DEFENSE PRACTICE UPDATE

MARTIN CLEARWATER & BELL LLP

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INTERPRETING THE COVID IMMUNITY STATUTE: LESSONS FROM RECENT CASE LAW

BY: BARBARA D. GOLDBERG AND MICHAEL F. BASTONE

As the COVID-19 pandemic spread through New York City and New York State, overloaded hospitals and skilled nursing facilities labored tirelessly to meet ever-changing State and Federal guidelines to care for the sick. Sweeping new protocols impacted how New York healthcare providers treated their patients, from the use of personal protective equipment (PPE) to the construction of new ICUs, patient care rooms, and even temporary medical facilities. In recognition of the unprecedented strain COVID-19 placed on New York's health care network, the State enacted the New York Emergency or Disaster Treatment Protection Act (EDTPA) on April 3, 2020 (N.Y. Public Health Law §§ 3080 – 3082).

The purpose of the law was to provide protection to covered healthcare providers from liability incurred due to the drastic changes in the delivery of healthcare due to the pandemic, in recognition of the "enormous response" needed from federal, state, and local governments, as well as private health care providers in the community. The Act covered care and treatment beginning March 7, 2020, the date the New York Governor issued an emergency declaration for COVID-19. The Act was considered controversial, and criticism of the Act and the Governor led to a revision of the Act months later in August 2020.

As with any new law, particularly one with sweeping mandates, the actual impact of the law was not initially known, and the interpretations and applications of the law by attorneys and Courts would take time to wind through the system. This article aims to examine some of the initial decisions interpreting the EDTPA to glean principles that can guide application of the law in future cases.

THE NEW YORK EMERGENCY OR DISASTER TREATMENT PROTECTION ACT

As originally enacted, the EDTPA mandated that health care facilities[1] "shall have immunity from any civil or criminal liability for any harm or damages alleged to have been sus-

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1. The Act broadly defined "health care professional" and "health care facility" to include doctors, nurses, nursing aides, technicians, hospitals, clinics, nursing homes etc.

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tained as a result of an act or omission in the course of arranging for or providing health care services." In order for the statutory immunity to apply, the following three conditions needed to be met:

- The health care facilities or health care professionals must have been "arranging for or providing health care services pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law."
- The conduct alleged to be negligent was done 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."
- The health care facility or health care professional was arranging for or providing health care services in good faith.

With respect to the last requirement of good faith, it is important to note that the law expressly exempts "willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm" from this immunity.[2]

Once the above conditions were met, the EDTPA acted to shield "health care services" provided by covered providers and facilities from liability. The EDTPA described three types of "health care services" covered by the Act: (a) the diagnosis, prevention, or treatment of COVID-19; (b) the assessment or care of an individual with a confirmed or suspected case of COVID-19; or (c) the care of any other individual who presents at a health care facility or to a health care professional during the period of the COVID-19 emergency declaration.[3]

Under this definition, the statutory immunity applied to any medical treatment provided to any patient irrespective of COVID-19, as long as the medical treatment occurred during the emergency declaration and the initial three conditions were met.

The first two types of "health care services" were tied to COVID-19 directly. The first covered the diagnosis, prevention, or treatment of COVID-19 itself, and the second category covered the assessment or treatment of patients who were known to be, or suspected to be, COVID-19 positive, even if the medical treatment at issue was not related to that COVID-19 diagnosis.

It was this third definition of "health care services" that garnered the most attention. Under this definition, the statutory immunity applied to any medical treatment provided to any patient irrespective of COVID-19, as long as the medical treatment occurred during the emergency declaration and the initial three conditions were met. Read together, the EDTPA statutory immunity provisions applied to any medical treatment provided to any patient during the emergency declaration, so long as the health care provider was providing services pursuant to the COVID-19 emergency rule, and the plaintiff/patient's medical treatment was "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 public health emergency.

The breadth of the resulting immunity led to an amendment of the EDTPA, passed on August 3, 2020—just four months after the Act was signed into law. The amendment removed "the care of any other individual who presents at a health care facility or to a health care professional during the period of the COVID-19 emergency declaration"(category c above) from the definition of "health care services" in §3081(5). This amendment was not retroactive, thereby creating a distinction between medical care provided during the period between March 7, 2020 and August 3, 2020, and treatment provided after August 3.

