff of substantial chance for better outcome); *Clune v Moore, 142 AD3d 1330, 38 NYS3d 852 (4th Dept 2016)* (plaintiff presented legally sufficient evidence that defendants' negligence deprived decedent of substantial possibility of surviving bowel perforation and resultant peritonitis); *Wolf v Persaud, 130 AD3d 1523, 14 NYS3d 601 (4th Dept 2015)* (evidence legally sufficient where plaintiff's expert testified that defendant's failure to order timely MRI study of plaintiff's iliac vein diminished her chance of better outcome or increased her injury); *Semel v Guzman, 84 AD3d 1054, 924 NYS2d 414 (2d Dept 2011)* (defendant's failure to communicate that instruments had been placed in decedent's throat delayed diagnosis of perforated esophagus); *Goldberg v Horowitz, 73 AD3d 691, 901 NYS2d 95 (2d Dept 2010)* (where defendant failed to recognize that EKG performed in his office indicated decedent was suffering from ischemia at rest, evidence was sufficient to infer decedent would have had better outcome if defendant had immediately referred him to hospital emergency room); *Dockery v Sprecher, 68 AD3d 1043, 891 NYS2d 465 (2d Dept 2009)* (evidence established defendant's failure to recommend surgery be performed within 24 hours diminished plaintiff's chance for better outcome or increased his injuries); *Alicea v Ligouri, 54 AD3d 784, 864 NYS2d 462 (2d Dept 2008)* (delayed diagnosis of

chorioamnionitis and gestational diabetes contributed to plaintiff's development of cerebral palsy); *Imbierowicz v A.O. Fox Memorial Hosp., 43 AD3d 503, 841 NYS2d 168 (3d Dept 2007)* (evidence sufficient to establish that, if defendant doctor had ordered appropriate test be done right away, it could have been conducted, accurate diagnosis of aortic dissection could have been made, and corrective surgery begun before decedent suffered cardiac arrest); *Flaherty v Fromberg, 46 AD3d 743, 849 NYS2d 278 (2d Dept 2007)* (delay in performing cesarean section diminished infant plaintiffs chance for better outcome); *Borawski v Huang, 34 AD3d 409, 824 NYS2d 362 (2d Dept 2006)* (evidence sufficient to establish that earlier diagnosis would have afforded decedent greater chance of survival where plaintiff's expert opined that defendant's deviation reduced plaintiff's chances of survival from 65-90% chance of being cured, to only 10% chance of long-term survival); *Wong v Tang, 2 AD3d 840, 769 NYS2d 381 (2d Dept 2003)* (testimony of plaintiff's expert that defendant's failure to call ambulance was substantial factor in causing decedent's death was sufficient to demonstrate that some diminution in chance of survival had occurred); *Cavlin v New York Medical Group, P.C., 286 AD2d 469, 730 NYS2d 337 (2d Dept 2001)* (failure to perform chest x-ray, which would had revealed cancerous mass, proximate cause of decedent's death sufficient to show it was probable that some diminution in chance of survival occurred); *Jump v Facelle, 275 AD2d 345, 712 NYS2d 162 (2d Dept 2000)* (evidence of causation was legally sufficient where plaintiffs expert testified negligent delay of 11 to 12 hours in performing surgery increased harm to decedent and decreased his chance of survival); see *Gagliardo v Jamaica Hosp., 288 AD2d 179, 732 NYS2d 353 (2d Dept 2001)* (where plaintiffs' theory was that earlier performed sonogram would have detected testicular cancer that subsequently caused decedent' death, trial court erred in denying plaintiffs' request for jury instruction regarding deprivation of substantial chance for cure); *Cannizzo v Wijeyasekaran, 259 AD2d 960, 689 NYS2d 315 (4th Dept 1999)* (court erred in failing to instruct jury on loss of chance doctrine where plaintiff's theory was that defendants' negligence deprived her of substantial possibility of having functioning kidney).

Cases where the evidence of loss of chance was sufficient to raise a triable issue of fact include: *Holland v Cayuga Medical Center at Ithaca, Inc., 195 AD3d 1292 (3d Dept 2021)* (plaintiffs expert opined that nurse's error in programming pump, which resulted in plaintiff receiving improper dose of medication, deprived plaintiff of substantial possibility of better outcome, up to and including a 100% recovery); *Neyman v Doshi Diagnostic Imaging Services, P.C., 153 AD3d 538, 59 NYS3d 456 (2d Dept 2017)* (plaintiff raised triable issue of fact through expert opinion that, had chemotherapy been instituted earlier, decedent's chances for recovery, or at least for prolonging her life and reducing her suffering, would have been substantially improved); *D'Orta v Margaretville Memorial Hosp., 154 AD3d 1229, 62 NYS3d 620 (3d Dept 2017)* (issue of fact where plaintiff's expert opined that defendant's failure to administer drug to plaintiff after he sustained stroke deprived him of "a substantial possibility for a better long-term neurological outcome, meaning a substantial chance for improved speech, movement and cognition"); *Hernandez v New York City Health and Hosp. Corp., 129 AD3d 532, 11 NYS3d 588 (1st Dept 2015)* (issue of fact as to whether plaintiff's partially severed finger could be salvaged where plaintiff's expert opined that viability of finger diminished with every passing hour, and that amputation could have been avoided had surgery occurred within 4-6 hours of injury, rather than 16-18 hours); *King v St. Barnabas Hosp., 87 AD3d 238, 927 NYS2d 34 (1st Dept 2011)* (issue of fact as to whether first responders' negligent failure to follow resuscitation protocol diminished decedent's chance for recovery).

Cases where the evidence of loss of chance was insufficient include: *Lopes v Lenox Hill Hospital, 172 AD3d 699, 99 NYS3d 384 (2d Dept 2019)* (verdict in favor of plaintiff properly set aside where there was no evidence that defendant OB/GYN would have changed his care and treatment of plaintiff if radiologist's interpretation of ultrasound had been communicated to him in timely manner); *Allen v Uh, 82 AD3d 1025, 919 NYS2d 179 (2d Dept 2011)* (citing PJI) (no rational interpretation of evidence at trial suggested that defendant doctor's negligence deprived plaintiff of substantial chance for cure); *Candia v Estepan, 289 AD2d 38, 734 NYS2d 37 (1st Dept 2001)* (in opposition to defendant's evidence that mesothelioma is, for all practical purposes, incurable, plaintiff failed to raise issue of fact as to whether, absent defendant's failure to timely diagnose, there was substantial possibility that decedent could have been cured or that her life could have been prolonged); *Brown v State, 192 AD2d 936, 596 NYS2d 882 (3d Dept 1993)* (affirming dismissal of claim, after trial, where State's witnesses testified that delay in diagnosis and treatment of claimant's tumor would not have resulted in better outcome).

