Chapter 1

Duties of Health Care Providers

I DUTY OF CARE

1-1 THE GENERALLY ACCEPTED STANDARD OF CARE

1-1:1 Introduction

Medical malpractice is generally defined as a deviation from the generally accepted standard of care. This definition is best understood by a historical review of the evolution of this concept. Perhaps the first case in New Jersey to hold that a plaintiff in a malpractice case must prove that the defendant deviated from the generally accepted standard of care is *Carbone v. Warburton*,[1] where the plaintiff contended that the defendant negligently treated a fractured tibia and fibula. Judge (later Justice) Francis, holding that the plaintiff must prove that the defendant departed from generally recognized medical standards, and that such proof required expert testimony, explained:

> When a physician is charged with negligence in the diagnosis or treatment of a patient's condition it must appear that he departed from the degree of skill required of him. And in order to demonstrate this ultimate fact two elements of proof are

[1] *Carbone v. Warburton*, 22 N.J. Super. 5 (App. Div. 1952), *aff'd*, 11 N.J. 418 (1953).

> essential. First, those standards must be established which are generally recognized and accepted by the branch of the profession to which he belongs as the customary and proper methods of diagnosis or treatment of the physical or mental condition concerned in the inquiry. Secondly, a departure from such standards under circumstances justifying the conclusion of want of the requisite degree of care.[2]

Similar language is found in *Clark v. Wichman*,[3] where plaintiff also alleged that her physician negligently treated a fracture. The Appellate Division explained that plaintiff's case failed because her experts "did not say or indicate that the defendant had in any way failed to exercise that degree of knowledge and skill in his diagnosis and treatment, which usually pertains to members of his profession in the area specializing in orthopedics. Their testimony did not establish an accepted standard of care."[4] The Appellate Division then added a comment that had been frequently quoted:

> The science of medicine is not an exact science . . . . A doctor is not an insurer of his patient's recovery. He is not a guarantor . . . . He is not liable for honest mistakes of judgment. Evidence of mere mistake or error is insufficient to sustain an action for negligence.[5]

As will be seen, the comment about "honest mistakes" later caused much confusion and controversy.

Thereafter, in the seminal case of *Schueler v. Strelinger*,[6] the Court explained in language that was incorporated directly into the then existing Model Jury Charge:

> The fact that a good result may occur with poor treatment, and that good treatment will not necessarily prevent a poor result must be recognized. So, if the doctor has brought the

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2. *Carbone v. Warburton*, 22 N.J. Super. 5, 10 (App. Div. 1952), *aff'd*, 11 N.J. 418 (1953).
3. *Clark v. Wichman*, 72 N.J. Super. 486 (App. Div. 1962).
4. *Clark v. Wichman*, 72 N.J. Super. 486, 498 (App. Div. 1962).
5. *Clark v. Wichman*, 72 N.J. Super. 486, 495 (App. Div. 1962).
6. *Schueler v. Strelinger*, 43 N.J. 330 (1964).

> requisite degree of care and skill to his patient, he is not liable simply because of failure to cure or for bad results that may follow. Nor in such case is he liable for an honest mistake in diagnosis or in judgment as to the course of treatment taken. A physician must be allowed a wide range in the reasonable exercise of judgment. He is not guilty of malpractice so long as he employs such judgment, and that judgment does not represent a departure from the requirements of accepted medical practice, or does not result in failure to do something accepted medical practice obligates him to do, or in the doing of something he should not be measured by the standard above stated.[7]

1-1:1.1 The Existence of a Duty

Whether a party owes a legal duty of care to another is a "question of law for the court to decide."[8] The seminal question of under what circumstances a health care provider owes a duty to a patient

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[7] *Schueler v. Strelinger*, 43 N.J. 330, 344-45 (1964).

Other cases reached similar conclusions. *See*, for example, *Fernandez v. Baruch*, 52 N.J. 127, 131 (1968), holding,

> The plaintiff's medical expert did not purport to express accepted medical standards . . . . Of course, much more than the personal opinion of a medical witness is necessary to establish a standard of accepted medical practice. The expert testimony must relate to generally accepted medical standards, not merely to standards personal to the witness.

Similarly, the Court in *Germann v. Matriss*, 55 N.J. 193, 208 (1970), held,

> The law does not make a dentist a guarantor that no harm or unfavorable consequence will arise from his treatment. The obligation assumed by him is to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field. Failure to have and to use such skill and care toward the patient as a proximate consequence of which injury results constitutes actionable negligence.

The reader may also wish to review *Sanzari v. Rosenfeld*, 34 N.J. 128, 132-34 (1961); *Klimko v. Rose*, 84 N.J. 496, 502 (1980); *Buckelew v. Grossbard*, 87 N.J. 512, 522 (1981); *Rosenberg by Rosenberg v. Cahill*, 99 N.J. 318, 325 (1985); *Largey v. Rothman*, 110 N.J. 204, 215 (1988); *Hearon v. Burdette Tomlin Mem'l Hosp.*, 213 N.J. Super. 98, 102 (App. Div. 1986); *Wagner v. Deborah Heart & Lung Ctr.*, 247 N.J. Super. 72, 77 (App. Div. 1991); *Adamski v. Moss*, 271 N.J. Super. 513, 518 (App. Div. 1994); *Ritondo v. Pekala*, 275 N.J. Super. 109, 115 (App. Div. 1994).

[8] *Coleman v. Martinez*, 247 N.J. 319, 348 (2021) (citing *Robinson v. Vivirito*, 217 N.J. 199, 208 (2014)).

was analyzed by the New Jersey Supreme Court in *Coleman v. Martinez*.[9] The unusual facts were summarized by the Court:

> After T.E. suffered a psychotic episode that included auditory hallucinations, the New Jersey Division of Child Protection and Permanency (DCPP) removed her five children and, in October 2013, referred T.E. for counseling to the defendant Sonia Martinez, a licensed social worker. Over the following thirteen months, Martinez learned of or was present for at least four episodes of T.E.'s auditory hallucinations. Martinez did not refer T.E. for psychiatric intervention, despite having been instructed to do so, and she contacted DCPP in October 2014 to facilitate unsupervised visits between T.E. and her children.
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> When plaintiff Leah Coleman, a DCPP employee, wrote to Martinez several weeks later explaining that T.E. had confided to a member of her family that T.E. continued to experience and conceal hallucinations, Martinez responded that she would be meeting with T.E. about a week later. At that meeting, Martinez told T.E. that Martinez had been informed of T.E.'s hallucinations and identified Coleman to T.E. as the source of that information. Believing the disclosure to be detrimental to her goal of regaining custody of her children, T.E. brutally stabbed Coleman at DCPP's offices ten days later, resulting in significant physical and psychological injuries.

The trial court concluded the defendant did not owe any duty to the plaintiff and dismissed the case. The Appellate Division reversed. In affirming, Justice Solomon framed the question as follows:

> [W]hether, under the facts of this case, the victim of a violent assault by a social worker's patient

[9] *Coleman v. Martinez*, 247 N.J. 319 (2021).

> may bring a negligence claim against the social worker.[10]

The record disclosed T.E. had been involved in two acts of violence involving stabbings prior to treatment by the defendant. T.E. had also once been found "standing in the middle of the street, screaming and clutching one of her children. According to police, T.E. claimed that aliens were after her. She also reported auditory hallucinations commanding self-harm."[11] As a result, T.E. was hospitalized and three of her children were placed with T.E.'s mother and two were placed with their paternal grandmother. T.E was diagnosed with a "bipolar disorder initially with a manic psychotic episode that later on progressed to a mixed episode with criteria for both a major depressive episode & mania being met at the same time."[12] T.E. was referred to the defendant, a "mental-health therapist," who concluded T.E. was at low risk, with "[n]o history of violence."[13]

During the course of counseling, the defendant noted that T.E. was seen "talking to herself and [t]hat during group [T.E.] got up and yelled that 'I just saw Jesus.'" The defendant later documented T.E. appeared to be hearing voices, "became upset that "others [were] `lying' about her (regarding `hearing voices')," and was concerned that those alleged lies could prevent her from regaining custody of her children."[14]

The plaintiff worked for the DCPP and was "tasked with ensuring the welfare of T.E.'s children."[15] Prior to the violent attack that gave rise to the case, the plaintiff advised the defendant that T.E. had heard "commanding voices, to which she fe[lt] an obligation to act on their commands."[16] The plaintiff "assumed" this disclosure would be kept confidential. The defendant met with T.E. on November 7, 2014, and told T.E. the plaintiff reported T.E. was experiencing hallucinations. During her deposition, the defendant "conceded that, as of the November 7 appointment, she

10. *Coleman v. Martinez*, 247 N.J. 319, 327 (2021).
11. *Coleman v. Martinez*, 247 N.J. 319, 328 (2021).
12. *Coleman v. Martinez*, 247 N.J. 319, 330 (2021).
13. *Coleman v. Martinez*, 247 N.J. 319, 330 (2021).
14. *Coleman v. Martinez*, 247 N.J. 319, 331 (2021).
15. *Coleman v. Martinez*, 247 N.J. 319, 331 (2021).
16. *Coleman v. Martinez*, 247 N.J. 319, 331 (2021).

was aware that (1) T.E. had a history of violence, (2) clients with children were often upset with DCPP, (3) T.E. had not met with her psychiatrist since July 2014, (4) T.E. needed to refill her Prozac prescription, which itself did not treat hallucinations, and (5) it was advisable that T.E. be seen by a psychiatrist. Nevertheless, "despite instructions to refer T.E. to the HFC psychiatrist immediately upon decompensation, the defendant encouraged T.E. to "follow up with medications" and attend her next psychiatric appointment."[17] A week later, T.E. went to the plaintiff's office and stabbed the plaintiff with a steak knife "twenty-two times in the face, chest, arms, shoulders, and back."[18]

The plaintiff filed a suit, asserting the defendant was "negligent in identifying her to T.E. as the source of information about T.E.'s auditory hallucinations." The plaintiff supplied the report of a professor of psychiatry opining the defendant committed malpractice by failing to "immediately contact T.E.'s psychiatrist" after being informed T.E. was experiencing hallucinations. The expert criticized the defendant for waiting "more than a week to meet with T.E. and "needlessly identified [The plaintiff] as the source of information to her psychotic patient." As noted above, the defendant moved for summary judgment asserting she had no duty to the plaintiff. The trial court granted summary judgment, but the Appellate Division reversed.

In affirming, Justice Solomon supplied a tutorial on the elements of negligence and the existence of a duty of care. The Court first reiterated that a plaintiff must prove "a duty of care owed by the defendant to the plaintiff, a breach of that duty by the defendant, injury to the plaintiff proximately caused by the breach, and damages."[19] The Court then defined the critical word "duty:"

> A duty is an obligation imposed by law requiring one party 'to conform to a particular standard of conduct toward another.' *Acuna v. Turkish*, 192 N.J. 399, 413 (2007) (quoting Prosser & Keeton on Torts: Lawyer's Edition § 53, at 356 (5th ed.

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17. *Coleman v. Martinez*, 247 N.J. 319, 332 (2021).

18. *Coleman v. Martinez*, 247 N.J. 319, 333 (2021).

19. *Coleman v. Martinez*, 247 N.J. 319, 337 (2021) (citing *Robinson v. Vivirito*, 217 N.J. 199, 208 (2014)).

> 1984)). Whether, in a given context, "a duty to exercise reasonable care to avoid the risk of harm to another exists is [a question] of fairness and policy that implicates many factors." *Carvalho v. Toll Bros. & Devs.*, 143 N.J. 565, 572 (1996).[20]

The Court explained "duty of care 'is a malleable concept that must of necessity adjust to the changing social relations and exigencies and man's relation to his fellows.'"[21] The court making this decision must consider "the foreseeability of harm to a potential plaintiff" and "whether accepted fairness and policy considerations support the imposition of a duty." The Court has adopted "a 4-prong test to make this determination, involving a consideration of the (1) relationship of the parties, (2) nature of the risk, (3) opportunity and ability to exercise care, and (4) public interest."[22]

The Court instructed that "foreseeability" may be based on actual constructive knowledge of a risk, and that "the defendant may be charged with knowledge if she is "in a position" to "discover the risk of harm."[23] Furthermore, Justice Solomon explained "When the risk of harm has been 'unreasonably enhanced,'" however, foreseeability does not require an identifiable victim or harm, but rather extends "to persons who fall normally and generally within a zone of risk created by the particular tortious conduct."[24]

The Supreme Court then turned to the case before it and applied the four-part test. The Court concluded the attack was foreseeable:

> The defendant was aware of T.E.'s prior acts of violence—both involving stabbing—the most recent of which had taken place just fourteen months prior to T.E.'s hospitalization. The defendant authored or received at least four accounts of

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20. *Coleman v. Martinez*, 247 N.J. 319, 337 (2021).

21. *Coleman v. Martinez*, 247 N.J. 319, 337 (2021) (citing *G.A.-H. v. K.G.G.*, 238 N.J. 401, 414-15 (2019)).

22. *Coleman v. Martinez*, 247 N.J. 319, 338 (2021) (citing *Hopkins v. Fox & Lazo Realtors*, 132 N.J. 426, 439 (1993)).

23. *Coleman v. Martinez*, 247 N.J. 319, 339 (2021).

24. *Coleman v. Martinez*, 247 N.J. 319, 340 (2021) (citing *Di Cosala v. Kay*, 91 N.J. 159, 175 (1982) and *Hill v. Yaskin*, 75 N.J. 139, 144-45 (1977)).

> T.E. experiencing hallucinations as reflected in the progress notes of April 1, July 2, and August 15 as well as the plaintiff's October 28 email. She had personally witnessed two of T.E.'s suspected auditory hallucinations. She further knew that T.E.'s last appointment with her psychiatrist predated both the August 15 incident and October 28 email. T.E. needed to refill her medication as of her final appointment with the defendant on November 7.[25]

The Court then turned to the public policy implications of the decision regarding the existence of a duty. "In considering whether the imposition of a duty is fair, we must 'bear in mind the broader implications that will flow from the imposition of a duty.'"[26] This requires consideration of the nature of the risk. In finding the defendant owed a duty to the plaintiff, the court observed: "The failure of a mental-health practitioner to exercise reasonable care may lead to serious physical harm to patients."[27] The court also concluded the "defendant had ample opportunity and ability to avoid the harm realized."[28] The Court therefore remanded the case for trial.

In concluding the Court stated: "[F]oreseeability in the proximate cause context relates to remoteness rather than the existence of a duty," *ibid.*, and generally, "[i]t suffices if [the cause] is a substantial contributing factor to the harm suffered . . . ."[29] The Court concluded by reiterating that "[proximate cause is generally a question for the jury, but courts may "reject the imposition of liability for highly extraordinary consequences."[30]

1-1:2 "Generally Accepted" and "Reasonably Prudent" Standards Distinguished

A significant distinction between the generally accepted standard of care and the reasonably prudent standard of care was explained

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25. *Coleman v. Martinez*, 247 N.J. 319, 350 (2021).
26. *Coleman v. Martinez*, 247 N.J. 319, 352 (2021).
27. *Coleman v. Martinez*, 247 N.J. 319, 353 (2021).
28. *Coleman v. Martinez*, 247 N.J. 319, 353 (2021).
29. *Coleman v. Martinez*, 247 N.J. 319, 355 (2021) (citing *Perez v. Wyeth Labs. Inc.*, 161 N.J. 1, 27 (1999)).
30. *Coleman v. Martinez*, 247 N.J. 319, 356 (2021).

in *Estate of Elkerson v. North Jersey Blood Center*.[31] In *Elkerson*, the plaintiff contended that her husband died of cirrhosis of the liver as the result of having received a blood transfusion contaminated with hepatitis. The transfusion was given in 1983, and the plaintiff's expert asserted that the defendant blood bank was negligent in failing to use the Hepatitis Core Antibody Test available at that time. The defendant blood bank asserted that it performed all of the tests that the majority of blood banks performed in 1983, and further that the majority of blood banks did not use the Hepatitis Core Antibody Test 1983.

> Plaintiff requested that the trial court instruct the jury that blood banks in New Jersey are required to take all measures and precautions which a reasonable and prudent blood banker would have taken at the time period referred to in this case, specifically, Spring of 1983.[32]

However, the trial court instructed that the blood bank need only comply with the "standard practice of blood banking in April 1983."[33] After a verdict in favor of the blood bank, the plaintiff argued that the trial court committed an error in charging professional negligence rather than ordinary negligence. Plaintiff contended that the charge given by the trial court virtually guaranteed a finding in favor of the blood bank because it had used the same tests that all blood banks used in 1983. The Appellate Division agreed and reversed, explaining that:

> [I]f the blood bank industry is allowed to establish its own custom or practice of testing for the presence of an infectious disease, then no matter how unreasonable such standard might be by ordinary judgment, all members of the blood bank industry would be insulated from liability as long as they conformed their practice to the industry's self-established norm. This result is not tolerable in our system of justice. The standard is not what test the average member of the blood

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31. *Estate of Elkerson v. N. Jersey Blood Ctr.*, 342 N.J. Super. 219 (App. Div. 2001).
32. *Estate of Elkerson v. N. Jersey Blood Ctr.*, 342 N.J. Super. 219, 228 (App. Div. 2001).
33. *Estate of Elkerson v. N. Jersey Blood Ctr.*, 342 N.J. Super. 219, 228 (App. Div. 2001).

> bank industry used to screen for the hepatitis B virus in 1983, but what test a reasonable blood bank should have used given reasonably available testing alternatives at the relevant time. Hence, 'when a risk is obvious and a precautionary measure available, an industry or professional standard or custom that does not call for such precaution is not conclusive, if, regardless of the standard or custom, the exercise of reasonable care would call for a higher standard.'[34]

The court therefore concluded that the charge given to the jury constituted reversible error because it did not permit the jury to reject the industry standard and apply the reasonably prudent standard of care. Given that a more effective test was available in 1983 to screen for hepatitis-tainted blood, the erroneous charge may have produced an unjust result, mandating a new trial. This logical argument would seem applicable to a wide variety of circumstances where an industry or professional standard is less demanding than a reasonably prudent standard of care.

1-1:3 Not All Deviations From the Standard of Care Constitute Malpractice

While all malpractice arises out of a deviation from the standard of care, at least one court has decided that not all deviations from the standard of care constitute actionable malpractice.

In *Zuidema v. Pedicono*,[35] the plaintiff alleged that the defendant physician forced her to perform a sexual act. The defendant denied engaging in any sexual relations with the plaintiff. The plaintiff asserted that the defendant committed an assault and battery, and did not present expert testimony regarding the standard of care. The trial judge nevertheless held that it was common knowledge that a physician should not engage in sexual activity with a patient.[36] The trial judge also instructed the jury that the

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34. *Estate of Elkerson v. N. Jersey Blood Ctr.*, 342 N.J. Super. 219, 230 (App. Div. 2001) (citing *Klimko v. Rose*, 84 N.J. 496, 506 n.4 (1980)).

35. *Zuidema v. Pedicono*, 373 N.J. Super. 135 (App. Div. 2004).

36. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 143 (App. Div. 2004).

New Jersey Administrative Code forbids physicians from engaging in sexual relations with patients, citing N.J.A.C. 13:35-6.3.

The jury, concluding that the plaintiff had consented to the sexual act, found that the plaintiff did not prove that the defendant committed an assault and battery, but that the defendant was "medically negligent."[37] The jury awarded $150,000 in damages to the plaintiff and her husband.[38] In reversing, the Appellate Division noted that a malpractice case must be based on a deviation from the standard of care.[39] However, the court explained, "the alleged sexual contact was neither related to or necessary for any actual medical service [the defendant] may have rendered."[40] As such, the plaintiff could not assert a claim for medical malpractice.

> A doctor's duty to refrain from sexual misconduct, a separate intentional act, does not give rise to a medical malpractice action, although other potential causes of action might exist. To conclude otherwise and allow a malpractice cause of action in such circumstances would essentially incorporate intentional sexual conduct as a part of a physician's professional service. And, as an intentional act, it generally would not be covered by professional malpractice insurance.[41]

The *Zuidema* court analogized a physician's intentional sexual relations with a patient to theft or false imprisonment by the physician:

> While these examples may be common knowledge of improper conduct by anyone, including a physician, or indeed any licensed professional, they are no different than the duties that every individual owes to others and not the performance of a professional service.[42]

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37. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 143 (App. Div. 2004).
38. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 144 (App. Div. 2004).
39. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 145 (App. Div. 2004).
40. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 145 (App. Div. 2004).
41. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 146 (App. Div. 2004) (citing *Princeton Ins. Co. v. Chunmuang*, 151 N.J. 80, 94-96 (1997)).
42. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 146 (App. Div. 2004).

The *Zuidema* court therefore concluded that the plaintiff's malpractice claim should have been dismissed.[43] The court explained:

> simply stated, sexual relations between a physician and patient are certainly not condoned, but [plaintiff] may not utilize a medical malpractice type theory to support a claim based on an intentional act independent of a physician's practice, or for a claim of sexual assault.[44]

If this is correct, then although consensual sexual activity between a doctor and patient may breach the standard of care, it is not malpractice because it is intentional.

The *Zuidema* court also held that it was error for the trial judge to charge the jury about the New Jersey Administrative Code 13:35-6.3(c), (d) and (i), prohibiting sexual activity between a physician and patient. The administrative code provides, *inter alia*, that participating in sexual activity with a patient "shall be deemed to constitute gross or repeated malpractice."[45] Nevertheless, the *Zuidema* court held that "although physicians generally owe a duty not to engage in sexual relations with their patients, such a duty is not part of any professional medical service."[46] The *Zuidema* court concluded that although sexual activity may be a crime or tort, "it does not constitute professional malpractice simply because it does not constitute a legitimate professional service and is not made a negligent act by the regulations."[47]

The *Zuidema* case equates a breach of the standard of care with negligence by the physician. In fact, a physician who engages in sexual activity with a patient intentionally, rather than negligently, deviates from the standard of care. Although the deviation is intentional, it nevertheless remains a deviation from the standard of care. To conclude otherwise would be to permit a psychiatrist to engage in consensual sexual relations with a patient, undeniably breaching

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43. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 146 (App. Div. 2004).
44. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 148-49 (App. Div. 2004).
45. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 150 (App. Div. 2004) (quoting N.J.A.C. 13:35-6.3(j)).
46. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 151 (App. Div. 2004).
47. *Zuidema v. Pedicono*, 373 N.J. Super. 135, 152 (App. Div. 2004).

the standard of care for that specialty, resulting in great harm to the patient, and nevertheless leave the patient without recourse. Although the psychiatrist may not be able to seek indemnification from an insurance policy that covers negligent acts, the patient should not be deprived of recourse, even if the deviation is the result of an intentional, rather than a negligent, act.

