Chapter 1

General Duty of Health Care Providers

1-1 INTRODUCTION

Medical malpractice is a form of negligence law where the required elements are duty, breach, causation, and damages. Legal duty is the starting point for analyzing the obligation of health care providers. This chapter’s discussion of the general duty of health care providers will be followed in later chapters by the discussion of particular forms of duty.¹

1-2 DUTY IN GENERAL

Legal duty is determined by two factors under Connecticut law: foreseeability and public policy.² The test for the existence of a legal duty of care entails: (1) a determination of whether an ordinary person in the defendant’s position, knowing what the defendant knew or should have known, would anticipate that harm of the general nature of that suffered was likely to result, and (2) a determination, on the basis of a public policy analysis, of whether the defendant’s responsibility for its negligent conduct should extend to the particular consequences or particular plaintiff in the case.³ Only the general nature of the harm—not the exact harm that occurred—must be reasonably foreseeable.

¹ These include duty to provide informed consent (see Chapter 6), duty of psychiatrists to third parties (see Chapter 16) and duty to maintain patient confidentiality (see Chapter 15).
Chapter 1  General Duty of Health Care Providers

If the general nature of the harm is foreseeable, there is a basis for liability even though the manner in which the accident happens is unusual, bizarre or unforeseeable.⁴

Even if the general nature of the harm is reasonably foreseeable, a court may find no duty exists on public policy grounds.⁵ The Supreme Court has identified four factors in determining the extent of a legal duty as a matter of public policy: (1) the normal expectations of the participants in the activity under review; (2) the public policy of encouraging participation in the activity while weighing the safety of the participants; (3) the avoidance of increased litigation; and (4) the decisions of other jurisdictions.⁶

Under Connecticut law the determination of whether duty exists and its scope is a question of law for the court, not a question of fact for the jury. Questions of duty may be amenable to disposition through summary judgment or directed verdict rather than trials.⁷ The question of whether a duty has been breached is a question of fact. If there is no duty, the question of breach is irrelevant.⁸

⁵ Murillo v. Seymour Ambulance Ass’n, Inc., 264 Conn. 474 (2003) (no duty to sister witnessing emergency medical procedure); Fraser v. United States, 236 Conn. 625, 634 (1996) (no duty to control noncustodial psychiatric patient to prevent harm to identifiable or unforeseeable third persons); DiTeresi v. Stamford Health Sys., Inc., 142 Conn. App. 72 (2013) (hospital owed no duty to report on an alleged sexual assault of an elderly woman suffering from dementia to her daughter in less than seven hours). The split decision of the Supreme Court in Ruiz v. Victory Properties, LLC, 315 Conn. 320 (2015) (a non-medical malpractice case), contains a fascinating discussion of the policy aspects of the duty determination. See Charles D. Ray and Matthew Weiner, Ruiz v. Victory Properties, LLC, 315 Conn. 320 (2015): How Narrowly Should the Foreseeability Inquiry Be Framed When Defining a Legal Duty of Care, Connecticut Lawyer, Mar. 2015, at 30. For example, an emerging area of controversy is the degree to which duties may be imposed on physicians to provide medical care against their religious beliefs. This subject is covered in more detail in Chapter 12.
⁶ Murillo v. Seymour Ambulance Ass’n, Inc., 264 Conn. 474, 480 (2003). In Charette v. Malone, No. HHBCV095014422S, 2012 WL 953373 (Conn. Super. Ct. Feb. 27, 2012), the court held that the physician was not relieved of duty on the ground that the patient committed a crime by lying about participating in a methadone program.
⁷ In Guerri v. Fiengo, 137 Conn. App. 437, cert. denied, 307 Conn. 920 (2012), the Appellate Court affirmed a refusal to submit to the jury a claim that a cardiologist had a duty to discuss every electrocardiogram with a treating physician when no critical value was present. In Pirecca v. Kolchin, 54 Conn. L. Rptr. 307 (Conn. Super. Ct. 2012), the court held that there is no independent cause of action for intentional alteration of a plaintiff’s medical record.
1-3 STANDARD OF CARE

Medical malpractice is defined by the standard of care. A medical malpractice case generally requires that a similar health care provider testify on the plaintiff’s behalf that the defendant’s conduct deviated from the standard of care.8

The term “standard of care” is a hybrid legal concept that evolved through several common law articulations. In what was largely a codification of the common law, the legislature defined it in the Tort Reform legislation of 1986 as:

The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.10

This standard is incorporated into the form instructions for a medical malpractice case on the Connecticut Judicial Department’s website.

