DEFENSE PRACTICE UPDATE

MARTIN CLEARWATER & BELL LLP

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COVID-19 Legislation: Current Status

By: Thomas A. Mobilia and Barbara D. Goldberg

While New York has recently limited the protections afforded to health care providers under the Emergency or Disaster Treatment Protection Act (EDTPA), the immunity provided by the federal 2005 Public Readiness and Emergency Preparedness (PREP) Act was recently expanded. This article will discuss these significant developments.

THE EDTPA

In April 2020, in response to burgeoning COVID-19 infections and deaths, the New York Legislature enacted the EDTPA. This legislation amended the Public Health Law to grant qualified immunity from civil and criminal liability to broadly defined classes of health care providers responding to the COVID-19 crisis.

The EDTPA took effect immediately, and was deemed to have been in full force and effect as of March 7, 2020, the date of Governor Andrew M. Cuomo's declaration of a public health emergency in New York State. The EDTPA applies to hospitals, nursing homes, administrators, board members, physicians, nurses, persons licensed to provide emergency medical services and home care services workers. As originally enacted, it also applied to liability stemming from the care and treatment of non-COVID-19 patients.

Harm or damages resulting from "willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm" were excluded;[1] however, health care providers were otherwise shielded from "any liability, civil or criminal, for any harm or damages[2] alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services" in response to the COVID-19 emergency, provided the following conditions were met:

> (a) the health care facility or health care professional is arranging for or providing health care services pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law;

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1. However, "acts, omissions, or decisions resulting from a resource or staffing shortage shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm." Public Health Law (PHL) § 3080 (2).
2. "Harm" is defined by §3081 (1) as including "physical and nonphysical contact that results in injury to or death of an individual," and "damages" is defined by §3081 (2) as meaning "economic or non-economic losses for harm to an individual."

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> (b) the act or omission occurs in the course of arranging for or providing health care services and the treatment of the individual is impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and
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> (c) the health care facility or health care professional is arranging for or providing services in good faith. Public Health Law (PHL) § 3080 (1).

Pursuant to an amendment effective August 3, 2020, the immunity conferred by the EDTPA was limited to health care professionals providing diagnosis and treatment directly to confirmed and suspected COVID-19 patients.[3] The amendment removed the "prevention" of COVID-19 from the definition of health care services and eliminated qualified immunity for facilities or professionals "arranging for" health care services, thereby effectively depriving nursing homes of many of its protections.

According to the Sponsor's Memo, the amendment was an attempt "to move forward from the uncertainty that faced the state from the impact of COVID-19 in late March." The amendment was enacted in response to lobbying efforts by interest groups critical of the immunity originally provided to nursing homes.

Since the amendment applies prospectively, it does not impact health care providers who treated patients prior to its effective date. Unfortunately, however, COVID-19 deaths and infections are surging exponentially once again. Despite the roll-out of apparently effective vaccines, the number of new cases is surpassing that of the early spring, due in part to increased travel over the holiday season and colder temperatures forcing people indoors.

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Health care providers treating COVID-19 patients will still be entitled to qualified immunity under the EDTPA; however, as a result of the amendment providers called upon to treat patients outside their areas of specialization will no longer be protected when treating non-COVID-19 patients. Providers may also face liability in situations where delays in care and treatment of non-COVID-19 patients are claimed to have resulted in injury. Similarly, nursing homes and other long-term care facilities may be forced to defend against alleged failures to "prevent" the transmission of COVID-19.

THE PREP ACT

In contrast, the PREP Act was recently amended in several significant respects to expand the protection it affords. By way of background, the PREP Act authorizes the Secretary of Health and Human Services (HSS) to issue written Declarations providing that a "covered person," including a qualified person who prescribes, administers, or dispenses "pandemic countermeasures," "shall be immune from suit and liability under Federal and State law with respect to all clams for loss covered by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure during a declared disease-related public health emergency." "Willful misconduct" resulting in death or serious physical injury is excluded.

Effective February 4, 2020, HHS Secretary Alex M. Azar relied on the PREP Act to declare a public health emergency for the entire United States. On March 10, 2020, the Secretary issued a Declaration for medical countermeasures against COVID-19 which was retroactively effective to February 4, 2020 "without geographic limitation" and which may remain in effect until as late as October 1, 2025.

If within the scope of the Secretary's Declarations, the PREP Act shields a covered person from legal liability for all claims relating to the administration or use of a covered countermeasure. For PREP Act immunity to apply, the following criteria must be satisfied: (1) the individual or entity

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3. PHL § 3081(5).

