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Eades on Jennings v. Badgett

2010 Emerging Issues 5226

Prof. Ronald W. Eades on *Jennings v. Badgett*, 2010 OK 7, 230 P.3D 861 (2010): Oklahoma medical malpractice plaintiff must prove existence of physician-patient relationship.

By Ronald Eades

August 2, 2010

SUMMARY: In *Jennings v. Badgett*, 230 P.3d 861, 2010 OK 7 (2010), the Supreme Court of Oklahoma addressed an issue of first impression: Whether a physician-patient relationship was an indispensable element in an action for medical malpractice against a physician. The Court held that it was. A second issue in this case was whether the plaintiff and one of the defendants had such a physician-patient relationship. The Court held that they did not.

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ARTICLE: The opinion in *Jennings v. Badgett*, 230 P.3d 861, 2010 OK 7 (2010), covers two issues. First, it states clearly that the existence of a physician-patient relationship is necessary for a patient to bring an action in medical malpractice against a physician. Second, it helps explain the elements of a physician-patient relationship by holding that, in this case, that relationship did not exist between the patient and one of the physician/defendants.

A. Requirement of physician-patient relationship in order for the plaintiff to successfully pursue an action for medical malpractice

The opinion of the Court started simply with the statement that an action in malpractice required the same four elements as other negligence claims. Those elements are duty owed to the defendant, a breach of that duty, injury and a causal connection between the breach and the injury. *Jennings v. Badgett*, 230 P.3d 861, 865, 2010 OK 7 (2010). The duty issue was the primary concern in this case.

The Court noted that the duty of care in a malpractice action essentially arises from an employment contract. The physician does not owe a duty to provide services to all, and, therefore, only owes a duty to those whom the physician consents to treat. *Jennings v. Badgett*, 230 P.3d 861, 865, 2010 OK 7 (2010). "Because the duty in a medical malpractice action is born out of a physician-patient contract, the relationship is essential to an action for a breach of the duty giving rise to the malpractice action." *Jennings v. Badgett*, 230 P.3d 861, 866, 2010 OK 7 (2010).

The Court noted that this requirement of a physician-patient relationship in order to pursue an action in malpractice was a common position throughout the *United States*. *Jennings v. Badgett*, 230 P.3d 861, 866, 2010 OK 7 (2010). The opinion cited numerous other jurisdictions which follow that position and Annot., What Constitutes Physician-Patient

Relationship for Malpractice Purposes, 17 A.L.R. 4th 132.

The Court did note that there is, at least, one area where a strict contractual relationship between the physician and plaintiff may not be required. Where the plaintiff would have been in a third party beneficiary position to the patient, that plaintiff may seek recovery. If the plaintiff, for example, was the child of the mother/patient and the child was injured during delivery, the child would have a malpractice claim against the physician. The contract between the mother and physician would have been for the purpose of protecting the good health of the child. That child would, therefore, be in the nature of a third party beneficiary of the physician-patient relationship and entitled to seek recovery for medical malpractice. *Jennings v. Badgett*, 230 P.3d 861, 866, 2010 OK 7 (2010).

B. The failure of the plaintiff to introduce sufficient evidence to show the existence of a physician-patient relationship

In this case, the Court reviewed the particular circumstances to determine whether a physician-patient relationship existed between the plaintiff and Dr. Schlinke, a physician that the plaintiff's attending physician had consulted. The Court noted that ordinarily the issue of whether that relationship exists is one of fact for the jury to decide. In this case, however, the material facts were undisputed and the Court could determine the issue as a matter of law. *Jennings v. Badgett*, 230 P.3d 861, 867, 2010 OK 7 (2010).

In the usual case, the attending physician would be one that was in a physician-patient relationship with the patient. Here, Dr. Badgett was the attending physician and would have held that relationship with the patient. Dr. Schlinke, however, had been contacted by Dr. Badgett to provide some advice and the issue was more complex as to him. The Court felt it necessary to consider some indicia of physician-patient relationships. *Jennings v. Badgett*, 230 P.3d 861, 867, 2010 OK 7 (2010).