Application in the Courts

In an early test of the reach of the law, the Court seized on the nexus between the treatment of the plaintiff and the COVID-19 response. In *Townsend v. Penus*, the court examined the defendants' motion to dismiss, and concluded that the defendants failed to make a requisite showing that the medical treatment they provided to the plaintiff was "impacted" by the emergency response to the pandemic. The Court found the defendants demonstrated only that the medical treatment they provided generally was impacted by COVID-19, but failed to show how

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2. The law does state, however, that "acts, omissions, or decisions resulting from a resource or staffing shortage shall not be considered" gross negligence, reckless misconduct etc.
3. PHL § 3081(5).

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the specific plaintiff was affected by their COVID-19 response.[4]

In reaching the opposite result, the Court in *Hampton v. City of New York* found the defendants did make a proper showing that treatment of the particular plaintiff was impacted by the defendants' emergency response to the pandemic.[5] In that case, the plaintiff had presented to the defendant Hospital's emergency department with a fractured leg. He refused transfer to another hospital and was instead discharged home in an immobilizer. The Hospital demonstrated that it was not performing orthopedic surgeries at the time due to the pandemic, and thus its treatment decisions of the plaintiff were impacted by COVID-19. The Court agreed and dismissed the case.

The Court in *Matos v. Chiong*, while denying a motion to dismiss, added an important aspect to this analysis. That Court noted that while the EDTPA required that a defendant demonstrate that the treatment of the specific plaintiff was impacted by defendant's COVID-19 response, it did not require a specific result. Any impact—positive, negative or otherwise—would be sufficient to meet the statutory showing and allow immunity to apply.[6]

Most recently, in *Crampton v. Garnet Health*, Judge Catherine Bartlett of the Supreme Court, Orange County issued the most comprehensive assessment of Public Health Law § 3082. Judge Bartlett echoed her colleagues in asserting that a defendant seeking to invoke the immunity provisions of the EDTPA must demonstrate that the medical treatment provided to the plaintiff was impacted by COVID-19 measures enacted by the defendant. Judge Bartlett highlighted that a defendant need not show that medical treatment of the plaintiff was impacted in some particular manner different from that of other patients, nor must a defendant demonstrate any particular manner in which the plaintiff's medical treatment was adversely affected. In order for immunity to attach, a defendant needs only to show a link between the defendant's COVID-19 measures and the treatment of the plaintiff.[7]

Pursuant to Judge Bartlett's decision in *Crampton*, once such a showing is established, the defendant is entitled to dismissal unless the plaintiff can show willful, wanton, or reckless conduct. The burden is on the plaintiff to plead and prove such conduct.

Guidance for Defendants

The text of the statute and the early interpretations of its provisions provide some guidance for the application of EDTPA immunity in cases with medical treatment that falls within the prescribed time period of March 7, 2020 through August 3, 2020. Defendants seeking dismissal must demonstrate a clear nexus between the actions taken by a health care provider in response to COVID-19—protocols, mitigation efforts, and other treatment decisions—and the medical treatment provided to the specific plaintiff. General statements regarding how the delivery of medical care was altered are not sufficient. Defendants must demonstrate that COVID-19 protocols and compliance reached the specific plaintiff. The "impact" need not be different for the plaintiff than other patients, but it must be felt by the plaintiff directly.

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Critically, defendants need not show that their compliance with COVID-19 guidance negatively impacted the medical care provided to the plaintiff, only that the plaintiff was impacted. This is an important distinction, because it means that defendants do not have to submit affidavits or other evidence stating that the treatment provided to the plaintiff was somehow lacking or deficient. Defendants thus do not have to provide plaintiffs with potential evidence of departures from the standard of care that could be used against them should a motion to dismiss be unsuccessful.

To date, no Court has articulated a required showing of a causal connection between the manner in which the plaintiff was impacted and the conduct that is alleged to be negligent, or the injuries suffered by the plaintiff. However, as a best practice, the more

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4. *Townsend v. Penus*, Sup. Ct., Bronx County, June 4, 2021, Higgitt, J., NYSCEF Doc. No. 48.
5. *Hampton v. City of New York*, Sup Ct, Bronx County, Jun. 3, 2021, Danzinger, J., NYSCEF Doc. No. 47.
6. *Matos v. Chiong*, 2021 WL 2766674 at *1 (Sup. Ct. Bronx Co., May 27, 2021.
7. *Crampton v. Garnet Health*, 2021 NY Slip Op 21242 (Sup. Ct. Orange Co. September 13, 2021).