1-2 THE ROLE OF THE PHYSICIAN'S JUDGMENT

1-2:1 Physician's Exercise of Reasonable Judgment Is Not Malpractice

It is not malpractice for a physician to exercise reasonable judgment in choosing one of two or more generally accepted courses of action. The relationship between the generally accepted standard of care and the physician's exercise of reasonable judgment was perhaps first analyzed by the Supreme Court in *Schueler v. Strelinger*,[48] where the plaintiff's decedent consulted the defendant for various abdominal complaints and the defendant recommended an operation. The defendant had ordered a prothrombin test to determine the rate at which the patient's blood coagulated. The defendant determined that the coagulation rate was acceptable, but the patient bled profusely after the operation, resulting in her death. Plaintiff's expert testified that the prothrombin test revealed a deficient blood clotting rate and, therefore, a second prothrombin test should have been done before the operation to see if the blood clotting rate had returned to normal. He further testified that if the coagulation rate was deficient, the operation should not have been performed.

Despite this testimony, the Supreme Court held that the plaintiff did not create an issue of fact regarding the defendants' deviation from the standards of care. The Court closely examined the plaintiff's expert's testimony and observed that the expert conceded that if the patient's coagulation rate was normal, then the defendant did not commit malpractice. The Court further noted that the expert's opinion that the prothrombin rate was

48. *Schueler v. Strelinger*, 43 N.J. 330 (1964).

abnormal was contradicted by the testimony of all of the other doctors who were involved in the patient's care, including the patient's hematologist who testified that the prothrombin rate was "a borderline level and could be within normal limits."[49] Finally, the Court also noted that the patient had been cleared for surgery by her internist. The Supreme Court concluded that plaintiff's expert, who was only qualified as an expert in general and trauma surgery, could not establish the normal prothrombin rate and that he could not state that the patient's prothrombin rate was abnormal. As such, the foundation of the expert's opinion was undermined, and the opinion rendered useless. Therefore, the Court concluded that plaintiff's proof did not create an issue of fact as to whether the patient's coagulation rate was deficient.

> The alleged duty to recheck the prothrombin rate before the operation was predicated on the factual thesis that the first test showed an abnormality. Existence of such proof was the base on which the claim of malpractice rested. We are satisfied from the record before us that plaintiffs' medical proof was insufficient to raise a factual issue as to whether decedent's blood-coagulation rate was deficient or abnormal prior to the first operation. Under the circumstances it was error to allow the jury to determine whether Dr. Strelinger departed from standard medical practice in failing to have the second test made.[50]

However, in addition to determining that the expert's opinion lacked a foundation in fact, the Supreme Court observed that the defendant was confronted with a difficult choice, operate and risk the patient's death from the surgery, or do not operate and risk the patient's death from the underlying condition. The Court concluded that if each treatment option was consistent with an accepted standard of care, the physician could not be deemed negligent for choosing an acceptable option. The Court's holding in

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49. *Schueler v. Strelinger*, 43 N.J. 330, 342 (1964).
50. *Schueler v. Strelinger*, 43 N.J. 330, 344 (1964).

Schueler was incorporated almost verbatim into what was then the Civil Model Jury Charge:

> The law recognizes that medicine is not an exact science. Consequently it does not make the physician a guarantor of the cure of his patient. When he takes a case it imposes upon him the duty to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field. Failure to have and to use such skill and care toward the patient as a result of which injury or damage results constitutes negligence.
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> The fact that a good result may occur with poor treatment, and that good treatment will not necessarily prevent a poor result must be recognized. So, if the doctor has brought the requisite degree of care and skill to his patient, he is not liable simply because of failure to cure or for bad results that may follow. Nor in such case is he liable for an honest mistake in diagnosis or in judgment as to the course of treatment taken. A physician must be allowed a wide range in the reasonable exercise of judgment. He is not guilty of malpractice so long as he employs such judgment, and that judgment does not represent a departure from the requirements of accepted medical practice, or does not result in failure to do something accepted medical practice obligates him to do, or in the doing of something he should not do measured by the standard above stated . . . . Since there was no competent proof in this instance that the exercise of normal medical care required Dr. Strelinger to have another prothrombin test, application of the above principles called for withholding the question from jury consideration.[51]

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[51] *Schueler v. Strelinger*, 43 N.J. 330, 344-45 (1964).

A few examples of the application of the reasonable judgment doctrine help illustrate its meaning. In *Fernandez v. Baruch*,[52] plaintiff's administratrix ad prosequendum sued the defendants alleging, *inter alia*, that they negligently failed to inform the police of the harmful effects of the discontinuation of the medication that her husband was taking, and that as a result he committed suicide. However, plaintiff's expert conceded that "the amount of the drug to be used and the duration of its use were matters of professional judgment for the treating physician."[53] The Court therefore concluded that, as a matter of law, the defendants could not be deemed to have committed malpractice by allowing the drug to be discontinued.

The judgment defense was extended to diagnosis in *Walck v. Johns-Manville Products Corp*.[54] In *Walck*, plaintiff filed suit alleging that her husband's physicians improperly read a series of electrocardiograms over the nine years prior to her husband's death. Plaintiff's expert, a board certified internist, stated that seven of the 10 EKGs were abnormal. However, plaintiff's expert admitted that the vast majority of general practitioners would have called the EKGs normal, and in fact the defendant produced an expert who testified that the EKGs were normal. The Court held there was no evidence that the defendants were negligent and even had the physicians been

> mistaken in their diagnosis, as the autopsy seems to indicate, on the record presented here it was an honest error of judgment, and not the result of a negligent departure from medical practice standards.[55]

1-2:2 Evolution of the Judgment Charge

As stated above, the Court's holding in *Schueler* was incorporated almost verbatim into what was then the Civil Model Jury Charge. However, the *Schueler*-based version of the Model Jury Charge

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52. *Fernandez v. Baruch*, 52 N.J. 127 (1968).
53. *Fernandez v. Baruch*, 52 N.J. 127, 132 (1968).
54. *Walck v. Johns-Manville Prods. Corp.*, 56 N.J. 533 (1970).
55. *Walck v. Johns-Manville Prods. Corp.*, 56 N.J. 533, 564 (1970).

on judgment eventually came under criticism.[56] Plaintiffs were often able to persuade trial courts that the "reasonable mistake" language and the phrase "exercise of judgment" were confusing. In *Morlino v. Medical Center of Ocean County*,[57] a unanimous Supreme Court agreed and instructed the Civil Charge Committee to revise the Civil Model Jury Charge.

In *Morlino*, plaintiff, then eight and one-half months pregnant, went to the emergency room complaining of a sore throat. The emergency room physician prescribed an antibiotic, Ciprofloxacin. Prior to prescribing the antibiotic, he reviewed the Physicians' Desk Reference (PDR) which contained warnings against the use of Ciprofloxacin by pregnant women because it caused lameness in immature dogs and because the risk to the fetus had not been ruled out. The emergency room doctor concluded that the risks to the fetus by the untreated infection outweighed the risks associated with the Ciprofloxacin and prescribed the medication. Thereafter, the fetus died, and plaintiff sued the emergency room doctor claiming that the antibiotic caused the fetal demise.

The emergency room doctor testified that he weighed the potential benefits and risks of Ciprofloxacin as well as the risks posed by the infection, and exercised reasonable judgment in prescribing Ciprofloxacin instead of other antibiotics. The Supreme Court noted that the trial court's charge was "virtually identical to Civil Model Jury Charge 5.36A," (now Model Jury Charge 5.50A) that includes the following sentence that was underscored by the Court: "The physician cannot be held liable if, in the exercise of his judgment, he nevertheless made a mistake."[58] Recognizing that the role of judgment in medical practice was in issue, the Court explained why judgment plays an essential role in the practice of medicine:

> Having made a diagnosis, the doctor must decide whether and how to treat the patient. Doctors must select treatment options from an evolving body of scientific and medical information . . . . The choice may not be clear and alternatives may

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56. *See, e.g.,* Dorothy E. Bolinsky, *New Jersey's Medical Malpractice Model Jury Instruction: @#!$%*, Comprehensible to the Jury?* 28 Rutgers L.J. 261 (1996).

57. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563 (1998).

58. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563 (1998).

> abound, but choose the doctor must. In selecting among alternative treatments, however, the doctor must exercise his or her judgment and select from alternatives that are objectively reasonable. The selection of an alternative that is objectively unreasonable would violate the doctor's duty of care to the patient.
>
> . . . Not recognizing the role of judgment in making a diagnosis or in deciding on a course of treatment would be to deny an essential element in the practice of medicine. Accordingly, Model Charge 5.36A[59] rightly recognizes that a physician may exercise judgment when choosing among acceptable treatment alternatives.[60]

The Supreme Court rejected the argument that the use of the term "exercise of judgment" might confuse jurors. The Court distinguished several out-of-state cases that rejected similar, but not identical, jury charges using terms such as "good faith judgment," "bona fide judgment," and "honest mistake."[61] However, the Court held that the use of the word "mistake" in the charge should be eliminated:

> One sentence in the Model Charge is problematic. The sentence reads, 'The physician cannot be held liable if, in the exercise of his judgment, he nevertheless made a mistake.'
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> The purpose of the sentence is to advise the jury that, as between two or more courses of action,

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59. Note that Model Jury Charge 5.36A is now Model Jury Charge 5.50A.

60. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563, 583-84 (1998).

61. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563, 587-88 (1998). The Court explained:

> [T]erms such as 'good faith,' 'honest,' and 'bona fide,' could lead the jury to believe that, to find the defendant negligent, the plaintiff must prove bad faith, dishonesty, or fraud. Motivation, however, plays no part in determining negligence with regard to an objective standard of care. The physician's exercise of judgment is to be evaluated not on the basis of the physician's good faith or honesty, but solely on whether it falls below an objective standard of care. Civil Model Jury Charge 5.36A [now 5.50A] does not contain the language that the out-of-state cases found offensive, and, as a whole, correctly describes the relationship between judgment and the standard of care.

Morlino v. Med. Ctr. of Ocean Cty., 152 N.J. 563, 587-88 (1998).

> each of which accords with accepted medical practice, a doctor will not be found negligent if the course of action he or she chooses turns out to be unsuccessful. Taken out of context, the sentence could be understood to mean that a doctor who deviates from the relevant standard of care is not liable if the mistake was the result of the exercise of medical judgment. The danger is that the sentence could be construed to mean that an honest, but mistaken, exercise of judgment insulates the physician from liability for a mistake that violates a relevant standard of care. A mistake, however, connotes an instance in which the physician violates such a standard of care. Consequently, a physician who fails to abide by an objective standard of care is subject to liability even if the failure results from the exercise of judgment.[62]

The Court also noted that the Civil Model Jury Charge has been criticized for the repetitive use of the word "judgment," observing that it is used in the charge 11 times. Concluding that the Civil Model Jury Charge "may benefit from review," the Court remanded Model Charge 5.36A (now 5.50A) to the Supreme Court Committee on Civil Model Jury Charges. The Court instructed the committee to determine whether "fewer than eleven references" to the word judgment would adequately communicate the concept to the jury and instructed that the sentence involving the non-liability for an honest mistake should be eliminated. The Court also asked the committee to make the entire charge "shorter and clearer."[63]

The Civil Model Jury Charge Committee promptly responded to the *Morlino* Court's directive and revised Civil Model Jury Charge 5.36A (now 5.50A), Medical Negligence (3/02). See the Appendix for information on where to find the Model Jury Charge online.

The revised model jury charge was explicitly ratified by the Supreme Court in *Aiello v. Muhlenberg Regional Medical Center*,[64] where the Court, in a unanimous opinion, explained that the

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62. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563, 588-89 (1998).
63. *Morlino v. Med. Ctr. of Ocean Cty.*, 152 N.J. 563, 590 (1998).
64. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618 (1999).

judgment charge should only be utilized in limited circumstances. In *Aiello*, the plaintiff suffered injuries to multiple blood vessels during the performance of a laparoscopic tubal ligation. Plaintiff's expert testified that the defendant deviated from the standard of care because a surgical instrument was "thrust into the abdomen at a depth far beyond the operative area."[65] Defendant's expert countered that insertion of the instrument required the defendant to "exercise judgment in determining the proper angle and depth of insertion."[66] Plaintiff nevertheless requested that the trial court delete the judgment charge when instructing the jury, arguing that there was no "judgment call in this case."[67] The trial court denied the request but modified the charge to add that the "good faith exercise of judgment does not insulate a defendant from liability if he did not adhere to the standard of care."[68] Additionally, the jury was instructed to decide whether the defendant had sustained the burden of proof in establishing "there were two courses of action and the doctor chose one."[69] The jury found for the defendant, but the trial court granted a judgment notwithstanding the verdict and granted plaintiff's motion for a new trial on damages. The trial court determined that the injury to the blood vessels could not have occurred in the absence of negligence and that it had erred in utilizing the judgment charge. The Appellate Division, in an unreported decision, reversed and reinstated the jury verdict. The Supreme Court reversed and remanded for a new trial, and in so doing provided additional guidance regarding the proper use of the judgment charge in medical malpractice cases.

The *Aiello* Court quoted the revised Civil Model Jury Charge 5.36A (now 5.50A)[70] and began the analysis by revisiting *Schueler v. Strelinger*,[71] where the Court held that a physician is not liable for an "honest mistake" in diagnosis or in judgment. The *Aiello* Court observed that this language formed the basis of the prior version of the judgment charge found in Civil Model Jury Charge 5.36A

65. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 624 (1999).
66. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 624 (1999).
67. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 625 (1999).
68. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 625 (1999).
69. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 625 (1999).
70. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 628 n.1 (1999).
71. *Schueler v. Strelinger*, 43 N.J. 330, 344 (1964).

(now 5.50A). The court then considered limitations on the application of the jury charge.

1-2:3 Limitations on Applicability of the Judgment Charge

The Supreme Court in *Aiello* took note of several Appellate Division decisions that had "limited the application of the 'exercise of judgment' charge to medical malpractice actions concerning misdiagnosis or the selection of one of two or more generally accepted courses of treatment."[72] The *Aiello* Court approved the reasoning of these decisions and further explained why the trial courts must be careful to limit use of the judgment charge to cases that actually involve the exercise of judgment, and not the use of due care:

> If the exercise of judgment rule is inappropriately or erroneously applied in a case that involves only the exercise of reasonable care, the aspect of the rule that excuses a physician for "mistakes" would enable the physician to avoid responsibility for ordinary negligence. The "mistake" that inheres in negligence, that is, the failure to exercise reasonable care, is not the kind of mistake that is excusable. If, therefore, the physician's professional conduct implicates only the exercise of reasonable care in the performance of a medical procedure and not the exercise of medical judgment in selecting among acceptable and medically reasonable courses of treatment, the medical judgment rule should not be invoked . . . . In that context, it is error to instruct a jury to determine whether the defendant "exercised judgment" and may not be responsible for mistakes.[73]

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[72] *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 628-29 (1999) (citing *Patton v. Amblo*, 314 N.J. Super. 1, 9 (App. Div. 1998); *Crego v. Carp*, 295 N.J. Super. 565, 575-76 (App. Div. 1996); *Hofstrom v. Share*, 295 N.J. Super. 186, 195 (App. Div. 1996); and *Adams v. Cooper Hosp.*, 295 N.J. Super. 5, 8-9, 10-11 (App. Div. 1996).

[73] *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 632 (1999).

The *Aiello* Court explained that the judgment charge should not have been given in a case involving the performance of surgery because the case did not involve a physician's choice between alternative courses of treatment or of different procedures. "The experts disagreed only on whether defendant performed the selected procedure in a negligent manner. This testimony does not support the 'exercise of judgment' charge."[74] The Court rejected the defendant's expert's testimony that performance of the procedure required the exercise of judgment. The Court concluded by instructing that the revised Civil Model Jury Charge 5.36A (now 5.50A) "correctly conveys the precise use of the term 'judgment' in connection with the practice of medicine."[75]

The *Aiello* Court explicitly held that the judgment charge is to be "avoided" in cases involving the defendant's skill in performing a surgical procedure or the failure to exercise reasonable care in rendering treatment.[76] The Court quoted with approval footnote 4 to the revised Civil Model Jury Charge that states:

> If a case does not involve a legitimate judgment call or two schools of thought, then the Trial Judge should omit [the "exercise of judgment"] portion of the charge. If a case involves judgment issues on some theories of liability, but not on others, the charge should be tailored to those facts. Medical malpractice practitioners should assist the court in framing tailored, objective statements of those issues which do involve legitimate dispute issues of judgment or two schools of thought. To give one example among many, if a distinct issue in a case involves a doctor who ordered a test and never received the result, the jury would appropriately be charged that there was no exercise of judgment or two schools of thought defense to that claim. In contrast, what steps to take in response to a test

74. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 632 (1999).
75. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 633 (1999).
76. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 633 (1999).

result might involve one or more issues of judgment.[77]

Aiello confirms that the reasonable judgment charge should not be utilized except in those cases where the health care professional was confronted with what the court in *Adams v. Cooper Hospital* called a "*Hobson*'s choice," i.e., two or more possible courses of action that comply with the standard of care, each with benefits and risks.[78] For example, in *Morlino*, the physician was faced with the choice of various medications, all of which provided potential benefits, but all of which posed certain risks. In contrast, there was no "*Hobson*'s choice" in *Aiello* or *Adams*, where the issues were of surgical skill or whether the nurse provided appropriate monitoring. It logically follows that the reasonable judgment charge has no application in cases involving surgical mishaps or other scenarios where judgment is not involved, for example, where a plaintiff alleges that a defendant negligently performed a procedure or failed to monitor a patient. To the contrary, the judgment charge must be limited to those cases where the defendant proves that there are two or more treatment plans that comply with the standard of care, and judgment was actually used in weighing the benefits and risks presented by the alternative treatment plans.

Any lingering doubts about the limited application of the judgment charge were put to rest by *Velazquez v. Portadin*,[79] where the Court observed, "This case presents another chapter in the continuing saga of the medical judgment charge."[80] Ms. Velazquez was admitted to the hospital in labor and was placed on an external fetal monitor. A medication, Pitocin, was given, and shortly thereafter the fetal monitor strips began to become difficult to read. The fetal monitor strips for the last 15 minutes prior to delivery were missing, and the mother claimed that she was not monitored during that time period. The plaintiffs' child

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77. *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 633 (1999) (quoting Revised Model Jury Charge 5.36A at 5 n.4).

78. *Adams v. Cooper Hosp.*, 295 N.J. Super. 5, 9 (App. Div. 1996).

79. *Velazquez v. Portadin*, 163 N.J. 677 (2000).

80. *Velazquez v. Portadin*, 163 N.J. 677, 680 (2000).

had no heartbeat when born and was later diagnosed as suffering from cerebral palsy.

All of the experts agreed that the use of Pitocin was proper and that constant monitoring was necessary. The experts disagreed about "whether the strips were sufficiently readable to allow defendants to determine [the fetus'] reaction to the Pitocin induced contractions."[81] Plaintiffs' experts testified that when the strips became unreadable, the defendants should have discontinued the Pitocin until the fetal monitor strip was reassuring or applied an internal fetal monitor to obtain a more accurate reading. The defendants' experts agreed that if the strips were unreadable, the Pitocin should have been stopped but both of the defendants' experts testified that the strips were readable and that any unreadable portions were followed by readable and reassuring tracings.

The trial court, over plaintiff's objection, gave the judgment charge, and the jury found for the defendants. The Appellate Division affirmed, only mentioning the judgment charge in passing.[82] The Supreme Court reversed and focused on the judgment charge:

> We agree with plaintiffs that the trial court's failure to untangle the facts in relation to the medical judgment charge left the jury free to excuse defendants based on the evidence of judgment in areas where no judgment was exercised. Because that error was not harmless, a new trial is necessary.[83]

The Supreme Court took note of the difficulty in the application of the judgment charge.

> [O]ur courts have often struggled in determining whether the facts of a particular case call for the application of the judgment charge. We have generally limited the application of the judgment charge to medical malpractice actions concerning

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81. *Velazquez v. Portadin*, 163 N.J. 677, 682-83 (2000).

82. *Velazquez v. Portadin*, 321 N.J. Super. 558, 585 (App. Div. 1999), *rev'd*, 163 N.J. 677 (2000).

83. *Velazquez v. Portadin*, 163 N.J. 677, 685 (2000).

> misdiagnosis or the selection of one of two or more generally accepted courses of treatment.[84]

The *Velazquez* Court re-emphasized that the judgment charge should be "limited to cases in which the physician exercised judgment in selecting among acceptable courses of action."[85] The Court instructed that:

> [A] trial court must not only administer the exercise of judgment charge solely in cases where the charge is appropriate, but it must also separate out those aspects of the medical care that involved judgment and those that did not . . . The failure to do so constitutes reversible error where the jury outcome might have been different had the jury been instructed correctly.[86]

This determination is essential because the inappropriate or erroneous application of the judgment charge might "enable the physician to avoid responsibility for ordinary negligence."[87] The *Velazquez* Court observed that "the point is driven home in a footnote to the most recent Model Charge," which it had quoted in *Aiello*, and which it again quoted.[88] The Court therefore reversed, observing that the trial court "failed to tailor the charge to the theories and facts presented."[89]

The *Velazquez* Court explained that since all experts agreed that monitoring was required, failure to do so was a deviation from the standard of care. The Court noted that whether the fetal monitor strips were readable did not involve medical judgment and that the judgment charge was thus inapplicable to that allegation of negligence. The Court further held that if the strips were readable,

> the issue was whether they revealed fetal distress. If there was no fetal distress, no action was required.

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84. *Velazquez v. Portadin*, 163 N.J. 677, 687 (2000) (citing *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618 (1999), *Patton v. Amblo*, 314 N.J. Super. 1 (App. Div. 1998), and *Adams v. Cooper Hosp.*, 295 N.J. Super. 5 (App. Div. 1996)).

85. *Velazquez v. Portadin*, 163 N.J. 677, 687 (2000).

86. *Velazquez v. Portadin*, 163 N.J. 677, 688 (2000).

87. *Velazquez v. Portadin*, 163 N.J. 677, 688 (2000).

88. *Velazquez v. Portadin*, 163 N.J. 677, 688-89 (2000) (quoting Model Jury Charge 5.36A (now 5.50A) n.4).

89. *Velazquez v. Portadin*, 163 N.J. 677, 689 (2000).