The law recognizes as a theoretical matter a difference between a bona fide error of judgment and a deviation from the standard of care.11 However, it has been held as error for a trial court to instruct a jury that a physician is not liable for bona fide errors in judgment because such a statement has been regarded as inaccurate and tending to obfuscate the minimum standard of professional conduct. Errors in judgment that occur with the best intentions constitute negligence if they result from a failure to use reasonable care.12

Where the treatment or procedure is one of choice among competent physicians, physicians cannot be held liable for malpractice in selecting

---


12. Krattenstein v. Thomas, 7 Conn. App. 604, 607, cert. denied, 201 Conn. 807 (1986), and cases cited therein. In Logan v. Greenwich Hospital Association, 191 Conn. 282, 299 (1983), the Court stated that it did not construe an earlier case as approval of the concept of a bona fide error in judgment as a definition of the standard of care.
Chapter 1 General Duty of Health Care Providers

the one which, according to their best judgment, is best suited to the patient’s needs.13

Upon an appropriate evidentiary foundation, a court may instruct a jury that when distinct and different schools of thought exist, a physician should be judged only by the practice of his school of thought.14

A physician does not guaranty a good medical result and a poor result is not by itself evidence of wrongdoing.15

Violations of hospital policies, by-laws or work rules may be viewed as evidence of negligence but violations thereof do not necessarily by themselves establish the standard of care.16

In the absence of an emergency, a physician is under a duty not to leave his patient at a critical stage without giving reasonable notice or making suitable arrangements for another physician to step in.17

Proof of the standard and the breach requires expert medical testimony.18 This proof will vary with the facts of a case. Though the term may have acquired certain accepted meanings within the medical profession, the standard of care concept has great elasticity in the law.19 Almost by definition, every case contested on liability


16. *Petriello v. Kalman*, 215 Conn. 377, 286 (1990); *Holmes v. Hartford Hosp.*, 147 Conn. App. 713 (2014). *But see Doe v. Saint Francis Hospital & Medical Center*, 309 Conn. 146 (2013), which stated that this general principle has been articulated only in cases in which there was no expert testimony that the hospital’s by-laws, rules or regulations did coincide with the standard of care. When there is such testimony, it was not error to have failed to instruct the jury that the by-laws do not themselves establish the standard of care. See Chapter 7 for additional discussion of hospital policies.


19. An example of a written opinion on the standard of care is *Nordstrom v. United States*, No. 3:01-cv-540 (CFD), 2010 WL 3418201 (D. Conn. Aug. 23, 2010), in which the court found when the standard of care required a prostate cancer test for the plaintiff. *See also Dallaire v. Hsu*, 130 Conn. App. 599 (2011), where the Appellate Court rejected the plaintiff’s contention that the defendant breached the standard of care by failing to consult with the decedent’s prior health care providers and failing to obtain her prior pharmacy records to determine her level of tolerance. In an interesting exception to the rule that the question of breach of the standard of care is normally an issue of fact, the Appellate Court held in *Montanaro v. Balcom*, 132 Conn. App. 520 (2011), that the defendant’s motion for summary judgment was properly granted because there was no issue of fact over whether the plaintiff had been “evaluated” in the hospital.
involves a difference of opinion between experts over what is required by the standard of care and whether a physician’s actions constituted a deviation.\textsuperscript{20}

Because medical malpractice claims are extremely variable, it serves little purpose to attempt a categorical generalization regarding what types of factual claims constitute deviations from the standard of care and what factual claims do not. Common claims in malpractice cases are failure to timely diagnose medical conditions, negligent performance of surgical procedures, failure to diagnose a complication of a surgical procedure, failure to provide informed consent, and negligent failure to inform.\textsuperscript{21}