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specific and related the "impact" to the plaintiff was, the greater the likelihood for success on an early motion. It is unclear, for example, if a mere showing that the plaintiff was required to wear a mask in a waiting room would be sufficient to invoke the statutory immunity for any medical treatment that was provided thereafter. The nexus of the "impact" and the alleged negligence is likely the next area of clarification by the Courts.

The *Crampton* decision also provided some guidance as to what to expect from plaintiffs seeking to avoid immunity. It can almost certainly be expected that Complaints will allege willful, wanton, and reckless conduct in an attempt to survive dismissal. The *Crampton* Court held that it is the plaintiff's burden to plead and prove such conduct, but it is unclear at present whether a properly pleaded Complaint alone is sufficient to avoid dismissal.

The amendment to the EDTPA removed from the immunity law medical treatment unrelated to COVID-19 beginning August 3, 2020. Accordingly, there is a limited window of time during which the more expansive immunity applies. As more lawsuits arising out of medical treatment during this time are filed, defendants must assess cases for potential motions to dismiss. Early cases have provided some guidance on how defendants can best position their cases for dismissal, and give an early view as to what defendants may expect from plaintiffs to avoid the broad reaches of the statutory immunity. ■

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Recent Clarification of the Scope of Employment Appears to Favor Defendant Employers in Malpractice Actions

By: Jeffrey A. Shor and Conrad A. Chayes, Jr.

The doctrine of *respondeat superior* stands for the proposition that an employer may be held responsible for the acts of their employees or agents, provided that the acts occur within the scope of the employment or agency. What constitutes an action that is within or outside the scope of employment, however, continues to evolve as a body of case law dating back to 1882.

In 1882, the Court of Appeals determined *Stewart v. Crosstown Rail Road Co.*, an appeal from a case that involved a carriage operator beating a non-paying rider. In so doing, the Court held that an employer shall be held liable for the acts of its employees—regardless of whether such acts transpired within the scope and course of the employment. In the Stewart case, liability was imposed despite the fact that the driver's job duties most certainly did not include chasing and assaulting a non-paying passenger.[1] Over one hundred years later, in determining a similar case in 1996, the Court of Appeals abrogated this standard, holding that the complained-of acts (there, an MTA token booth operator attacked a rider) were indisputably outside of the employee's job duties. Thus, the Court of Appeals held that acts "outside the scope of employment" are insufficient to give rise to vicarious liability on the part of the employer.[2]

Since that time, the New York Courts have declined to impose vicarious liability upon healthcare institutions and

1. *Stewart v. Brooklyn & Crosstown R.R. Co.*, 90 N.Y. 588 (1892).
2. *Adams v. New York City Transit Authority*, 88 N.Y.2d 116 (1996).

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There are, of course, certain pitfalls attendant to raising this argument which, if unsuccessful, leaves the defendant institution in the position of having made what could be considered admissions as to their employee departing from the standard of care.

facilities for the alleged acts of their employees in instances where it was fairly obvious the employee was acting outside the scope of their employment; liability will not be imposed upon the employer where the employee acts negligently or intentionally, so long as the tortious conduct is not generally foreseeable or a natural incident of the employment.[3] In contrast with the 1882 standard, liability would not be imposed where the employee "departed from his duties for solely personal motives unrelated to the furtherance of the Hospital's business."[4] This more recent standard presents much more favorable to the defendant employer, though it was most commonly applied in instances involving a physical or sexual assault during the rendition of medical services.

For example, in *N.X. v. Cabrini Medical Center*, the First Department held that the hospital would not be vicariously liable for the sexual assault committed by a resident, where the resident was not assigned to the patient, was not furthering the hospital's business, had a glowing employment history, and previously demonstrated no propensity to commit such an act.

While applied in instances involving conduct where it was fairly obvious the employee's conduct fell outside the duty of rendering medical care, the Courts still looked to whether the employee was acting intentionally or in furtherance of personal interests—until recently, there was little clarification as to conduct that could be deemed grossly negligent or even reckless.