The Court first noted that, ordinarily, informal discussions among physicians do not create a physician-patient relationship among all of the physicians and the patient. *Jennings v. Badgett*, 230 P.3d 861, 867, 2010 OK 7 (2010). The Court further stated that a physician-patient relationship was unlikely where the physician had never seen the patient; the patient had never requested or engaged the defendant as a consultant; the treating physician had merely discussed the matter with the defendant physician; there was no compensation for the defendant's remarks or opinions; the treating physician did not employ the defendant physician to treat the patient; and there was no evidence that the defendant agreed to treat the patient. *Jennings v. Badgett*, 230 P.3d 861, 867, 2010 OK 7 (2010).

In this case, the defendant physician (Dr. Schlinke) had been consulted by the attending physician (Dr. Badgett), no compensation was provided, the defendant physician had never seen the patient, the defendant physician had not been employed to treat the patient by the attending physician or the patient and the defendant physician had not consented to treat the patient. As such there was no evidence of the type of contract necessary to create the physician-patient relationship as to the consulted physician. *Jennings v. Badgett*, 230 P.3d 861, 868, 2010 OK 7 (2010).

CONCLUSION

In summary, the Court held that to bring a medical malpractice action against a physician, the plaintiff must have had a physician-patient relationship with that physician. Alternatively, the plaintiff could establish that the physician owed him a duty of care due to plaintiff's status as a third party beneficiary. See generally, *Jennings v. Badgett*, 230 P.3d 861, 2010 OK 7 (2010). In this case, the court reviewed the typical facts that would either prove or disprove the existence of such a physician-patient relationship and found them lacking. As such, the summary judgment in favor of the consulted physician was affirmed. *Jennings v. Badgett*, 230 P.3d 861, 869, 2010 OK 7 (2010).

A. Strategic Point-Plaintiff-Proof of physician-patient relationship

The case law in Oklahoma is now clear on the issue of the necessity of a physician-patient relationship in order to successfully assert a cause of action for medical malpractice. In addition, it is also clear that the plaintiff will have the

burden to prove that the relationship existed. The case of *Jennings v. Badgett*, 230 P.3d 861, 2010 OK 7 (2010) illustrates what types of facts must be shown in order to prove that relationship. It is unlikely that the courts will require that all of the "indicia" be proven, but the plaintiff's attorney must seek to provide evidence of as many of the "indicia" as are supported by the facts.

To establish the existence of a physician-patient relationship, plaintiff's counsel should attempt to develop the following facts:

1. There was some direct relationship between the patient and physician. This might include some direct correspondence or conversation between the patient and the defendant-physician.
2. The patient requested or engaged the physician to provide advice, opinions or treatment.
3. The physician was engaged by the patient or some other treating physician to provide advice, opinions or treatment for the patient.
4. There was some compensation provided for the advice, opinions or treatment.
5. The physician consented to the engagement to provide advice, opinions or treatment.

B. Strategic Point-Defendant-Issue of physician-patient relationship

Jennings v. Badgett, 230 P.3d 861, 2010 OK 7 (2010) makes it clear that proof of a physician-patient relationship is a necessary element of a medical malpractice claim and that the plaintiff has the burden to prove the facts that support such a relationship. Since the plaintiff has the burden on that issue, defense counsel should do substantial pre-trial discovery on those points. Just as the plaintiff's attorney will find it necessary to prove the factors that are part of the "indicia" of the relationship, those factors will be the issues that the defendant's attorney will need to discover. Subsequent to discovery, if the defendant's attorney finds that the factors that are a part of the "indicia" of the physician-patient relationship are either weak or non-existent, then a motion for summary judgment would be appropriate.