In *Wild v Catholic Health System, 85 AD3d 1715, 927 NYS2d 250 (4th Dept 2011)* (citing PJI), aff'd, *21 NY3d 951, 969 NYS2d 846, 991 NE2d 704 (2013)*, based on evidence presented, the court concluded that plaintiffs "omission" theory should be subject to the trial court's loss of chance charge, while plaintiffs "commission" theory should be subject to PJI 2:70's general proximate cause charge. On appeal, the Court of Appeals determined that the defendant's challenge to the viability of the loss of chance doctrine was not preserved for appellate review and, therefore, was not properly before it. The only issue preserved was whether the trial court's proximate cause charge improperly reduced the plaintiffs burden of proof. In affirming, the Court of Appeals did not address the omission/commission distinction drawn by the Fourth Department, but concluded that the charge as a whole, which included PJI 2:70 and the standard preponderance of the evidence charge, PJI 1:23, did not improperly alter the causation standard or plaintiff's burden of proof.

In *Daniele v Pain Management Center of Long Island, 168 AD3d 672, 91 NYS3d 496 (2d Dept 2019)*, the evidence was legally sufficient to establish that defendants' departures were a substantial factor in depriving plaintiff of a substantial chance for an improved outcome. However, the case was remitted for a new trial because the trial court deprived the defendant physicians of the opportunity, pursuant to *CPLR 1601*, to adduce evidence of the negligence of two nonparty physicians that may also have deprived plaintiff of a substantial chance for an improved outcome.

Case law from the Second Department uses the phrase "substantial chance," rather than the phrase "substantial possibility," used in the other departments, see *Allen v Uh, 82 AD3d 1025, 919 NYS2d 179 (2d Dept 2011)* (citing PJI); *Gagliardo v Jamaica Hosp., 288 AD2d 179, 732 NYS2d 353 (2d Dept 2001)*. The "substantial possibility" phrase employed by the First, Third, and Fourth Departments should not be confused with an instruction to the jury that plaintiff has the burden of demonstrating that there was "substantial probability" that the defendant's negligent conduct caused her injuries, *Dempsey v Methodist Hosp., 159 AD2d 541, 552 NYS2d 406 (2d Dept 1990)*. Such a charge would be erroneous because it incorporates an improper standard of proof, thereby increasing the plaintiffs burden of proof from the usual "more probable than not" language, id, which, of course, is the applicable standard, *Leal v Simon, 147 AD2d*

198, 542 NYS2d 328 (2d Dept 1989); Mertsaris v 73rd Corp., 105 AD2d 67, 482 NYS2d 792 (2d Dept 1984); see Kimball v Scors, 59 AD2d 984, 399 NYS2d 350 (3d Dept 1977).

B. Delayed Diagnosis

A delayed diagnosis, even if the delay constitutes a deviation from accepted practice, is insufficient standing alone to establish proximate cause, Kaffka v New York Hosp., 228 AD2d 332, 644 NYS2d 243 (1st Dept 1996). In Kaffka, plaintiff alleged that defendant was negligent in failing to diagnose her breast cancer. Based on uncontested evidence that plaintiff's cancer was at an advanced stage when the defendant had an opportunity to make a timely diagnosis, the court ruled that no factual nexus existed between the alleged malpractice and the affirmative harm to plaintiff and dismissed plaintiffs claims, id. Likewise, in *Lyons v McCauley, 252 AD2d 516, 675 NYS2d 375 (2d Dept 1998)*, the court ruled that plaintiff's medical malpractice claim for failure to diagnose cancer was properly dismissed because there was no expert testimony causally linking the defendant's negligence with any delay in the diagnosis of her breast cancer or with any injury that was separate and apart from the underlying cancer, see also Giambona v Stein, 265 AD2d 775, 697 NYS2d 399 (3d Dept 1999). In contrast, recovery was permitted for defendant physician's failure timely to diagnose a patient's cancer, where there was expert evidence that the delay in diagnosis had reduced the patient's life expectancy, there was no contention that the patient's cancer was incurable at the time defendant failed to diagnose the condition and the patient's chance of surviving five years had dropped from 78% to 7% by the time the condition was diagnosed, Schaub v Cooper, 34 AD3d 268, 824 NYS2d 241 (1st Dept 2006). In these circumstances, it could not be said as a matter of law that the delay was not responsible for a diminished chance of survival or for a death that was earlier than it should have been, id; see Polanco v Reed, 105 AD3d 438, 963 NYS2d 57 (1st Dept 2013); Hughes v New York Hospital-Cornell Medical Center, 195 AD2d 442, 600 NYS2d 145 (2d Dept 1993). Similarly, in Luna v Spadafora, 127 AD3d 933, 7 NYS3d 413 (2d Dept 2015), a verdict in favor of a plaintiff was sustained for defendants-physicians' failure to timely diagnose plaintiffs thyroid cancer, where plaintiff adduced expert testimony that the delay caused the cancer condition to advance from stage II with a 10-year survival rate of 85-90% to stage IV with a 10-year survival rate of 40-50%. The Second Department determined that the jury rationally concluded that the delay in diagnosing plaintiffs cancer proximately caused her to have a worsened prognosis or decreased 10-year survival rate, Luna v Spadafora, supra. However, a conclusory statement that a physician's departure from accepted practice resulted in delayed diagnosis and treatment leading to a less favorable prognosis is insufficient to raise a triable question of fact regarding causation, Mosezhnik v Berenstein, 33 AD3d 895, 823 NYS2d 459 (2d Dept 2006). Recovery of damages proximately caused by malpractice for the possibility of the future outbreak of latent or new conditions not manifested at the time of trial requires medical proof of a reasonable certainty that such developments will occur, Matott v Ward, 48 NY2d 455, 423 NYS2d 645, 399 NE2d 532 (1979); Bossio v Fiorillo, 210 AD2d 836, 620 NYS2d 596 (3d Dept 1994).