> If fetal distress was evident, the issue was whether continuing the Pitocin without remedying that distress comported with the standard of care. Again, no judgment was required.[90]

In concluding, the Court explained:

> [T]he bulk of this case implicated the question of deviation from the standard of care, not judgment. The able defense lawyers, knowing the power of the judgment charge, took every opportunity to lead the court and jury into thinking that the entire case revolved around the exercise of judgment. It did not. Although one or possibly a few judgment issues may have been implicated, the heart of the case was about whether there was a deviation from the standard of care. The undifferentiated instruction on medical judgment misled the jury and thus improperly insulated the defendants from liability.
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> . . . .
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> Because the judgment charge was not tailored to the facts of this case, its coverage was overbroad and had the potential to improperly insulate defendants from liability. Accordingly, a new trial is required.[91]

Velazquez requires trial courts to analyze the testimony and theories "in detail" and "on the record,"[92] to determine whether the reasonable judgment charge is applicable and, if so, to which issues. Thus, it is now clear that the defendants must specify which decisions constituted the exercise of medical judgment and support, with expert testimony, the contention that there were two generally accepted schools of medical thought as to each decision.

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90. *Velazquez v. Portadin*, 163 N.J. 677, 688-89 (2000).
91. *Velazquez v. Portadin*, 163 N.J. 677, 689-90 (2000).
92. *Velazquez v. Portadin*, 163 N.J. 677, 690 (2000).

1-2:4 Specific Cases Addressing the Judgment Charge

Subsequent to *Velazquez*, the Supreme Court reiterated that the jury charge must be carefully crafted in cases where a defendant claims the benefit of the medical judgment charge. In *Das v. Thani*,[93] the defendant relied upon a practice known as "maternal fetal monitoring," where the mother-to-be counts the number of times she feels the fetus move during a specific time frame, instead of utilizing modern technology such as ultrasonography, electronic fetal monitoring, and biophysical profiling to monitor the health of the fetus. The plaintiff was unable to detect any fetal movement during the 39th week of her pregnancy, and went to the hospital, where her child was born by a caesarean section. The plaintiff's child died four days later. The plaintiff's expert testified that the failure to use modern methods to monitor the fetus deviated from the standard of care and described the defendant's conduct as "1960's medicine."[94] The plaintiff's expert specifically criticized the failure to use modern methods of monitoring the pregnancy after it was discovered that the plaintiff was diabetic, and after the defendant prescribed insulin during the 32nd week of pregnancy.[95] The defendant contended that the choice of fetal monitoring was an appropriate use of medical judgment. The jury found for the defendant and the Appellate Division affirmed, but the Supreme Court remanded for reconsideration in light of *Velazquez v. Portadin*.[96] On remand, the Appellate Division again affirmed and the Supreme Court then reversed.

The *Das* Court first instructed that medical judgment generally involves "misdiagnosis or the selection of one of two or more generally accepted courses of treatment."[97] The Court then observed that plaintiff's expert had testified that the failure to use modern methods to monitor the fetus constituted a deviation from the standard of care. In contrast, the defendant's expert testified that the defendant complied with the standard of care and that it was a matter of judgment as to which techniques to use. The

93. *Das v. Thani*, 171 N.J. 518 (2002).
94. *Das v. Thani*, 171 N.J. 518, 522 (2002).
95. *Das v. Thani*, 171 N.J. 518, 522 (2002).
96. *Velazquez v. Portadin*, 163 N.J. 677 (2000).
97. *Das v. Thani*, 171 N.J. 518, 527 (2002).

Court explained that in such circumstances the defendant has the burden of proving that each course of treatment "must be an 'equally acceptable approach' in order not to be considered a deviation from the appropriate standard of care."[98] The Supreme Court again warned that if a medical judgment charge is given in a case that only involves the exercise of reasonable care, a physician might improperly be permitted to "avoid responsibility for 'ordinary negligence.'"[99]

The *Das* Court re-emphasized that the trial court and counsel must analyze the evidence "in detail" and "on the record" to determine whether the judgment charge should be applied and, if so, the charge must then be specifically tailored to the facts of the case.[100] The *Das* Court concluded that a reversal was mandated by the fact that the trial court did not adapt the jury charge to the "theories and facts" of the case.[101]

> [T]he jury should have been instructed that in order for defendant to prevail based on the exercise of medical judgment, the jury had to find that maternal fetal monitoring represented an equally acceptable approach to the other, more modern alternatives. The jury instructions must incorporate the evidence and the legal theories of liability and make clear that medical "judgment does not represent a departure from the requirements of accepted medical practice."[102]

Because the jury was not properly instructed, the jury may have excused the defendant's actions by using a "lesser standard" such as "good faith."[103] The failure to so instruct the jury mandated a reversal.

Additionally, the *Das* Court recalled that in *Velazquez* it had instructed the Civil Model Jury Charge Committee to revise the

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98. *Das v. Thani*, 171 N.J. 518, 528 (2002) (citing *Velazquez v. Portadin*, 163 N.J. 677, 690 (2000)).

99. *Das v. Thani*, 171 N.J. 518, 528 (2002) (citing *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618 (1999)).

100. *Das v. Thani*, 171 N.J. 518, 528 (2002).

101. *Das v. Thani*, 171 N.J. 518, 528 (2002).

102. *Das v. Thani*, 171 N.J. 518, 529 (2002) (citations omitted).

103. *Das v. Thani*, 171 N.J. 518, 529 (2002).

Model Jury Charge. The Civil Jury Charge Committee did so promptly, and the *Das* Court explicitly approved the revised Model Civil Jury Charge.[104] See the Appendix for how to find the revised charge, Model Jury Charge 5.36G, Medical Judgment (Extracted from 5.36A, 2/01; revised 3/02) (now 5.50G) online.

The Appellate Division reiterated that the judgment defense is primarily applicable to cases involving the failure to make a correct diagnosis or the choice of one of two or more accepted courses of treatment, and that the failure to give the jury a judgment charge when applicable is reversible error in *Schectman v. Bransfield*.[105] In *Schectman*, the plaintiff sued the defendant, a psychiatrist, alleging that the defendant negligently failed to monitor the plaintiff's medications and deteriorating mental status. The plaintiff further alleged that as a result, the plaintiff attempted suicide leaving him with severe injuries when he survived.[106] The jury found for the plaintiff, and the defendant appealed, contending that the trial court erred by not giving the judgment charge.

The plaintiff's expert opined that defendant deviated from the standard of care by failing to "appropriately monitor, supervise and assess the patient's clinical condition over a period of time when that condition was clearly deteriorating."[107] The expert further testified that the plaintiff's condition was deteriorating, and the standard of care required that the plaintiff be seen at least once a week. The expert concluded that it was foreseeable that the plaintiff might harm himself given his deteriorating condition. The defendant and his medical experts opined that there is no standard of care requiring that a psychiatrist evaluate a patient "at any certain interval" and that the decision is best "left to the physician's judgment."[108] The defendant's expert further opined that defendant had "totally

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104. *Das v. Thani*, 171 N.J. 518, 528 (2002).

105. *Schectman v. Bransfield*, 403 N.J. Super. 487 (App. Div. 2008).

106. *Schectman v. Bransfield*, 403 N.J. Super. 487, 491 (App. Div. 2008). The plaintiff had a decades-long history of mental illness. The defendant began treating the plaintiff in 1991, when the plaintiff had complaints of depression, and had a history of chronic mental illness. In October 2000, the defendant instructed the plaintiff to stop taking one medication and start another medication. The plaintiff attempted to commit suicide a month later. *Schectman v. Bransfield*, 403 N.J. Super. 487, 490-91 (App. Div. 2008).

107. *Schectman v. Bransfield*, 403 N.J. Super. 487, 494 (App. Div. 2008).

108. *Schectman v. Bransfield*, 403 N.J. Super. 487, 497 (App. Div. 2008).

complied" with the applicable standard of care.[109] Nevertheless, the trial court refused the defense request for a judgment charge. The jury awarded damages, finding that: 1) the defendant deviated from the standard of care between June 2000 and November 2000, 2) the deviation was a proximate cause of plaintiff's suicide attempt, and 3) the plaintiff was not negligent.

In reversing, the Appellate Division first reiterated that the "judgment charge is generally limited to medical malpractice actions concerning misdiagnosis or the selection of one of two or more generally accepted courses of treatment."[110] The court then observed that the plaintiff's expert initially opined that the standard of care in the case required "very close monitoring and supervision," and that defendant should have seen the plaintiff "on a weekly basis, if not more frequently."[111] However, on cross-examination, the plaintiff's expert conceded that the timing of visits is a "medical decision, and that's a decision that the doctor makes."[112] Furthermore, the defendant and his expert both testified that the manner in which a psychiatrist monitors a patient is a matter of medical judgment. Thus, "there was sufficient evidence in this case of two schools of medical treatment."[113] The failure to give the jury the judgment charge was reversible error, and the case was remanded for trial.

Those researching this issue may also wish to review *Patton v. Amblo*,[114] where plaintiff's stomach was traumatically ruptured during performance of a laparoscopic tubal ligation. Plaintiff's expert testified that the defendant made the initial incision too deep. The defendant conceded she made the initial incision too deep but her experts argued that this was a risk of the procedure and was not negligence.[115] The trial judge gave the Civil Model Jury Charge in existence at the time on reasonable medical judgment, and read it again when the jury had a question. The jury

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109. *Schectman v. Bransfield*, 403 N.J. Super. 487, 495 (App. Div. 2008).

110. *Schectman v. Bransfield*, 403 N.J. Super. 487, 498 (App. Div. 2008) (citing *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 159 N.J. 618, 628-29 (1999)).

111. *Schectman v. Bransfield*, 403 N.J. Super. 487, 498-99 (App. Div. 2008).

112. *Schectman v. Bransfield*, 403 N.J. Super. 487, 499 (App. Div. 2008).

113. *Schectman v. Bransfield*, 403 N.J. Super. 487, 500 (App. Div. 2008).

114. *Patton v. Amblo*, 314 N.J. Super. 1 (App. Div. 1998).

115. *Patton v. Amblo*, 314 N.J. Super. 1, 6 (App. Div. 1998).

found for the defendant. The Appellate Division reversed, noting that the judgment charge should not have been given in this case.[116]

The court rejected the defendant's argument that she chose from accepted options in performing the surgery. "Defendant's error dealt with the skill in which she performed the surgery."[117] The court explained:

> Even if we accept defendant's admission that she made her initial incision too deep, it is clear that she did not employ any judgment when she was incising the skin. It was not her intention to pierce all three layers of skin. Regardless of the method in which she performed the incision, either by elevating the skin prior to the initial incision or by simply holding the skin taut, she simply cut too deep. She did not use her judgment to determine the depth. If she had, she would have incised only the first two layers of skin. Her incision of the peritoneum was a mistake and cannot be considered an exercise of judgment.[118]

The judgment in favor of the defendant was therefore reversed by the appellate court.

Similarly, in *Gilmartin v. Weinreb*,[119] the plaintiff sued after her husband died from an overdose of Colchicine, which had been prescribed by the defendant to treat the decedent's multiple sclerosis. The drug is toxic when administered in excess of recommended doses, however, and the decedent had been injected with between two and four times the maximum safe dose. Plaintiff settled with the physician who administered the overdose and continued

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116. *Patton v. Amblo*, 314 N.J. Super. 1, 8-9 (App. Div. 1998). The court explained:

> The charge is only appropriate, however, in instances where a surgeon selects one of two courses, "either one of which has substantial support as proper practice by the medical profession." *Schueler v. Strelinger*, 43 N.J. 330, 346 (1964). *See Adams v. Cooper Hospital*, 295 N.J. Super. 5, 8 (App. Div. 1996) (determining that the judgment rule did not apply to a nurse who exercised no judgment when she failed to monitor a patient for thirty minutes; the issue was only whether the nurse had a duty to constantly monitor the patient, not whether she used her judgment in timing the monitoring), *certif. denied*, 148 N.J. 463 (1997).

Patton v. Amblo, 314 N.J. Super. 1, 8-9 (App. Div. 1998).

117. *Patton v. Amblo*, 314 N.J. Super. 1, 8-9 (App. Div. 1998).

118. *Patton v. Amblo*, 314 N.J. Super. 1, 9 (App. Div. 1998).

119. *Gilmartin v. Weinreb*, 324 N.J. Super. 367 (App. Div. 1999).

the case against another doctor who prescribed the medication, alleging that this defendant should have recommended immediate hospitalization when the plaintiff called with symptoms of the overdose. The defendant testified that he initially suspected an overdose but, after considering all of the factors, rejected that diagnosis. The trial court utilized the old Civil Model Jury Charge 5.36A (now 5.50A), that was in effect when the case was tried in March 1998, and that contained the following sentence: "The physician cannot be held liable if, in the exercise of his judgment, he nevertheless made a mistake." The jury found that this defendant was not negligent. The Appellate Division observed that in *Morlino* the Supreme Court rejected the old Civil Model Jury Charge and instructed the Civil Model Jury Charge Committee to revise the Civil Model Jury Charge to eliminate that sentence. The Appellate Division held that use of the old Civil Model Jury Charge required a reversal and remanded for a new trial.[120]

The judgment charge was held inapplicable in *Adams v. Cooper Hospital*,[121] where plaintiff had been hospitalized after a motor vehicle accident, and had a tracheal tube inserted. The defendant, a nurse, was ordered to watch the plaintiff and suction the mucus from his throat. The court noted that the nurse left plaintiff unattended for thirty minutes and that:

> During that time, plaintiff began to choke on mucous accumulated at the tracheal tube. Unable to speak, he attempted to use a bedside call button designed to summon a nurse. His effort to do so led to his falling out of bed. The defendant and the trauma doctor found plaintiff lying on the floor surrounded by his urine and fecal matter. Subsequent suctioning of plaintiff's throat, according to the trauma doctor, brought out a 'copious' amount

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120. *Gilmartin v. Weinreb*, 324 N.J. Super. 367, 385 (App. Div. 1999). The court explained:
> In the present case, we conclude that in the face of compelling evidence of Dr. Weinreb's deviation the 'mistake sentence' had the capacity to confuse the jury and tip the scales in defendant's favor. Additionally, the jury instruction regarding a physician's judgment was given in the abstract without an attempt to relate the principles of law to the evidence in the case.

Gilmartin v. Weinreb, 324 N.J. Super. 367, 385 (App. Div. 1999).

121. *Adams v. Cooper Hosp.*, 295 N.J. Super. 5 (App. Div. 1996).

> of mucous. Plaintiff sustained a comminuted fracture of his left hip and a head trauma as the result of the fall.[122]

The trial court refused to instruct the jury that the defendant nurse had a right to exercise judgment as to how frequently to suction the patient's throat, and "refused defendants' request to instruct that a medical professional must be allowed a wide range in the reasonable exercise of judgment as to the course of treatment taken."[123] The jury determined that the nurse was negligent and awarded plaintiff $1,660,000. In affirming, the Appellate Division noted:

> The medical judgment rule does not apply to all medical malpractice actions. *Schueler* set its parameters. '[W]hen a surgeon selects one of two courses . . . either one of which has substantial support as proper practice by the medical profession, a claim of malpractice cannot be predicated solely on the course pursued.' . . . The *Schueler* Court emphasized that, when a matter exists 'about which there are differing schools of medical opinion . . . the plain inference is that the matter must be left to the good faith judgment of the experienced attending surgeon.' The Court relied on this principle to absolve the defendant doctor of liability because he chose between two medically confirmed alternatives. Those alternatives were to operate quickly and risk the patient's bleeding to death because of a blood-clotting problem or to take additional time to improve the blood's clotting and risk the spread of her possible cancer. These *Hobson*'s choice circumstances induced the Court's reversal of a judgment against the doctor. Here, no such choicelessness existed.[124]

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122. *Adams v. Cooper Hosp.*, 295 N.J. Super. 5, 10 (App. Div. 1996).
123. *Adams v. Cooper Hosp.*, 295 N.J. Super. 5, 8 (App. Div. 1996).
124. *Adams v. Cooper Hosp.*, 295 N.J. Super. 5, 8-9 (App. Div. 1996).

The use of the judgment charge was affirmed in *Saks v. Ng*,[125] where the plaintiff alleged that the defendant used retrobulbar anesthesia during the operation, rather than the alternative of peribulbar anesthesia. On cross-examination, the plaintiff's expert conceded that "he had no criticism of Ng's decision to use retrobulbar anesthesia" and that "the choice of the type of anesthesia is a matter of medical judgment."[126] The defendant testified that "peribulbar anesthesia was not appropriate for Saks' surgery" because the surgery is "very delicate." "The patient must achieve 'total akinesia,' that is, no movement in the eye muscle."[127] The defendant's expert testified that the operation could not have been performed using peribulbar anesthesia. After the jury found for the defendant, the plaintiffs contended on appeal that the trial court erred in instructing the jury on medical judgment, as per Model Jury Charge (Civil) 5.36G (now 5.50G) "Medical Judgment" (03/02). The plaintiffs argued that the judgment charge should not have been given because the defendant "did not consider and weigh the alternatives between retrobulbar and peribulbar anesthesia."[128] The court quickly disposed of that argument:

> Here, Ng testified that because Saks' procedure was long and complicated, he was not an appropriate candidate for peribulbar anesthesia. Kazan agreed the retrobublar anesthesia was an inappropriate form of anesthesia for Saks' surgery. Soloway admitted that the choice of anesthesia is a matter of medical judgment. In view of this evidence, Ng clearly was entitled to the judgment charge.[129]

The Appellate Division also rejected the plaintiff's claim that the trial court did not specifically "separate out those aspects of the medical care that involved judgment and those that did not."[130]

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125. *Saks v. Ng*, 383 N.J. Super. 76 (App. Div. 2006).

126. *Saks v. Ng*, 383 N.J. Super. 76, 86 (App. Div. 2006).

127. *Saks v. Ng*, 383 N.J. Super. 76, 86 (App. Div. 2006).

128. *Saks v. Ng*, 383 N.J. Super. 76, 85 (App. Div. 2006).

129. *Saks v. Ng*, 383 N.J. Super. 76, 96 (App. Div. 2006).

130. *Saks v. Ng*, 383 N.J. Super. 76, 96-97 (App. Div. 2006) (citing *Velazquez v. Portadin*, 163 N.J. 677, 688 (2000) and *Patton v. Amblo*, 314 N.J. Super. 1, 8-9 (App. Div. 1998)). The court explained:

> The record makes plain that the issue of medical judgment in this case is related to Ng's choice of anesthesia. The judge instructed the jury to focus on whether

1-2:5 Need for Informed Consent Charge When Judgment Charge Is Given

Finally, in most cases involving a defendant's claim of the exercise of reasonable judgment, the court must also give an informed choice or consent charge. Simply stated, where the physician contends that there were two or more reasonable alternative treatment options, it is generally the right of the patient to be informed of the benefits and risks of each treatment option and to choose the treatment to be pursued. A detailed discussion of the relationship between the physician's judgment and informed choice and consent is available in Chapter 2.[131]

1-3 PERSONAL STANDARDS DO NOT ESTABLISH THE STANDARD OF CARE

An expert witness must testify that the physician deviated from a "generally accepted standard of care," not the standard personal to the expert. In *Fernandez v. Baruch*,[132] plaintiff claimed that the defendants failed to institutionalize her husband when he was at risk for harming himself, negligently allowed him to be placed in the custody of the police and negligently failed to inform the police of the risks posed by the discontinuation of his medication. The Supreme Court held that the defendants should have been granted summary judgment because the plaintiff's expert did not express generally accepted medical standards but rather testified only as to his personal opinion. The Court explained:

> We think that the testimony of the plaintiff's expert fell short of establishing a medical

> 'standard medical practice allowed judgment to be exercised as to diagnosis and treatment alternatives.' . . . We are convinced that, when viewed in its entirety, and considered in light of the totality of evidence presented at trial, the medical judgment charge was properly focused on the choice between the peribulbar and retrobulbar anesthesia. In the particular circumstances of this case, the jury could not have been confused or misled into believing that the judgment charge applied to something other than the choice of anesthesia. We therefore are satisfied that the charge was properly tailored to the evidence in this case.

Saks v. Ng, 383 N.J. Super. 76, 96-97 (App. Div. 2006) (citing *Velazquez v. Portadin*, 163 N.J. 677, 688 (2000) and *Patton v. Amblo*, 314 N.J. Super. 1, 8-9 (App. Div. 1998)); *see also Colucci v. Oppenheim*, 326 N.J. Super. 166 (App. Div. 1999) (use of the judgment charge requires a fact-sensitive analysis of the proofs developed at trial).

131. *See Matthies v. Mastromonaco*, 310 N.J. Super. 572 (App. Div. 1998), *aff'd*, 160 N.J. 26 (1999).

132. *Fernandez v. Baruch*, 52 N.J. 127 (1968).

> standard pertaining to the relationship of homicidal and suicidal tendencies and thus the issue should not be considered by a jury. The plaintiff's medical expert did not purport to express accepted medical standards. He prefaced his testimony on the inter-reaction between homicidal and suicidal drives by the statement, 'it is my opinion,' and did not say that his view represented the view generally accepted in the profession. Of course, much more than the personal opinion of a medical witness is necessary to establish a standard of accepted medical practice. The expert testimony must relate to generally accepted medical standards, not merely to standards personal to the witness. See *Carbone v. Warburton*, 11 *N.J.* 418, 425, 94 *A.2d* 680 (1953). See also, *Schueler v. Strelinger*, 43 *N.J.* 330, 346, 204 *A.2d* 577 (1964). Here, the plaintiff failed to produce evidence upon which the jury could find that the consensus of medical opinion required that the defendant doctors envision a suicide potential solely because a mentally ill patient had exhibited violent tendencies toward others.[133]

A similar conclusion is found in *Sesselman v. Muhlenberg Hospital*,[134] where plaintiff alleged that she sustained dental injuries during the administration of anesthesia. In holding that the plaintiff's expert improperly testified as to his personal opinion, the court stated:

> A medical expert testifying in a malpractice case is limited to the recitation of his understanding as to what comprises the standards in the profession, rather than a statement as to his feelings as to what are legal bases for a physician's responsibility. An expert witness should distinguish between what he knows as an expert and what he may believe as a

[133] *Fernandez v. Baruch*, 52 N.J. 127, 131 (1968).

[134] *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285 (App. Div. 1973).