RELATED LINKS: For general discussion of the physician-patient relationship, see

- 22-106 Personal Injury--Actions, Defenses, Damages § 106.02;
- 1-8 Medical Malpractice § 8.03

For an example of a jury instruction on the necessity of a physician-patient relationship, see

- 1-3 Jury Instructions on Medical Issues 3-47

For an example of a jury instruction allowing recovery by a third party beneficiary of a physician-patient relationship, see

- 1-3 Jury Instructions on Medical Issues 3-52

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David Fish on Heastie v. Roberts, 226 Ill.2d 525 (2007)

2008 Emerging Issues 2516

David Fish on Heastie v. Roberts, 226 Ill.2d 525 (2007): Expert Testimony Not a Prerequisite to Assertion of Res Ipsa Loquitur in Certain Medical Malpractice Claims.

By David Fish

July 14, 2008

SUMMARY: In a recent decision, *Heastie v. Roberts, 226 Ill.2d 525 (2007)*, the Illinois Supreme Court reminded practitioners that expert testimony is not always a prerequisite to invoking res ipsa loquitur in a medical malpractice case. Even in a specialized environment, some things still speak for themselves.

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ARTICLE: Cite as: Fish, David. *Heastie v. Roberts, 226 Ill.2d 525 (2007)*: Expert Testimony Not a Prerequisite to Assertion of Res Ipsa Loquitur in Certain Medical Malpractice Claims. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

In *Heastie v. Roberts, 226 Ill.2d 525 (2007)*, a medical malpractice case, the Illinois Supreme Court held that expert medical testimony is not a prerequisite to [invoke] the res ipsa doctrine. *Id. at 537*. Instead, the Court reiterated the Illinois common law view that a plaintiff alleging a res ipsa loquitur claim must plead and prove that he or she was injured (1) in an occurrence that ordinarily does not happen in the absence of negligence, (2) by an agency or instrumentality within the defendants exclusive control. *Heastie, 226 Ill.2d 531-32, citing Gatlin v. Ruder, 137 Ill.2d at 295*.

In *Heastie*, the Plaintiff, whose intelligence was described by the Court as extremely low to borderline deficient, sued to recover damages for personal injuries sustained while involuntarily restrained on a gurney in a hospital emergency room. The Plaintiff had been found lying intoxicated in a residential driveway extremely drunk, unable to stand, uncooperative, disoriented, and incapable of making rational decisions for himself yelling and combative. *Heastie v. Roberts, 226 Ill.2d at 519 (2007)*.

Due to his condition, upon admission to the emergency room, the Plaintiff was involuntarily restrained over his wrists and ankles on a cart. *Id. at 520-21*. After being placed in hard restraints over his wrists and ankles, the Plaintiff was put into a separate section of the emergency area that was a segregated room without windows. The room did not have a smoke detector. The Plaintiff was then left alone and restrained in this room, in violation of hospital policy. While left alone, Plaintiff somehow caught on fire and was badly burned. *Id. at 522-23*. An investigation of the fire that harmed Plaintiff did not establish any known cause, however, a disposable lighter was found on the floor sometime after

the fire had been extinguished. *Id.*

Plaintiff brought a negligence suit against the hospital. One count asserted was a claim of negligence based on the res ipsa loquitur doctrine. *Heastie*, 226 Ill.2d at 524-25. The claim alleged that in the ordinary course of operation of a hospital emergency room, fires do not start in the rooms of patients who are in restraints unless the hospital or its personnel were negligent, and that all items that could cause a patient injury, such as matches or a lighter, were under the defendants control. *Id.* at 524-25. The Defendants argued that Plaintiff should not be allowed to bring a res ipsa claim because the Plaintiff lacked testimony from a properly qualified and competent expert to substantiate the proposition that hospital patients do not ordinarily catch fire absent negligence. *Id.* at 535.