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must be a "covered person"; (2) the legal claim must be for a "loss"; (3) the loss must have a "causal relationship" with the administration or use of a covered countermeasure;[4] and (4) the medical product that caused the loss must be a "covered countermeasure."[5]

A "Covered Countermeasure" means a "qualified pandemic or epidemic product" or a "security countermeasure." Covered Countermeasures include any antiviral, any other drug, any biologic, any diagnostic, any device, or any vaccine, used to treat, diagnose, cure, prevent, or mitigate COVID-19 or the transmission of SARS-CoV-2 or a virus mutating therefrom, or any device used in the administration of any such product. Examples include FDA-approved drugs, devices and biological products that are "manufactured, used, designed, developed, modified, licensed or procured to diagnose, mitigate, prevent, treat, or cure a pandemic or epidemic or limit the harm such a pandemic or epidemic might otherwise cause;" as well as other "drugs, biologic products, or devices authorized for investigational or emergency use." "Covered Person" is defined as including manufacturers, distributors, program planners, and "qualified persons", and their officials, agents, and employees, as well as the United States.

The March 10, 2020 Declaration has since been amended four times, each time expanding and/or clarifying the scope of the protections afforded by the PREP Act. Most recently, it was amended on December 3, 2020. Among other things, the amendment added an additional category of "Qualified Persons," i.e., healthcare personnel using telehealth to order or administer covered countermeasures in a state other than the state where the healthcare personnel are permitted to practice, provided such activities are in compliance with the requirements of the licensing state.

PREP Act coverage was also expanded to additional private distribution channels, and the amendment made it explicit that there can be situations where not administering a covered countermeasure to a particular individual can fall within the PREP Act and the Declaration's liability protections. Of particular significance, the amendment makes it explicit that

> …there are substantial federal legal and policy issues, and substantial federal legal and policy interests, in having a unified whole-of-nation response to the COVID-19 pandemic among federal, state, local and private sector entities. The world is facing an unprecedented pandemic. To effectively respond, there must be a more consistent pathway for Covered Persons to manufacture, distribute, administer or use Covered Countermeasures across the nation and the world.

Hospitals and other health care providers qualify as "covered persons" for purposes of the PREP Act.[7] The PREP act will almost certainly apply to the administration of vaccines against COVID-19 as "covered countermeasures," as well as other drugs and devices. Whether it will apply to an alleged failure to "prevent" the transmission of COVID-19 remains unclear, as does the issue of whether it will apply to the failure to administer a vaccine.[8] The latter scenario, however, appears to have been addressed by the December 3, 2020 amendment.

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Existing precedent indicates that the PREP Act should be broadly construed to accomplish its intended purposes. In fact, the New York State Appellate Division has concluded that given the breadth of the PREP Act's preemption clause, together with the "sweeping language" of the statute's immunity provision, "Congress intended to preempt all state law tort claims arising from the administration

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4. *See* Kevin J. Hickey, "The PREP Act and COVID-19: Limiting Liability for Medical Countermeasures," Congressional Research Service, updated September 21, 2020, p. 2.
5. *Id*.
6. Department of Health and Human Services, "Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 and Republication of the Declaration."
7. 42 USCA § 247d-6d (i)(2)(B)(iv), 42 USCA § 247d-6d (i)(5).
8. *See Casabianca v. Mount Sinai Medical Center*, 2014 WL 1043521 (N.Y. Sup. 2014) (hospital not immunized against liability where it decided against administering a vaccine for H1N1 to a patient hospitalized for a medical procedure who later contracted and died from H1N1).

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of covered countermeasures by a qualified person pursuant to a declaration by the Secretary…"[9] A broad interpretation is also implicit in the December 3, 2020 amendment.

The potential impact of the PREP Act cannot be overemphasized. If a claim is covered by the PREP Act, state courts are divested of jurisdiction.[10] The only exception to the immunity conferred on "covered persons" by the PREP Act is a cause of action to recover for death or serious physical injury caused by "willful misconduct." A "serious physical injury" must be life-threatening, permanently impair a body function, permanently damage a body structure, or require medical intervention to avoid such permanent injury or damage. The covered person must have acted (i) intentionally to achieve a wrongful purpose, (ii) knowingly without legal or factual justification; and (iii) in disregard of a known or obvious risk that is so great as to make it highly probably that the harm will outweigh the benefit.

Before filing suit, an injured person must first seek compensation through the Countermeasures Injury Compensation Program. The potential plaintiff cannot sue if he or she elects to receive compensation through that program. If the would-be plaintiff chooses to sue, the suit must be brought in the United States District Court for the District of Columbia. These requirements are likely to prove an insurmountable hurdle for many, if not most plaintiffs. ■

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Mitigating Future Care Medical Damages Involving International Plaintiffs and State-Funded Healthcare Systems

By: Peter T. Crean and Kathryn D. Blackmer

Defending against exposure for the cost of significant future medical care involving a non-US resident as a plaintiff can present a complex set of challenges in litigation. Obtaining reliable collateral source information, medical history, and records in the plaintiff's home country, including ensuring the proper translation of such material, is significantly more difficult and costly than in a case involving a U.S. resident. However, when an international plaintiff is the citizen or resident of a country with a state-funded healthcare system, obtaining these materials and determining the statutory scheme and function of that state-funded healthcare system can greatly reduce damages related to the cost of future medical care.