> layman. It is not his function to instruct as to the law or to be the ultimate trier of the facts which is a role of the judge and jury respectively. The fact trier may be misled if an expert goes beyond that which he can contribute as an expert.[135]

Similar reasoning is found in *Ziemba v. Riverview Medical Center*,[136] where plaintiff brought suit against the defendants alleging violations of the Involuntary Commitment Act.[137] In *Ziemba*, plaintiff, after having a marital dispute, reported to several friends that he was having suicidal thoughts. Fearing he was going to commit suicide, plaintiff's friends called the police who stopped the plaintiff's vehicle and transported him to the hospital. While at the hospital, plaintiff was evaluated by an emergency room physician, a psychiatric nurse, and then a psychiatrist. The psychiatrist concluded that plaintiff was a danger to himself and should be involuntarily committed for a period of seven days. The plaintiff thereafter brought suit alleging that he was improperly committed. The Appellate Division rejected the opinions of plaintiff's expert because the expert "failed to identify any applicable standard of care or state that such standard was violated by any of these defendants."[138] The court noted that although the plaintiff's expert stated the quality of care at the hospital was "inadequate," the expert did not state that any of the defendants deviated from the standard of care. Moreover, plaintiff's expert did not assert that the hospital failed to meet a standard of care accepted in the medical field, but rather merely asserted "a personal opinion as to the inadequacy of care."[139] The court therefore reversed and remanded for an entry of judgment in favor of the defendants.

However, in *Nguyen v. Tama*,[140] plaintiff alleged that an obstetrician improperly managed her labor and delivery and failed to treat preeclampsia. The defendant appealed a verdict for the plaintiff, arguing that the plaintiff's expert testified as to his

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135. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285, 289-90 (App. Div. 1973).
136. *Ziemba v. Riverview Med. Ctr.*, 275 N.J. Super. 293 (App. Div. 1994).
137. N.J.S.A. 30:4-27.
138. *Ziemba v. Riverview Med. Ctr.*, 275 N.J. Super. 293, 302 (App. Div. 1994).
139. *Ziemba v. Riverview Med. Ctr.*, 275 N.J. Super. 293, 303 (App. Div. 1994).
140. *Nguyen v. Tama*, 298 N.J. Super. 41 (App. Div. 1997).

personal opinion and did not testify as to the generally accepted standard of medical practice. The court rejected this argument, stating:

> This witness was a professor at two major medical schools which aided him in knowing what he thought was a minimum standard. The standard to which [plaintiff's expert] testified comported with the textbook with which he was cross-examined. Even the defense expert acknowledged the same standard in his testimony. Therefore, contrary to defendant's assertion that the testimony of [the expert] was completely subjective, [the expert] testified to the proper standard.[141]

Nguyen is consistent with prior cases that hold that although the expert must identify the standard of care that was breached by the defendant, and cannot testify as to a standard of care personal to the expert, the expert is not required to produce a treatise or other documentary evidence of the standard of care to support his opinion.

For example, in *Bellardini v. Krikorian*,[142] plaintiff alleged that the defendant negligently prescribed certain drugs to plaintiff's mother while his mother was pregnant. Plaintiff alleged that the ingestion of these drugs caused severe birth defects. During his deposition, plaintiff's expert could not cite specific medical literature establishing the standard of care regarding prescribing drugs to women of childbearing age. Defendant moved to bar the testimony of plaintiff's expert, arguing it was a net opinion.[143] The trial court barred the plaintiff's expert from testifying since he did not provide "evidential support" for his opinion.[144] The Appellate Division reversed, explaining:

> Obviously, the support for such expert opinion can be based on what the witness has learned from personal experience or from persons with adequate training and experience.

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141. *Nguyen v. Tama*, 298 N.J. Super. 41, 49 (App. Div. 1997).
142. *Bellardini v. Krikorian*, 222 N.J. Super. 457 (App. Div. 1988).
143. *See* Chapter 7, § 7-10 regarding the net opinion rule.
144. *Bellardini v. Krikorian*, 222 N.J. Super. 457, 461 (App. Div. 1988).

> . . . The requisite knowledge can be based on either knowledge, training or experience. Obviously the expertise of a witness may be based on knowledge or experience acquired over a period of years.[145]

The court explicitly concluded that "the expert is not required to produce a treatise to support his opinion."[146] These issues are discussed further in Chapter 7 under the qualification of the expert and the requirements of expert testimony.

1-4 DUTIES OF SPECIFIC MEDICAL PROVIDERS

1-4:1 Duty of Examining or Consulting Physician Acting for Third Party

1-4:1.1 General Duty of Care

A medical professional who examines someone for the benefit of a third party may nevertheless owe a duty of care to the person being examined. The issue arose in *Beadling v. Sirotta*,[147] where plaintiff was asked to take a pre-employment physical examination that included a chest X-ray. The physician who took the X-ray reported to the prospective employer that the plaintiff had "active reinfection pulmonary tuberculosis."[148] Plaintiff was not offered a job. He then consulted his own physicians and was hospitalized for eleven days and confined to home for six weeks while waiting for the results of various tests. Thereafter, plaintiff's treating doctor stated plaintiff had recovered from a "questionable active pulmonary tuberculosis."[149] Plaintiff sued the examining doctor alleging that the defendant negligently diagnosed tuberculosis when in fact this condition did not exist. After a judgment was entered for the plaintiff, the defendant appealed, contending that there was no physician-patient relationship and therefore that

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145. *Bellardini v. Krikorian*, 222 N.J. Super. 457, 462-63 (App. Div. 1988).
146. *Bellardini v. Krikorian*, 222 N.J. Super. 457, 463 (App. Div. 1988).
147. *Beadling v. Sirotta*, 41 N.J. 555 (1964).
148. *Beadling v. Sirotta*, 41 N.J. 555, 558 (1964).
149. *Beadling v. Sirotta*, 41 N.J. 555, 560 (1964).

he had no duty to the plaintiff. The Supreme Court rejected this argument, holding that an examining physician owes the examinee a duty of reasonable care.[150]

There are many reasons to support this conclusion, and the Court noted that one such reason is that the public good is best served by discovering those who may endanger the health of their co-workers or the public. However, the Court held that the duty of a doctor performing a pre-employment physical "is clearly not coextensive with the duty owed to a private patient who seeks from the doctor a report as to the status of his health."[151] Ultimately, the Court decided not to define the scope of the duty in such circumstances:

> On the facts of the present case we need not decide the scope of the duty owed to such examinees, for even assuming a duty was owed to the plaintiff to examine and report with reasonable care, we find no evidence of its breach.[152]

In another case involving a third-party examination, *Ryans v. Lowell*,[153] plaintiff brought suit against a psychiatrist who examined plaintiff at the request of the New Jersey Commission for the Blind and Visually Impaired. The Commission told plaintiff that it would only continue benefits if plaintiff complied with certain conditions, some of which were recommended by defendant. Plaintiff did not comply with the conditions imposed by the Commission and his benefits were terminated. Plaintiff then sued the examining psychiatrist, asserting that the doctor negligently

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150. *Beadling v. Sirotta*, 41 N.J. 555, 561 (1964). The Court explained:

> On this appeal Dr. Sirotta first contends that there was no physician-patient relationship between him and the plaintiff but that his contract with Langston merely required him to observe the condition of the plaintiff's chest and report to Langston facts bearing on his employability. Accordingly, he argues that no duty to the plaintiff was breached by his fulfillment of that contract. Whether or not a physician-patient relationship exists, within the full meaning of that term, we believe that a physician in the exercise of his profession examining a person at the request of an employer owes that person a duty of reasonable care . . . . It is clear that the doctor cannot negligently burn him by overexposure to X-ray during the examination without incurring liability.

Beadling v. Sirotta, 41 N.J. 555, 561 (1964).

151. *Beadling v. Sirotta*, 41 N.J. 555, 561 (1964).

152. *Beadling v. Sirotta*, 41 N.J. 555, 561-62 (1964).

153. *Ryans v. Lowell*, 197 N.J. Super. 266 (App. Div. 1984).

examined him. The psychiatrist's motion for summary judgment was granted and, in affirming, the Appellate Division noted that a medical malpractice claim generally arises out of breach of the duties created by the physician-patient relationship.[154]

The court acknowledged that even in a non-traditional physician-patient relationship, a doctor examining a person at the request of an employer still owes that person a duty of reasonable care.[155] However, the *Ryans* court noted that plaintiff must first establish that the defendant violated a duty owed to the plaintiff, and the court concluded that defendant did not owe a duty to plaintiff:

> In the present case the duty of defendant was to the Commission, not plaintiff . . . .
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> . . . .
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> Here, the Commission in the administration of its services to prospective clients is certainly entitled to the advice and guidance, not only of its own staff, but outside experts and consultants as well to determine the continuance of benefits to clients. Just as in *Beadling v. Sirotta, supra*, where the duty of the defendant doctor was limited to the needs of the employer for whom he examined plaintiff as a condition of employment, . . . the duty of the defendant in these proceedings is limited to the Commission, and is not owed to plaintiff.[156]

The same conclusion is found in *Delbridge v. Schaeffer*,[157] where plaintiff brought malpractice claims against medical professionals who examined plaintiff's children, resulting in their placement in a foster care home by the Division of Youth and Family Services. The court held that the medical professionals could not be liable to the plaintiff since they owed no duty of care to the plaintiff.[158] Furthermore, any medical examinations performed on behalf of

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154. *Ryans v. Lowell*, 197 N.J. Super. 266, 273 (App. Div. 1984).

155. *Ryans v. Lowell*, 197 N.J. Super. 266, 274 (App. Div. 1984) (citing *Beadling v. Sirotta*, 41 N.J. 555, 561 (1964)).

156. *Ryans v. Lowell*, 197 N.J. Super. 266, 276-77 (App. Div. 1984).

157. *Delbridge v. Schaeffer*, 238 N.J. Super. 323 (Law Div. 1989).

158. *Delbridge v. Schaeffer*, 238 N.J. Super. 323, 366 (Law Div. 1989).

the Division of Youth and Family Services could not be the basis of a claim for malpractice pursuant to N.J.S.A. 59:6-4, that provides immunities to public employees who perform certain examinations of a person's physical or mental condition.[159]

However, in *Ranier v. Frieman*,[160] the Appellate Division held that a physician examining a person for the Department of Labor, Division of Disability Determinations, could be liable for breaching the duty to exercise reasonable professional care in rendering a diagnosis. In *Ranier*, plaintiff could no longer perform his job assembling electronic equipment due to problems with his eyesight. Plaintiff applied for disability benefits and the Division of Disability Determinations referred plaintiff to an ophthalmologist. The doctor advised the department that he found no ocular abnormalities and concluded that there was the possibility of malingering.[161] Based upon the doctor's report, the disability claim was rejected. Plaintiff then saw his own ophthalmologist who ordered an MRI of the brain that revealed a large tumor in the optic chasm.

Plaintiff sued several physicians, including the ophthalmologist retained by the Division of Disability Determinations, alleging that they negligently failed to diagnose the tumor. The ophthalmologist moved for and was granted summary judgment, but the Appellate Division granted plaintiff's motion for leave to appeal and reversed. The court first noted that the ophthalmologist asserted that he did not owe any duty to the plaintiff, and contended that "this rather startling legal proposition is supported by and is consistent with *Beadling v. Sirotta* . . . ."[162]

The *Ranier* court disagreed, stating, "We are, however, persuaded that defendant both misreads and overreads *Beadling*."[163] The court based its decision on the fact that in *Beadling* the examination was made for a third-party, an employer, whereas in *Ranier* the investigation was made at "the behest of a governmental agency needing to know what, if anything, is wrong with the examinee in order to properly process a disability claim."[164] The court

159. *Delbridge v. Schaeffer*, 238 N.J. Super. 323, 365 (Law Div. 1989).
160. *Ranier v. Frieman*, 294 N.J. Super. 182 (App. Div. 1996).
161. *Ranier v. Frieman*, 294 N.J. Super. 182, 186 (App. Div. 1996).
162. *Ranier v. Frieman*, 294 N.J. Super. 182, 187 (App. Div. 1996).
163. *Ranier v. Frieman*, 294 N.J. Super. 182, 187 (App. Div. 1996).
164. *Ranier v. Frieman*, 294 N.J. Super. 182, 187 (App. Div. 1996).

explained that the decision in *Beadling* was grounded in the absence of a "traditional professional relationship between physician and patient."[165] However, the *Ranier* court explained that after *Beadling* was decided, the New Jersey Supreme Court extended the duty of care in a number of situations that lack "privity" between the parties. The *Ranier* court then noted that the liability of a professional had been extended, not only to the patient but also to those "third-parties who will foreseeably and reasonably rely on his skill and care in the performance of a particular professional undertaking."[166]

The court concluded that there was no public policy against requiring a physician performing an examination for a public entity to make a competent diagnosis. The court contrasted the case with *Beadling*, where the interests of the employer and the prospective employee were at odds, explaining, "Here, to the contrary, the interests of the Division and the examinee are considerably more congruent."[167] The court cautioned:

> We add these caveats. We do not intend to impose upon the examining physician the same scope of duty as is owed to the traditional patient. We address only the specific professional function undertaken by the examining physician. We simply hold that when an examinee presents himself with specific complaints that are the occasion for the third-party reference for the examination, the examining physician owes the examinee the duty of examining and diagnosing the examinee in the same professional manner and with the same professional skill and care as would be employed in

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165. *Ranier v. Frieman*, 294 N.J. Super. 182, 188 (App. Div. 1996).

166. *Ranier v. Frieman*, 294 N.J. Super. 182, 189 (App. Div. 1996). Since the determination of the existence of duty is a question of law for the court, it must decide as a matter of law:

> [S]imply whether, as a matter of fairness and policy and considering the other relevant determinants of the existence of a duty, the Division's examining physician had a duty to the examinee as well as to the Division to make a professionally reasonable and competent diagnosis. We have no doubt that the answer to this question must be affirmative.

Ranier v. Frieman, 294 N.J. Super. 182, 189 (App. Div. 1996).

167. *Ranier v. Frieman*, 294 N.J. Super. 182, 190 (App. Div. 1996).

> examining and diagnosing a 'traditional patient' with those complaints. Indeed, we would think that a physician's professional and ethical obligations imposed by the license to practice would demand no less.[168]

The defendant in *Ranier* also contended that *Beadling* limited the liability of a physician in performing a third-party examination to cases where the physician injures the patient, such as in providing too much radiation while performing an X-ray. The court rejected that argument, stating:

> First, *Beadling* itself does not suggest that affirmative infliction of injury is the sole possible deviation from reasonable care in the absence of a full and traditional physician-patient relationship. Rather, we read *Beadling* to hold that the substantive content of reasonable care in the third-party situation is dependent upon relevant negligence principles applied consistently with appropriate public policy concerns.[169]

Thus, the issue is whether the interests of the patient and the entity requesting the examination are the same. In the case of a worker's compensation examination, or an examination for a personal injury protection carrier, the interests coincide and the physician owes the patient the "skill and care as would be employed in examining and diagnosing the 'traditional patient.'"[170] In contrast, a lesser duty is owed where the examination is at the request of, for example, the Division of Youth and Family Services, that may have interests that are divergent from those of the patient.

1-4:1.2 Duty to Report Findings to Patient

1-4:1.2a Duty of Examining Physician

The duty of the examining physician was reexamined in *Reed v. Bojarski*,[171] where the Supreme Court analyzed the duty of a

168. *Ranier v. Frieman*, 294 N.J. Super. 182, 192 (App. Div. 1996).
169. *Ranier v. Frieman*, 294 N.J. Super. 182, 188 (App. Div. 1996).
170. *Ranier v. Frieman*, 294 N.J. Super. 182, 192 (App. Div. 1996).
171. *Reed v. Bojarski*, 166 N.J. 89 (2001).

physician who performs a pre-employment examination to disclose to the patient the discovery of a potentially dangerous medical condition. In *Reed*, the plaintiff was required by his employer to undergo a pre-employment physical and was referred to the defendant, Dr. Bojarski, for the examination. Another physician, a radiologist, read a chest X-ray taken of the plaintiff, and advised Dr. Bojarski that plaintiff had a widened mediastinum, that may be a symptom of lymphoma or Hodgkin's disease. Dr. Bojarski reported the abnormal X-ray to the overseeing entity, EMR. However, he did not convey the radiologist's recommendation of a follow up CT scan to the plaintiff or to EMR. The plaintiff was advised by a doctor employed by EMR that he was in "good health." Seven months later, the plaintiff was admitted to the hospital, where a chest X-ray disclosed a large mass in the mediastinum. Plaintiff was diagnosed with Hodgkin's disease and died eight months later at the age of 28. His wife brought suit on behalf of her husband's estate. The radiologist was granted summary judgment; EMR settled, and plaintiff went to trial against Dr. Bojarski and Dr. Bojarski's employer, Life Care Institute, Inc.

Plaintiff's expert testified that Dr. Bojarski had an obligation to convey the results of the abnormal X-ray to the patient and to do further testing. The defendant's expert testified that Dr. Bojarski was merely obligated to report to EMR. The trial court charged the jury, in relevant part:

> You must make the determination of whether Dr. Bojarski took reasonable steps to inform the plaintiff, Mr. Reed, of any findings under the facts of this case. In other words, you must determine whether it was reasonable for Dr. Bojarski to forward the materials concerning Mr. Reed to EMR and rely upon EMR's contractual obligation to review the materials and inform Mr. Reed of any adverse findings. If you find that it was reasonable for Dr. Bojarski to expect EMR to do that, then you may not find Dr. Bojarski negligent. On the other hand, if you find that Dr. Bojarski acted unreasonably in relying on EMR to inform the patient of findings, and in not informing EMR or the plaintiff of [the radiologist's] findings,

> including her letter to him diagnosing a widened mediastinum, you must determine Dr. Bojarski's conduct to have been negligent.[172]

The jury determined Dr. Bojarski had not deviated from the standard of care. Plaintiff appealed and the Appellate Division affirmed but the Supreme Court reversed, observing that "New Jersey has long recognized that a physician owes a duty of reasonable care to the nontraditional patient in the context of a third-party examination."[173]

The Supreme Court adopted the analysis of *Ranier*, holding:

> In short, under *Ranier*, when a person is referred to a physician for a pre-employment physical, a physician-patient relationship is created at least to the extent of the examination, and a duty to perform a professionally reasonable and competent examination exists. A professionally unreasonable examination that is detrimental to the examinee is not immunized from liability because a third-party authorized or paid for the exam. Included within the notion of a reasonable and competent examination is the need to 'take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee's physical or mental well being.' *Ranier v. Frieman, supra*, 294 N.J. Super. at 191 . . . .
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> We fully subscribe to that articulation of the duty of a physician performing a pre-employment physical examination under contract to a third party.[174]

The *Reed* Court explained that the existence of duty is "ultimately a question of fairness," and that in this circumstance it is

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172. *Reed v. Bojarski*, 166 N.J. 89, 95 (2001).

173. *Reed v. Bojarski*, 166 N.J. 89, 103 (2001) (citing *Beadling v. Sirotta*, 41 N.J. 555 (1964); *Ranier v. Frieman*, 294 N.J. Super. 182 (App. Div. 1996)).

174. *Reed v. Bojarski*, 166 N.J. 89, 105-06 (2001).

not unfair to impose the duty of disclosure upon the examining physician.[175]

The *Reed* Court also held that any contract purporting to delegate the duty to communicate an abnormal finding, or attempting to "insulate" the physician from liability in such a case violates public policy.[176] The Court relied on N.J.A.C. 13:35-6.5(f), noting that the Administrative Code "describes our public policy regarding the scope and extent of the duty a physician owes to a person he or she examines,"[177] and that this Administrative Code provision provides "*that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment*."[178]

The Supreme Court also cited the American Medical Association's counsel on Ethical and Judicial Affairs, Opinion E-10.03, that states: "The physician has a responsibility to inform the patient about important examination abnormalities that he or she discovers during the course of the examination."[179] The *Reed* Court concluded by observing:

> There is nothing earth shaking about those principles. Indeed we believe them to fall squarely within our established jurisprudence as exemplified by the seminal decision in *Beadling*, and the more

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175. *Reed v. Bojarski*, 166 N.J. 89, 105-06 (2001). The Court added:

> Although the pre-employment physical clearly does not establish a traditional physician-patient relationship, that is of no moment. The exact nature of the relationship is simply a factor to be considered in determining what duty exists. What is crucial is that a relationship is created in which a physician is expected to exercise reasonable care commensurate with his expertise and training, both in conducting the examination and in communicating the results to the examinee. Concomitantly, the patient is entitled to rely on the physician to tell him of a potential serious illness if it is discovered. Any reasonable person would expect that and the duty to communicate with a patient who is found to be ill is non-delegable. When the doctor who ascertains the abnormality communicates it directly to the patient, he or she has the best chance of obtaining prompt remedial care and the best hope of avoiding falling through the cracks of a multi-party system. To the extent that a contract purports to insulate the examining physician from liability for breaching the duty to communicate abnormalities found in a pre-employment exam, it violates the basic public policy of New Jersey, along with common law notions of duty embodied in our case law.

Reed v. Bojarski, 166 N.J. 89, 106 (2001).

176. *Reed v. Bojarski*, 166 N.J. 89, 106 (2001).

177. *Reed v. Bojarski*, 166 N.J. 89, 106 (2001).

178. *Reed v. Bojarski*, 166 N.J. 89, 107 (2001) (emphasis in original).

179. *Reed v. Bojarski*, 166 N.J. 89, 108 (2001).

> extensive analysis in *Ranier*, and to accord with the fundamental notions of duty embodied in our jurisprudence and in the developing caselaw across the country.[180]

However, the Court in a footnote stated that nothing in the opinion should be viewed as requiring pathologists or radiologists to convey test results directly to the patient.[181]

The duty of a consulting physician to disclose test results was also at issue in *Sinclair v. Roth*.[182] In *Sinclair,* the plaintiff's decedent was referred by the decedent's personal physician to the defendant, a consulting cardiologist, for the performance of a stress test. The defendant interpreted the stress test as "within normal limits."[183] The plaintiff's decedent died eleven days after the stress test was done, and the plaintiff alleged the defendant was negligent in interpreting the stress test. The plaintiff requested that the trial court instruct the jury that the defendant had a duty to inform the decedent of his findings and that this duty was not satisfied by merely sending a report to the referring personal physician. The trial court declined to give such a charge and the jury found that the defendant did not deviate from the standard of care. The Appellate Division affirmed, concluding that the defendant did not have a duty to communicate the results of the test directly to the patient.[184] The *Sinclair* panel found nothing in *Reed v. Bojarski*[185] that obligated such direct communication. Furthermore, the *Sinclair* panel observed that the defendant thought the results of the stress test were normal and so reported to the primary care physician. Therefore, "Defendant's alleged negligence essentially went to his evaluation of Sinclair's condition. Additional communication would have had no impact if their contents were wrong."[186] The *Sinclair* Court therefore affirmed the decision below.