Causation is relevant both to liability and to damages, Oakes v Patel, 20 NY3d 633, 965 NYS2d 752, 988 NE2d 488 (2013). For example, in a medical malpractice case, liability cannot be established unless it is shown that the defendant's malpractice was a substantial factor in causing the plaintiffs injury, id. But even where liability is established, the plaintiff may recover only for those injuries and related damages proximately caused by the malpractice, id. More

specifically, where the plaintiff had a pre-existing condition, the plaintiff is not entitled to recover for injuries that the pre-existing condition would have caused even in the absence of malpractice, id.

C. Effect of Patient's Conduct

A failure by plaintiff to follow medical advice after the alleged malpractice occurred does not constitute comparative negligence, but rather may only be considered in mitigation of damages, *Dombrowski v Moore, 299 AD2d 949, 752 NYS2d 183 (4th Dept 2002)*; but see *Bellas v Kurpis, 182 AD2d 542, 582 NYS2d 708 (1st Dept 1992)* (jury's finding of plaintiffs comparative negligence need not be disturbed where plaintiff declined to follow full course of treatment). The same principle was applied in pre-comparative fault cases, where the patient's failure to follow medical advice could be considered in mitigation of damages, but did not constitute contributory negligence barring recovery, *Du Bois v Decker, 130 NY 325, 29 NE 313 (1891)*; *Ferrara v Leventhal, 56 AD2d 490, 392 NYS2d 920 (2d Dept 1977)*; *Dunn v Catholic Medical Center of Brooklyn & Queens, Inc., 55 AD2d 597, 389 NYS2d 123 (2d Dept 1976)*; *Heller v Medine, 50 AD2d 831, 377 NYS2d 100 (2d Dept 1975)*; *Quinones v Public Adm'r of Kings County, 49 AD2d 889, 373 NYS2d 224 (2d Dept 1975)*.

A comparative fault charge is appropriate when there is evidence that a plaintiff shares responsibility for harm that was inflicted as a result of a defendant's medical malpractice, *Vallone v Saratoga Hosp., 141 AD3d 886, 35 NYS3d 544 (3d Dept 2016)*; see *DiCicco v Cattani, 59 AD3d 660, 874 NYS2d 518 (2d Dept 2009)*. Thus, where it was claimed that the patient bore major responsibility for her periodontal disease due to heavy use of prescription drugs and tobacco, failure to give complete medical history and delay in treatment, the patient's conduct could be considered on the issue of her comparative fault, *Elkins v Ferencz, 263 AD2d 372, 694 NYS2d 27 (1st Dept 1999)*. The comparative fault rule may apply where prior to the malpractice, the patient fails to reveal part of his or her medical history, *Ogle v State, 191 AD2d 878, 594 NYS2d 824 (3d Dept 1993)*. A comparative fault charge should not be given when a plaintiffs alleged negligence preceded the alleged medical malpractice and is not otherwise alleged to have contributed to the harm resulting from the medical malpractice, id.

Where a patient's criminal conduct is a foreseeable result of the alleged malpractice, recovery may be allowed, *Levitt v Lenox Hill Hosp., 184 AD2d 427, 585 NYS2d 401 (1st Dept 1992)*.

For a charge on mitigation of damages, see PJI 2:325. For a proximate cause charge, see PJI 2:70.

XIII. Liability for Acts and Omissions of Another

When two or more physicians are employed together by the patient and make a joint diagnosis or treatment, they are jointly liable, see *Arshansky v Royal Concourse Co., 28 AD2d 986, 283 NYS2d 646 (1st Dept 1967)*; *Graddy v New York Medical College, 19 AD2d 426, 243 NYS2d 940 (1st Dept 1963)*; CJS, Physicians and Surgeons, § 107; *AmJur2d, Physicians, Surgeons, and Other Healers § 270*; see also *Ruane v Stillwell, 195 AD2d 836, 600 NYS2d 803 (3d Dept 1993)* (evidence insufficient to show that physician who only shared office space with

alleged negligent doctor was acting in concert with his "partner"). Where physicians are partners, each is vicariously liable for the negligent acts of a partner undertaken in furtherance of partnership business, *Hardter v Semel, 197 AD2d 846, 602 NYS2d 259 (4th Dept 1993)*.

Referral of a patient by one physician to another competent physician generally does not, absent partnership, employment or agency, furnish a basis for the referring physician's liability, *Kavanaugh by Gonzales v Nussbaum, 71 NY2d 535, 528 NYS2d 8, 523 NE2d 284 (1988)*; *Mandel v New York County Public Adm'r, 29 AD3d 869, 815 NYS2d 275 (2d Dept 2006)*; *Harrington v Neurological Institute of Columbia Presbyterian Medical Center, 254 AD2d 129, 679 NYS2d 17 (1st Dept 1998)*, even where the referral is because of the temporary absence of the referring physician and the referring physician shares in the fee, *Arshansky v Royal Concourse Co., 28 AD2d 986, 283 NYS2d 646 (1st Dept 1967)*; *Graddy v New York Medical College, 19 AD2d 426, 243 NYS2d 940 (1st Dept 1963)*. Thus, a physician is not vicariously liable for the malpractice of another physician who, though not a partner or joint venturer, merely covers for the referring physician, *Kavanaugh by Gonzales v Nussbaum, supra*; *Reeck v Huntington Hosp., 215 AD2d 464, 626 NYS2d 516 (2d Dept 1995)*. However, a physician who commits malpractice does not avoid liability by referring the patient to another physician who thereafter commits further acts of malpractice, *Datiz by Datiz v Shoob, 71 NY2d 867, 527 NYS2d 749, 522 NE2d 1047 (1988)*; see *Yanchynska v Wertkin, 178 AD3d 1122, 115 NYS3d 84 (2d Dept 2019)* (defendant who referred plaintiff to breast surgeon potentially liable for her own alleged malpractice in failing to advise breast surgeon that her own examination of plaintiff's breast differed from breast surgeon's examination that detected no palpable lumps); *Nicholas v Reason, 84 AD2d 915, 447 NYS2d 55 (4th Dept 1981)* (fact that one defendant attended patient while other was on vacation does not absolve former from liability as a matter of law); see also *Harding v Noble Taxi Corp., 182 AD2d 365, 582 NYS2d 1003 (1st Dept 1992)*; *Tiernan v Heinzen, 104 AD2d 645, 480 NYS2d 24 (2d Dept 1984)*. Liability also may be imposed for negligence in the selection of a covering physician and for failure to advise the covering physician of the potential risks confronted by the patient, *Kavanaugh by Gonzales v Nussbaum, supra.* A referring physician may be held jointly liable for the negligence of the treating physician where the referring physician was involved in decisions regarding diagnosis and treatment to the extent of making them his or her own negligent acts, *Reyz v Khelemsky, 44 AD3d 640, 844 NYS2d 49 (2d Dept 2007)*; Mandel v New York County Public Adm'r, supra; see *Yanchynska v Wertkin, supra.* In such circumstances, the referring physician and the treating physician are liable based on each one's relative responsibility, *Mandel v New York County Public Adm'r, supra.*