Earlier this year, the Appellate Division, First Department, rendered their decision in *Troy v. Fagelman*, which arguably serves to broaden the criteria an employer may rely upon to avoid vicarious liability for the acts of wayward or even grossly negligent employees. In the underlying Supreme Court action, a receptionist at a medical practice engaged in a physical confrontation with a patient over the practice's use of foam cups, and the plaintiff sought to hold the physician and his practice responsible for the alleged assault. Plaintiff argued that the receptionist had a "bad disposition" and therefore it was reasonably foreseeable that she could cause harm to others. In the Answer served on behalf of the defendant physician, the affirmative defense of culpable conduct on the part of non-parties was asserted. While the receptionist was not individually-named, she was represented at her non-party deposition by the attorneys for the physician and his practice.

Ultimately, the defense moved for summary judgment on the argument that the physician had never received any complaints regarding the receptionist, who served as his employee for eight years without incident, and that this singular altercation constituted an act that was outside the scope of the receptionist's employment by the practice. In opposition, the plaintiff cited, *inter alia*, various Yelp reviews that unnamed staff members at the practice were "hit or miss," "berated" patients, and "yelled at" patients during their interactions; some of the reviews cited discussions with the physician regarding these issues, reportedly without any subsequent remedial actions taken.

In determining the physician's motion for summary judgment, the Supreme Court cited numerous factors, including the receptionist's eight-year history of employment without incident and the lack of any evidence submitted by the plaintiff of prior violent acts by the receptionist, and granted summary judgment. While the Court found the reviews to be inadmissible, it held that even if considered, same failed to raise any triable issues of fact. The dismissal was affirmed by the First Department, which concluded that the conduct alleged by the plaintiff was a "significant departure from the methods of performance of the job."[5]

This language would appear to widen the scope of employee acts or omissions that an employer may use in furtherance of an argument seeking to defeat claims of vicarious liability, and arguably extends to standard of care

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3. *Judith M. v. Sisters of Charity Hospital*, 93 N.Y.2d 932 (1999).
4. *Id.* at 933.
5. *Troy v. Fagelman*, 135 N.Y.S.3d 841 (1st Dept. 2021).

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arguments. For instance, imagine a scenario where a practitioner neglects to restart mechanical life support following a routine equipment check and reset; under the language included in the *Troy* decision, the employer facility may consider an argument that it cannot be held responsible for the actions of their employee, as the employee departed substantially from the manner in which the job was to be performed, i.e. from the standard of care.

There are, of course, certain pitfalls attendant to raising this argument which, if unsuccessful, leaves the defendant institution in the position of having made what could be considered admissions as to their employee departing from the standard of care. New York Courts have held that judicial admissions, i.e. "any act or statement made during the course of a judicial proceeding which essentially concedes a disputed fact," constitutes a substitute for evidence and absolves the parties with the need to present evidence that is the subject of the admission.[6]

In an instance where a healthcare facility or institution is the sole defendant in a case, where the basis for liability on the part of the facility is vicarious liability for the alleged acts or omissions of employees or agents, there exists a greater risk in employing this strategy. Other factors important to consider include whether the employer was responsible for training the employee and whether the employee had an otherwise uneventful employment history performing the same tasks without incident.

Further, if the employee is not named as a party to the action, ethical concerns may arise where the employer's counsel interviews or has discussions with the employee prior to ultimately arguing that the employee significantly deviated from their job duties—a scenario which could also result in the disclaimer of insurance coverage if the practitioner's only coverage is through their employer. Accordingly, such an argument is best reserved for instances where the employee is a named party and is represented by separate counsel, and where the employer could not have prevented the employee's conduct by way of additional training or implementation of policies and procedures.

As there have yet to be any decisions citing the holding in *Troy*, it remains to be seen whether future decisions will rely upon the expanded standard set forth by the Court of Appeals in that case. In the interim, even if such a stratagem is not pursued formally by a practice or institution's counsel by way of a motion to dismiss, the mere ability to raise such an argument may instead serve as leverage in potential settlement discussions. ■

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6. *Zegarowicz v. Ripatti*, 77 A.D.3d 650 (2d Dept. 2010).