A defendant in a medical malpractice case with exposure for substantial future medical costs must offer an alternative source of payment for future medical care costs that is "reasonably certain" to be available to the plaintiff in order for that source of payment to be treated as a "collateral source" by the

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9. *See Parker v. St. Lawrence County Public Health Dept.*, 102 A.D.3d 140 (3rd Dept. 2012).
10. *See Parker, supra*.

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Court in a CPLR Article 50A or 50B hearing and offset a future care award.[1] Knowledge of the applicable coverage available through a state-funded system, together with an accompanying expert opinion explaining that the plaintiff is eligible to participate in that system, can meet the statute's criteria so that the state-funded coverage can qualify as a valid collateral source for future medical care, thereby significantly decreasing exposure.

We were recently successful in obtaining extensive medical and collateral source records and researching the applicable national healthcare statutory framework in a matter involving a severely injured Luxembourg citizen residing in the UK.[2] These materials, together with the opinion of a highly qualified expert, who interpreted and confirmed the significant coverage scheme potentially available to the plaintiff, allowed us to demonstrate a valid third party source for the future medical costs asserted in the plaintiff's life care plan. We offer an illustrative roadmap for assessing the validity of claimed future medical costs when a plaintiff has access to a state-funded healthcare system by virtue of citizenship, residency, or international travel.

When a lawsuit involves care rendered in the U.S. to international plaintiffs, obtaining prior and subsequent foreign records is the most difficult first hurdle. HIPAA is not applicable and many countries have different health privacy laws. For instance, the EU adopted regulation (EU), 2016/679, the General Data Protection Regulation (GDPR), in 2016. While similar to HIPAA, the GDPR and EU Member States' additional laws may bar the dissemination of materials directly to a third party, even if the plaintiff has authorized disclosure of the information.

In our case, we learned that the plaintiff, as a Luxembourgish citizen, received prior and subsequent care through Luxembourg's state-funded system, governed by *Union des Caisses de Maladie*. Although we received an authorization to obtain records from this entity, due to privacy laws and the inapplicability of HIPAA, we ultimately required an affirmative statement signed by the plaintiff and addressed to this governing entity seeking the release of her records. Pursuant to Luxembourg statutory law, the materials could be sent only to the plaintiff, which we arranged with Court direction. Awareness of the restrictions imposed by these privacy laws can therefore expedite the receipt of information, including collateral source information.

Plaintiffs' attorneys may argue that their client's state-funded system fails to provide adequate coverage for a therapy or treatment, or that availability of this coverage cannot be established with reasonable certainty. However, acquiring the collateral source records may provide the means of refuting these arguments.

The collateral source information we obtained included correspondence to the state system for in-state reimbursement programs and an accounting of costs covered by the state versus those owed by the citizen. This demonstrated a vastly different picture than the enormous costs projected in the plaintiff's life care plan.

Plaintiffs' attorneys may argue that their client's state-funded system fails to provide adequate coverage for a therapy or treatment, or that availability of this coverage cannot be established with reasonable certainty. However, acquiring the collateral source records may provide the means of refuting these arguments. The records we obtained included discussions of cross-border agreements and reimbursement provisions for out-of-country care. We learned that member states of the EU, the European Economic Area (EEA), UK, and Switzerland allow citizens of differing member states to receive medical treatment and either have this treatment funded upfront, or subsequently reimbursed, depending on the applicable treaty and the statutes. If the plaintiff requires subsequent treatment where a cross-border agreement does not exist, many countries will compensate or reimburse such treatment on the basis of rates established by verification officers or analogized to those of the plaintiff's home country.[3] Thorough review of the foreign statutory framework as to

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1. *Stylianou v. Calabrese*, 297 A.D.2d 798, 748 N.Y.S.2d 36 (2d Dept 2002); *Caruso v. Russell P. LeFrois Builders, Inc.*, 217 A.D.2d 256 (4th Dept. 1995); *see also* CPLR §§ 4545, 5031, 5041.
2. Loss of two legs and an arm requiring lifelong care.
3. *See e.g.*, NHS Act 2006 6BA and 6BB; Article 26, subsections 3 and 4 of the Bylaws for the *Union des Caisses de Maladie*.

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reimbursement can demonstrate an available collateral source that is "reasonably certain" to be provided, thereby preventing windfalls in future damage calculations, even if a procedure occurs outside the plaintiff's country of citizenship.

Citizenship is often not a requirement for a party to receive medical care in another country, even if the other country also maintains a separate state-funded system. In our case, the plaintiff, while a citizen of Luxembourg, was a resident of the UK. With a thorough understanding of the UK National Health Service (NHS), we were able to establish the plaintiff's eligibility for coverage with the NHS, both for surgery in the United States and even coverage in Iran, where the plaintiff traveled frequently, should she seek medical care there.