Under common law, the standard of care was measured by the “locality rule.” In other words, a physician was judged against his peers in the same “general neighborhood.” This locality rule was later expanded throughout state of Connecticut.\textsuperscript{22} In 1983, the Supreme Court broadened the geographical limitation to the entire nation.\textsuperscript{23}

Federal policy increasingly may impose certain metrics with respect to the practice of medicine. In early 2015, Congress passed and President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10), which provides that “the development, recognition, or implementation of any guideline or

\begin{quotation}
\textsuperscript{20} But see Editorial, Medical Standards of Care Should Be Better Defined, Conn. L. Trib., June 1, 2015. There have occasionally been (mostly unsuccessful) legislative proposals at both the federal and state level to establish a “safe harbor” if a doctor follows a published evidence based guideline. A bill of this nature (RB 6305) was stripped from the Sustinet bill by the Connecticut General Assembly in 2011.

\textsuperscript{21} There is a difference between failure to provide informed consent and negligent failure to inform. See Downs v. Trias, 306 Conn. 81 (2012). (“[A] physician has both a duty to exercise medical care in accordance with prevailing professional standards and a duty to provide patients with material information concerning a proposed course of treatment. The issue in the present case concerns the relationship between the two obligations. Specifically, may a physician, in failing to provide a patient with information, incur liability for failing short of the professional standard of care? The answer to this question is plainly yes. In such a case, a physician has a professional duty to possess or obtain certain medical knowledge as well as an additional “lay” duty to communicate a subset of that information to the patient. A physician who fails to apprise a patient of a certain fact may therefore, in appropriate circumstances, be held liable for failing to know the fact in the first place (medical malpractice) \textit{and} for failing to convey the fact to the patient for his or her consideration in making medical treatment decisions (lack of informed consent).”). For an interesting discussion, see article titled \textit{Malpractice Risk According to Physician Specialty}, New Eng. J. of Med., Aug. 18, 2011.

\textsuperscript{22} Fitzmaurice v. Flynn, 167 Conn. 609, 617 (1975).

\textsuperscript{23} Logan v. Greenwich Hosp. Ass’n, 191 Conn. 282, 301 (1983). In Smith v. Andrews, 289 Conn. 61 (2008), the Supreme Court held that expert testimony establishing a local standard of care at a particular hospital is relevant only if it comports with an accepted national standard of care.
\end{quotation}
other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.”

1-4 DUTY TO NONPATIENTS
A physician generally owes a duty only to a patient.24 “Under Connecticut law, a physician-patient relationship is created when the professional services of a physician are rendered to or accepted by another for the purposes of medical or surgical treatment.”25 “There can be no actionable negligence on the part of the physician unless there is a physician-patient relationship.”26 Generally, the physician-patient relationship does not exist if the physician is retained solely to examine an employee on behalf of an employer.27 But if the physician, during the course of the examination, affirmatively treats

24. Levin v. State, 329 Conn. 701 (2018) (dismissal of plaintiff’s malpractice claim against mental health facility was proper where decedent was fatally attacked by psychiatric patient because Connecticut does not recognize cause of action for medical malpractice by a non-patient). The rule that a physician does not owe a duty to a non-patient has been applied by the appellate courts in two cases involving a claim that a physician should have warned an impaired patient not to drive. In Jarmie v. Troncale, 306 Conn. 578 (2012), the Supreme Court held that a gastroenterologist had no such duty to the injured plaintiff in the case of a patient who blacked out. While ruling against the plaintiff on particular facts, the Court in Jarmie allowed for the possibility that the rule that a doctor owes a duty only to a patient could be circumvented by characterizing the action as one for ordinary negligence rather than medical malpractice. For an interesting article about Jarmie and other duty cases, see Charles D. Ray & Matthew A. Weiner, Deciding ‘Duty’—Grenier v. Commissioner of Transportation, Jarmie v. Troncale, and Sic v. Nunan, Connecticut Lawyer, Jan. 2013. Note that the rule as articulated in Jarmie contrasts with the rule in Massachusetts as articulated in Coombes v. Florio, 877 N.E.2d 567 (Mass. 2007). In Weigold v. Patel, 81 Conn. App. 347 (2004), the Appellate Court held that a psychologist and a psychiatrist had no such duty in the case of a patient who caused an accident while driving without taking prescribed medication. See also Sackter v. St. Onge, No. CV91-0504004 S, 1993 WL 126466 (Conn. Super. Ct. Apr. 14, 1993). But see Maisener v. Saranchak, No. HHBCV075004003, 2008 WL 853773 (Conn. Super. Ct. Mar. 13, 2008) (rejecting argument that physician owed no duty to fetus because fetus was not the physician’s patient).