Case and Comment: The Impact of *Guido v. Fielding* on Custom and Practice Testimony

By: Daniel L. Freidlin

A common theme in the defense of a surgeon whose patient sustains an injury during a surgical procedure is the "known complication" defense. For example, it is well-known and reported that injury to adjacent structures such as the bowel, bladder and ureters may occur during pelvic and abdominal surgeries as a complication. The lawyer for the plaintiff understands this and thus often focuses the case on whether the defendant physician took the necessary steps to not only prevent injury but detect the injury intraoperatively.

The surgeon often will not specifically remember the surgical procedure at issue as it was routine and occurred years earlier. Thus, the surgeon will often rely on the operative report to support the defense that the relevant structures, i.e. the bowel or ureters, were inspected for injury prior to completion of the operation. Unfortunately, many surgeons fail to document critical parts of a surgery such as "running the bowel" or inspecting the ureters. Many feel that because these steps are so routine and occur at the end of every surgery, they need not be documented. The surgeon will testify that these steps are routine and "custom and practice." The surgeon relies on "custom and practice" to support his or her defense notwithstanding the lack of recollection and/or documentation.

Historically, New York Courts have allowed physicians to testify as to custom and practice as habit evidence to support their position that they acted the same way in this specific case. However, the ability to rely on custom and practice in establishing what a defendant physician did in a specific situation, has recently by limited by the New York appellate courts. In *Guido v. Fielding*, 190 A.D.3d 49 (1st Dept. 2020), the Court held that the testimony of the defendant surgeon concerning his custom and practice of "running the bowel" for defects at the end of a LAP-BAND surgery was inadmissible.

Historically, New York Courts have allowed physicians to testify as to custom and practice as habit evidence to support their position that they acted the same way in this specific case. However, the ability to rely on custom and practice in establishing what a defendant physician did in a specific situation, has recently by limited by the New York appellate courts.

In *Guido*, the defendant surgeon testified at trial that his custom and practice was to inspect the bowel for defects or perforations following gastric bypass surgery. The defense attorney then elicited expert testimony that the defendant surgeon's intraoperative management conformed to the standard of care. The jury returned a defense verdict and the plaintiff appealed.

On appeal, the First Department overturned the verdict and held that because the physician did not testify that inspecting the bowel was so routine of a step that did not vary from patient to patient, the defense could not rely on this routine to show that it occurred in this surgery. Because the surgeon's testimony did not establish that this routine surgical step did not vary from patient to patient, it was improper for the expert to rely on it to conclude that the defendant surgeon conformed to the standard of care.

The First Department's holding in *Guido* follows the Second Department holding from one year earlier. In *Martin v. Timmins*, 178 A.D.3d 107 (2d Dept. 2019), the Court held that the custom and practice testimony of the defendant surgeon in performing a hernia repair surgery was inadmissible.

The Courts in *Martin* and now *Guido* restrict the reliance on custom and practice to specific procedures which are repetitive and do not vary from patient to patient. To be admissible, the custom and practice must be "routine, without variation from patient to patient." *Guido*, 190 A.D.3d at 54.

With the *Martin* and *Guido* decisions, the First and Second Department now uniformly holds that custom and practice in medical malpractice cases is only admissible in the case of "routine" procedures that do not vary from surgery to surgery. When the

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steps at issue are not documented in the operative report, it become critically important to lay an appropriate foundation for custom and practice testimony. It is not enough for a defendant physician to testify that he or she performs hundreds of the same procedure; the physician must testify that the procedure does not vary for patient to patient, and is routinely performed in the same manner in every patient. Should the procedure not warrant such testimony, if it does vary from patient to patient, then it is vital that the physician maintain detailed records concerning what was done during the procedure. In *Guido* the physician would not have needed the custom and practice testimony if he stated that he palpated the bowel for perforations in his operative report. ■

Daniel L. Freidlin is a Senior Trial Partner at Martin Clearwater & Bell LLP. Mr. Freidlin focuses his practice on the defense of medical malpractice and professional liability cases and represents major teaching hospitals in New York as well as individual physicians.