The NHS is the publicly funded service that provides comprehensive healthcare in the UK, where eligibility is based on residency, not citizenship.[4] Registration with the NHS is achieved by intent to remain as a resident in the UK and choosing a general practitioner.[5] Access to NHS is based on clinical need, not an ability to pay. Therefore, NHS services are typically free at point of use, unless expressly provided for in legislation, e.g., certain prescriptions and dentistry.[6] We were able to demonstrate by statute that Brexit was inapplicable to limit the Luxembourgish plaintiff's access to treatment in the UK, because her registration with the NHS was based on her establishment of residency, which she accomplished by her schooling there.

After establishing the applicability of the state-funded system, the next essential process is comparing each item of the plaintiff's life care plan with the statutory coverage provisions in the state-funded system. This will likely establish that the state-funded system either definitively covers the majority of the purported future medical costs in their entirety, or provides a substantial subsidy.

In our case, plaintiff's counsel submitted a life care plan that included costs associated with healthcare, therapy, home modifications, and necessary medical devices for a full life expectancy. A thorough comparison of NHS statutes and regulations, with the assistance of expert review, allowed us to present an alternative verifiable life care plan at a fraction of the cost.

We first established that the plaintiff's residency in the UK provided access to a general practitioner, referral to specialists, physical and occupational therapies, prosthetics/orthotics and other medical devices, and potential surgeries, all of which were entirely funded by the NHS.[7] Any medication prescribed by the aforementioned healthcare providers would also likely be covered, absent express statutory language that stated otherwise.[8]

Citizenship is often not a requirement for a party to receive medical care in another country, even if the other country also maintains a separate state-funded system.

We were also able to point to a wide range of disability related financial supports, including tax credits, reimbursement programs, grants and concessions available to the plaintiff which could be completed via a "needs assessment."[9] Part 1, Section 9 of the Care Act of 2014 details the assessment of an adult's needs for care and support. The assessment includes an application process completed by a team of healthcare professionals who review the type of help needed, the complexity, intensity and unpredictability of the assistance, including the risk to a person's health if care were unavailable.[10]

One major issue to be assessed in researching these programs is whether a financial component is included in a

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4. *See* NHS Constitution for England, January 2019.
5. *Id*.
6. *See* NHS Act 2006.
7. *See* NHS Act of 2006 Sections 83, 99, 115, and 126; NHS Act of 2006 Section 1, noting that prescription charges, dental charges, certain ophthalmic charges, and overseas visitor charges are the only treatments allowed to charge for services; *see also* NHS Act of 2006 Section 1 (3); https://www.nhs.uk/conditions/physiotherapy/accessing/; Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Part 9 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012; Regulations 7 and 8 of the National Institute for Health and Care Excellence; Social Care Information Centre (Functions) Regulations 2013.
8. *See* NHS Act of 2006 Sections 172, 175-176, 179-180.
9. *See* NHS Care Act 2014 Part 1, Section 9 "Assessment of an Adult's Needs for Care and Support."
10. *See e.g.*, https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/care-and-support-you-can-get-for-free/; https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/.

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needs assessment, as settlement may lower a plaintiff's eligibility for certain programs. This was especially important when assessing larger cost items such as home nursing care.[11] However, our detailed research of other programs including allowance programs for caregivers[12] and reimbursements for home modifications on a per-item basis, rather than in totality,[13] allowed us to alleviate significant concerns regarding the impact of financial components of needs based assessments.

A thorough understanding of the applicability of the state-funded health systems available to the plaintiff was critical to mitigation of future damages. A highly experienced expert assisted us in interpreting our research and assessing the significance of certain aspects of the statutory framework. Careful comparison of that statutory framework to the life care plan demonstrated that the costs of future care could be dramatically reduced thereby preventing a windfall as contemplated by the CPLR. ■

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Best Medical Practices During the Pandemic

By: Michael F. Madden and Michelle A. Frankel

There are many changes in how medical care is being sought and provided during the pandemic. Some patients are foregoing medical appointments by their own volition and some non-emergent and routine medical appointments and procedures are being deferred by patients and also sometimes by practitioners due to upswings in the amount of COVID-19 cases. For these reasons, it is particularly important for medical providers to vigilantly ensure their compliance with well-settled standards of care as the pandemic continues. This will serve to ensure appropriate patient monitoring and a continuum of care coordination and lead to appropriate intervention if and when necessary. In a sense, a heightened cognizance of patients' needs and potential needs is more important than ever, otherwise conditions could be left untreated and complications and problems may arise that could have otherwise easily been avoided. Proper documentation remains critical as well since it is unclear precisely how various medical issues and complications that occur during the pandemic may be alleged as medical malpractice claims in years to come.

The "best" medical practices generally referenced herein are those that comply with accepted standards of care. The standard varies depending on the specific medical specialty involved and based on the type of medical provider from private physician practices to hospitals, nursing homes, urgent care centers and others. It is well-known that medical malpractice cases in New York involve a contrast of the allegedly negligent care and treatment that was provided to the standard of care in the medical specialty at issue at the time of the treatment. Plaintiffs' attorneys will likely craft new theories and probe medical care and treatment provided during the pandemic with an especially close eye to try and identify alleged devia-

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11. *See* NHS Care Act 2014 Part 1, Section 9 "Assessment of an Adult's Needs for Care and Support."
12. *See e.g.*, https://www.gov.uk/carers-allowance.
13. *See e.g.*, https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/care-and-support-you-can-get-for-free/.