The Illinois Supreme Court rejected the Defendants argument and held that expert medical testimony is not always required for a medical malpractice claim. *Heastie*, 226 Ill. 2d at 537. As the Court explained:

A preliminary flaw in defendants' argument is that it presupposes that expert medical testimony is a prerequisite to invocation of the res ipsa doctrine. That is clearly not the case. To be sure, the determination as to whether the res ipsa loquitur doctrine should apply in a given case may be based on expert testimony. Nothing in Illinois law, however, makes expert testimony a prerequisite to reliance on the doctrine in every case. That is so even in medical malpractice actions. Under *section 2-1113 of the Code of Civil Procedure* , a trial court is specifically authorized to rely upon either the common knowledge of laymen, if it determines that to be adequate or upon expert medical testimony. [W]e believe this is one of those situations where the common knowledge of laymen is sufficient.

Strategic Considerations. *Heastie* reiterates the clear (but often overlooked) right not to call an expert in a medical injury/malpractice case. Although many practitioners automatically assume that expert testimony is required, this assumption is erroneous. Expert testimony typically is required only if it is determined that the standard of care requires consideration of knowledge, skill, or training in a technical area outside the comprehension of a layperson. *Prairie v. University of Chicago Hospitals*, 298 Ill.App.3d at 321, 232 Ill.Dec. 520, 698 N.E.2d 611 (1998).

Many lawyers faced with the situation presented in *Heastie* would have used an expert (such as an opinion witness physician with expertise in emergency care) to establish, for example, that a patient in Mr. Heasties condition should have been more closely monitored. However, as recognized in *Heastie*, expert testimony is not required if the health-care provider's conduct is so grossly negligent or the treatment so common that a layman could readily appraise it or where the act alleged to be negligent is not an implicit part of the medical procedure.

Pleading Requirements. When asserting res ipsa loquitur in a specialized setting it is essential to sufficiently plead and lay the foundation for the res ipsa count in the complaint. The practitioner should clearly explain why the injury does not happen in the absence of negligence and show the exclusive control of the defendant. The complaint should highlight why the negligence is so obvious that no expert testimony is required, for instance, as in *Heastie*, pointing out that humans do not spontaneously combust or catch on fire, especially when restrained, unless there was some kind of negligence.

Proceed with Caution. The temptation to avoid using an expert should be considered carefully. While experts are expensive, they may well be worth the cost. Counsel for plaintiffs should consider how a jury will think about their case if defense counsel uses an expert and the plaintiff presents no one to contradict the experts testimony. Likewise, defense counsel should consider whether calling an expert can backfire. For instance, one could only imagine the jurys reaction if an expert testified that a hospital was not negligent when it allowed a patient in Mr. Heasties condition to catch on fire. Some testimony is just not credible.

For additional discussion, see Illinois Tort Law § 14.05[3] Res Ipsa Loquitur; Illinois Tort Law § 15.02 [9] Res Ipsa Loquitur in Medical Malpractice Cases.

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Mr. Fish has litigated numerous multi-million dollar disputes throughout the United States. Mr. Fish has represented a broad array of clients including large publicly traded companies, governmental bodies, privately held companies, small corporations, and individuals. Mr. Fish graduated second in his law school class from Northern Illinois University College of Law in DeKalb, Illinois. He received his undergraduate degree from Illinois State University (Major: Political Science, Minor: Philosophy). Prior to starting his own firm, Mr. Fish was employed as an associate or summer associate by larger law firms. (Including, Jenner & Block in Chicago, Klein, Thorpe & Jenkins in Chicago and The Collins Law Firm, P.C. in Naperville). The Fish Law Firm is located in Naperville, Illinois, DuPage County.

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Eades on Linog v. Yampolsky, 2008 S.C. LEXIS 10

2008 Emerging Issues 1966

Eades on Linog v. Yampolsky, 2008 S.C. LEXIS 10

By Ronald W. Eades

February 29, 2008

SUMMARY: In *Linog v. Yampolsky, 2008 S.C. LEXIS 10 (S.C. 2008)*, the South Carolina Supreme Court held that South Carolina does not recognize the tort of medical battery, even in situations where plaintiffs claim they did not consent to a particular procedure. The plaintiff in a medical malpractice claim must prove negligence. The evidence must show that the health care provider departed from the recognized and generally accepted standards of care.