A physician can be vicariously liable for another physician's active negligence if the former had some control of the latter's treatment of the patient, *Ross v Mandeville, 45 AD3d 755, 846 NYS2d 276 (2d Dept 2007)*. Thus, a hospital staff physician who allowed a third-year resident to make an incision could be held liable for the injuries resulting from the resident's negligence, since there was evidence that the resident was under defendant physician's direct supervision, id; see *Macancela v Wyckoff Heights Medical Center, 176 AD3d 795, 109 NYS3d 411 (2d Dept 2019)* (question of fact as to whether attending physician deviated from good and accepted practice by failed to recommend repeat testing in light of notes prepared by medical residents and fellows). With respect to employment, a staff physician may, in the circumstances of a particular case, be the ad hoc employee of the patient's surgeon, *O'Rourke v Halcyon Rest, 281*

App Div 838, 118 NYS2d 693 (2d Dept 1953), aff'd, *306 NY 692, 117 NE2d 639 (1954)*, as may a staff nurse, *Annot: 12 ALR3d 1017*; *29 ALR3d 1065, 1075*. As to ad hoc employees, see PJI 2:238. As to when a physician is an independent contractor, see *Brink v Muller, 86 AD3d 894, 927 NYS2d 719 (3d Dept 2011)*; *Roberts v El-Hajal, 23 AD3d 733, 804 NYS2d 819 (3d Dept 2005)*; *Santiago v Archer, 136 AD2d 690, 524 NYS2d 106 (2d Dept 1988)*; *Campbell v Emma Laing Stevens Hosp., 118 AD2d 988, 499 NYS2d 993 (3d Dept 1986)*; *Felice v St. Agnes Hospital, 65 AD2d 388, 411 NYS2d 901 (2d Dept 1978)*; *Mduba v Benedictine Hospital, 52 AD2d 450, 384 NYS2d 527 (3d Dept 1976)*; PJI 2:255. The key consideration for finding that a medical practitioner was an independent contractor is the alleged principal's lack of power to regulate the manner in which the practitioner's work was performed, *Roberts v El-Hajal, supra.*

Physicians who are shareholders, employees, or agents of a professional service corporation are liable for their own acts of malpractice and those over whom they exert direct supervision and control when rendering services on behalf of the corporation, *BCL § 1505(a)* (domestic professional service corporation); § 1527 (foreign professional service corporation); *Ruggiero v Miles, 125 AD3d 1216, 4 NYS3d 648 (3d Dept 2015)*; see *Wise v Greenwald, 208 AD2d 1141, 617 NYS2d 591 (3d Dept 1994)* (supervising dentist-shareholder may be held liable for malpractice by dentist-employee, who was not a shareholder in professional corporation). However, physicians who are employees, officers or shareholders of a professional corporation are not vicariously liable for the malpractice of other physician employees-officers-shareholders, *Yaniv v Taub, 256 AD2d 273, 683 NYS2d 35 (1st Dept 1998)*; *Polokoff v Palmer, 190 AD2d 897, 593 NYS2d 129 (3d Dept 1993)*; *Paciello v Patel, 83 AD2d 73, 443 NYS2d 403 (2d Dept 1981)*. A doctor who is both an employee and supervisor of a professional services corporation is subject to liability for the acts of a fellow employee where, under the circumstances, there is an unreasonable risk of physical harm to others resulting from a risk that the doctor's direction or permission creates, *Yaniv v Taub, supra.* A doctor's participation in weekly group staff meetings of a professional corporation at which a patient's care was discussed does not, without more, give rise to a physician-patient relationship between the doctor attending the meetings and the patient discussed, *Sawh v Schoen, 215 AD2d 291, 627 NYS2d 7 (1st Dept 1995)*.

A hospital is responsible for the malpractice of a physician or nurse in its employ, see PJI 2:151; *Kavanaugh by Gonzales v Nussbaum, 71 NY2d 535, 528 NYS2d 8, 523 NE2d 284 (1988)*; or a professional whom it holds out as performing the service it offers, even though in fact he or she is an independent contractor, *Mduba v Benedictine Hospital, 52 AD2d 450, 384 NYS2d 527 (3d Dept 1976)*; see *Felter v Mercy Community Hosp. of Port Jervis, N.Y., 244 AD2d 385, 664 NYS2d 321 (2d Dept 1997)*; *Felice v St. Agnes Hospital, 65 AD2d 388, 411 NYS2d 901 (2d Dept 1978)*. Likewise, a party who founded a clinic, was one of its principals, interviewed, hired and paid the clinic's doctors and controlled all aspects of the clinic's administration may be held liable for the negligent acts of its physicians regardless of whether the physicians were independent contractors or employees of the clinic, *Brown v LaFontaine-Rish Medical Associates, 33 AD3d 470, 822 NYS2d 527 (1st Dept 2006)* (injured patient did not seek out any physician, but instead selected clinic, which assigned particular physicians to procedures). Thus, where a patient has come to a hospital emergency room seeking treatment from the hospital rather than from an individual physician, the hospital is liable for the negligent acts of a physician who provided emergency care, even though the physician was not a hospital employee, *St. Andrews v Scalia, 51 AD3d 1260, 857 NYS2d 807 (3d Dept 2008)*; *Salvatore v*