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tions from accepted standards of care. Certain medical specialties that are experiencing downturns in patient appointments and therefore a reduction in prescribed or recommended procedures, for instance, and hospitals or specialties that are especially inundated treating pandemic related issues now may be more vulnerable in the future since these situations may be more likely to lead to patients and caregivers allowing some medical issues to fall "through the cracks."

As a result, medical providers should ensure that their staff are up to date on all of their own policies and procedures as well as rules and state regulations and/or any informal practices that are used to schedule their annual and/or follow-up appointments or referrals. Any formal policies and procedures should be consistent with current standards of care for specific specialties. Primary care physicians may be faced with a heightened risk of potential medical malpractice claims since patients often rely on or think of them as their "gatekeeper" physician who will direct their care and oversee specific care coordination with other medical specialties as needed. Of course, all medical providers should have basic care coordination procedures in place but some providers may be subject to heightened standards of care depending on the patient population served. Any providers that are specifically certified by NY State as an Accountable Care Organization (ACO) may be further subject to additional requirements under Public Health Law § 2999-p.[1] There are Medicare-only ACOs as well so it is important to know the proper characterization of one's medical employer to know what specific standards apply when providing care.

Unwarranted or inadvertent lapses in the facilitation of specialty referrals or setting up and rescheduling of ancillary or community services could lead to medical issues that might be alleged later as failures or delays to provide timely care that will be alleged as deviations from the accepted standards of care.

More specifically, patients' needs and duties may vary depending on the type of medical provider or institution involved. Personalized care plans may be a critical part of coordinating care for certain patient populations. This may involve internal coordination at a nursing home, for instance, where wound care, nutrition and physical therapy personnel must collaborate to ensure the provision of sufficient medical care. Alternatively, external coordination may be required. Unwarranted or inadvertent lapses in the facilitation of specialty referrals or setting up and rescheduling of ancillary or community services could lead to medical issues that might be alleged later as failures or delays to provide timely care that will be alleged as deviations from the accepted standards of care. For example, if a gynecologist examines a patient and notices a suspicious breast lump for possible further follow-up treatment i.e. mammogram, referral to a breast surgeon, potential biopsy, etc., it would be critically important to document the findings and any referrals as well as to ensure that the patient understands the relatively urgent need to proceed with imaging and/or present to a breast surgeon for further evaluation. If the series of steps involved in addressing such a situation is not carefully explained and documented then should the patient be diagnosed with cancer subsequently and claim that there were various deviations from accepted standards of care when the suspicious finding was initially noted by the gynecologist, inadequate documentation could critically effect the defense. In addition, it is important to ensure that systems are in place when radiology imaging results are received so that pertinent findings are properly and timely reported upon. Failing to timely report on and follow-up on imaging results could also give rise to malpractice claims. Otherwise office error in receiving and failing to review the imaging may give rise to malpractice claims too.

It is always important to ensure and make certain that there is adequate, acceptable and proper documentation. During the pandemic when there may be larger time periods between in-office presentations, it will likely be particularly helpful and beneficial to the defense of future claims to document any and all measures performed to facilitate care whether annual, follow-up, or referral coordination. It could be critically important to the defense of a future suit to document when and how the patient was contacted, and more so, exactly what was relayed or

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1. *See generally*, Accountable Care Organization (ACO), NEW YORK STATE DEPARTMENT OF HEALTH, https://www.health.ny.gov/health_care/medicaid/redesign/aco/.

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explained. Likewise, such documentation could be pivotal and crucial when defending against allegations that there were negligent follow-ups, delays and/or referrals and failures to coordinate care. For instance, it would be beneficial and advantageous to a defendant to be able to rely on records that specifically documented that a patient was clearly advised about the risks associated with declining to present for an in-person examination related to a wound that was assessed via telehealth but remained suspicious and needed to be examined in-person for further wound cultures and diagnostic tests. It would also be invaluable to employ and display good bedside manner and prompt responses to patients' questions since historically patients are less inclined to initiate medical malpractice claims if they feel they are being properly treated by their physicians.

The aforementioned best medical practices should always be employed to ensure the provision of care and treatment that is compliant with the standard of care. However, it is particularly important during the pandemic to be conscious about what further care and treatment, referrals etc. need to be performed and what individual patients or patient groups may need, and at the least, to specifically document efforts made to meet such needs. This will only help to promote the continuity and coordination of warranted and necessary care in a changing world and facilitate a stronger defense should a medical malpractice claim arise in the future. ■

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MCB CASE RESULTS

June 2020: Summary Judgment Granted – Court Found Plaintiff's Expert's Opinion in Opposition to the Motion to be Conclusory

Senior Partner Sean F. X. Dugan, and Partner Matthew M. Frank's motion for summary judgment was granted in Nassau County Supreme Court before Judge Steinman. Plaintiff underwent joint urogynecology and colorectal surgery and later was found to have a skin lesion on her lower back. Plaintiff claimed the electrosurgical grounding pad used during surgery was misplaced and/or our colorectal surgeon used excessive electrosurgery, leading to thermal skin burn.