or affirmatively advises the employee, a physician-patient relationship may be created.\(^{28}\)

Several Superior Court opinions have held that a physician does not have a duty in the case of a “fitness for duty” determination or an independent medical examination where the physician is acting at the request of an employer or an opposing litigant rather than the examinee.\(^{29}\) The Supreme Court (applying New York law) held that there was no duty in the case of a fitness for duty determination but that a duty may arise if the physician affirmatively treated the examinee or affirmatively advised him as to treatment.\(^{30}\)

Issues of fact may be presented over whether a doctor’s conduct creates a physician-patient relationship.\(^{31}\) There has been some division in authority on duties to patient’s relatives. Just because harm was foreseeable does not necessarily mean legal duty exists.\(^{32}\) See also Chapter 2, § 2-3:2.2 dealing with cases involving injury to third persons caused by the discharge of patients under the effects of medication.


FIDUCIARY DUTY

Fiduciary duty is the highest standard of behavior imposed by law. The Connecticut Supreme Court quoted the famous phrase of Justice Cardozo in referring to fiduciary duty as “the punctilio of an honor the most sensitive.” The Court has also referred to a fiduciary duty as involving a unique degree of trust and confidence.

Several appellate level cases strongly suggest that a fiduciary relationship exists between physician and patient. Numerous superior court decisions hold, or strongly suggest, that physicians owe fiduciary duties to their patients. Most other jurisdictions that have directly addressed the issue found a physician-patient relationship gives rise to fiduciary standards.

In the case of hospitals, the fiduciary concept may be less applicable than in the case of physicians.

Since the existence of a fiduciary relationship implicates a duty of loyalty and honesty, it is unlikely that pure acts of medical malpractice (e.g., negligent failure to diagnose), state a cause of action for breach of fiduciary duty. In the legal malpractice context, Connecticut courts have indicated causes of action for breach of fiduciary duty are more concerned with breaches of a duty of loyalty and honesty.40
Cases holding that a physician has violated a fiduciary duty usually concern breaches of loyalty (e.g., disclosing confidential information), acts of dishonesty (e.g., concealing facts from patients, at times to hide acts of malpractice) and immorality (e.g., sexual exploitation).

The establishment of a fiduciary relationship may have profound litigation consequences because, upon a showing of such a relationship, the burden of proof shifts to the fiduciary to prove by “clear, convincing, and unequivocal evidence” that the fiduciary has dealt fairly with the plaintiff.

**1-6 SEXUAL EXPLOITATION CASES**

The leading case in Connecticut exploring the concept of duty in the case of sexual exploitation is *Doe v. Saint Francis Hospital & Medical Center*, a case involving the notorious Dr. Reardon who was found to have sexually exploited children during the course of what purported to be a research study. The plaintiffs’ claim was that the hospital did not follow its own rules for conducting research. The Court found that it was not error to have failed to instruct the jury that it could not find for the plaintiffs unless the hospital knew or should have known that Dr. Reardon was a pedophile. The Court’s opinions (majority and dissenting) are a treatise on the law of duty in this context.

A seminal case in another jurisdiction involving a physician’s alleged breach of trust and confidence by means of sexual exploitation held that there is the potential and opportunity for a physician to take advantage of a patient’s vulnerabilities. However, the mere proof of duty.