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180. *Reed v. Bojarski*, 166 N.J. 89, 109 (2001).
181. *Reed v. Bojarski*, 166 N.J. 89, 109 n.1 (2001).
182. *Sinclair v. Roth*, 356 N.J. Super. 4 (App. Div. 2002).
183. *Sinclair v. Roth*, 356 N.J. Super. 4, 7 (App. Div. 2002).
184. *Sinclair v. Roth*, 356 N.J. Super. 4, 14-15 (App. Div. 2002).
185. *Reed v. Bojarski*, 166 N.J. 89 (2001).
186. *Sinclair v. Roth*, 356 N.J. Super. 4, 15 (App. Div. 2002).

1-4:1.2b Duty of Consulting Physician Not Examining Patient

A consulting physician also owes the patient a duty of care, even where the doctor never examines or treats the patient. In *Jenoff v. Gleason*,[187] the patient was hospitalized for wrist surgery. The hospital policy required that a routine X-ray examination be performed prior to any operation. Two X-rays of the patient's chest were taken, and a radiologist diagnosed a "possible bronchogenic neoplasm (a lung tumor)."[188] However, the radiologist did not advise the treating physicians of his findings other than by preparing a written report that was placed in the hospital chart after the patient had been discharged. The orthopedic surgeon reviewed the wrist X-rays, but did not see the chest X-rays and signed a discharge summary stating that the chest X-ray was unremarkable. Approximately two months later, the patient's hospital records were reviewed by a nurse on behalf of the patient's worker's compensation carrier and she notified patient's treating physicians of the existence of the tumor. Thereafter, the diagnosis was made and treatment rendered, but the patient died. The patient and then her estate pursued a malpractice action against the plaintiff's family doctor, the radiologist, and the orthopedic surgeon. At the end of the trial, the court dismissed the claim as to the radiologist due to the absence of expert testimony regarding any deviation from the standard of care as to the radiologist.

The Appellate Division reversed, holding that as a matter of law:

> [C]ommunication of an unusual finding in an X-ray so that it may be beneficially utilized, is as important as the finding itself. The fact that a physician may be an indirect provider of medical care is but one relevant circumstance. In some situations, indirect service may provide justification for the absence of direct communication with the patient, but that does not in any way justify failure of communication with the primary care physician.[189]

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187. *Jenoff v. Gleason*, 215 N.J. Super. 349 (App. Div. 1987).
188. *Jenoff v. Gleason*, 215 N.J. Super. 349, 353 (App. Div. 1987).
189. *Jenoff v. Gleason*, 215 N.J. Super. 349, 357 (App. Div. 1987).

The *Jenoff* court even suggested that since the duty is imposed by law, the plaintiff need not present expert testimony on the issue:

> Modes of communication are not so peculiarly within the expertise and knowledge of the medical profession as to necessitate expert testimony. The manner of communication is not so complex and technical that it should escape the comprehension of a lay jury . . . . The trier of facts should be permitted to pass on the issue of the adequacy of the radiologist's communication.[190]

1-4:1.2c Duty of Third Party to Disclose Test Results

The duty of an insurance company to disclose abnormal test results was analyzed in *Nolan v. First Colony Life Insurance Co*.[191] In *Nolan*, the plaintiff's decedent underwent blood testing as part of an insurance examination. The blood work revealed abnormal liver enzymes, but the plaintiff's decedent was not informed of the test result. The plaintiff learned of the prior abnormal liver enzyme test result after the plaintiff's decedent discovered that he had liver cancer. The plaintiff asserted that the insurance company had breached its duty to inform the decedent of the abnormal test result. The plaintiff contended that the abnormal liver enzyme tests would have provided early warning of the liver cancer that ultimately took the decedent's life. Nevertheless, the trial court dismissed the case, and the Appellate Division affirmed. The *Nolan* court concluded that only a physician would have a duty to warn in similar circumstances. The court distinguished *Reed v. Bojarski*,[192] noting that *Reed* involved a physician, while in *Nolan* no doctor ever reviewed the laboratory findings.[193] The *Nolan* panel also relied on *Beadling*, and *Ranier*, to support its conclusion that the duty to warn is limited to a physician.[194] Finally, the *Nolan* court observed that, pursuant to N.J.S.A. 17:23A-13.1, an insurance company

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190. *Jenoff v. Gleason*, 215 N.J. Super. 349, 357 (App. Div. 1987).

191. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142 (App. Div. 2001).

192. *Reed v. Bojarski*, 166 N.J. 89 (2001).

193. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142, 149-50 (App. Div. 2001) (citing *Reed v. Bojarski*, 166 N.J. 89, 106 (2001)).

194. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142, 151 (App. Div. 2001).

is only obligated to disclose communicable diseases discovered during an examination.[195]

In a concurring opinion, Judge Kestin disagreed with the conclusions of the majority as to the meaning of *Reed*.[196] However, Judge Kestin concluded that the plaintiff did not make any showing that disclosure of the test results "would probably have resulted in discovery of the condition that, if promptly treated, would have forestalled or prevented the decedent's death."[197] Thus, Judge Kestin concurred in the dismissal.

1-4:1.3 Duty to Persons Other Than Patient

Finally, it should be noted that a medical professional may also owe certain duties to persons other than the patient.[198]

1-4:2 Duty of a Specialist

A physician who claims to be a specialist must comply with a higher standard of care and provide a higher level of skill or knowledge. This concept was explained in *Lewis v. Read*,[199] which held:

> [O]ne who holds himself out as a specialist must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ

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195. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142, 152 (App. Div. 2001).

196. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142, 155-58 (App. Div. 2001) (Kestin, J. concurring).

197. *Nolan v. First Colony Life Ins. Co.*, 345 N.J. Super. 142, 158 (App. Div. 2001) (Kestin, J. concurring).

See also N.J.A.C. 13:35-6.5(f)(3), which provides that:

> should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

See also P.T. v. Richard Hall Cmty. Mental Health Care Ctr., 364 N.J. Super. 460 (App. Div. 2003). In *P.T.*, the plaintiffs attempted to assert a malpractice claim against a court-appointed psychologist arising out of child custody proceedings. The trial court, relying on *Delbridge v. Schaeffer*, 238 N.J. Super. 323 (Law Div. 1989), granted summary judgment to the court-appointed psychologist. The Appellate Division affirmed, holding that a treating psychologist owes no duty of care to a parent who was accused of sexual abuse and, further, that the record disclosed no evidence that anything done by the treating psychologist was the proximate cause of any injuries. *P.T. v. Richard Hall Cmty. Mental Health Care Ctr.*, 364 N.J. Super. 460, 462 (App. Div. 2003).

198. *See* discussion in §§ 1-8:3, 1-8:4 and 1.9.

199. *Lewis v. Read*, 80 N.J. Super. 148 (App. Div. 1963).

> or disease or injury involved, having regard to the present state of scientific knowledge.[200]

This concept has been incorporated in Civil Model Jury Charge 5.50A.

The line between a general practitioner and specialist is not always clear. In *Liguori v. Elmann*,[201] the trial court created a hybrid charge to deal with such a circumstance. In *Liguori*, the plaintiff's mother underwent quadruple coronary artery bypass surgery performed by the defendant Dr. Elmann, a cardiovascular and thoracic surgeon. During the operation Dr. Elmann was assisted by the defendant Dr. Hunter, who was a cardiac surgery fellow. Soon after the operation, the plaintiff's mother developed a pneumothorax. Doctors Elmann and Hunter were in the middle of another operation, and Dr. Elmann instructed Dr. Hunter to assess Mrs. Liguori's status and, if necessary, to insert a chest tube. The court noted that Dr. Elmann "testified that he warned Hunter to be careful because Mrs. Liguori had an enlarged heart."[202]

After examining Mrs. Liguori, Dr. Hunter decided to insert a chest tube to relieve the air pressure in the patient's chest. The court observed that "Hunter testified that he knew Mrs. Liguori's heart was enlarged and that he took precautions to avoid injuring it."[203] Dr. Hunter testified that he was "totally satisfied that the tube was functioning [and] that the problem was relieved. There was no evidence of bleeding and the blood pressure was stable."[204] Soon thereafter, the patient was noted to have substantial bleeding. Dr. Elmann had another doctor, Dr. Praeger, a board-certified cardiothoracic surgeon, examine the patient, and Dr. Praeger "discovered a hole in the left ventricle of her heart, which he repaired. He noted that the hole was related to the insertion of the chest tube and advised Dr. Elmann of Mrs. Liguori's status."[205] Approximately one month after the operation another doctor told

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200. *Lewis v. Read*, 80 N.J. Super. 148, 171 (App. Div. 1963) (quoting *Carbone v. Warburton*, 22 N.J. Super. 5, 9 (App. Div. 1952), which was approvingly quoted by the Supreme Court in *Carbone v. Warburton*, 11 N.J. 418 (1953)).

201. *Liguori v. Elmann*, 191 N.J. 527 (2007).

202. *Liguori v. Elmann*, 191 N.J. 527, 532 (2007).

203. *Liguori v. Elmann*, 191 N.J. 527, 533 (2007).

204. *Liguori v. Elmann*, 191 N.J. 527, 533 (2007).

205. *Liguori v. Elmann*, 191 N.J. 527, 534 (2007).

the patient's daughter that her mother's heart had been lacerated during insertion of a chest tube, and that her mother "had sustained a significant amount of bleeding."[206] The patient's children immediately transferred their mother to another hospital, however, "Mrs. Liguori suffered from a series of 'cascading complications,' resulting in her death from septic shock in February 2000."[207]

The plaintiffs contended that Dr. Hunter should be held to "the standard of care applicable to a specialist in the field of surgery because the procedure he performed was, in fact, a surgical procedure."[208] The trial judge—noting that Dr. Hunter was not a surgeon but only an "assistant cardiac surgeon or an assistant cardiac thoracic surgeon fellow," and further that "all of the experts agreed that even a resident would be permitted to insert a chest tube"—instructed the jury that Dr. Hunter should be held to the standard of care of a general practitioner rather than a specialist.[209] The jury ruled for the defendants on all claims, deciding that Dr. Hunter did not "deviate from the accepted standard of medical practice in the insertion of the chest tube."[210]

The court began the analysis of the status of Dr. Hunter by observing that after completion of medical school, Dr. Hunter entered a two-year surgical residency program. After completing the surgical residency program, he completed a third year of residency, and then began working as a "surgery house officer" at a hospital. His duties included assisting in the operating and emergency rooms and caring for patients after surgery. These duties required that he evaluate patients and insert chest tubes. The court then noted that Dr. Hunter began inserting chest tubes as a resident and he was qualified to independently place chest tubes by the second year of his residency. Dr. Hunter began to work at the Hackensack University Medical Center as a cardiac surgery assistant/fellow eight years before the surgery in question. His duties included assisting with cardiac surgery, and "performing any procedures that are required either on an emergent or

206. *Liguori v. Elmann*, 191 N.J. 527, 536 (2007).
207. *Liguori v. Elmann*, 191 N.J. 527, 537 (2007).
208. *Liguori v. Elmann*, 191 N.J. 527, 541 (2007).
209. *Liguori v. Elmann*, 191 N.J. 527, 542 (2007).
210. *Liguori v. Elmann*, 191 N.J. 527, 537 (2007).

non-emergent or elective basis."[211] By 1999, Dr. Hunter had been inserting chest tubes for approximately 13 years, and he estimated that he had "inserted between 100 and 200 chest tubes."[212] Based upon this analysis, the Appellate Division affirmed the dismissal, with a dissent on the issue involving the jury instructions as to Dr. Hunter.

In affirming, the Supreme Court first reviewed the model jury charge on the standard of care. Model Jury Charge (Civil) 5.36A (now 5.50A), Medical Negligence, explains that "to decide this case properly you must know the standard of care . . . against which the defendant's conduct as a [member of that profession] should be measured." The Court then observed that this portion of the Model Charge is "followed by two options, namely, option a, the instructions concerning specialists, and option b, the instructions concerning general practitioners."[213] Both options advise that a defendant is to be judged "against others of like skill, training and knowledge."[214] The Court then explained that:

> Ordinarily, it is apparent whether a particular physician is a specialist or a general practitioner and the decision about which of these options to choose is not contested . . . . This case is perhaps an unusual one, in that Hunter had a position with HUMC that is not itself a recognized specialty, but that might appear, by the description of the role he played and the training he had, to encompass more skill and knowledge than that possessed by a general practitioner.[215]

In affirming the jury charge employed by the trial court, the Supreme Court ratified the decision of the trial court:

> Although Hunter was a doctor who had some training in surgery and was capable of performing some surgical procedures, he plainly was not a surgeon. Faced with this circumstance, the trial

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211. *Liguori v. Elmann*, 191 N.J. 527, 540 (2007).
212. *Liguori v. Elmann*, 191 N.J. 527, 540 (2007).
213. *Liguori v. Elmann*, 191 N.J. 527, 543 (2007).
214. *Liguori v. Elmann*, 191 N.J. 527, 543 (2007).
215. *Liguori v. Elmann*, 191 N.J. 527, 544 (2007).

> judge concluded that Hunter would be held only to the standard of care of a general practitioner. Nevertheless, in charging the jury at trial, he referred to Hunter as a general practitioner and used the general practitioner option, but then, in fact, crafted a hybrid charge. He did so by also stating that Hunter is an assistant cardiac surgeon or assistant cardiac thoracic fellow and by charging the jury that "to decide this case properly, you must know the standard of care [applicable to an] assistant cardiac surgeon or assistant cardiac thoracic surgeon fellow."[216]

The Supreme Court deemed significant the undisputed trial testimony that a resident could insert a chest tube, and thus it was "not a procedure reserved for specialists."[217]

> Rather, the debate was about whether Hunter performed the procedure as he said he did, in compliance with the applicable standard of care, or whether he deviated from that standard, directly causing the injury to Mrs. Liguori's heart. The jury was not misled about that debate nor were they misinformed by the judge's reference to Hunter's job description during the charge. Therefore, the trial judge's effort to span what he perceived to be a gap in the model charge by referring to Hunter's job title, while not entirely in keeping with the model charge, nonetheless did not result in error.[218]

As such, *Liguori* clearly supports the conclusion that the Model Jury Charge's bifurcation of all medical practitioners into "general practitioners" and "specialists" must yield to the modern day realities of multiple levels of expertise and training, and the jury charge must be adjusted on a case-by-case basis to accommodate this reality.

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216. *Liguori v. Elmann*, 191 N.J. 527, 544 (2007).
217. *Liguori v. Elmann*, 191 N.J. 527, 544 (2007).
218. *Liguori v. Elmann*, 191 N.J. 527, 545 (2007).

1-4:3 Standard of Care for Hospital Resident Physician

Hospital residents are generally to be held to the standard of care of a general practitioner, although a hybrid charge may be warranted, depending on the circumstances of the case. In *Clark v. University Hospital/UMDNJ*,[219] the plaintiff's decedent was injured in an accident and came under the care of the defendants, who were residents at the University Hospital. The plaintiff alleged that these residents failed to properly drain the contents from the decedent's stomach, "causing him to choke to death on his own vomit during a period of at least four minutes."[220] The trial court, without objection, charged the jury that "the defendants were both residents training for their medical specialties, but for purposes of this case are considered to be general practitioners in medicine" and that defendants were required to "employ [the] knowledge and skill normally possessed by the average physician practicing his or her profession as a general practitioner."[221] The jury awarded the decedent's widow $2 million for her husband's pain and suffering and $1 million for the wrongful death.

On appeal, the defendants contended that the trial judge "erred when he instructed the jury that the conduct of defendant residents should be judged against a standard applicable to general practitioners."[222] The defendants asserted that a resident "must be judged by the standard particular to that resident at that particular point in his or her training."[223] The Appellate Division affirmed, relying upon N.J.S.A. 45:9-1 to 9-58 and N.J.A.C. 13:35-1 to -2.13 (physicians) and 13:35-4.1 to -4A.18 (surgeons). The court explained:

> In this case, Dr. Forsythe was in her fourth year as a resident, and had also completed an additional year of research after her successful completion of medical school. Acting as the chief resident, she referred to herself as a 'doctor' and held herself out as 'able to diagnose, treat, operate or prescribe

219. *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108 (App. Div. 2007).
220. *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 111 (App. Div. 2007).
221. *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 113 (App. Div. 2007).
222. *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 117 (App. Div. 2007).
223. *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 113 (App. Div. 2007).

> for any human disease, pain, injury, deformity or physical condition [.]' [224]

Similarly:

> In November 2001, Dr. Chiodo had graduated from dental school, completed a one-year general medical practice residency, completed a one-year surgical internship and was in his second year of his four-year surgical residency. He had also completed five months of general anesthesia training before he treated Mr. Clark, where he "essentially . . . function[ed] as [an] anesthesiologist," at the hospital, where he administered drugs to put patients to sleep and inserted breathing tubes.[225]

The court then explained why these residents would be held to the standard of care of a general practitioner:

> Reducing the standard of care for licensed doctors in their residencies because of the limited nature of their training would set a problematic precedent. For example, should we reduce the standard for doctors who are inexperienced in a particular procedure that they negligently performed? Or should we also reduce the standard of care for doctors who graduated in the lower third of their medical school? Defendants held themselves out as doctors and should be held to the standard of care they claimed to profess. Anything less would not comport with the care William Clark expected and was entitled to receive.[226]

This holding should of course be read in conjunction with the holding in *Liguori v. Elmann*,[227] discussed in § 1-4:2, concerning specialists' duties.

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[224] *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 113 (App. Div. 2007) (quoting N.J.S.A. 45:9-18).

[225] *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 115 (App. Div. 2007) (footnotes omitted).

[226] *Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 116 (App. Div. 2007).

[227] *Liguori v. Elmann*, 191 N.J. 527 (2007).

1-4:4 Duty of a Supervisor

A health care professional, including a physician, may be liable for the negligence of another health care professional working under his or her supervision. The liability of a supervisory physician must be based upon breach of a duty to the patient. An example of liability being attributed to supervisory physicians, i.e., the director of emergency services at the emergency room and the attending physician and clinical instructor on duty, is found in *Tobia v. Cooper Hospital University Medical Center*.[228] In *Tobia*, the Court noted that when plaintiff was admitted to the Cooper Hospital, she was 85 years old and "in urgent need of medical care."[229] Plaintiff had been left unattended on an unlocked stretcher with its side rails down and fell as she attempted to get off the stretcher. Plaintiff alleged that the emergency room physician was "negligent in breaching Cooper Hospital's emergency room policy and safety procedure number 1," that specifies the following:

> Any patient not being attended, or directly supervised or observed, either by a nurse or doctor, shall be secured by having safety side rails raised on stretcher. This procedure will be especially monitored when handling patients who have symptoms of alcohol, drug ingestion, or unconscious, confused or elderly.[230]

However, the emergency room doctor testified that he was not aware of the existence of this protocol. The Supreme Court held that the supervisory physicians were proper defendants because the emergency room physician's testimony was sufficient to allow a jury to determine that the supervisory physicians were negligent in not informing the treating physician of the policy. The Court advised that it was not resurrecting the "captain of the ship doctrine," that had been repudiated in *Sesselman v. Muhlenberg Hospital*,[231] because the supervisory doctors are liable for the breach of the duty owed to plaintiff to train and supervise the emergency

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228. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335 (1994).

229. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 339 (1994).

230. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 339 (1994).

231. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285 (App. Div. 1973). *See* discussion of supervisory nurses' duties in § 1-4:6.

room physician and not merely because they were the supervisors on duty.

Other cases have reached similar conclusions regarding the liability of a supervisor for the negligence of a subordinate. A physician with overall supervision of an operation may be liable for the negligence of another doctor where the supervisory physician controls the actions of the other doctor. In *Terhune v. Margaret Hague Maternity Hospital*,[232] plaintiff alleged that she was burned as a result of the improper administration of an anesthetic during childbirth. The court noted that the obstetrician was not entitled to a dismissal since:

> [I]t may eventuate from an examination and trial of him and the other doctors in the room on plaintiffs' case that Dr. Zampella, as attending obstetrician in charge of the case, had over-all supervision of the entire medical team working on the delivery. While this defendant may have had no direct control of the anesthetist in the handling of the apparatus, the latter may have been subject to instructions from the doctor as to changes in the amount of ether to be administered, or other details of the anesthesia.[233]

Terhune does not further define the circumstances imposing liability on the professional with "over-all supervision" of, for example, an operating room. However, it would appear that unless the obstetrician was actively controlling the anesthesiologist, the former should not be liable for the negligence of the latter.

The issue was also examined in *Stumper v. Kimel*,[234] where a surgeon left written orders on the hospital chart for the irrigation of a feeding tube that had been inserted into the plaintiff's intestine. After being advised that the wrong lumen of the tube may have been irrigated, the surgeon ordered that the tube be removed. A resident attempted to remove the tube and in so doing perforated the plaintiff's esophagus and partially collapsed one of plaintiff's lungs. The tube was then surgically removed and an examination

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232. *Terhune v. Margaret Hague Maternity Hosp.*, 63 N.J. Super. 106 (App. Div. 1960).
233. *Terhune v. Margaret Hague Maternity Hosp.*, 63 N.J. Super. 106 (App. Div. 1960).
234. *Stumper v. Kimel*, 108 N.J. Super. 209 (App. Div. 1970).

revealed that the tube had been improperly irrigated which prevented its normal removal. Plaintiff settled with all defendants other than the surgeon and the jury found in the surgeon's favor. On appeal, plaintiff contended that the surgeon should be "vicariously liable for the negligence of a hospital-employed resident physician carrying out his orders requiring the expertise of a doctor."[235] The Appellate Division disagreed and held that the surgeon was not liable for failing to supervise the resident in the absence of knowledge that the procedure is hazardous or that the resident is not qualified to perform the procedure.[236] The court explained that the surgeon can only be liable:

> [I]f the patient proves the surgeon was negligent in giving his instructions, or he knew the resident was not qualified to perform the task assigned, or he was present and could have avoided the injury, or that some special contract arrangement existed with the patient or the resident which would require a different result.[237]

This holding is significant in that it establishes four theories for supervisory liability: (1) negligent instruction, (2) negligent qualification or credentialing,[238] (3) failure to intervene, and (4) special considerations.

There is an unusual discussion of this issue in *Swidryk v. St. Michael's Medical Center*,[239] where a resident being sued for malpractice brought a claim against the director of medical education at St. Michael's Hospital. The resident alleged that the medical director negligently supervised the Intern and Resident program, and that as a result the resident was sued by a child who was born during the resident's first year in the obstetrics and gynecology residency program. The Director of Medical Education moved for summary judgment, and the court granted the motion, stating:

> To allow a physician to file suit for educational malpractice against his school and residency

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235. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
236. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
237. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
238. *See* § 1-6:1 for discussion of the duty of a credentialer.
239. *Swidryk v. St. Michael's Med. Ctr.*, 201 N.J. Super. 601 (Law Div. 1985).