MCB CASE RESULTS

July 2021: Plaintiff Hangs Up on Robocall Claim

Partners Kenneth R. Larywon and Gregory J. Radomisli obtained a successful discontinuance in the Eastern District of New York. Plaintiff sued the defendant arguing violation of the Telephone Consumer Protection Act, alleging that the defendant used an automatic telephone dialing system to sell its services. In a pre-Answer motion to dismiss, MCB argued that 1) the plaintiff was not a consumer, but a sushi restaurant; 2) the defendant was not selling goods or services because it was a healthcare provider; and 3) the plaintiff was not able to allege the phone number from which the calls were allegedly made, the phone number to which the calls were allegedly made or the content of any of the calls.

After requesting multiple adjournments, plaintiff's counsel conceded that he could not state a cause of action, and discontinued the case.

August 2021: Plaintiff Lets Claim for Migrating IUD Slip Through Her Fingers

Partners Jeff Lawton and Gregory J. Radomisli obtained a partial summary judgment win in Supreme Court, New York County in a case involving an IUD. Plaintiff brought allegations of improper insertion of, and failure to recognize migration of, an intra-uterine device ("IUD"), purportedly in 2004, allegedly leading to perforation of the uterus, appendix, and colon. Plaintiff treated with our client from 2003 through 2006 and between 2001 and January 2015. She did not bring her lawsuit until November 2015.

MCB successfully moved for summary judgment to dismiss all claims arising out of treatment rendered in 2011 and before. We effectively had any claim regarding the improper insertion of the IUD dismissed, and limited plaintiff's claims to two visits—one at which she never complained of abdominal pain, and the second at which the migrating IUD was actually diagnosed.

September 2021: Unanimous Defense Verdict in Alleged Surgical Negligence During Labor Case

Senior Trial Partner Bruce G. Habian obtained a unanimous defense verdict in Kings County Supreme Court before Justice Pamela Fisher.

The plaintiff was admitted to the client Hospital at 40 plus weeks gestation per her non-party attending obstetrician. This admission was for delivery of her second pregnancy; the plaintiff had undergone a prior C-section for a breech presentation. She was desirous of a trial of labor (TOL) for a potential vaginal birth after section (VBAC). Because of a failure to progress in labor and the persistent threat of non-reassuring fetal heart tracings, the defendant OB, maternal-fetal specialist, recommended abandoning the trial of labor; the plaintiff initially refused this advice. The second C-section was complicated by a laceration of the left uterine artery, a tear in the broad ligament, all secondary to dense adhesions from the first C-section, and a very thin lower uterine segment. During the repair process, the defendant obstetrician suspected possible ureter compromise. A recommendation for an intravenous pyelogram was made the night of surgery for the first post-operative day. An accompanying cystoscopy revealed a 2 cm. blockage of dye in the left ureter and an inability to place a stent. A nephrostomy tube was administered for kidney hydronephrosis; what followed were multiple interventional radiology procedures

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to release the stenosis of the ureter, which most likely was caused by the emergency repair procedures – a partial suture. Three months later the ureter became patent.

Plaintiff proceeded on a claim of surgical negligence, claiming that the persistent labor and fetal heart tracings allowed for an emergency section and the resultant tissue injuries. She also claimed inadequate consent information during the trial of labor.

October 2021: Summary Judgment Win on Behalf of our Client Hospital in Kings County Supreme Court

Senior Trial Partner Peter T. Crean and Partner Emma B. Glazer secured summary judgment on behalf of our client hospital in Kings County Supreme Court before the Honorable Ellen M. Spodek.

This case involves a then 25-year-old married woman with two children who was 12 weeks pregnant and presented to the our client hospital Emergency Department on March 15, 2014 with cough, low grade fever, and chest pain on inspiration. She reported that she recently saw her internist and was prescribed Prednisone. She presented to co-defendant hospital Emergency Department the previous night and underwent an x-ray and ENT evaluation, and was apparently discharged home without medications, but her symptoms worsened. Upon examination, there was concern for pneumonia versus pulmonary embolism, and x-ray findings were consistent with pneumonia. She became hypoxic and was placed on an NRB. Ceftriaxone/Azithromycin, Tylenol, and Tamiflu were given and she was admitted to the MICU. She rapidly developed hypoxic respiratory failure and was intubated. Refractory hypoxia continued following intubation, and she was in shock. The plan was transfer to our client hospital for ECMO, which was initiated at our client hospital around 5:30 a.m. on March 16th, and she developed PEA arrest. Sinus tachycardia returned following CPR and ACLS medications. That morning, she was transferred to our client hospital, where she died later that day.