---


42. E.g., Harrison v. United States, 708 F.2d 1023, 1028, n.1 (5th Cir. 1983); Sheets v. Burman, 322 F.2d 277, 279 (5th Cir. 1963).


a sexual relationship between patient and physician does not, ipso facto, result in a breach of fiduciary duty. It is generally accepted that consensual sexual activity between a health care provider and patient does not constitute medical malpractice.

Several cases in other jurisdictions held that a plaintiff can maintain a medical malpractice cause of action if “the sexual relationship was initiated by the physician under the guise of treatment of the patient.” Most of these cases involve psychiatrists and alleged mishandling of the “transference phenomenon.” The majority view in other jurisdictions, however, appears to be that sexual exploitation does not constitute the rendering of professional health care services even in cases where the pretense of medical care is employed. In these circumstances, the appropriate cause of action would be breach of fiduciary duty. That is because the action arises out of a breach of trust, not the negligent failure to comply with a recognized standard of care for rendering of medical services.

On the other hand, a Connecticut Superior Court has held that a claim of sexual exploitation survives a motion to strike under theories of intentional infliction of emotional distress and medical malpractice.

One case raises some question regarding whether Connecticut would follow the rule that sexual exploitation does not constitute the rendering of professional health care services even where the pretense of medical care is employed. This insurance coverage case centered on whether a professional liability policy provided coverage when

---


---

10 CONNECTICUT MEDICAL MALPRACTICE
a dentist sexually molested a patient while administering nitrous oxide. In a controversial decision that included a vigorous dissent, the Supreme Court held that the policy provided coverage when the medically negligent procedure is inextricably intertwined and inseparable from the intentional conduct that served as the basis for the claim of sexual assault.  

Issues have arisen over whether sexual exploitation cases are governed by the statute of limitations for medical malpractice cases (§ 52-584) or the longer statute of limitations for sexual exploitation cases (§ 52-577d).

1-7 RECKLESSNESS

Connecticut has defined recklessness as highly unreasonable conduct involving an extreme departure from ordinary care. A finding of recklessness, instead of mere negligence, may entitle a plaintiff to punitive as well as compensatory damages. Several Superior Court decisions have recognized a recklessness claim in the context of medical malpractice.

---

54. Note that the insurance policy involved in Shernow did not contain a sexual assault exclusion.


1-8 VICARIOUS LIABILITY

Under the theory of vicarious liability, a principal can be held liable for the negligent acts of its agent. “[T]he three elements required to show the existence of an agency relationship include: (1) a manifestation by the principal that the agent will work for him; (2) acceptance by the agent of the undertaking; and (3) an understanding between the parties that the principal will be in control of the undertaking.” 59 The burden of proving agency is on the party asserting its existence. 60 If there is a finding that the allegedly negligent actor is not an employee or agent, the claim of vicarious liability must fail.

Practice group corporations and hospitals that employ health care providers can be vicariously liable for the negligent acts of those employees. 61 However, the fact that a physician holds staff privileges at a hospital is not itself sufficient to support a finding that an agency relationship was created. 62

There also exists an issue as to whether a hospital may be vicariously liable for acts or omissions of a physician practice group that has been retained to staff a hospital department. 63 When a patient sues a health care provider employed by a practice group that staffs a hospital...
department, he or she typically also sues the hospital under the law of agency, i.e., respondeat superior. Typically, hospitals attempt to contractually insulate themselves from such vicarious liability by including in the hospital/practice group agreements language tending to show that the hospital is not in control of the undertaking, i.e., (1) express acknowledgments that the physician group is an independent contractor; and (2) express provisions that the hospital shall not control the medical judgment exercised by the physician group.64 This language is strongly indicative that the physician group is an independent contractor and, without evidence to the contrary, would be sufficient to conclude that it is not the agent of the hospital.65