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ARTICLE: Introduction

The plaintiff was seeing a periodontist to have an invasive dental procedure. Because of her fear of dental work, the plaintiff was to have the procedure under sedation. She was sedated, but during the procedure, she continued to move her head and mumble. After three and one-half hours, the periodontist decided to discontinue the procedure because of difficulty completing it. It was discovered after the procedure that the plaintiff had suffered a herniated disk.

The plaintiff sued the periodontist, asserting causes of action for medical negligence and medical battery. However, she did not retain a qualified expert to provide testimony on the appropriate standard of care. Instead, she contended that the periodontist and the anesthesiologist committed a medical battery because she withdrew her consent to the procedure after it had begun. To support this claim, she pointed to deposition testimony from the defendants which stated that plaintiff moved her head and mumbled throughout the procedure. The plaintiff claimed that this evidence showed her withdrawal of consent. The trial court granted summary judgment for the defendants on both causes of action. The South Carolina Supreme Court granted review of the case to decide whether the state recognized a cause of action for medical battery.

Analysis

The Court determined that there were two clear types of claims that could arise under medical circumstances in South Carolina. First, the plaintiff could seek to prove a traditional claim of negligent malpractice against the health care provider. To prove such a claim, the plaintiff would have to "provide evidence, through expert testimony, showing (1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners in the physician's field of medicine under the same or similar circumstances, and (2) that the physician

departed from the recognized and generally accepted standards." *Linog v. Yampolsky*, 2008 S.C. LEXIS 10, 6 (S.C. 2008).

The second type of claim in a medical setting can arise as an intentional tort. Such a claim may arise where the plaintiff sustains an "injury as a result of a physician's intentional act. In these cases, a patient may bring a civil battery claim against a physician where the physician commits an offensive touching outside of the medical scope." *Linog v. Yampolsky*, 2008 S.C. LEXIS 10, 7 (S.C. 2008).

With those two types of actions available to an injured plaintiff, the Supreme Court of South Carolina did not believe that a claim for medical battery should be available. It was thought that such a claim would be "unnecessary and superfluous." *Linog v. Yampolsky*, 2008 S.C. LEXIS 10, 7 (S.C. 2008). The Court held that other South Carolina opinions that may have suggested the possibility of a medical battery claim would be limited to that extent and should not be read to support such a claim. Those holdings which the Court expressly limited include *Hook v. Rothstein*, 281 S.C. 541, 316 S.E.2d 690 (Ct. App. 1984); *Harvey v. Strickland*, 350 S.C. 303, 566 S.E.2d 529 (2002); and *Banks v. Medical University of South Carolina*, 314 S.C. 376, 444 S.E.2d 519 (1994).

Since the Court would not recognize a claim of medical battery where there was a lack of consent or revocation of consent, it was necessary for the Court to indicate how such facts should be analyzed. The Court noted that such claims should be brought as a traditional negligent malpractice action. Significantly, the plaintiff must "show through expert testimony that the physician deviated from the relevant standard of care in failing to obtain proper consent, unless the subject matter lies within common knowledge." *Linog v. Yampolsky*, 2008 S.C. LEXIS 10, 8 (S.C. 2008). Additionally, in situations where a medical practitioner's intentional touching was outside the scope of medical treatment, the plaintiff would not need expert testimony to prove the claim.

In this case, the plaintiff was seeking to use the now discredited claim for medical battery. The summary judgment would be affirmed. The plaintiff received the alleged injury during a medical treatment and procedure. She failed to produce expert testimony that illustrated the defendants' deviation from the standard of care.