Winthrop University Medical Center, 36 AD3d 887, 829 NYS2d 183 (2d Dept 2007). The hospital's liability for the negligent acts of non-employee physicians in such situations is based on agency by estoppel principles and applies to acts of an independent physician where the physician was provided by the hospital or was otherwise acting on the hospital's behest or where plaintiff could reasonably believe that the physician was acting at the hospital's behest, *Malcolm v The Mount Vernon Hosp., 309 AD2d 704, 766 NYS2d 185 (1st Dept 2003)*; see *Sarivola v Brookdale Hosp. and Medical Center, 204 AD2d 245, 612 NYS2d 151 (1st Dept 1994)*. To impose liability on a hospital based on a physician's "apparent authority," there must be words or conduct by the hospital that give rise to the appearance that the doctor has authority to act on behalf of the hospital, *Pratt v Haber, 105 AD3d 429, 963 NYS2d 32 (1st Dept 2013)* (television "blurb" about physician and procedure insufficient to raise issue as to whether physician was hospital's agent). On a motion by a hospital for summary judgment, the hospital must come forward with evidence to rule out any inference that the negligent physician was its agent, *Malcolm v The Mount Vernon Hosp., supra.*

The facts that the physician had teaching and clinical responsibilities, was chosen from a number of cardiologists "on staff" and came to assist in plaintiff's care in response to a hospital employee's page preclude a grant of summary judgment in the hospital's favor, *Malcolm v The Mount Vernon Hosp., 309 AD2d 704, 766 NYS2d 185 (1st Dept 2003)*. A clinic or hospital is responsible for malpractice committed on patients who sought care from the institution rather than from any individual physician, *Hill v St. Clare's Hosp., 67 NY2d 72, 499 NYS2d 904, 490 NE2d 823 (1986)* (citing PJI); *Johnson v Jamaica Hosp. Medical Center, 21 AD3d 881, 800 NYS2d 609 (2d Dept 2005)*; *Ryan v New York City Health and Hospitals Corp., 220 AD2d 734, 633 NYS2d 500 (2d Dept 1995)*; *Brown v LaFontaine-Rish Medical Associates, 33 AD3d 470, 822 NYS2d 527 (1st Dept 2006)*; see *Santiago v Brandeis, 309 AD2d 621, 766 NYS2d 25 (1st Dept 2003)* (defendant hospital's assertion that it did not employ allegedly negligent physician not sufficient to justify summary judgment dismissing complaint where there was no evidence that plaintiff requested physician; fact questions were raised as to whether plaintiff reasonably believed defendant had provided physician and was acting as defendant's agent); *Culhane v Schorr, 259 AD2d 511, 686 NYS2d 105 (2d Dept 1999)* (although decedent was originally admitted through emergency room of hospital, there was no competent proof in record that decedent believed he was receiving care from hospital in general, as opposed to doctors specifically); *Gunther v Staten Island Hosp., 226 AD2d 427, 640 NYS2d 601 (2d Dept 1996)*, as is a department store which holds itself out as conducting a dentist's business, even though to do so is illegal, *Hannon v Siegel-Cooper Co., 167 NY 244, 60 NE 597 (1901)*. However, where a steamship company provides a physician whose use by a passenger is optional and over whom the company has no control, it is responsible only for the selection of a competent physician, *Allan v State S.S. Co., 132 NY 91, 30 NE 482 (1892)*; *Laubheim v De Koninglyke N.S. Co., 107 NY 228, 13 NE 781 (1887)*. The same rule governs a compensation carrier which provides a doctor for an injured employee, *Stone v Goodman, 241 App Div 290, 271 NYS 500 (1st Dept 1934)*; see *Santiago v Archer, 136 AD2d 690, 524 NYS2d 106 (2d Dept 1988)* (as to liability of union health and welfare fund for malpractice of physicians at clinic that fund provided for union members).

A defendant that merely leases its premises to medical practitioners is not subject to liability for medical malpractice of the lessee doctors, *Slavik v Parkway Hosp., 242 AD2d 376, 661*

NYS2d 274 (2d Dept 1997); Hylton v Flushing Hosp. and Medical Center, 218 AD2d 604, 630 NYS2d 748 (1st Dept 1995).

XIV. Liability of Employers Providing Medical Care

If a company maintains a medical facility exclusively for its employees, an action for malpractice arising out of treatment there is barred by workers' compensation, Garcia v Iserson, 33 NY2d 421, 353 NYS2d 955, 309 NE2d 420 (1974); *Marange v Slivinski, 257 AD2d 427, 684 NYS2d 199 (1st Dept 1999)*; Cronin v Perry, 244 AD2d 448, 664 NYS2d 123 (2d Dept 1997). That the facility occasionally treats, on an emergency basis, other people authorized to be on the employer's grounds does not detract from the fact that the facility was essentially an exclusive employee clinic not open to the general public, *Woods v Dador, 187 AD2d 648, 590 NYS2d 240 (2d Dept 1992)*; see Feliciano Delgado v The New York Hotel Trades Council and Hotel Ass'n of New York City Health Center, Inc., 281 AD2d 312, 722 NYS2d 498 (1st Dept 2001); see also *Ruiz v Chase Manhattan Bank, 211 AD2d 539, 621 NYS2d 345 (1st Dept 1995)* (fellow-employee rule inapplicable to suit against pharmacist because pharmacist's services available to all persons working in building, not just those employed by plaintiff's employer). Further, the fact that a company-employed physician performed some of the treatment off the premises of the company is not a "distinction of relevance" in determining whether the co-employee rule barring recovery is applicable, Golini v Nachtigall, 38 NY2d 745, 381 NYS2d 45, 343 NE2d 762 (1975).

Workers' compensation is not a bar to a common-law action where the injuries which result from negligent treatment do not arise from the patient's employment, at least where the treatment was provided as part of the medical service available to the public and was not exclusively available to employees, Firestein v Kingsbrook Jewish Medical Center, 137 AD2d 34, 528 NYS2d 85 (2d Dept 1988) (hospital clerk injured at work and treated at employer-hospital where injuries were aggravated by negligence of another hospital employee); see Litwak v Our Lady of Victory Hosp. of Lackawanna, 238 AD2d 879, 660 NYS2d 912 (4th Dept 1997) (Workers' Compensation Law did not bar action of employee where employee was being treated as hospital patient, not as employee, and defendant doctor was not required as part of his employment with employer to treat employees off employer's premises or personally oversee employees' treatment by other doctors or hospitals); *Milashouskas v Mercy Hospital, 64 AD2d 978, 408 NYS2d 808 (2d Dept 1978)*; *Stevens v Nassau, 56 AD2d 866, 392 NYS2d 332 (2d Dept 1977)*. In any event, the applicability of the Workers' Compensation Law falls within the primary jurisdiction of the Workers' Compensation Board, Botwinick v Ogden, 59 NY2d 909, 466 NYS2d 291, 453 NE2d 520 (1983); see also Introductory Statement preceding PJI 2:215.