Judge Steinman held that we established entitlement to summary judgment by establishing no departure from the standard of care and that plaintiff's claimed injuries were not proximately caused by our client doctor. The Court then held that the affirmation of plaintiff's anonymous general surgery expert was conclusory, riddled with speculation, and conceded to various uncertainties as to the cause. The Judge noted that plaintiff's expert failed to describe a standard of care or opine as to the manner in which our client doctor departed. Accordingly, Judge Steinman granted summary judgment, dismissing the complaint against our client doctor.

July 2020: Summary Judgment Granted in Lumbar Puncture Case Based on Radiological Imaging

Partner John J. Barbera and Associate Christopher J. Daniel's motion for Summary Judgment was granted in Supreme Court Orange County. A young patient with several medical problems alleged severe and permanent neurological injuries following a lumbar puncture, (LP), performed by a resident to rule out meningitis. Despite claiming that the spinal nerve was compressed by a pressure inducing hematoma via a negligently performed LP at the wrong level, causing nerve damage, the defense was able to establish via expert reviews that the neuro-radiology images of the spine showed the presence of an infectious collection of fluid in the spinal canal that pre-existed the LP and was responsible for causing a transient pressure inducing environment. The images were discussed extensively to allow the defense to demonstrate that the images were not consistent with a hematoma in terms of MRI signal and time line resolution over serial studies. The plaintiff was unable to rebut the expert findings put forward by the defense resulting in dismissal of a case of high exposure.

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July 2020: Internist Obtains Dismissal via Summary Judgment in Case Involving Alleged Failure to Diagnose Aneurysm

Partner Michael A. Sonkin, and Associates Kathryn R. Baxter and Nicole S. Barresi's motion on behalf of our client hospital and an individually named internist was granted in a Kings County case involving a married 35-year-old father of three children, in which there were claims of a failure to diagnose an aneurysm which ruptured leading to intracerebral hemorrhage and death. The decedent had complained of headaches in the past, and in July 2014 the decedent presented to the internist with complaints of a headache that had lasted for "a couple of days." He was diagnosed with a tension headache. The decedent's wife called the internist the following day and reported that the decedent's headache had not resolved and the internist told him to go to the Hospital. He allegedly suffered a ruptured aneurysm causing an intracerebral hemorrhage, underwent a coiling procedure, and ultimately died 11 days later.

The Court granted the defendants' motion for summary judgment ruling that plaintiff's expert affirmation by a neurosurgeon was speculative. In this case, plaintiff submitted the affirmation of a board certified neurosurgeon but the Court ruled that he could not opine as to appropriateness of the primary care and emergency medical care as that was outside his specialization and he laid no foundation to support his opinion. The Court also noted that the expert relied on speculation that the decedent told our internist he was nauseous, and that the expert did not dispute that many people who complain of headaches and nausea actually have migraines and that triage rather than an immediate scan is the correct approach. Therefore, the Court ruled the defendants' met their prima facie burden of establishing there was no departure from the standard of care and plaintiff's expert affirmation was speculative and therefore did not raise an issue for trial, dismissing the Complaint.

July 2020: Summary Judgment Granted in Case Involving a Tractor Trailer Crash

Court grants motion by John Barbera and Michael Bastone to dismiss wrongful death case alleging failure to diagnose an embolic stroke in a 46-year-old who crashed his truck into a tollbooth. Head CT in the ED was interpreted as showing an arthrosclerotic lesion in the right middle cerebral artery, considered by the radiologist to be chronic and unrelated. Our ED and Trauma physicians diagnosed a concussion. The patient was sedated and admitted. A massive stroke was diagnosed the next day. Defendants argued no departures were committed via a Board Certified Emergency Medicine Physician who agreed that there were no stroke factors or symptoms in the ED and that it was reasonable to diagnose a concussion following the MVA with resulting traumatic injuries. On causation, a Board Certified Neuroradiologist opined that tPA administration was contraindicated in a setting of suspected trauma and that the Head CT in the ED revealed a significant percentage of ischemic brain injury, eliminating any emergent treatment options including airlift for clot extraction. Plaintiff countered with similar experts. The Court held that the defense established that our clients treatment met the standard of care, and that the plaintiff's expert opinions on departures and causation were speculative. The case against our Hospital, Trauma Surgeon and Emergency Medicine physician was dismissed, along with the co-defendant radiologists.