Conclusion

The decision by the Supreme Court of South Carolina is not consistent with the traditional rules of tort law followed in the United States. Most jurisdictions would allow the tort of intentional battery to be used in the medical context where there was an absence or revocation of consent to treatment. For example, Kentucky allows a claim for battery where the physician fails to get consent or continues a procedure when consent has been revoked. See *Vitale v. Henchey*, 24 S.W.3d 651, 653 (Ky. 2000) (surgery without consent); *Coulter v. Thomas*, 33 S.W.3d 522 (Ky. 2000) (continuing procedure when patient says stop).

The courts in South Carolina will have to watch the future development of the absence of a claim for medical battery closely. Most jurisdictions recognize the right of a patient to make decisions for his or her own health care. Those decisions are allowed to be the subjective determination of the individual patient. The health care provider usually is not allowed to contravene that decision even when most patients and physicians would decide otherwise. The position of the Supreme Court of South Carolina in this case, however, may allow physicians to make decisions about patient care based on what reasonable physicians believe is best for the patient. A patient will not be able to allege a battery claim where the patient, for personal reasons, opted to refuse treatment or revoke treatment once it had started. The patient will only be able to seek a claim in negligence, which must be supported by competent expert testimony on the appropriate standard of care.

The opinion is also interesting due to a comment found in a footnote. The Court stated that it had "serious doubts as to whether a patient could ever revoke consent to a medical procedure while under anesthesia or some other method of significant sedation. For this reason expert testimony as to the standard of care ought to be critically important in cases of this type." *Linog v. Yampolsky*, 2008 S.C. LEXIS 10, 8 n.1 (S.C. 2008). This statement suggests that actions

where the plaintiff seeks to prove a revocation of consent will be extremely difficult to prove. The Court will require clear expert testimony of the revocation of consent.

Strategic Point -- Plaintiff. Claims for lack of consent must be framed as traditional medical malpractice negligence claims. The complaint must allege that the defendant's conduct fell below the standard of care. The plaintiff's attorney must also provide expert testimony that will show that the defendant failed to seek consent or continued after the revocation of consent in a manner that was inconsistent with standard practice.

Strategic Point -- Defendant. The decision provides a powerful opportunity for the health care provider. If the plaintiff alleges a medical battery, defense counsel should file a motion to dismiss or summary judgment pursuant to *Linog v. Yampolsky*, 2008 S.C. LEXIS 10 (S.C. 2008). If the plaintiff's attorney frames the claim as one of traditional negligence, the plaintiff's attorney will need to produce expert testimony explaining how the defendant deviated from the standard of care. Absent that evidence, the defense attorney may again file a motion for summary judgment. It is only where the plaintiff's attorney frames the claim as one of medical negligence and produces expert testimony that the defense will need to produce expert testimony to illustrate how the defendant followed the standard of care.

Additional References

For a discussion of consent, including the use of battery as a claim for absence of consent, see 3-52 Personal Injury Defense Techniques § 52.04; and 4-22 Medical Malpractice, Consent to Treatment § 22.02.

For a jury instruction and further citations where an action for medical battery may be brought, see Ronald W. Eades, Jury Instructions on Medical Issues, § 5-8 Unconsented-to treatment as a battery.

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Horowitz on Arons v. Jutkowitz

2008 Emerging Issues 873

Horowitz on Arons v. Jutkowitz

By David Paul Horowitz

November 5, 2007

SUMMARY: In a unanimous decision, the Second Department became the first of New York's four Appellate Divisions to rule on an issue that has bedeviled trial courts overseeing pre-trial disclosure in medical malpractice cases: may a trial court order a plaintiff to furnish a HIPAA compliant authorization permitting defense counsel to conduct an informal, post-note of issue interview with plaintiff's treating physician. The court was unable to find statutory or regulatory authority to compel a plaintiff to execute an authorization permitting such an interview. The court explained that this was the reason for the longstanding rule that interviews prior to the filing of the note of issue are prohibited, and this reasoning extended to the post-note of issue period.