Recovery from a physician whose malpractice aggravated an employee's injury is not precluded by the employee's election to take workers' compensation and medical benefits, Workers' Compensation Law § 29(1); see Becker v Huss Co., Inc., 43 NY2d 527, 402 NYS2d 980, 373 NE2d 1205 (1978); Annot: 28 ALR3d 1066.

XV. Malpractice Actions Against Governmental Entities

Where the State engages in a proprietary function, such as providing medical and psychiatric care, the State is held to the same standards as are applicable to private practitioners and

institutions engaging in the same activity, *Schrempf v State, 66 NY2d 289, 496 NYS2d 973, 487 NE2d 883 (1985)*; *D'Avolio v Pluck), 277 AD2d 877, 715 NYS2d 827 (4th Dept 2000)*; *Rattray v State, 223 AD2d 356, 636 NYS2d 43 (1st Dept 1996)*.

When the defendant is a physician, intern or resident, dentist, podiatrist or optometrist rendering services to a person, without receiving compensation from such person, in a public institution maintained in whole or in part by a municipal corporation or rendering services in the course of a home care service maintained by such public institution, a notice of claim must be served in compliance with *General Municipal Law § 50-e* before action can be maintained against either the municipal corporation or such individual defendant, *GML § 50-d*; *Derlicka v Leo, 281 NY 266, 22 NE2d 367 (1939)*; see *Schiavone v Nassau, 51 AD2d 980, 380 NYS2d 711 (2d Dept 1976)*, aff'd, *41 NY2d 844, 393 NYS2d 701, 362 NE2d 252 (1977)*. Similar requirements are imposed with respect to the New York City Health and Hospitals Corporation, see *Plummer ex rel. Heron v New York City Health and Hospitals Corp., 98 NY2d 263, 746 NYS2d 647, 774 NE2d 712 (2002)*; *Young v New York City Health & Hospitals Corp., 91 NY2d 291, 670 NYS2d 169, 693 NE2d 196 (1998)*; *Allende v New York City Health and Hospitals Corp., 90 NY2d 333, 660 NYS2d 695, 683 NE2d 317 (1997)*; Unconsolidated Laws of New York § 7401(2). The continuous treatment doctrine, if otherwise applicable to the facts of a case, applies to the time in which to file a notice of claim under *General Municipal Law § 50-e*, *Plummer ex rel. Heron v New York City Health and Hospitals Corp., supra*; *Young v New York City Health & Hospitals Corp., supra*; *Allende v New York City Health and Hospitals Corp., supra.*

XVI. Liability of Health Insurers

The Employee Retirement Income Security Act (ERISA) does not preempt a plaintiffs medical malpractice, breach of contract and breach of fiduciary duty claims against a primary care physician who allegedly delayed in submitting a specialist's referral form for approval by a health maintenance organization governed by *ERISA, Nealy v U.S. Healthcare HMO, 93 NY2d 209, 689 NYS2d 406, 711 NE2d 621 (1999)*. A medical expense insurer in whose plan medical groups participate is not liable for malpractice by one of these groups, *Mitts by Mitts v H.I.P. of Greater New York, 104 AD2d 318, 478 NYS2d 910 (1st Dept 1984)*. However, if a union health and welfare fund provides a clinic for its members and holds itself out as a health care provider or controls the operation of the clinic, the fund may be held liable for malpractice committed by physicians at the clinic, *Welch v Scheinfeld, 21 AD3d 802, 801 NYS2d 277 (1st Dept 2005)*; see *Santiago v Archer, 136 AD2d 690, 524 NYS2d 106 (2d Dept 1988)*.

Public Health Law § 4410 explicitly provides that an HMO is not engaged in the practice of medicine. The Fourth Department has held, however, that nothing in the statute expressly bars an HMO from being held vicariously liable for the acts of its employees, *Wisholek v Douglas, 280 AD2d 220, 722 NYS2d 316 (4th Dept 2001)*, rev'd on other grounds, *97 NY2d 740, 743 NYS2d 51, 769 NE2d 808 (2002)*; *Burg v Health Care Plan, 281 AD2d 976, 722 NYS2d 843 (4th Dept 2001)*. In *Jones v U.S. Healthcare, 282 AD2d 347, 723 NYS2d 478 (1st Dept 2001)*, the court held that an HMO could not be held vicariously liable for a doctor's and hospital's alleged malpractice where plaintiffs Group Master Contract, membership card and Member Handbook, clearly stated that doctors and hospitals participating in the HMO's healthcare program were independent contractors.

XVII. Bars to Malpractice Recovery

Since claims of medical malpractice and claims for health service providers' fees are inexorably intertwined, recovery by the doctor of a money judgment against the patient for services rendered bars a later action for malpractice by the patient for the same services, *Ahearn v Aryan, 2 AD3d 469, 767 NYS2d 886 (2d Dept 2003)*; see *Blair v Bartlett, 75 NY 150 (1878)*; *Harris v Stein, 207 AD2d 382, 615 NYS2d 703 (2d Dept 1994)* (default judgment); *Hunt v Godesky, 189 AD2d 854, 592 NYS2d 781 (2d Dept 1993)*; *Kissimmee Memorial Hosp. v Wilson, 188 AD2d 802, 591 NYS2d 239 (3d Dept 1992)*; but see *Kossover v Trattler, 82 AD2d 610, 442 NYS2d 554 (2d Dept 1981)* (concurring opinion questioning continued vitality of Blair in light of modern cases applying the doctrine of res judicata). However, an infant plaintiff, not in privity with her father and guardian, was not barred from commencing a malpractice action because of a prior determination against the father-guardian in an action to recover fees for the rendering of the same professional medical services, *Palacio by Palacio v Weissberg, 244 AD2d 536, 664 NYS2d 814 (2d Dept 1997)*. Where a dentist was exonerated of all wrongdoing in a grievance filed by plaintiff with the Office of Professional Discipline of the New York State Education Department, the plaintiff was not collaterally estopped from prosecuting her civil action, *David v Biondo, 92 NY2d 318, 680 NYS2d 450, 703 NE2d 261 (1998)*.