July 2020: Plaintiff Discontinues ER Physician following Summary Judgment Motion in Case Involving Failure to Provide tPA

Senior Partner John J. Barbera, Partner Jayne L. Brayer, and Associate Christopher J. Daniel's motion for summary judgment was granted in a Westchester County Supreme Court Action. The matter involved an 86-year-old women who presented to the Emergency Room with stroke-like symptoms. Prior to the decedent's arrival, the Emergency Room attending physician initiated the stroke code." Upon arrival, the decedent was evaluated by the Emergency Room attending physician and stabilized. The decedent was ultimately found not to be a candidate for tPA or stroke intervention by the neurology physicians. Ultimately, the decedent was admitted to the hospital for a month and a half then transferred to a rehabilitation facility and passed away a month later. Earlier in the litigation, Plaintiff's Counsel settled and discontinued all other defendants from the action, thereby proceeding solely against MCB's client, the Emergency Room physician. Defendant moved for summary judgment with support of an emergency medicine expert who opined that the Emergency Room physician conformed to the standard of care by initiating the stroke code prior to the decedent's arrival and stabilized the decedent so that the decedent's neurological symptoms could be evaluated by the neurology team. Plaintiff was unable to obtain expert support to counter these opinions and Plaintiff agreed to voluntarily discontinue the action with prejudice.

July 2020: Successful Motion for Summary Judgment Results in Dismissal of Wrongful Death Action

Senior Partner Michael Sonkin and Partner Conrad Chayes, Jr.'s motion for summary judgment on behalf of our client, an Internist, was granted by the Kings County Supreme Court in this wrongful death action alleging failure of all defendants to diagnose and treat lower extremity thrombophlebitis in a 34-year-old, morbidly obese female patient from 2013 up to her death in December 2015 secondary to pulmonary thromboembolism. Plaintiff claimed that our Internist failed to recognize the signs and risk factors for DVT in the Decedent,

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CASE RESULTS

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who last presented to our client in August 2015 with a history of shortness of breath upon exertion and multiple ED presentations where Decedent reported negative chest x-rays and relief from bronchodilators.

We argued, through multiple expert affirmations, that in the absence of any leg swelling, tenderness, discoloration or other symptoms or risk factors for DVT/PE, Decedent's symptoms were suggestive of a chronic or asthmatic process for which a timely pulmonology referral was made and successfully distinguished the earlier periods of shortness of breath from that immediately preceding the Decedent's death. We further highlighted the speculative nature of the Plaintiff's expert's purported opinions, which the Court agreed constituted conclusions based on speculation, misstatements of the facts, were without basis in medicine, and were insufficient to overcome the opinions set forth in our expert affirmations. The case will continue against the codefendant medical practice and pulmonologist.

September 2020: Summary Judgment Win in Home Nursing Care Case in Nassau County

Senior Partner Rosaleen T. McCrory and Of Counsel Antony M. Chionchio secured a summary judgment win on behalf of our home care client in Nassau County. The plaintiff alleges that defendants failed to provide good and accepted care resulting in multiple infected decubitus ulcers, sepsis, and wrongful death. We submitted the affirmation of a Geriatric Medicine expert and argued that our client complied with the standards of care.

Namely, we asserted that our client's overall care was limited to short visits and its staff was responsible for examining pressure ulcers and providing treatment as ordered by the decedent's physician. Our client was not responsible for daily preventative measures such as turning and repositioning, which duties fell under the responsibilities of the co-defendant home health aide agency. Moreover, we set forth that plaintiff failed to make any showing of gross recklessness or malicious or wanton disregard warranting an award of punitive damages.

The Court found that we made a prima facie showing of entitlement to summary judgment. Neither plaintiff nor co-defendant's counsel who asserted cross claims against our client opposed our application. Accordingly, the Court granted our motion in its entirety.

September 2020: MCB Summary Judgment Win in ENT Surgery Case

Senior Partner Peter T. Crean and Senior Associates Emma B. Glazer and Nicole S. Barresi won on summary judgment on behalf of our ENT client physician before Judge Rakower in New York County. This case involved a patient with obstructive sleep apnea who underwent a surgical procedure to widen the. After several consent discussions, the patient agreed and signed two separate consent forms. Following surgery, the patient complained of swallowing difficulties, dysphagia, and weight loss. Plaintiff's alleged medical malpractice and lack of informed consent.

Our expert otolaryngologist opined that the patient was an appropriate surgical technique, there were no findings intraoperatively that increased the risk of complications, and he was appropriately consented. In addition, there was no actual of dysphagia or weight loss. She also opined that his swallowing difficulties were more likely attributable to his underlying medical history.

Interestingly, plaintiff opposed the motion solely on the basis of informed consent. He did not provide any expert commentary regarding the malpractice cause of action. In Reply, we argued that plaintiff failed to meet his burden to defeat summary judgment because his expert did not adequately address causation and that plaintiff's expert did not comply with PHL 2805-d, requiring expert commentary on what a "reasonably prudent person" would have decided. The Court agreed and granted our motion in its entirety, dismissing plaintiff's case.