> program each time he is sued for malpractice would call for a malpractice trial within a malpractice case. Creation of the tort of educational malpractice in this context would substantially increase the amount of time which a medical malpractice case takes to try now as well have the potential to confuse the jury in its consideration of the underlying issues. The litigation explosion has limits and this is one area in which those limits should be definitely marked. Therefore, for reasons of public policy, there is no duty which will support a tort for medical malpractice in this class of case.[240]

1-4:5 Duty of a Supervisor of Physician Assistants

New Jersey first granted licenses to physician assistants and 1991. However, in recognition of the increasingly significant role played by physician assistants, the Physician Assistant Licensing Act was substantially amended in 2016 to clearly define the scope and limitations of the practice of a physician assistant.[241]

One must graduate from an accredited program and pass the national certifying examination administered by the National Commission on Certification of Physician Assistants in order to earn a license to practice as a physician assistant in New Jersey.[242] The licensing statute requires that every physician assistant "be under the supervision of a physician at all times during which the physician assistant is working in an official capacity."[243] The supervising physician need not be physically present "provided that the supervising physician and physician assistant maintain contact through electronic, or other means of, communication."[244]

The statute requires the supervising physician or physician assistant to inform the patient that the medical services are being provided by a physician assistant. Additionally, the physician assistant must "conspicuously" wear an identification tag using the

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240. *Swidryk v. St. Michael's Med. Ctr.*, 201 N.J. Super. 601, 608 (Law Div. 1985).
241. *See* N.J.S.A. 45:9-27.10 et. seq.
242. *See* N.J.S.A. 45:9-27.13.
243. N.J.S.A. 45:9-27.18.
244. N.J.S.A. 45:9-27.18.

term "physician assistant" or the designation "PA-C" or "PA."[245] Additionally, all notations in any clinical record by a physician assistant must be signed and followed by the designation, "PA-C" or "PA."[246]

Both the supervising physician and physician assistant are obligated to ensure that the physician assistant's scope of practice is clearly identified and that the physician assistant is competent to perform the medical tasks delegated by the physician.[247] The licensing statute defines the scope of the practice of a physician assistant, and explicitly provides that a physician assistant may perform the following procedures:

> (1) Approaching a patient to elicit a detailed and accurate history, perform an appropriate physical examination, identify problems, record information, and interpret and present information to the supervising physician;
>
> (2) Suturing and caring for wounds including removing sutures and clips and changing dressings, except for facial wounds, traumatic wounds requiring suturing in layers, and infected wounds;
>
> (3) Providing patient counseling services and patient education consistent with directions of the supervising physician;
>
> (4) Assisting a physician in an inpatient setting by conducting patient rounds, recording patient progress notes, determining and implementing therapeutic plans jointly with the supervising physician, and compiling and recording pertinent narrative case summaries;
>
> (5) Assisting a physician in the delivery of services to patients requiring continuing care in a private home, nursing home, extended care facility, or other setting, including the review and monitoring of treatment and therapy plans; and

245. N.J.S.A. 45:9-27.15.
246. N.J.S.A. 45:9-27.15.
247. *See* N.J.S.A. 45:9-27.18.

> (6) Referring patients to, and promoting their awareness of, health care facilities and other appropriate agencies and resources in the community.

The statute permits a physician assistant to perform the following procedures only when ordered to do so by the supervising physician:

> (1) Performing non-invasive laboratory procedures and related studies or assisting duly licensed personnel in the performance of invasive laboratory procedures and related studies;
>
> (2) Giving injections, administering medications, and requesting diagnostic studies;
>
> (3) Suturing and caring for facial wounds, traumatic wounds requiring suturing in layers, and infected wounds;
>
> (4) Writing prescriptions or ordering medications in an inpatient or outpatient setting in accordance with section C.45:9-27.19; and
>
> (5) Prescribing the use of patient restraints.

A physician assistant may perform additional medical services not explicitly authorized by the licensing statute pursuant to a signed "delegation agreement."[248] The delegation agreement must include the following provisions:

> (1) The physician assistant's role in the practice, including any specific aspects of care that require prior consultation with the supervising physician;
>
> (2) A determination of whether the supervising physician requires personal review of all charts and records of patients and countersignature by the supervising physician of all medical services performed under the delegation agreement, including prescribing and administering medication as authorized under section 10 C.45:9-27.19. This provision shall state specified time period in which

248. N.J.S.A. 45:9-27.17(d).

> a review and countersignature shall be completed by the supervising physician. If no review and countersignature is necessary, the agreement must specifically state such provision.

However, a physician assistant is not permitted to perform procedures such as an electromyography (EMG), even if under the supervision of a physician. In *Selective Insurance Co. v. Rothman*,[249] the Appellate Division ruled that an insurance company did not have to pay for the cost of an EMG performed by a physician assistant because the relevant statute limits performance of EMGs to those who are licensed to "practice medicine and surgery in this State pursuant to chapter 9 of Title 45 of the Revised Statutes."[250] The Supreme Court affirmed, adding:

> Defendant's suggestion that a PA can perform a needle EMG based on the statutory authorization for a PA to "assist" a physician, N.J.S.A. 45:9-27.16(b)(1), is similarly flawed. That approach, which requires a reading of the word "assist" that would equate it with "perform in the place of," would not only be contrary to the clear word that the Legislature chose but also would expand the authority given to PAs well beyond the boundaries that the statute established.[251]

There has not yet been a reported case in New Jersey that discusses the vicarious liability of a physician for the actions of the physician assistant. However, the statute provides:

> c. In the performance of all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services, a physician assistant shall be conclusively presumed to be the agent of the physician under

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249. *Selective Ins. Co. v. Rothman*, 414 N.J. Super. 331 (App. Div. 2010), *aff'd*, 208 N.J. 580 (2012).

250. *Selective Ins. Co. v. Rothman*, 414 N.J. Super. 331, 337 (App. Div. 2010), *aff'd*, 208 N.J. 580 (2012).

251. *Selective Ins. Co. v. Rothman*, 208 N.J. 580, 583 (2012).

> whose supervision the physician assistant is practicing.[252]

Given this language, a strong argument can be made that the physician responsible for supervising the physician assistant remains responsible for the negligence of the physician assistant.

Additionally, the supervising physician remains responsible for the actions of the physician assistant in many circumstances. The statute provides:

> b. Any physician who permits a physician assistant under the physician's supervision to practice contrary to the provisions of C.45:9-27.10 et seq.) shall be deemed to have engaged in professional misconduct in violation of subsection e. of section 8 of C.45:1-21 and shall be subject to disciplinary action by the board pursuant to C.45:1-14 et seq.

There has not been a reported case in New Jersey that discusses the standard of care to be applied in a case asserting that a physician assistant was negligent. However, as with nurses and other medical providers, it would be fair to conclude that a physician assistant must act in accordance with the standard of care for reasonably prudent physician assistants in similar circumstances.

Curiously, although the Legislature has in recent years amended the affidavit of merit statute to include such diverse professions as physical therapists, land surveyors, pharmacists, veterinarians, insurance producers and midwives, the Legislature has not yet added physician assistants to the list of medical providers who are entitled to an affidavit of merit.[253] Nevertheless, the reasonably prudent malpractice attorney would obtain an affidavit of merit from a licensed physician assistant prior to filing a malpractice case against a physician assistant.

The statute provides a limited immunity from damages to physicians and physician assistants for actions in response to emergencies.[254] Response to emergencies; immunity from civil damages. Neither the supervising physician nor the physician assistant is liable for personal

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252. N.J.S.A. 45:9-27.17(c).
253. *See* N.J.S.A. 2A:53A-26.
254. *See* N.J.S.A. 45:9-27.18a.

injuries resulting from the negligence of the medical provider "who voluntarily and gratuitously, and other than in the ordinary course of employment or practice, renders emergency medical assistance."[255] However the immunity does not apply to "an act or omission constituting gross, willful, or wanton negligence or when the medical assistance is rendered at a hospital, physician's office, or other health care delivery entity where those services are normally rendered."[256]

As are other medical providers, physician assistants are required to maintain medical malpractice insurance or a letter of credit.[257]

1-4:6 Duty of a Supervisor of Nurses

A physician is not responsible for the negligence of a nurse, unless the physician instructed or otherwise controlled the nurse's actions. In *Martin v. Perth Amboy General Hospital*,[258] plaintiff complained of pain in his abdomen after an operation. An X-ray disclosed a foreign object that was determined to be a laparotomy pad left in plaintiff's body during the operation. The surgeon appealed from that portion of the charge that held that he was responsible for the acts or omissions of the nurses, contending that the charge adopted the "captain of the ship doctrine" which was not the law of the state. The Appellate Division noted that courts in *Niebel v. Winslow*,[259] and *Stawicki v. Kelley*,[260] stated that the nurses are agents only of the hospital and that "only the hospital and not the doctor is liable for the nurse's negligence in making that count [of surgical pads]."[261] However, the *Martin* court noted that the surgeon ordered removal of a metal ring from the surgical pad and plaintiff's expert testified this deviated from the standards of care.

> By exercising control of the nurses to the extent of directing them to remove the rings and thus eliminating the safeguards provided by the

255. *See* N.J.S.A. 45:9-27.18a.
256. *See* N.J.S.A. 45:9-27.18a.
257. *See* N.J.S.A. 45:9-27.13a.
258. *Martin v. Perth Amboy Gen. Hosp.*, 104 N.J. Super. 335 (App. Div. 1969).
259. *Niebel v. Winslow*, 88 N.J.L. 191 (E. & A. 1915).
260. *Stawicki v. Kelley*, 113 N.J.L. 551 (Sup. Ct. 1934), *aff'd*, 115 N.J.L. 190 (E. & A. 1935).
261. *Martin v. Perth Amboy Gen. Hosp.*, 104 N.J. Super. 335, 347 (App. Div. 1969).

> hospital to insure a proper count by its employees (particularly since he knew that there would be a change in the shift of nurses during the operation), [the defendant] became, in our view, the nurses' "temporary or special employer" insofar as their duties involved the laparotomy pads used in the operation. As such, he was equally liable with their general employer for their subsequent negligence in counting the pads.[262]

The general rule that a physician is not liable for a nurse's negligence was followed by *Stumper v. Kimel*,[263] which held that a surgeon was not vicariously responsible for the negligence of a nurse.[264]

The rule was also applied in *Sesselman v. Muhlenberg Hospital*,[265] where plaintiff alleged that she sustained dental injuries during the administration of anesthesia. Plaintiff's expert testified that the physician was in charge of everything that occurred in the operating room and was responsible for any adverse incident, whether the fault of the surgeon or a subordinate. The jury entered a verdict against the physician, but the Appellate Division reversed, holding that the physician was not vicariously liable for the acts of a nurse.[266] The Appellate Division explained the trial judge improperly instructed the jury that the physician may be responsible for the negligence of the nurse. In so doing, the Appellate Division explicitly rejected the "captain of the ship doctrine."[267] The court concluded that the nurse "did not become the legal servant or agent" of the physician merely because she received instructions from him as to the work to be performed.[268] The same conclusion is found in *Johnson v. Mountainside Hospital*,[269] where the court affirmed the dismissal of

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262. *Martin v. Perth Amboy Gen. Hosp.*, 104 N.J. Super. 335, 348 (App. Div. 1969).

263. *Stumper v. Kimel*, 108 N.J. Super. 209 (App. Div. 1970).

264. *Stumper v. Kimel*, 108 N.J. Super. 209, 214 (App. Div. 1970) (citing *Martin v. Perth Amboy Gen. Hosp.*, 104 N.J. Super. 335 (App. Div. 1969)).

265. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285 (App. Div. 1973).

266. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285, 289 (App. Div. 1973).

267. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285, 290 (App. Div. 1973).

268. *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285, 290 (App. Div. 1973).

269. *Johnson v. Mountainside Hosp.*, 239 N.J. Super. 312 (App. Div. 1990).

several supervisory physicians, reiterating the rejection of the "captain of the ship" doctrine.

In *Diakamopoulos v. Monmouth Medical Center*,[270] involving the wrongful death of plaintiff's child, the Appellate Division criticized plaintiff's counsel for referring to the defendant as "captain of the ship."[271] The Appellate Division explained that such comments were grossly improper:

> Twenty-five years ago, in *Sesselman v. Muhlenberg Hosp.*, 124 N.J. Super. 285, 290 (App. Div.1973), we rejected the 'captain of the ship' doctrine as a basis for liability. The doctrine remains in disfavor. *See, e.g., Tobia v. Cooper Hosp. University Med. Center*, 136 N.J. 335, 346 (1994); *Lanzet v. Greenberg*, 243 N.J. Super. 218, 231-32, (App. Div.1990), *rev'd on other grounds*, 126 N.J. 168, 175 (1991); *Johnson v. Mountainside Hosp.*, 239 N.J. Super. 312, 322 (App. Div.), *certif. denied*, 122 N.J. 188 (1990); *Whitfield v. Blackwood*, 206 N.J. Super. 487, 503 A.2d 311 (App. Div.1985), *aff'd in part, rev'd in part*, 101 N.J. 500 (1986). The doctrine suggests imposing vicarious liability on a doctor because of the negligence of others not under the doctor's control or supervision. Where a litigant improperly seeks to utilize this doctrine, we have imposed an affirmative obligation on the trial judge 'to make certain that the jury [is] not misled by legal doctrines not urged as a proper basis for liability.' *Whitfield v. Blackwood, supra*, 206 N.J. Super. at 493-94.[272]

Thus, a physician is only liable for the negligence of a nurse where it can be demonstrated that the physician knew or should have known that the nurse was not qualified for the assigned task, gave the nurse improper or inadequate instructions, or was aware of the negligent treatment and failed to prevent the injury.

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270. *Diakamopoulos v. Monmouth Med. Ctr.*, 312 N.J. Super. 20 (App. Div. 1998).
271. *Diakamopoulos v. Monmouth Med. Ctr.*, 312 N.J. Super. 20, 33 (App. Div. 1998).
272. *Diakamopoulos v. Monmouth Med. Ctr.*, 312 N.J. Super. 20, 34-35 (App. Div. 1998).

1-4:7 The Scope of Chiropractic Care

In *Bedford v. Riello*,[273] the Supreme Court discussed the scope of the practice of a chiropractor, and specifically whether "adjustment of a knee is permitted by N.J.A.C. 13:44E-1.1(a), which allows for chiropractic manipulation of 'the articulations of the spine and related structures.'"[274] The trial court had held that the knee is always a "related structure," but the Appellate Division held that a knee can never be considered a related structure because N.J.S.A. 45:9-14.5 limits chiropractic practice to manipulation of "the articulations of the spinal column."[275] The Supreme Court held that whether a condition of an extremity is connected to a spinal condition is a question of fact to be resolved on a case-by-case basis.

In *Bedford*, the plaintiff alleged that she sustained injuries as a result of defendants' negligent chiropractic adjustments of her knee. The plaintiff contended that N.J.S.A. 45:9-14.5 and N.J.A.C. 13:44E-1.1 prohibited a chiropractor from adjusting a patient's knee. The trial judge held the regulation permitted chiropractors to adjust extremities. The plaintiff's expert was therefore "prohibited from testifying that knee adjustment falls outside the scope of chiropractic."[276] The plaintiff's expert did testify as to other deviations from the standard of care. The defendant's expert testified that "chiropractors routinely adjust extremities, including the knee, and that such adjustments are appropriate because there is a 'kinetic linkage' between the extremities and the spine."[277]

The jury found for the defendants and the Appellate Division reversed, citing N.J.S.A. 45:9-14.5 and concluding that, "as a matter of law, the practice of chiropractic is confined to adjustments of the articulations of the spinal column and does not include adjustment of the extremities."[278] The Appellate Division therefore held that the trial court "should have instructed the jury that knee adjustment is outside the scope of legitimate chiropractic practice

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273. *Bedford v. Riello*, 195 N.J. 210 (2008).
274. *Bedford v. Riello*, 195 N.J. 210, 212 (2008).
275. *Bedford v. Riello*, 195 N.J. 210, 212 (2008).
276. *Bedford v. Riello*, 195 N.J. 210, 214 (2008).
277. *Bedford v. Riello*, 195 N.J. 210, 215 (2008).
278. *Bedford v. Riello*, 195 N.J. 210, 215 (2008).

and, as such, could be considered evidence of negligence. In light of its ruling, the court remanded the case for a new trial."[279]

The Supreme Court reversed and remanded for a new trial. The Court first reviewed in detail the history of chiropractic regulation in New Jersey, explaining that the scope of chiropractic has been long defined as:

> the adjustment and manipulation of the articulations of the spine and related structures and whose purpose is the relief of certain abnormal clinical conditions of the human body causing discomfort resulting from the impingement upon associated nerves.[280]

The Court noted that in 1991 the Chiropractic Board promulgated N.J.A.C. 13:44E-1.1(a), entitled "Scope of Practice," which reaffirmed the prior regulations permitting manipulation of the spine and "related structures."[281] The Supreme Court then observed that the chiropractic board has consistently permitted adjustment of an ankle "as long as the adjustment *is connected* to spinal adjustment."[282] The Court then quoted N.J.A.C. 13:44E-1.1(a), that provides: "The practice of chiropractic is that patient health care discipline whose methodology is the adjustment and/or manipulation of the articulations of the spine and related structures."[283] The Court explained that the rule obviously,

> contemplates adjustments that are not limited to the spine. Although the term "related structures" is not defined in the rule and cannot be given ready meaning from the language itself, it is clear that the rule intends to include within the scope of chiropractic practice the adjustment of some structures beyond the articulations of the spine itself. Any reading to the contrary would

279. *Bedford v. Riello*, 195 N.J. 210, 215 (2008).

280. *Bedford v. Riello*, 195 N.J. 210, 218 (2008).

281. *Bedford v. Riello*, 195 N.J. 210, 218 (2008).

282. *Bedford v. Riello*, 195 N.J. 210, 220 (2008) (quoting State Board of Chiropractic Examiners, Public Session Minutes: July 18, 1996, § B(6)) (emphasis added).

283. *Bedford v. Riello*, 195 N.J. 210, 222 (2008).

> render superfluous the inclusion of the "related structures" language.[284]

The Court therefore concluded that:

> N.J.A.C. 13:44E-1.1(a) permits manipulation of articulations beyond those of the spine when there exists a causal nexus between a condition of the manipulated structure and a condition of the spine. Whether adjustment of a particular portion of the body is permissible as a "related structure" under N.J.A.C. 13:44E-1.1(a) must be determined and demonstrated by the practitioner on a case-by-case basis, focusing on whether a condition of the adjusted structure bears a causal relationship to a condition of the spine. Under that reading, it may or may not be permissible to adjust a knee. Whether the adjustment of a knee properly falls within the scope of chiropractic practice under N.J.A.C. 13:44E-1.1(a) must be determined on the facts of each case.[285]

The Court also held that N.J.A.C. 13:44E-1.1(a) does not exceed the statutory limitation on the scope of chiropractic practice found in N.J.S.A. 45:9-14.5, that defines chiropractic as "[a] system of adjusting the articulations of the spinal column by manipulation thereof." The Court concluded:

> We take from the Legislature's long-standing acquiescence to the Board's interpretation of the Act the conclusion that it did not intend to prohibit all extra-spinal manipulation. Rather, it appears that the Legislature was satisfied to allow the Board to provide the nuances of the statutory scheme, including permitting extra-spinal adjustments that are related to a spinal condition.[286]

Therefore, the Court explained:

> whether the adjustment of a structure beyond the spine properly falls within the scope of chiropractic

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284. *Bedford v. Riello*, 195 N.J. 210, 222 (2008).
285. *Bedford v. Riello*, 195 N.J. 210, 223-24 (2008).
286. *Bedford v. Riello*, 195 N.J. 210, 228 (2008).

> practice is dependent on whether the adjustment bears a nexus to a condition of the spine.[287]

The Court therefore remanded the case for a new trial, where the parties

> may present evidence regarding whether a condition of the knee adjusted in this case bore a nexus to a spinal condition, thus qualifying it as a manipulation of a related structure.[288]

The Court added that while this would be a matter requiring expert testimony, no expert should be permitted to testify

> that a chiropractor can manipulate any extremity because there is "a kinetic linkage" between all extremities and the spine . . . the experts must focus on the specific facts of the case and state what it was about the extra-spinal condition that was or was not related either by cause or effect to a spinal condition. Moreover, evidence of documentation of that relationship in the patient's record will be relevant. The jury should be instructed that, if it concludes that no condition of the adjusted structure was properly related to a spinal condition, the adjustment would fall outside the scope of chiropractic practice in New Jersey, as defined in the statutes and regulations, and that such violation may be considered evidence that defendants were negligent.[289]

1-4:8 Duty of Emergency Department

The duties of an emergency department are controlled by the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA).[290] The Appellate Division has held that in order to establish a violation of EMTALA's stabilization requirement, a plaintiff is required to prove that (1) he had an emergency

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287. *Bedford v. Riello*, 195 N.J. 210, 228 (2008).
288. *Bedford v. Riello*, 195 N.J. 210, 228 (2008).
289. *Bedford v. Riello*, 195 N.J. 210, 227 (2008).
290. 42 U.S.C. 1395dd.

medical condition, (2) the hospital actually knew about the condition, and (3) he was not stabilized before being transferred or discharged.[291]

1-4:9 Duty of Nursing Home

The New Jersey Legislature has taken a special interest in the care of the patients in a nursing home. In 1976, the New Jersey Legislature passed the Nursing Home Responsibilities and Rights of Residents Act (the Act),[292] in an effort "to ameliorate the harsh conditions of the elderly in nursing homes[.]"[293] The Act imposes certain responsibilities on nursing homes,[294] and it declares the "[r]ights of nursing home residents."[295] These rights include a right to "considerate and respectful care that recognizes the dignity and individuality of the resident," and a right "[n]ot [to] be deprived of any constitutional, civil[,] or legal right solely by reason of admission to a nursing home."[296]

When enacting the Nursing Home Patient's Bill of Rights, the Legislature stated that

> the well-being of nursing home residents in the State of New Jersey requires a delineation of the responsibilities of nursing homes and a declaration of a bill of rights for such residents.[297]

This statute creates unprecedented rights for the protection of such patients. The following summarizes some of the more important provisions of this statute. N.J.S.A. 30:13-2 broadly defines a "Nursing home" to include:

> [A]ny institution, whether operated for profit or not, which maintains and operates facilities for extended medical and nursing treatment or care for two or more nonrelated individuals who are suffering from acute or chronic illness or injury, or

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291. *Garaffa v. JFK Med. Ctr.*, No. A-4105-04T2, 2006 N.J. Super. Unpub. LEXIS 2038 (N.J. Super. App. Div. July 21, 2006).