An exculpatory agreement between patient and physician made prior to the commission of an act of malpractice may be invalid or unenforceable if the public interest is affected or the agreement is not clear in its terms. Thus, *Creed v United Hosp., 190 AD2d 489, 600 NYS2d 151 (2d Dept 1993)*, and *Ash v New York University Dental Center, 164 AD2d 366, 564 NYS2d 308 (1st Dept 1990)*, held unenforceable a covenant not to sue a dental clinic that was given by a prospective patient in advance of surgery in consideration of reduced rates.

The National Childhood Vaccine Injury Act of 1986, which provides a no-fault compensation program for "vaccine-related injury or death," *42 USC § 300aa-15(a)*, precludes civil actions in state or federal court for damages in excess of $ 1,000 unless a petition has been filed for compensation under the no-fault program, id § 300aa-11(a)(2)(A); see Bruesewitz v Wyeth LLC, 131 SCt 1068 (2011). The preclusive effect of this provision extends to actions for failures to properly diagnose or treat conditions allegedly caused by vaccinations, *Crucen ex rel. Vargas v Leary, 55 AD3d 510, 867 NYS2d 49 (1st Dept 2008)*.

XVIII. Liability for Breaches of Confidentiality

Although New York does not recognize a common law right of privacy, *Juric v Bergstraesser, 44 AD3d 1186, 844 NYS2d 465 (3d Dept 2007)*, a physician is liable in tort for breaching physician-patient confidentiality, *Chanko v American Broadcasting Companies Inc., 27 NY3d 46, 29 NYS3d 879, 49 NE3d 1171 (2016)*; see *MacDonald v Clinger, 84 AD2d 482, 446 NYS2d 801 (4th Dept 1982)*; *CPLR 4504*; *Juric v Bergstraesser, supra* (characterizing claim as one for breach of implied covenant of trust and confidence inherent in patient-physician relationship); *Anderson v Strong Memorial Hosp., 151 AD2d 1033, 542 NYS2d 96 (4th Dept 1989)* (merely allowing media or member of public to be in waiting room where other persons in room can be observed does not amount to breach of confidentiality); see also *Doe v Roe, 42 AD2d 559, 345 NYS2d 560 (1st Dept 1973)*, aff'd, *33 NY2d 902, 352 NYS2d 626, 307 NE2d 823 (1973)*; Note, Breach of Confidence, An Emerging Tort, 82 Col L Rev 426. The elements of a cause of action

for breach of physician-patient confidentiality are: (1) the existence of a physician-patient relationship; (2) the physician's acquisition of information relating to the patient's treatment or diagnosis; (3) the disclosure of such confidential information to a person not connected with the patient's medical treatment, in a manner that allows the patient to be identified; (4) lack of consent for that disclosure; and (5) damages, *Chanko v American Broadcasting Companies Inc., supra.*

A physician is not liable for disclosing patient records to a malpractice insurer when the physician reasonably believes that the patient will be making a claim against the physician, *Rea v Pardo, 132 AD2d 442, 522 NYS2d 393 (4th Dept 1987)*. A physician may also be justified, under curtain circumstances, in disclosing confidential medical information to a third party to protect that individual from danger posed by the patient, see *Julie v Bergstraesser, 105 AD3d 1301, 963 NYS2d 755 (3d Dept 2013)*. A physician is also under a duty to refrain from providing false statements regarding a patient's medical condition to the patient's insurance company, which duty is part of the existing physician-patient relationship and the confidence and trust arising out of such relation ship, *Aufrichtig v Lowell, 85 NY2d 540, 626 NYS2d 743, 650 NE2d 401 (1995)*.

In *Arons v Jutkowitz, 9 NY3d 393, 850 NYS2d 345, 880 NE2d 831 (2007)*, the Court of Appeals discussed the impact of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) on the obligation of health care providers to preserve the confidentiality of their patients' information, The issue in Arons was whether a party's attorney may conduct an ex parte interview with the adverse party's treating physician when the adverse party has affirmatively placed his or her medical condition in issue. The Arons Court held that such informal discovery may be conducted, provided that an authorization conforming to *45 CFR 164.508* is executed by the patient, a court or administrative order has been issued, or the health care provider is responding to a validly issued subpoena, discovery request or other lawful process(with satisfactory assurance that the attorney seeking the interview has made reasonable efforts to ensure that the adverse party has been notified or has made reasonable efforts to secure a qualified protective order), *Arons v Jutkowitz, supra*, citing *45 CFR 164.512(e)(1)(i)*-(ii). The Arons Court did not consider whether a health care provider may be held liable in tort for violating HIPAA's confidentiality provisions.

XIX. Collateral Source Rule

At common law, damages awards for personal injuries were not reduced by the amount of payments made to the plaintiff from collateral sources such as wage replacement or medical-expense reimbursement plans, *Healy v Rennert, 9 NY2d 202, 213 NYS2d 44, 173 NE2d 777 (1961)*. However, in 1975, the Legislature responded to a perceived "crisis" in the medical malpractice insurance industry by adopting former CPLR 4010, which permitted juries in medical malpractice cases to consider collateral-source payments, L 1975, ch 109; see *Oden v Chemung County Indus. Development Agency, 87 NY2d 81, 637 NYS2d 670, 661 NE2d 142 (1995)*. In 1981, collateral-source set-offs became mandatory and the responsibility for calculating the set-offs was transferred from the jury to the court, L 1981, ch 269. The rules for collateral source set-offs are now embodied in *CPLR 4545*. *CPLR 4545(a)*, which governs awards for past and future damages in medical, dental and podiatric malpractice actions, requires set-offs for collateral source payments that plaintiff has received or is reasonably

certain to receive. For a more detailed discussion of the principles governing collateral-source reductions under *CPLR 4545*, see Comment to PJI 2:301.