October 2020: Defense Verdict in Alleged Failure to Diagnose/Wrongful Death Case

Senior Partner Rosaleen McCrory, assisted by Of Counsel Elizabeth Sandonato, obtained a defense verdict in Supreme Court, Nassau County. The case involved a 73-year-old woman who called our client internist's medical practice reporting that she felt ill with fever and a deep cough. She declined to present for an office visit as she felt too sick. She was told to schedule an appointment when she felt well enough and in the interim was prescribed antibiotics. On examination five days later, she reported feeling better but was fatigued and felt as though she pulled a muscle in her chest from coughing. Two days later, she was diagnosed with a heart attack and died one week later. Plaintiff contended that the complaints were signs of an ongoing "stuttering" heart attack. The defense established through expert testimony that it was reasonable to treat decedent for a presumed infection, and that the trend of the cardiac enzymes demonstrated that the heart attack occurred after the last contact with the defendants. The jury returned a unanimous defense verdict. ■

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What's New at MCB?


JOHN J. BARBERA

SENIOR PARTNER JOHN BARBERA PRESENTS AT PHELPS HOSPITAL GRAND ROUNDS DISCUSSION

On Friday, December 11, 2020 Senior Partner John J. Barbera was a guest speaker at the 2020 Phelps Hospital Grand Rounds Discussion, and presented An Introduction to New York State's Office of Professional Medical Conduct.

The presentation concentrated on actions brought by New York State Department of Health's Office of Professional Medical Conduct (OPMC). Mr. Barbera detailed the oversight authority of OPMC, as well as the potential impact upon professional licenses in the medical and allied health professions, including Physician Assistants.

SENIOR PARTNER SEAN F.X. DUGAN MODERATES ABOTA CLE: HOW TO EFFECTIVELY USE A NEUROSURGEON IN THE COURTROOM

Senior Partner Sean F.X. Dugan, Member & Past President of ABOTA, moderated CLE program: *How to Effectively use a Neurosurgeon in the Courtroom* on Thursday, November 12th. The New York City Chapter of the American Board of Trial Advocates (ABOTA) & The Defense Association of New York Proudly Co-Sponsored this program.


SEAN F.X. DUGAN


MAUREEN P. BLAZOWSKI

CONGRATULATIONS TO MAUREEN P. BLAZOWSKI, OF COUNSEL, ON HER APPOINTMENT BY THE BOARD OF TRUSTEES OF THE AMERICAN BOARD OF IMAGING INFORMATICS TO A THREE-YEAR TERM

MCB congratulates Maureen P. Blazowski, Of Counsel, on her appointment by the Board of Trustees of the American Board of Imaging Informatics to a three-year term on its Continuing Education Committee effective January 1, 2021. We are excited for this opportunity for Ms. Blazowski.

MARTIN CLEARWATER & BELL LLP RECEIVES RECOGNITION FROM *U.S. NEWS – BEST LAWYERS*® IN ITS TENTH EDITION OF "BEST LAW FIRMS"

Martin Clearwater & Bell LLP is pleased to have been named a Tier 1 New York "Best Law Firm" in three practice areas: Legal Malpractice Law – Defendants; Medical Malpractice Law – Defendants; and Personal Injury Litigation – Defendants by ***U.S. News – Best Lawyers***® in 2021.

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WHAT'S NEW AT MCB

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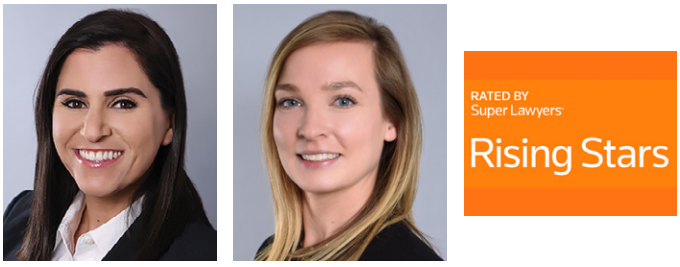
MCB CONGRATULATES 7 PARTNERS FOR SELECTION TO 2020 NEW YORK SUPER LAWYERS

SELECTED TO SUPER LAWYERS

Top Row: Peter T. Crean, Kenneth R. Larywon, Anthony M. Sola
Second Row: Bruce G. Habian, Jeffrey A. Shor, Sean F. X. Dugan, Gregory J. Radomisli

MCB CONGRATULATES 2 ATTORNEYS FOR SELECTION TO 2020 NEW YORK RISING STARS

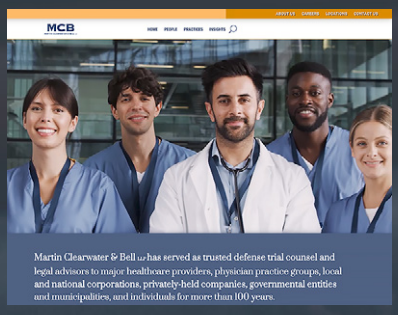


SELECTED TO RISING STARS

Above: Partner Samantha E. Shaw, and Associate Alexandra E. Claus

MCB LAUNCHES NEW WEBSITE!

MCB is excited to announce the recent launch of its new website at www.mcblaw.com. In addition to a modern upgrade, our goal is to provide richer content, and to make it easier for our visitors to find the information they are looking for. We welcome your visit and your feedback!



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