However, in rebuttal, plaintiffs offer evidence of other language in the hospital/physician group agreement that requires the group physicians to comply with the hospitals’ by-laws, rules, regulations, policies, directives, and codes of conduct; to work with the hospital to establish procedures and assure consistency of quality of services; to render medical care in a safe, effective, competent, and professional manner, consistent with quality improvement standards of the hospital; to participate in pre- or post-operative rounds in accordance with standards of the JCAHO or as may be designated or requested by the hospital from time to time.66 Plaintiffs also offer evidence that the hospital supplies the instrumentalities, tools, and place of work. Given this conflicting evidence on the issue of control, Connecticut Superior Courts routinely decide that hospitals retain enough control over the physician group so as to create an issue of fact as to whether they should be vicariously liable for the acts or omissions of the group.67

---


65. Carano v. Kabadi, No. CV116009251, 2014 WL 4413267 (Conn. Super. Ct. July 22, 2014) (“The hospital has presented sufficient evidence on the issue of control to support a finding that Coddett was not its agent and the burden now shifts to the plaintiff to raise any issues of fact with regard to the existence of an actual agency relationship between the parties.”).


Chapter 1  General Duty of Health Care Providers

1-8:1  Respondeat Superior

Under Connecticut law, the doctrine of respondeat superior in medical malpractice situations rests on common law agency principles of vicarious liability. Under these principles, a master is responsible for the acts of his servant committed within the scope of employment and in the furtherance of the master’s business. The determination of whether someone is an employee or an independent contractor depends on the existence or nonexistence of the right to control the means and method of work.

Agency law has elements of both a control test and a benefit test. These factors can affect the analysis of cases. For example, a military physician participating in a residency program of a private hospital may render both the military and the private hospital liable under principles of vicarious liability.

Connecticut has never adopted the “Captain of the Ship” doctrine under which physicians are automatically responsible for everything done under their supervision.

1-8:2  Borrowed Servant Doctrine

Under the doctrine of respondent superior, a master (employer) is liable for the negligence of a servant (employee). But under the theory known as the “borrowed servant” rule, responsibility for the employee can be transferred when the employee is loaned to another who assumes control over the employee’s work.

In medical malpractice context, the borrowed servant doctrine may be applied so that a surgeon supplants a hospital as the “master” of hospital employees (typically residents or nurses) by supervising, controlling, and directing the manner of their work during a surgical

---

71. See Bria v. St. Joseph’s Hosp., 153 Conn. 626, 630 (1966) (“In the absence of assumption of control and direction by the doctor, the nurses did not become his servants.”); Larsen Chesley Realty Co. v. Larsen, 232 Conn. 480, 501 (1995) (“But it must be the affairs of the principal, and not solely the affairs of the agent, which are being furthered in order for the doctrine to apply.”).
73. See Sheriden v. Quarry, 127 Conn. 279 (1940) (operating surgeon not responsible for aftercare left in the hands of other health care providers).

14  CONNECTICUT MEDICAL MALPRACTICE
procedure. The borrowed servant doctrine makes the surgeon, rather than the hospital, liable for the actions of the residents or nurses. As a practical matter, the borrowed servant doctrine may amount to what is essentially a conflict between two financial institutions: the insurer for the physicians, and the insurer (or self-insured retention) of the hospital.

The law in Connecticut is somewhat varied on the application of the borrowed servant doctrine.\textsuperscript{75}

\textbf{1-8:3 Successor Liability}

The trend toward physician group practice acquisitions and hospital mergers can give rise to questions of successor liability.\textsuperscript{76} Normally an asset purchaser is not liable for the liabilities of the predecessor. There are exceptions to this rule (i.e., express or implied assumption of liability, consolidation or merger, fraudulent transaction, or mere continuation or reincarnation).\textsuperscript{77}