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ARTICLE: Second Department Bars Post-Note of Issue Interviews of Treating Physicians by Defense Counsel

In *Arons v. Jutkowitz*, the Appellate Division, Second Department, became the first of New York's four Appellate Divisions to rule on an issue that has bedeviled trial courts overseeing pre-trial disclosure in medical malpractice cases: may a trial court order a plaintiff to furnish a HIPAA compliant authorization permitting defense counsel to conduct an informal, post-note of issue interview with plaintiff's treating physician?

Resolving this issue required an analysis of the scope of disclosure and the application of the physician-patient privilege, a review of permissible disclosure devices, and an examination of the impact of HIPAA.

In commencing a medical malpractice action, plaintiff partially waives the physician-patient privilege with respect to those physical or mental conditions which he or she affirmatively places in issue in the lawsuit. With this waiver, disclosure may be obtained of otherwise privileged information. The Second Department explained that [i]n order to obtain this [medical] information, a defendant may therefore resort to the discovery devices provided by CPLR article 31 and the Uniform Rules for the New York State Trial Courts (hereinafter Uniform Rules). So was there a disclosure device that the defendant could resort to that the court would direct plaintiff to respond to?

In a unanimous decision, the Second Department held that neither Article 31 of the CPLR nor the Uniform Rules included a provision authorizing defense counsel to meet privately with plaintiff's treating physicians. The court was unable to find statutory or regulatory authority to compel a plaintiff to execute an authorization permitting such an

interview. The court explained that this was the reason for the longstanding rule that interviews prior to the filing of the note of issue are prohibited, and this reasoning extended to the post-note of issue period. These limits on disclosure are imposed not because of the physician-patient privilege, which is generally waived by bringing a malpractice action, but by the very design of the specific disclosure devices available in CPLR article 31.

Given the absence of authority permitting a court to order a post-note of issue interview, the Second Department modified the order of the trial court, replacing the provision ordering plaintiff to exchange the authorization, with a grant of leave to the defendant to move for additional pre-trial disclosure of plaintiffs treating physicians, based upon the unsettled nature of the law, thus satisfying the unusual or unanticipated circumstances provision of Uniform Rule 202.21(d).

Strategic Considerations. Post-note of issue interviews of plaintiffs treating physician by defense counsel have the tactical advantage of permitting defense counsel to obtain information from a plaintiffs treating physician informally, through an interview, rather than formally, via a non-party deposition. An informal interview permits information to be obtained, keeping open the possibility of subsequently memorializing favorable information, while making no record of unfavorable information. With non-party deposition, on notice to all counsel, all testimony, both favorable and unfavorable, is memorialized.

Trial Court Confusion. Prior to the *Arons* decision, trial courts split over whether post-note of issue interviews of treating physicians were permissible. From 2004, when the first unpublished decision appeared, *Beano v. Post*, Index Number 5694-2001 (March 12, 2004, Sup. Ct. Queens County), through the end of 2006, trial courts had issued numerous decisions that ran the gamut of possible relief.

Some courts permitted the informal disclosure to be conducted, without the need of the party conducting the interview to exchange any information from the interview, holding matter so gathered to be attorney work product. *Smith v. Rafalin*, 6 Misc. 3d 1041A, 2005 N.Y. Misc. LEXIS 546 (Sup. Ct. New York County 2005). Other courts permitted the interviews, but required any written statements, materials, or notations obtained from the health care provider, together with copies of memorandum, notes, audio or video recording and statements made by the health care provider, to be provided to opposing counsel. *Kescheki v. St. Vincents Medical Center*, 5 N.Y. Misc. 3d 539, 785 N.Y.S.2d 300 (Sup. Ct. Richmond County 2004). Still other courts declined to order the disclosure, holding that doing so would authorize post-note-of-issue discovery without fidelity to the discovery devices, without the consent of both parties and without a showing of the "unusual or unanticipated circumstances" required for obtaining information once the note of issue has been filed. *Brown v. Horbar*, 6 Misc. 3d 780, 789, 792 N.Y.S.2d 314, 321 (Sup. Ct. New York County 2004).