Justice Spodek granted summary judgment as to the Hospital on causation and denied the summary judgment motion of codefendants. As to the arguments made on behalf of the Hospital, Justice Spodek found that we demonstrated that any departures by the Hospital were not the proximate cause of the decedent's deterioration and death. In the expert affirmation of our pulmonary medicine and critical care expert, our expert asserted that given the decedent's aggressive pneumonia, septic shock and quick deterioration, the decedent's death was inevitable upon admission to the Hospital. The expert affirmation of Plaintiffs' anesthesiology expert failed to demonstrate an issue of fact with respect to causation because the expert did not address our expert's assertion that some patients do not exhibit abnormal vital signs, that the decedent's ability to oxygenate would not have improved until the infection was cleared from her lungs, and because he did not address the lab values or the decedent's hypotension. Accordingly, Justice Spodek granted the Hospital summary judgment on causation.

October 2021: Successful Motion for Summary Judgment in a Premises Liability Case

Partner Jacqueline D. Berger and Of Counsel Gregory A. Cascino were successful in obtaining dismissal of the Complaint in a slip and fall case at a Hospital. In the case, plaintiff, who was admitted to the Hospital's Chemical Dependency Unit, slipped and fell in front of the nursing station at approximately 9:15 a.m., allegedly causing permanent injury. The plaintiff testified at her deposition that she saw no substance on the floor before she fell, but later assumed it was water that she slipped on, as her pants were wet.

The Court granted MCB's motion for summary judgment on behalf of the defendant Hospital on the basis that the Hospital did not cause the condition, and had no actual or constructive notice of the condition. In support of the motion, we submitted documentation of environmental rounds performed by two staff members that morning at 7:30 a.m., which did not document any hazards. We further submitted affidavits from those two staff members, further establishing the Hospital could not have created the condition nor could it have had actual or constructive notice of a hazardous condition.

The court agreed that we had established our prima facie case of entitlement to summary judgment sufficient to eliminate any issues of fact in the case, that the Hospital had neither created, nor had notice of the alleged dangerous condition at the time of the incident. The court found that in opposition, plaintiff failed to raise any issues of fact as to defendant's notice, and dismissed the case in its entirety on liability. ■

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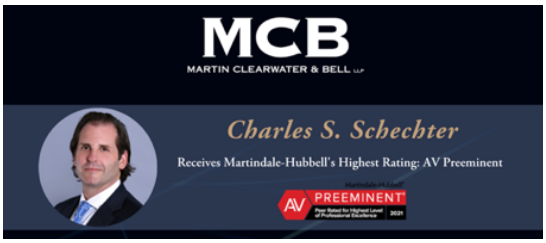
What's New at MCB?

MCB Presents CLE Program with MLMIC and Fager Amsler Keller & Schoppman, LLP

Over the summer, Kenneth R. Larywon, Thomas A. Mobilia, John J. Barbera, and Gregory A. Cascino joined MLMIC and Fager Amsler Keller & Schoppman, LLP on a panel for a CLE program for Northwell Health. The program was entitled "Provider Protection Education: Addressing Liability Risks During the Pandemic." We were pleased to engage in an interesting discussion that touched on many different areas.

Senior Trial Partner Charles S. Schechter Receives Highest Rating from Martindale Hubbell®

Congratulations to our Senior Trial Partner Charles S. Schechter for receiving Martindale-Hubbell®'s Highest Rating: AV Preeminent! This rating is given to attorneys who are ranked at the highest level of professional excellence for their legal expertise, communication skills, and ethical standards. For more than 130 years, Martindale-Hubbell® has been providing verified ratings for attorneys based not only on their legal ability and ethical standards as judged by their peers, but also based on reviews from their clients. All Senior Partners at MCB have been rated AV Preeminent.



Seven Partners from Martin Clearwater & Bell LLP Selected to the 28th Edition of The Best Lawyers in America© 2022

Top Row: Peter T. Crean, Sean F.X. Dugan, Bruce G. Habian, Kenneth R. Larywon

Bottom Row: Michael F. Madden, Anthony M. Sola, Michael A. Sonkin

Ten MCB Attorneys Listed in Best Lawyers Ones to Watch 2022

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