\textsuperscript{75} In \textit{Alswanger v. Smego}, No. X05CV 920125294S, 1999 WL 259686 (Conn. Super. Ct. Apr. 21, 1999), aff'd on other grounds, 257 Conn. 58 (2001), the Superior Court, applying the borrowed servant doctrine, held that the independent contractor surgeon rather than the hospital was exclusively liable for the resident’s negligence because the surgeon had control over the resident during the operation. The court rejected the argument that the resident was acting in the scope of his employment for two masters (the surgeon and the hospital). The U.S. District Court for the District of Connecticut came to an opposite conclusion in \textit{Aldridge v. Hartford Hospital}, 969 F. Supp. 816 (D. Conn. 1996), when it found both the surgeon and the resident’s employer may be liable for the resident’s actions. Several Superior Court opinions have held that the borrowed servant doctrine presents a question of fact. \textit{See Rice v. Fotovat}, No. CV970345122, 2003 WL 283834 (Conn. Super. Ct. Jan. 16, 2003); \textit{Doe v. Bradley Mem’l Hosp.}, No. CV010509999, 2003 WL 22133707, at *6 (Conn. Super. Ct. July 24, 2003). Aldridge appears to follow the Restatement (Second) of Agency and represents what is likely the majority rule that an agent can be the servant of two masters. \textit{Brickner v. Normandy Osteopathic Hosp.}, 746 S.W. 2d 108, 113 (Mo. App. 1988). \textit{See also Restatement (Second) of Agency \S 226 and Restatement (Second) of Agency \S 227}; Stewart R. Reuter, \textit{Professional Liability in Postgraduate Medical Education: Who Is Liable for Resident Negligence?} 15 J. Leg. Med. 485, 498-99 (1994); Lynn D. Lisk, \textit{A Physician’s Respondent Superior Liability for the Negligent Acts of Other Medical Professional—When the Captain Goes Down Without His Ship}, 13 U. Ark Little Rock L.J. 183, 194-95 (1991).


\textsuperscript{77} In \textit{Robbins v. Physicians for Women’s Health}, 311 Conn. 707 (2014), the Supreme Court held in a medical malpractice context that a settlement with a predecessor forecloses a successor liability claim against a successor. The Court articulated the rule of successor non-liability and its four exceptions. \textit{See Jeff White and Kate Dion, Successor Liability, Retaliation, and Sanctions}, Conn. L. Trib., Sept. 22, 2014, at 17.
Chapter 1  General Duty of Health Care Providers

1-8:4  Apparent Authority
The Connecticut Supreme Court recognized the doctrine of apparent authority in *Cefaratti v. Aranow*.

A more complete discussion of the *Cefaratti* rule may be found at Chapter 7, § 7-4.

1-9  CONTRIBUTORY NEGLIGENCE
A patient in a medical malpractice setting may also have a duty, breach of which could lead to an affirmative defense of contributory negligence.

Pursuant to Connecticut law, a medical malpractice plaintiff would be completely barred from recovery if his negligence was found to be greater than the combined negligence of the defendants.

Contributory negligence must be affirmatively pleaded and the defendant retains the burden of proof.

A plaintiff is statutorily presumed to be in the exercise of reasonable care.

A person’s mental disability could impinge upon whether he is capable of exercising reasonable care, but a person’s mental disability is not an automatic bar to that person’s contributory negligence liability.

In circumstances where a healthcare provider accepts responsibility to prevent a patient from committing suicide, and the patient succeeds

---

81. Conn. Gen. Stat. § 52-114; Conn. Practice Book § 10-53. In *Bradford v. Herzog*, 33 Conn. App. 714, cert. denied, 229 Conn. 920 (1994), the court declined to decide a claim that the apportionment statute, Connecticut General Statutes § 52-572h, is in conflict with Connecticut General Statutes § 52-114 and, therefore, relieves a defendant of pleading contributory negligence because it held that the defense of contributory negligence was not supported by the evidence. In *Juchniewicz v. Bridgeport Hospital*, 86 Conn. App. 310 (2004), cert. granted, 272 Conn. 917-18 (2005), the Appellate Court, following *Borkowski v. Sacheti*, 43 Conn. App. 294, 315-327, cert. denied, 239 Conn. 945 (1996), held that Connecticut General Statutes § 52-114 did not entitle the plaintiff to an instruction that the plaintiff’s decedent was presumed to be in the exercise of reasonable care. In *Mulcahey v. Hartell*, 140 Conn. App. 444 (2013), the court held that evidence that the plaintiff allegedly wiped an acupuncture area with a dirty hand or non-sterile paper tissue was properly admitted absent a special defense of contributory negligence. *See also* new § 9-15 dealing with noncompliant patients.
82. Conn. Gen. Stat. § 52-114. In *Juchniewicz v. Bridgeport Hospital*, 281 Conn. 29 (2007), the Court held that Connecticut General Statutes § 52-114 did not entitle the plaintiff to an instruction that the plaintiff’s decedent was presumed to be in the exercise of reasonable care.
in doing so, the healthcare provider may not plead contributory negligence as an affirmative defense.\textsuperscript{84}