Interviews Not Permitted Pre- Note of Issue. Acknowledging the broad power of a trial court to supervise disclosure, the court in *Arons* issued a reminder to the bench that the supervision by the trial court must be in accordance with Article 31 and the Uniform Rules. Citing to prior rulings, the court noted that neither authorize private, ex parte interviews as a disclosure device (*see generally* CPLR 3102[a]). Rather, compulsion of such unsupervised, private and unrecorded interviews plainly exceeds the ambit of article 31.

No Rule Permitting Post-Note of Issue Interviews. In *Arons*, the court discussed the origin of post-note of issue interviews, suggesting that two prior decisions have been misread: [W]e did not declare that defense counsel have a right to such informal, post-note of issue interviews, nor did we require plaintiffs to consent to them. Rather, we merely held, under the circumstances, that the treating physician's unique and highly relevant testimony would not be precluded.

One of the cited cases referenced by *Arons*, *Zimmerman v. Jamaica Hospital, Inc.*, 143 A.D.2d 86, 531 N.Y.S.2d 337 (2d Dept. 1988), simply stated that a treating physicians testimony should not be precluded at trial solely on the grounds that defense counsel had conducted post-note interviews. However, the second case, decided a year after *Zimmerman*, *Levande v. Dines*, 153 A.D.2d 671, 544 N.Y.S.2d 864 (2d Dept. 1989) clearly left the impression that

post-note of issue interviews were different from pre-note of issue interviews:

The rationale for this rule [barring pre-note of issue interviews] is the sanctity of the physician-patient privilege during discovery [citing *Zimmerman*]. We find that the trial court's reliance on the Anker case was misplaced. The record contains no indication that the defendant conducted such prohibited interviews. The defendant first contacted Dr. Moccio after the note of issue had been filed, when the discovery phase of the action clearly had been completed [citing *Zimmerman*].

The Second Department's protestations in *Arons* notwithstanding, *Levande* clearly suggested that the rule barring pre-note of issue interviews did not apply to post-note of issue interviews.

Post-Note of Issue Limitations on Disclosure to Be Enforced. *Arons* emphasized that stringent limitations are placed on a court's authority to order post-note of issue disclosure. Indeed, after the filing of a note of issue, a court's authority to allow additional pretrial disclosure is limited to a party's demonstration of "unusual or unanticipated circumstances" (22 NYCRR § 202.21[d]). In the absence of additional statutory authority, the courts should not become involved in post-note of issue trial preparation matters and should not dictate to plaintiffs or defense counsel the terms under which interviews with non-party witnesses may be conducted.

HIPAA Issue. Lower courts ruling on defendants' requests for post-note of issue physician interviews had struggled with the applicability and impact of HIPAA (Health Insurance Portability and Accountability Act) 42 USC § 1320d et seq. (enacted by Congress in 1996 and imposing patient privacy protection provisions nationwide commencing in 2003). In *Arons*, the court did not have to struggle with the issue, since it reversed the trial court order directing the exchange of an authorization, although it acknowledged that any authorization permitting an interview be HIPAA compliant.

However, HIPAA might play a role on defendants' subsequent motion to the trial court: Conversely, whether, as here, the filing of the note of issue preceded the April 14, 2003, effective date of the Privacy Rule is plainly a relevant factor for consideration in determining if a defendant has established "unusual or unanticipated circumstances" warranting this additional disclosure.

CROSS REFERENCES

See *LexisNexis AnswerGuide New York Civil Disclosure* § 8.13 (asserting medical or physician-patient privilege); ch. 25 (post-note of issue disclosure); ch. 2 (scope of disclosure); *New York Civil Practice: CPLR* (Weinstein, Korn & Miller), 3402, 4504.

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