XX. Punitive Damages

In the context of professional malpractice cases, the standard for an award of punitive damages is that a defendant manifest evil or malicious conduct beyond any breach of professional duty, *Dupree v Giugliano, 20 NY3d 921, 958 NYS2d 312, 982 NE2d 74 (2012)*. Punitive damages may be recovered in a medical malpractice action where defendant's conduct is so "intentional, malicious, outrageous, or otherwise aggravated beyond mere negligence" to warrant such an award, *Graham v Columbia-Presbyterian Medical Center, 185 AD2d 753, 588 NYS2d 2 (1st Dept 1992)*; see *Marsh v Arnot Ogden Medical Center, 91 AD3d 1070, 937 NYS2d 383 (3d Dept 2012)*. Punitive damages may be appropriate in a medical malpractice action where the defendant abandoned the plaintiff when he or she was in need of emergency medical treatment, or willfully failed to disclose pertinent medical information to evade a malpractice claim, id; see *Abraham v Kosinski, 251 AD2d 967, 674 NYS2d 557 (4th Dept 1998)*. Punitive damages may also be appropriate where the defendant's conduct is wantonly dishonest or grossly indifferent to patient care, see *Schiffer v Speaker, 36 AD3d 520, 828 NYS2d 363 (1st Dept 2007)*; see also *Williams v Halpern, 25 AD3d 467, 808 NYS2d 68 (1st Dept 2006)*. Where defendant doctor's conduct was not wantonly dishonest, grossly indifferent to patient care or malicious and/or reckless, an award of punitive damages is not appropriate, *Charell v Gonzalez, 251 AD2d 72, 673 NYS2d 685 (1st Dept 1998)*; see *Peltier v Wakhloo, 20 AD3d 870, 798 NYS2d 277 (4th Dept 2005)*. As to punitive damages generally, see PJI 2:278.

XXI. Actions for Birth-Related Neurological Injuries

Article 29-D of the Public Health Law was enacted in 2011 and established a medical indemnity fund, administered by an agency within the executive branch of state government, to pay health care costs of qualified infant-plaintiffs who have birth-related neurological injuries. The purpose of article 29-D is to reduce the medical malpractice insurance premiums of health care providers by shifting the responsibility of paying the future medical expenses of infants with birth-related neurological injuries from health care providers to the fund, *Public Health Law § 2999-g* Thus, where article 29-D is applicable, the fund will pay for a plaintiffs "qualified [future] health care costs," *Public Health Law § 2999-j(1)*, to the extent those costs will not be paid by a collateral source other than Medicaid or Medicare, *Public Health Law § 2999-j(3)*. The defendant health care provider is relieved of the obligation to pay an award after trial (or that portion of a settlement) covering future medical expenses, see *Public Health Law § 2999-j(1)*, (6), (13). While article 29-D may have a significant effect on an award for a plaintiff's future medical expenses, it has no direct effect on awards for pain and suffering or past medical expenses or the amount of the attorneys' fee to which plaintiffs counsel is entitled, *Public Health Law § 2999-j(14)*. Article 29-D applies to all actions pending on and after April 1, 2011.

In an action in which a jury or court has made an award for future medical expenses arising out of a birth-related neurological injury, any party may apply to the court for a provision in the judgment that reflects that, in lieu of the award for future medical expenses and upon a determination by the administrator of the fund that plaintiff is a "qualified plaintiff," plaintiffs future medical expenses will be paid out of the fund, *Public Health Law § 2999-j(6)(b)*. *Public Health*

Law § 2999-h(4) defines a "qualified plaintiff' as every plaintiff or claimant who (a) has been found by a jury or court to have sustained a "birth-related neurological injury" as a result of alleged medical malpractice, or (b) has settled a lawsuit or claim therefor. *Public Health Law § 2999-h(1)*, in turn, defines a "birth-related neurological injury" as (a) an injury to the brain or spinal cord of a live-born infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during a delivery admission (b) that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as defined by *Mental Hygiene Law § 1.03*. The court must grant the application if the court determines that the party making the application made a prima facie showing that plaintiff is a "qualified plaintiff," with the ultimate determination of whether a plaintiff qualifies reserved for the administrator of the fund. In an action arising out of a plaintiffs birth-related neurological injury that is settled, which settlement includes for the payment of plaintiffs future medical expenses, the settlement must contain a provision stating that if the administrator of the fund determines that plaintiff is a "qualified plaintiff" all payments for future medical expense will be made by the fund, *Public Health Law § 2999-j(6)(a)*.

As noted above, the fund administrator determines if a plaintiff is qualified. Generally, where the fund administrator determines that a plaintiff is qualified under article 29-D, the defendant is not obligated to pay that portion of the judgment or settlement allocated to future medical expenses. Once a plaintiff is qualified, the fund will pay for "qualified health care costs," *Public Health Law § 2999-h(3)*, i.e. future medical, hospital, surgical, nursing, dental, rehabilitation, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by plaintiff. The administrator, in accordance with article 29-D and its implementing regulations, determines which future heath costs are to be paid from the fund, *Public Health Law § 2999-j(2)*, (8)(a). A qualified plaintiff is assured of receiving medical care or assistance that would, at a minimum, be authorized under the Medicaid program, id. The fund closes to new applicants if its liabilities reach 80% of its assets, *Public Health Law § 2999-i(6)(a)*. In that event all judgments must be satisfied and all settlements paid as if the fund legislation had not been enacted, *Public Health Law § 2999-i(6)(b)*.

All awards for damages other than future health care costs are to be paid in accordance with article 50-A of the CPLR. The plaintiff's attorney fee is paid by the defendant as if the fund were not involved, that is on the entire sum awarded by the jury or the full amount of the settlement, with the fee portion allocated to non-fund damages deducted from the non-fund portion of the award in a proportional manner, *Public Health Law § 2999-j(14)*. Because the determinations as to whether an individual is a "qualified plaintiff" and, if so, which costs are "qualified health care costs" are assigned to the fund administrator, there does not appear to be any reason to modify either the court's charge or the verdict sheet in a case in which Public Health Law article 29-D may be implicated.

"Wrongful birth" claims would not appear to be affected by Public Health Law article 29-D. Under certain circumstances, a wrongful birth claim permits the parent of a child who was born with a congenital abnormality or defect to recover damages for the costs of the medical care and

treatment of the child, see Comment to PJI 2:150. As discussed above, Public Health Law article 29-D only applies to an infant plaintiff who suffered a birth-related neurological injury, i.e. an injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during a delivery admission, see *Public Health Law § 2999-h(1)*. Thus, a child with a congenital abnormality or defect--the type of condition an infant must exhibit to give rise to a claim for wrongful birth--generally will not exhibit a "birth-related neurological injury" as that phrase is defined under Public Health Law article 29-D.

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