292. N.J.S.A. 30:13-1 to -17.

293. *In re Conroy*, 98 N.J. 321, 377 (1985).

294. N.J.S.A. 30:13-3.

295. N.J.S.A. 30:13-5.

296. N.J.S.A. 30:13-5 (j), (m).

297. *See* N.J.S.A. 30:13-1.

> are crippled, convalescent or infirm and are in need of such treatment or care on a continuing basis. Infirm is construed to mean that an individual is in need of assistance in bathing, dressing or some type of supervision.[298]

The many responsibilities of a nursing home are found in N.J.S.A. 30:13-3. A nursing home is responsible for maintaining all funds, personal property, and possessions of a resident; providing for the spiritual needs of residents; admitting only the number of residents for which it can provide nursing care; providing any applicant who is denied admission with the reason for such denial in writing; prohibiting discrimination due to age, race, religion, sex, or national origin; ensuring that no resident shall be physically restrained except upon written orders of a physician "for a specific period of time when necessary to protect such resident from injury to himself or others;" ensuring that drugs shall not be employed for purposes of punishment or convenience of the nursing home staff, "or in such quantities so as to interfere with a resident's rehabilitation or his normal living activities;" permitting residents to have access to personal, social, and legal services; "ensuring compliance with all applicable State and federal statutes and rules and regulations;" and providing every resident and the resident's family or guardian with a copy of the contract or agreement between the nursing home and the resident prior to or upon the resident's admission.

N.J.S.A. 30:13-5 provides for maintenance of the rights of privacy and dignity of nursing home residents. This statute states that every nursing home resident shall have the right to manage his own financial affairs; wear his own clothing; retain and use his personal property; receive and send unopened correspondence; have unaccompanied access to a telephone; retain his or her own physician; and to enjoy privacy. Additionally, every nursing home resident has the right to "complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand." A nursing home resident also has the right to

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298. N.J.S.A. 30:13-2.

confidentiality regarding his or her medical condition, treatment, and records. Nursing home residents must have the right to "unrestricted communication, including personal visitation with any persons of his choice, at any reasonable hour." They also must have the opportunity to present grievances without fear of discharge or reprisal; a safe living environment; and

> reasonable opportunity for interaction with members of the opposite sex. If married, the resident shall enjoy reasonable privacy in visits by his spouse and, if both are residents of the nursing home, they shall be afforded the opportunity, where feasible, to share a room, unless medically inadvisable.[299]

In sum, a resident of a nursing home may "[n]ot be deprived of any constitutional, civil or legal right solely by reason of admission to a nursing home."[300]

In order to ensure compliance with the statute, the Legislature enacted N.J.S.A. 30:13-4.2, that provides a cause of action for violation of any provision of the act, and permits the award of punitive damages and attorney's fees and costs to a prevailing plaintiff. Similarly, N.J.S.A. 30:13-8 also provides a cause of action for violation of any provision of the act, and also permits the award of punitive damages and attorney's fees and costs to a prevailing plaintiff.

See also *Estate of Davis v. Vineland Operations*,[301] where plaintiff contended that defendant negligently treated the decedent's bed sore. The defendant's expert witness testified that the decedent's bed sore was the result of her pre-existing paralysis and diabetes. The jury allocated 30 percent of the injury to the defendant's negligence, and awarded $49,200.11 for medical bills but nothing for pain and suffering. Plaintiff moved for additur and counsel fees under N.J.S.A. 30:13-8(a).[302]

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299. N.J.S.A. 30:13-5l.

300. N.J.S.A. 30:13-5m.

301. *Estate of Davis v. Vineland Operations*, No. A-2950-11T4, 2013 N.J. Super. Unpub. LEXIS 176 (N.J. Super. App. Div. Jan. 30, 2013).

302. *Estate of Davis v. Vineland Operations*, No. A-2950-11T4, 2013 N.J. Super. Unpub. LEXIS 176, at *3-4 (N.J. Super. App. Div. Jan. 30, 2013).

The trial court denied the motion for attorney's fees, holding that the Nursing Home Bill of Rights, does not apply to "ordinary negligence cases."[303] In affirming, the appellate division explained:

> *N.J.S.A.* 30:13-8(a) authorizes payment of reasonable attorney's fees to nursing home residents where their rights as enumerated in *N.J.S.A.* 30:13-5 are violated. As the trial judge observed, however, plaintiff did not assert 'a violation of the statutory rights afforded by the [A]ct.' Although plaintiff alleged some causes of action created by the Nursing Home Bill of Rights, the actual jury instructions, verdict sheet, and recovery were all based on theories of ordinary negligence and not on a violation of any patient rights.
>
> We have previously allowed statutory fees when a nursing home patient was transferred on a nonemergent basis from one facility to another without appropriate notice, in violation of *N.J.S.A.* 30:13-6. *Brehm v. Pine Acres Nursing Home, Inc.*, 190 N.J. Super. 103, 108 (App. Div. 1983). But in that case, the defendant nursing home violated a specific statutory provision of the Nursing Home Bill of Rights. In this case, the judge's denial stemmed from the fact no violation of the Nursing Home Bill of Rights occurred, a decision with which we can only concur. Hence *N.J.S.A.* 30:13-8(a) does not apply to this situation.[304]

Furthermore, "treble damages may be awarded to a resident or alleged third party guarantor of payment who prevails in any action to enforce the provisions" of N.J.S.A. 30:13-3.1.[305]

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303. *Estate of Davis v. Vineland Operations*, No. A-2950-11T4, 2013 N.J. Super. Unpub. LEXIS 176, at *6 (N.J. Super. App. Div. Jan. 30, 2013).

304. *Estate of Davis v. Vineland Operations*, No. A-2950-11T4, 2013 N.J. Super. Unpub. LEXIS 176, at *11-12 (N.J. Super. App. Div. Jan. 30, 2013).

305. *See also Castro v. NYT Television*, 370 N.J. Super. 282 (App. Div. 2004), where the plaintiffs were videotaped after being admitted to the Jersey Shore Medical Center for a television show called "Trauma: Life in the ER," and the Appellate Division observed that the Nursing Home Residents' Bill of Rights Act, N.J.S.A. 3:13-1 to -11 expressly "authorized private causes of action for any violation of the rights recognized thereunder. *N.J.S.A*. 30:13-8(a)." *Castro v. NYT Television*, 370 N.J. Super. 282, 291 (App. Div. 2004).

The attempt by some nursing homes to limit liability and compel arbitration of tort claims is discussed in Chapter 8, § 8-15, and the case of *Estate of Ruszala v. Brookdale Living Communities*,[306] is also discussed in Chapter 8, § 8-15.

The definition of a nursing home was at issue in *Bermudez v. Kessler Institute for Rehabilitation*. In addition to asserting common law negligence claims, the plaintiff alleged that the defendant violated the New Jersey Nursing Home Act, N.J.S.A. 30:13-1 et seq., and multiple federal regulations.[307] Kessler moved to dismiss the claims brought under the NHA and the federal regulations, arguing that its facility was a "comprehensive rehabilitation hospital, rather than a nursing home."

In resolving the issue, the Appellate Division observed that whether the facility was a "nursing home" was significant because "the Act allows the recovery of treble damages and attorneys' fees by a successful plaintiff, N.J.S.A. 30:13-4.2,-8, relief which would not be available in a traditional negligence action."[308] In holding that Kessler's facility was not a nursing home, the court first quoted the statutory definition of a "nursing home:"

> The Nursing Home Act defines a "nursing home" as any institution, whether operated for profit or not, which maintains and operates facilities for extended medical and nursing treatment or care for two or more nonrelated individuals who are suffering from acute or chronic illness or injury, or are crippled, convalescent or infirm and are in need of such treatment or care on a continuing basis. Infirm is construed to mean that an individual is in need of assistance in bathing, dressing or some type of supervision. [N.J.S.A. 30:13-2(c).][309]

In contrast, a "rehabilitation hospital" is defined as:

> [A] hospital licensed by the Department to provide comprehensive rehabilitation services to patients for the alleviation or amelioration of the disabling effects

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306. *Estate of Ruszala v. Brookdale Living Cmtys.*, 415 N.J. Super. 272 (App. Div. 2010).
307. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45 (App. Div. 2015).
308. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 49 (App. Div. 2015).
309. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 51 (App. Div. 2015).

> of illness. Comprehensive rehabilitation services are characterized by the coordinated delivery of multidisciplinary care intended to achieve the goal of maximizing the self-sufficiency of the patient. A rehabilitation hospital is a facility licensed to provide only comprehensive rehabilitation services or is a distinct unit providing only comprehensive rehabilitation services located within a licensed health care facility.[310]

The court noted that a "comprehensive rehabilitation hospital" and a "nursing home" are "commonly understood to be different entities." The court pointed out that two types of institutions to treat different types of patients and that nursing home residents

> are a particularly vulnerable population. Nursing-home residents are often quite elderly, with an average age of 82 nation-wide. Most suffer from chronic or crippling disabilities and mental impairments, and need assistance in activities of daily living. The vast majority of patients who enter a nursing home will eventually die there, and their illnesses and deaths will be viewed as consistent with their advanced age and general infirmity.[311]

The court observed that nursing-home residents "are often without any surviving family" and that "physicians play a much more limited role in nursing homes than in hospitals."[312] For all of these reasons, nursing home patients need the additional protections provided by the NHA.[313]

The Appellate Division concluded that although the Legislature drafted "a broad definition of 'nursing home,'" nevertheless "a comprehensive rehabilitation hospital, such as Kessler's West Facility, is not a 'nursing home' within the meaning of

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310. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 51 (App. Div. 2015). *See* N.J.A.C. 8:33-1.3.

311. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 52 (App. Div. 2015) (quoting *In re Conroy*, 98 N.J. 321, 374-77 (1985)).

312. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 52 (App. Div. 2015) (quoting *In re Conroy*, 98 N.J. 321, 374-77 (1985)).

313. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 56 (App. Div. 2015).

N.J.S.A. 30:13-2(c) and, as a consequence, is not subject to the provisions of the Nursing Home Act."[314]

The definition of a "nursing home" was also considered in *Ptaszynski v. Atlantic Health Systems, Inc.*,[315] which involved the Mt. Kemble Rehabilitation facility at the Morristown Memorial Hospital. The plaintiff's decedent was a patient at these two facilities where her decedent developed pressure sores and a methicillin-resistant staphylococcus aureus (MRSA) infection, resulting in her demise. The plaintiff asserted that the defendant failed to comply with New Jersey and federal statutes and regulations regarding nursing homes.

In rejecting the plaintiff's claims, the Appellate Division first explained that the term "nursing home" is defined by N.J.S.A. 30:13-2(c). The Appellate Division remanded the case for a hearing to determine whether the facility was a nursing home, and in so doing, provided guidance as to what factors should be considered in making this determination:

> We are convinced that the record does not provide sufficient information to determine whether MKR is a "nursing home" for purposes of the NHA . . . . The record indicates that the DOH issued two licenses to defendant. One license authorized defendant to operate a comprehensive rehabilitation hospital consisting of thirty-eight beds. The other license permitted defendant to operate a hospital-based, long-term care facility with forty beds. The licenses do not state, however, that MKR is licensed to operate as a nursing home.
>
> We also note that nothing in the record indicates that the DOH ever issued a separate certificate of need ("CN") to defendant authorizing the establishment of a nursing home. N.J.S.A. 26:2H-7 provides that a CN is required for the construction or expansion of "health care facilities," a term defined in N.J.S.A. 26:2H-2(a) to include "nursing

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314. *Bermudez v. Kessler Inst. for Rehab.*, 439 N.J. Super. 45, 55-56 (App. Div. 2015).
315. *Ptaszynski v. Atl. Health Sys., Inc.,* 440 N.J. Super. 24 (App. Div. 2015).

> homes." *See also* N.J.S.A. 26:2H-7.2 and -7.3 (exempting certain nursing homes from the CN requirement).
>
> In addition, it is not clear from the record whether MKR is a facility that would be permitted to provide care on "a continuing basis," which is an essential element of the definition of a "nursing home" in the NHA. N.J.S.A. 30:13-2(c). As defendant notes, patients are treated temporarily at MKR, with the expectation that they will be moved to another facility for long-term or "continuing" care if needed.
>
> Plaintiff insists that, because MKR is required to comply with certain standards that apply to the care provided to persons in nursing homes, MKR must be considered a "nursing home" under the NHA. Defendant maintains, however, that MKR is a "hospital" even though those standards also may apply to the care provided to persons treated at MKR. The trial court should address these arguments on remand.
>
> The parties should be afforded an opportunity to present additional evidence in support of their respective arguments on whether MKR is a "nursing home" for purposes of the NHA. This court's recent decision in *Bermudez v. Kessler Institute for Rehabilitation* . . . may provide the trial court and the parties with some guidance in resolving this issue.[316]

Additionally, the *Ptaszynski* court concluded that a patient does not have the right to pursue a private cause of action against a nursing home for violation of the statutes, rules and regulations that govern nursing homes:

> There is no indication that, in enacting the amendments to the NHA, the Legislature intended to confer upon nursing home residents the ability to

[316] *Ptaszynski v. Atl. Health Sys., Inc.,* 440 N.J. Super. 24, 43-44 (App. Div. 2015).

> bring actions to enforce any violation of the NHA. The 1991 legislation imposed upon nursing homes new, specific requirements pertaining to security deposits, and allowed residents to bring actions to enforce those requirements, not other responsibilities that nursing homes have under the law . . . . We therefore conclude that N.J.S.A. 30:13-4.2 does not permit plaintiff to assert a cause of action for the alleged failure by defendant to fulfill its responsibility under N.J.S.A. 30:13-3(h) to comply with all applicable state and federal statutes, rules and regulations. The trial court erred by permitting plaintiff to pursue the claim in count two.[317]

The manner of proving a claim under the NHA and the award of attorney's fees was upheld in the unpublished case of *Moody v. The Voorhees Care & Rehab. Ctr.*,[318] wherein the appellate division clarified and distinguished *Ptaszynski*. In *Moody*, the plaintiff alleged the defendant nursing home negligently monitored her blood sugar, resulting in a hospitalization. The Court observed:

> Once at the hospital, plaintiff's blood sugar was tested and it indicated her blood sugar level was 840. Her blood urea nitrogen was still 58, her ketones measurement was 29.7, and her bicarbonate was low at 19. Plaintiff developed severe hyperglycemia, which was the cause of her blood sugar rising to over 800. In addition, plaintiff suffered from dehydration, ketoacidosis, hyperosmolar nonketosis, and hypokalemia.

The plaintiff asserted the defendant was negligent and violated the plaintiff's nursing home resident's rights under the NHA, as well as federal regulations dealing with nursing homes under the Omnibus Budget Reconciliation Act of 1987 (OBRA), codified under 42 C.F.R. §§ 483.1-483.480. The jury verdict was $225,000, which included $100,000 on the claim for the violation of the patient's rights as per the NHA. The trial court entered a final

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317. *Ptaszynski v. Atl. Health Sys., Inc.,* 440 N.J. Super. 24, 35-36 (App. Div. 2015).

318. *Moody v. The Voorhees Care & Rehab. Ctr.*, No. A-5561-18, 2021 N.J. Super. Unpub. LEXIS 267 (N.J. Super. App. Div. Feb. 17, 2021).

judgment in the amount of $349,687.45, which including attorney's fees and costs in the amount of $124,687.45.

On appeal, the defendant argued the plaintiff's expert should not have been permitted to testify about violations of the NHA, specifically, the violations of nursing home residents' rights in *N.J.S.A.* 30:13-5(j) that were alleged pursuant to the cause of action recognized under *N.J.S.A.* 30:13-8(a). The trial judge prohibited the expert from providing an opinion on the meaning of "dignity," in accordance with Ptaszynski, but permitted the expert to testify that the defendants violated the statute, which is what plaintiff's counsel asserted. The appellate court explained:

> During his testimony, Dr. Kirby, who the judge determined was qualified as an expert in internal medicine and geriatrics and was called as an expert as to defendants' negligence and violation of the statutes, explained that he was familiar with federal and state statutes and regulations, including the NHA, as he "need[ed] to know what sort of the broad brush standard of care is [as] a physician's work and a nurse's work will fall under those regulations." After testifying in detail as to why he believed that defendants' staff deviated from the applicable standard of care, which caused harm to plaintiff, Dr. Kirby addressed the NHA and stated that plaintiff's "rights as a nursing home resident were violated," specifically "her rights to a safe and decent living environment," "her right to care that recognized her dignity," and "her right to care that recognized her individuality."

The trial judge charged the jury as follows:

> The plaintiff . . . asserts that the defendant violated N.J.S.A. 30:13-5(j) which states, "Every resident of a nursing home shall have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." If you find that the defendant has violated any of these statutes, you have found a violation of the New Jersey Nursing

> Home Responsibilities and Residents Rights Act and a violation of Dorothy L. Moody's rights. You are not, however, simply to duplicate damages for the negligence claims . . .
>
> In support of the claims of violation of rights, the plaintiff alleges violation of federal law under the code of federal regulations. One federal regulation, for example, that the plaintiff has claimed was violated is that of 42 CFR § 483.25, Quality of Care. That regulation states that, "Each resident[ ] must receive and the facility might [sic] provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care." The statutes and regulations in question set up standards of conduct for nursing homes. If you find that the defendant has violated any nursing home law which caused harm to Ms. Moody, the defendant violated the plaintiff's nursing home rights.

The appellate panel then explained the history and purpose of the NHA:

> The NHA "was enacted in 1976 to declare 'a bill of rights' for nursing home residents and define the 'responsibilities' of nursing homes." *Ptaszynski*, 440 N.J. Super. 24, at *32. The patient's "rights" are enumerated in N.J.S.A. 30:13-5(a) to (n). The nursing home's "responsibilities" are enumerated in N.J.S.A. 30:13-3(a) to (j). Under N.J.S.A. 30:13-8(a), a person can only bring an action for violation of one of the enumerated residents' "rights," set forth in N.J.S.A. 30:13-5. *Ptaszynski*, 440 N.J. Super. 24, at *33-36. While there are several rights enumerated under the act, in relevant part, N.J.S.A. 30:13-5(j) specifically states:
>
> Every resident of a nursing home shall . . . [h]ave the right to a safe and decent living environment and considerate and respectful care that recognizes

> the dignity and individuality of the resident, including the right to expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care consistent with sound nursing and medical practices.

In ratifying the decision to permit the expert to so testify, the *Moody* Court distinguished *Ptaszynski*:

> Dr. Kirby was not qualified as an expert in nursing home law or any law. Rather he was questioned extensively about his professional experience and familiarity with nursing home procedures and was found to be "qualif[ied] as an expert in internal medicine and geriatrics." Moreover, he never defined "dignity" or any other words in the NHA. Dr. Kirby only confirmed that he believed plaintiff's rights under the NHA to "a safe and decent living environment," "to care that recognized her dignity," and her "right to care that recognized her individuality" were violated. It was defense counsel who attempted to question Dr. Kirby on the meaning of "dignity," but after the trial judge overruled plaintiff's objection to the question, defense counsel thought better not to ask. There were no definitions given by the doctor, as there were in *Ptaszynski* that could have misled the jurors from applying the plain meaning of the act's language as instructed by the trial judge. And, the jury was properly instructed that they could not award plaintiff damages for defendants' violation of the NHA and its negligence based on the same injuries, unlike in *Ptaszynski*. Permitting Dr. Kirby to testify as he did was not an abuse of discretion.

Ptaszynski and *Moody*[319] clarify that although a violation of *N.J.S.A.* 30:13-4.2 does not provide a private cause of action,

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[319] The Honorable Judge Douglas Fasciale. J.A.D., sat on both panels.

a patient may seek damages for a violation of *N.J.S.A.* 30:13-8(a). Indeed, the *Ptaszynski* Court cited *N.J.S.A.* 30:13-8(a) that provides:

> [A]ny person or resident whose rights as defined herein are violated shall have a cause of action against any person committing such violation . . . The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for their violation. Any plaintiff who prevails in any such action shall be entitled to recover reasonable attorney's fees and costs of the action . . . Thus, under the NHA as initially enacted, a person could only bring a claim for a violation of a nursing home resident's "rights" as defined in the law.[320]

The *Ptaszynski* and *Moody* Courts explain that although pursuant to *N.J.S.A.* 30:13-4.2 only the Department of Health may bring an action for violations of a patient's "responsibilities," nevertheless, pursuant to *N.J.S.A.* 30:13-8(a), a patient may bring a claim for violation of a patient's "rights."[321] This is a critical distinction that will guide future cases.

In *Estate of Burns by and through Burns v. Care One at Stanwick, LLC*, the Appellate Division held that an estate had no implied private cause of action against a facility for breach of a statutory bill of rights for an assisted living facility resident.[322] Judge Fischer pointed out that the Legislature, when considering other similar facilities, expressly declared both a bill of rights and a private cause of action, but for assisted living residences the Legislature only enacted a bill of rights.[323] Based on the departure "from the norm," the Appellate Division held that it was assumed to be a conscious decision of the Legislature to withhold a private cause of action.[324] The Appellate Division invited the Legislature to

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320. *Ptaszynski v. Atl. Health Sys., Inc.*, 440 N.J. Super. 24, 33 (App. Div. 2015).

321. *Ptaszynski v. Atl. Health Sys., Inc.*, 440 N.J. Super. 24, 33 (App. Div. 2015).

322. *Estate of Burns v. Care One at Stnawick, LLC*, 468 N.J. Super. 306 (App. Div. 2021).

323. *Estate of Burns v. Care One at Stnawick, LLC*, 468 N.J. Super. 306, 319 (App. Div. 2021).