As a matter of trial strategy, a physician being sued for medical malpractice may be reluctant to assert a defense of contributory negligence because it could put the physician in the unpalatable position of appearing to blame the patient. In such circumstances, a physician may prefer to simply assert a defense that his actions were not a proximate cause of the injury because the patient did not provide complete information or follow directions.\textsuperscript{85} Evidence of a plaintiff’s contribution to his own injury is generally admissible under a general denial of causation.

\textbf{1-10 THE WRONGFUL CONDUCT RULE}

In most cases, misconduct by the plaintiff is taken into account under doctrines of contributory or comparative negligence or causation. In rare instances, however, in which a plaintiff who seeks the court’s aid has violated the law in connection with the very transaction as to which he seeks legal redress, a court may bar the action under the wrongful conduct rule ("ex turpi causa non orbitur actio").

This principle found expression in \textit{Greenwald v. Van Handel},\textsuperscript{86} an unusual case in which a plaintiff alleged that his social worker’s failure to treat his predilection to internet child pornography led to emotional distress arising from fear of prosecution. While declining to adopt a sweeping rule or exceptions thereto, the Court held that in these narrow circumstances, it would violate public policy to allow the plaintiff to profit from his own wrong in this manner.\textsuperscript{87} The Court emphasized that it did not hold that the defendant did not have a duty to exercise care in the treatment of the patient and that the wrongful conduct rule

\textsuperscript{84} \textit{McKeever v. Hartford Hosp.}, 66 Conn. L. Rptr. 629 (2018) (“The court held that, as a matter of law, the hospital may not complain of a custodial patient’s comparative negligence manifested by committing or attempting to commit self-harm, including suicide, where the hospital knew the patient is actively suicidal and when the custodial admission is for the purpose of preventing the patient’s self-harm.”); \textit{Newlan v. State}, No. 564396, 2003 WL 21321849, 34 Conn. L. Rptr. 681 (Conn. Super. Ct. May 27, 2003) (“the defense of contributory negligence is not valid where the decedent’s suicide is the foreseeable consequence of the physician’s tortious act”).

\textsuperscript{85} \textit{See Parkins v. United States}, 834 F. Supp. 569, 575 (D. Conn. 1993) (failure of plaintiff to follow reasonable and proper instructions and monitor personal hygiene rather than conduct of doctors was proximate cause of the injury). See also \textit{Juchniewicz v. Bridgeport Hosp.}, 281 Conn. 29 (2007).

\textsuperscript{86} \textit{Greenwald v. Van Handel}, 311 Conn. 370 (2014).

would not apply if the patient sustained injuries independent of the legal consequences of his criminal acts as a result of the defendant’s negligent treatment of his underlying condition.

1-11 PRENATAL DUTY OF CARE

Connecticut law acknowledges “that a physician rendering prenatal care to a mother also has a physician-patient relationship with the fetus.”

“...And, although medical interventions may, at times, be directed more particularly to either the mother or her fetus, ‘the welfare of each is intertwined and inseparable.’”

It has been held that “the physician-patient relationship between the defendants and [the child], while in utero, was not extinguished because the medical judgment at issue related to the termination of the pregnancy. The defendants’ professional relationship with [the unborn child] gave rise to a duty to conform to professional standards with regard to an appropriate abortion technique.”

Therefore, the defendants would be liable to the child (born alive) for prenatal injuries caused by a negligently performed abortion.