324. *Estate of Burns v. Care One at Stnawick, LLC*, 468 N.J. Super. 306, 319 (App. Div. 2021).

correct or alter the determination if it felt that the judgment was mistaken or overly cautious.[325]

1-4:10 Non-Delegable Duty of Jail or Prison

A jail or prison has a non-delegable duty to provide adequate medical care to an inmate. This duty was discussed in *Scott-Neal v. New Jersey State Department of Corrections*,[326] where the vicarious liability of the Department of Corrections for the malpractice of an independent contractor employed to provide medical care to inmates was at issue. In reversing the dismissal of claims against several contractors, the court observed:

> The dismissal of the negligence claims was based on the conclusion that CMS was an independent contractor. As we previously indicated, the agencies cannot delegate the responsibility for providing adequate inmate healthcare. *West, supra*, 487 U.S. at 56, 108 S. Ct. at 2259, 101 L. Ed. 2d at 54; *McCormick v. City of Wildwood*, 439 F. Supp. 769, 776 (D.N.J. 1977) ("[a] jailer's duty to provide reasonable medical care is non-delegable. This duty attaches as soon as a prisoner is placed under the jailer's Custody."); *Saint Barnabas Med. Ctr. v. Essex County*, 111 N.J. 67, 74 (1988) ("As a matter of both state and federal law, defendant Essex County had an absolute duty to see that [the prisoner] received medical treatment for his injuries."); *accord Medley v. North Carolina Dep't of Corr*., 412 S.E.2d 654 (1992) (holding that the state has nondelegable duty to provide adequate medical services to inmates); *Shea v. City of Spokane*, 562 P.2d 264, 267-268 (Wash. Ct. App. 1977), *aff'd per curiam*, 578 P.2d 42 (1978) (rejecting the city's contention that it was not liable for negligent medical treatment given jail inmate by independent-contractor doctor); *cf. Marek v. Prof'l*

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325. *Estate of Burns v. Care One at Stnawick, LLC*, 468 N.J. Super. 306, 322 (App. Div. 2021).

326. *Scott-Neal v. N.J. State Dep't of Corr.*, 366 N.J. Super. 570 (App. Div. 2004).

> *Health Servs., Inc.*, 179 N.J. Super. 433, 440-443 (App. Div.), *certif. granted*, 88 N.J. 470, *appeal dismissed* 93 *N.J.* 232 (1981) (holding that health care entity could not delegate to an independent medical contractor its duty of care in reading patient's x-ray).[327]

Judge Sabatino, in *McCormick v. State*,[328] highlighted the State's non-delegable duty in footnote 4 to the opinion:

> Generally, "[c]ontracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody[.] *Scott-Neal v. N.J. Dep't of Corr.*, 366 N.J. Super. 570, 575-576, 841 A.2d 957 (App. Div. 2004) (quoting *West v. Atkins*, 487 U.S. 42, 56, 108 S. Ct. 2250, 2259, 101 L. Ed. 2d 40, 54 (1988). The "non-delegable" nature of this duty "is an exception to the general rule that one who hires an independent contractor is not liable for the negligence of that contractor. *Ibid.*

1-5 DUTIES IN SPECIFIC CIRCUMSTANCES

1-5:1 Duty Regarding Treatment of Body/Deceased

A medical professional has a duty to respect the dignity of the deceased. The violation of this duty gives rise to a cause of action by the family of the deceased. In *Muniz v. United Hospitals*,[329] plaintiffs alleged that the hospital was unable to locate the body of the plaintiffs' baby or confirm the child's death for a period of three weeks. The trial court dismissed the complaint, but the Appellate Division reversed, stating:

> [C]onceivably, a claim for relief for emotional distress or physical disability or both, might be based on (1) plaintiffs' property or other right with respect to the corpse of their deceased child; or

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327. *Scott-Neal v. N.J. State Dep't of Corr.*, 366 N.J. Super. 570, 577 (App. Div. 2004).
328. *McCormick v. State*, 446 N.J. Super. 603 (App. Div. 2016).
329. *Muniz v. United Hosps.*, 153 N.J. Super. 79 (App. Div. 1977).

> (2) an implied contract with the hospital which may have been violated; or (3) conduct by the hospital which would warrant recovery for the tort of outrage; or (4) a deviation from the standard of care reasonably to be expected of a hospital in dealing with corpses and the reasonable forseeability that such a deviation would cause emotional and substantial physical disability with respect to persons normally constituted.[330]

However, the court declined to express any opinion as to the "extent of damages if any, that may be recovered by plaintiffs."[331]

The Supreme Court has approved the award of damages for the mishandling of a corpse. In *Strachan v. John F. Kennedy Memorial Hospital*,[332] plaintiff's son attempted suicide by shooting himself in the head and was taken to the hospital where he was diagnosed as "brain dead" and placed on a respirator. Thereafter, the plaintiffs were asked for permission to "harvest" their son's organs for transplantation. The parents declined to decide that day but returned the next morning and told the defendants that they did not wish to donate any organs. The parents requested that their son be taken off the respirator. The hospital did not have any procedures to remove the plaintiffs' son from the respirator, and it took two days for this to be accomplished. Plaintiffs alleged that the defendants negligently prevented a proper burial. The jury awarded each plaintiff $70,000. The Court held that the defendants were obligated to take reasonable steps to release the body to the next of kin,[333] and that there was ample support for the jury's conclusion that the defendants negligently held the body of plaintiff's son and prevented his proper funeral.[334] The Court relied on the Restatement of Torts (2d), § 868 (1977), that provides:

> Interference With Dead Bodies. One who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of

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330. *Muniz v. United Hosps.*, 153 N.J. Super. 79, 82 (App. Div. 1977).
331. *Muniz v. United Hosps.*, 153 N.J. Super. 79, 82 (App. Div. 1977).
332. *Strachan v. John F. Kennedy Mem'l Hosp.*, 109 N.J. 523 (1988).
333. *Strachan v. John F. Kennedy Mem'l Hosp.*, 109 N.J. 523, 531 (1988).
334. *Strachan v. John F. Kennedy Mem'l Hosp.*, 109 N.J. 523, 533 (1988).

> a dead person or prevents its proper internment or cremation is subject to liability to a member of the family of the deceased who is entitled to the disposition of the body.

The Court specifically cited a comment to this section of the Restatement that provides that "[t]here is no need to show physical consequences of the mental distress" in order to recover for the mishandling of a corpse. The Court therefore concluded that "plaintiffs need not demonstrate any physical manifestations of their emotional distress" in order to recover, approving the holding of *Muniz v. United Hospitals.*[335] The Court explicitly rejected the need to prove the four elements of a claim for emotional distress cited in *Portee v. Jaffee.*[336]

1-5:2 Duty to Elderly and Infirm Patient

The health care professional has a special responsibility to the elderly and infirm. This duty was recognized in *Tobia v. Cooper Hospital University Medical Center*,[337] where the Court was concerned with the relationship between patients who are unable to protect themselves from injury because of "age, substance abuse, or mental derangement."[338] In *Tobia*, when plaintiff was admitted to the Cooper Hospital, she was 85 years old and "in urgent need of medical care."[339] Plaintiff had been left unattended on an unlocked stretcher with its side rails down and fell when she attempted to get off the stretcher. The Court concluded that a medical professional has a duty to exercise reasonable care "to prevent such a patient from engaging in self-damaging conduct" and further that as a result of this special duty, the medical professional "may not assert contributory negligence as a defense to a claim arising from the patient's self-inflicted injuries."[340] The

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335. *Strachan v. John F. Kennedy Mem'l Hosp.*, 109 N.J. 523, 538 (1988) (citing *Muniz v. United Hosps.*, 153 N.J. Super. 79, 80 (App. Div. 1977)).

336. *Portee v. Jaffee*, 84 N.J. 88 (1980). *See* discussion regarding emotional distress in Chapter 5, § 5-12.

337. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335 (1994).

338. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 338 (1994).

339. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 339 (1994).

340. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 338 (1994).

Court noted that such patients "may require an extra measure of care by health-care professionals."[341]

The Court analogized to the duty to exercise care to protect the suicidal patient, citing *Cowan v. Doering*,[342] and products liability cases which impose a duty to "prevent a party from engaging in self-damaging conduct."[343] A similar holding is found in *Nowacki v. Community Medical Center*,[344] where plaintiff alleged that she fell while attempting to lift herself onto a treatment table. The court noted that the jury could have found that plaintiff's injuries were caused by the defendant's negligence in failing to take "adequate precautions with a patient in plaintiff's state of health."[345]

1-5:3 Duty to Suicidal Patient

A medical professional has a duty to exercise reasonable care to prevent a patient from engaging in self-damaging conduct. In *Fernandez v. Baruch*,[346] the plaintiff's administratrix ad prosequendum alleged that the defendants failed to institutionalize her husband when he was at risk for harming himself, negligently allowed her husband to be placed in the custody of the police, and negligently failed to inform the police of risks posed by discontinuation of her husband's medication. The Court framed the issue in the case as

> whether the defendant doctors, in the application of accepted medical practice, knew or should have known that Fernandez presented a suicide risk requiring special precautions.[347]

The Court instructed that

> the controlling factor in determining whether there may be a recovery for failure to prevent a suicide is whether the defendants reasonably should have

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341. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 338 (1994).

342. *Cowan v. Doering*, 111 N.J. 451 (1988). *See* discussion in § 1-5:3 regarding duty to suicidal patients.

343. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 341 (1994) (citing *Green v. Sterling Extruder*, 95 N.J. 263 (1984); *Suter v. San Angelo Foundry & Mach. Co.*, 81 N.J. 150 (1979)).

344. *Nowacki v. Cmty. Med. Ctr.*, 279 N.J. Super. 276 (App. Div. 1995).

345. *Nowacki v. Cmty. Med. Ctr.*, 279 N.J. Super. 276, 289 (App. Div. 1995) (citing *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 338 (1994)).

346. *Fernandez v. Baruch*, 52 N.J. 127 (1968).

347. *Fernandez v. Baruch*, 52 N.J. 127, 130 (1968).

> anticipated the danger that the deceased would attempt to harm himself.[348]

This holding was followed in *Cowan v. Doering*,[349] where plaintiff alleged that the defendants negligently failed to prevent her from attempting suicide. The evidence revealed that plaintiff, a nurse, had entered into a sexual relationship with one of the defendants, Dr. Doering. Plaintiff took an overdose of sleeping pills that Dr. Doering had prescribed for her and was brought to the emergency room. While at the hospital, plaintiff jumped from a second floor window sustaining serious injuries. The trial court refused to charge comparative negligence. The Appellate Division affirmed,[350] as did the Supreme Court, stating that "plaintiff committed the very act that defendants were under a duty to prevent."[351] The Supreme Court explained that since the defendants' duty to exercise reasonable care included a duty to prevent plaintiff from engaging in self-damaging conduct, such conduct could not be the basis of a claim of comparative negligence.[352] The Court noted the duty of care to prevent self-inflicted harm arose "because there was a foreseeable risk that plaintiff's condition, as it was known to defendants, included the danger that she would injure herself."[353]

A similar conclusion was reached in *Gaido v. Weiser*,[354] that also involved allegations that the defendant negligently failed to prevent plaintiff's husband from committing suicide. Plaintiff's husband, who had a history of depression and attempted suicide, was found dead six days after his discharge from a psychiatric hospital. The court cited *Fernandez*, for the following holding:

> The controlling factor in determining whether there may be a recovery for failure to prevent a suicide is whether the defendants reasonably should have anticipated the danger that the deceased would attempt to harm himself.[355]

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348. *Fernandez v. Baruch*, 52 N.J. 127, 132 (1968).
349. *Cowan v. Doering*, 111 N.J. 451 (1988).
350. *Cowan v. Doering*, 215 N.J. Super. 484 (App. Div. 1987), *aff'd*, 111 N.J. 451 (1988).
351. *Cowan v. Doering*, 215 N.J. Super. 484, 495 (App. Div. 1987), *aff'd*, 111 N.J. 451 (1988).
352. *Cowan v. Doering*, 111 N.J. 451, 459 (1988).
353. *Cowan v. Doering*, 111 N.J. 451, 462 (1988).
354. *Gaido v. Weiser*, 227 N.J. Super. 175 (App. Div. 1988), *aff'd*, 115 N.J. 310 (1989).
355. *Gaido v. Weiser*, 227 N.J. Super. 175, 195 (App. Div. 1988), *aff'd*, 115 N.J. 310 (1989).

The court also quoted the Appellate Division decision in *Cowan*[356] for the proposition:

> Where it is reasonably foreseeable that a patient by reason of his mental or emotional illness may attempt to injure himself, those in charge of his care owe a duty to safeguard him from his self-damaging potential. This duty contemplates the reasonably foreseeable consequences of self-afflicted injury regardless of whether it is a product of patient's volitional or negligent act.[357]

The court also instructed that "the duty imposed upon those responsible for the care of a patient in an institutional setting differs from that which may be involved in the case of a psychiatrist treating patients on an out-patient basis."[358] The Supreme Court affirmed and Justice Handler, in a concurring opinion, noted that "plaintiff's burden of proving proximate causation, however, has been relaxed" in such cases by application of the Restatement of Torts (2d), § 323(a), that provides that a person is liable for failing to exercise reasonable care to protect another person if the failure to exercise such care increases the risk of harm.[359]

The duty to protect a patient from self-harm was analyzed in *Marshall v. Klebanov.*[360] In *Marshall*, the plaintiff's wife, a 36-year-old mother of two young children, committed suicide two days before a scheduled appointment with her psychiatrist, the defendant. The plaintiff claimed that the defendant refused to see his wife for a regularly scheduled appointment because she was unable to pay his fee. The psychiatrist claimed that he would have seen the patient, but that she refused to wait. The plaintiff alleged that the defendant had abandoned his wife and had otherwise deviated from the standard of care.

The trial court granted summary judgment to the psychiatrist, relying upon N.J.S.A. 2A:62A-16, that provides in relevant part that

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356. *Cowan v. Doering*, 215 N.J. Super. 484, 494-95 (App. Div. 1987), *aff'd,* 111 N.J. 451 (1988).

357. *Gaido v. Weiser*, 227 N.J. Super. 175, 195 (App. Div. 1988), *aff'd*, 115 N.J. 310 (1989).

358. *Gaido v. Weiser*, 227 N.J. Super. 175, 196 (App. Div. 1988), *aff'd*, 115 N.J. 310 (1989).

359. *Gaido v. Weiser*, 115 N.J. 310, 313 (1989).

360. *Marshall v. Klebanov*, 378 N.J. Super. 371 (App. Div. 2005), *aff'd*, 188 N.J. 23 (2006).

a person licensed in this state to practice "psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling" is immune from "any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth" in N.J.S.A. 2A:62A-16(b) and "fails to discharge that duty as set forth" in N.J.S.A. 2A:62A-16(c). A health care practitioner incurs a "duty to warn and protect" when:

(1) the patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe that the patient intended to carry out the threat; or

(2) the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself.[361]

The practitioner may discharge the "duty to warn and protect" by doing one or more of the following:

(1) arranging for the patient to be admitted voluntarily to the psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital, or a psychiatric facility;

(2) initiating procedures for the involuntary commitment of the patient;

(3) advising a local law enforcement authority of the patient's threat and the identity of the intended victim;

(4) warning the intended victim of the threat, or, in the case of an intended victim who is under the

361. *See* N.J.S.A. 2A:62A-16(b).

> age of 18, warning the parent or guardian of the intended victim; or
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> (5) if the patient is under 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient.[362]

The court observed that this duty is consistent with prior New Jersey cases that have established the duty of a mental health practitioner to protect the patient from "a reasonably foreseeable self-inflicted injury."[363]

The Appellate Division explained that the purpose of N.J.S.A. 2A:62A-16 is to codify the duty to "warn and protect" and protect the health care provider from claims of improperly disclosing confidential information. The court added:

> the purpose of the statute was not to immunize mental health practitioners from all liability for a patient's suicide regardless of the reasonable likelihood of suicide or the gravity of the practitioner's deviation from the pertinent standard of care.[364]

The Appellate Division therefore reversed, noting that plaintiff had supplied the report of an expert who opined that the defendant had deviated from the standard of care, resulting in the suicide of plaintiff's wife.

The Supreme Court affirmed,[365] concluding that N.J.S.A. 2A:62A-16 does not immunize a psychiatrist who "deviates from the applicable standard of care in the treatment of a patient and that deviation proximately causes harm to the patient."[366] The Court affirmed the summary judgment as to the plaintiff's claim that the defendant had a duty to warn that his wife was in imminent danger of committing suicide because there was no evidence to support the claim of imminent danger.[367] However, the Court held that:

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362. *See* N.J.S.A. 2A:62A-16(c).

363. *Marshall v. Klebanov*, 378 N.J. Super. 371, 378 (App. Div. 2005), *aff'd*, 188 N.J. 23 (2006) (citing *Cowan v. Doering*, 215 N.J. Super. 484, 495 (App. Div. 1987), *aff'd*, 111 N.J. 451 (1988)).

364. *Marshall v. Klebanov*, 378 N.J. Super. 371, 379 (App. Div. 2005), *aff'd*, 188 N.J. 23 (2006).

365. *Marshall v. Klebanov*, 188 N.J. 23 (2006).

366. *Marshall v. Klebanov*, 188 N.J. 23, 34 (2006).

367. *Marshall v. Klebanov*, 188 N.J. 23, 40 (2006).

> the statutory immunity provisions of *N.J.S.A.* 2A:62A-16 do not immunize a mental health practitioner from potential liability if the practitioner abandons a seriously depressed patient and fails to treat the patient in accordance with accepted standards of care in the field.[368]

The Court therefore remanded the case to resolve the disputed facts as to whether the psychiatrist "abandoned" the decedent two days prior to her suicide.[369]

1-6 LIABILITY OF THIRD PARTIES FOR PHYSICIAN'S BREACH OF DUTY OF CARE

1-6:1 Duty of a Credentialer

Hospital accreditation organizations require that hospitals ensure the quality of care provided to patients by their medical staff. Medicare also imposes such a duty to ensure quality of care and requires review of medical staff qualifications and periodic appraisal of medical staff members.[370] This process is known as credentialing. "Credentialing" is defined by The Joint Commission[371] as "[t]he process of granting authorization by the governing body to provide specific patient care and treatment services in the hospital."[372] In January 2007, the Joint Commission adopted significantly revised credentialing and privileging standards. These standards require that health care organizations must conduct ongoing professional practice evaluations for each practitioner, conduct focused evaluations when issues affecting care are identified, and use the reviews and information to determine the status of each practitioner's privileges.[373]

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368. *Marshall v. Klebanov*, 188 N.J. 23, 38 (2006).

369. *Marshall v. Klebanov*, 188 N.J. 23, 39 (2006). *See also In re Involuntary Commitment of J.R.*, 390 N.J. Super. 523 (App. Div. 2007) (standard for involuntary commitment).

370. *See* 42 C.F.R. 482.22 (hospital conditions for participation in Medicare program).

371. The Joint Commission was formerly named the Joint Commission on Accreditation of Healthcare Organizations.

372. The Joint Commission, Accreditation Manual for Hospitals 222 (1993).

373. *See* The Joint Commission Standards on Focused Performance Monitoring Standards MS.4.30; and Ongoing Professional Practice Evaluation, MS.4.40 (2007).

A health care professional may be liable for improperly "credentialing" another health care professional. This was explained in *Stumper v. Kimel*,[374] where plaintiff had surgery and the surgeon left orders for the irrigation of a feeding tube that had been inserted into the plaintiff's intestine. After being advised that the wrong lumen of the tube may have been irrigated, the surgeon ordered that the tube be removed. A resident attempted to remove the tube and in so doing perforated the plaintiff's esophagus and caused the partial collapse of one of plaintiff's lungs. The tube was then surgically removed and an examination revealed that the tube had been improperly irrigated, that prevented its normal removal. Plaintiff settled with all defendants other than the surgeon and the jury found in the surgeon's favor. Plaintiff contended that the surgeon should be liable for the negligence of the resident.[375] The Appellate Division disagreed, but did recognize that liability could be imposed if the procedure was beyond the resident's "training and qualifications."[376] The court explained:

> We disagree and hold that a surgeon rendering post-operative care to a patient is not liable for the negligence of a hospital-employed resident physician, when the orders given relate to procedures which are not potentially dangerous to the patient and fall within the ambit of his training and qualifications, and is the accepted medical and hospital standard of practice . . . .
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> . . . .
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> . . . There are exceptions to this rule; as examples only, if the patient proves the surgeon . . . knew the resident was not qualified to perform the task assigned.[377]

Subsequent cases illustrate this affirmative duty. In *Corleto v. Shore Memorial Hospital*,[378] the court expressly acknowledged the

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374. *Stumper v. Kimel*, 108 N.J. Super. 209 (App. Div. 1970).
375. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
376. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
377. *Stumper v. Kimel*, 108 N.J. Super. 209, 213 (App. Div. 1970).
378. *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302 (Law Div. 1975).

existence of a cause of action for improperly credentialing a physician. In *Corleto*, plaintiff alleged that a hospital, through its administrators, board of directors, and medical staff, knew that a surgeon was not competent to perform surgery, but nevertheless permitted him to do so, resulting in the death of plaintiff's decedent. The complaint alleged that the defendants had a duty to investigate the qualifications and credentials of the physicians performing surgery at the hospital and to allow only qualified physicians to exercise the privilege to perform surgery at the hospital. The plaintiff also alleged that the defendants had a duty to remove the surgeon from the case "when it was obvious that the situation had gone completely beyond his control and competence."[379] The *Corleto* court concluded that "the permitting of an operation by one known to be incompetent to perform it, as well as the failure to remove him from the case when problems have become obvious, would be a basis upon which to impose liability on those responsible."[380]

The *Corleto* decision was followed in *Suenram v. Society of the Valley Hospital*,[381] where plaintiff, a 70-year-old woman afflicted with terminal cancer, sought to restrain the defendant hospital from prohibiting her treatment with laetrile. The court noted that laetrile was not generally recognized as a "safe and effective cancer drug."[382] However, the court also noted that the plaintiff had undergone extensive chemotherapy, that her prognosis was poor and that her "death is imminent."[383] Thus, although laetrile had not been recognized as a safe and effective treatment, the plaintiff could not have been harmed by the treatment since she was expected to die within the month. Nevertheless, the court also took note of the fact that:

> Valley has a profound interest in maintaining high standards of medical care in protecting the health and lives of its patients. It is not disputed that the hospital does have a duty to review the quality of

379. *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 305-06 (Law Div. 1975).
380. *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 305-06 (Law Div. 1975).
381. *Suenram v. Soc'y of the Valley Hosp.*, 155 N.J. Super. 593 (Law Div. 1977).
382. *Suenram v. Soc'y of the Valley Hosp.*, 155 N.J. Super. 593, 595 (Law Div. 1977).
383. *Suenram v. Soc'y of the Valley Hosp.*, 155 N.J. Super. 593, 596 (Law Div. 1977).

> patient care and provide safeguards to insure that, for instance, only competent physicians are admitted to the hospital's surgical staff.[384]

The *Corleto* decision suggests that a hospital may even be held liable for knowingly allowing an independently retained doctor to perform an operation that would constitute an act of malpractice per se.[385]

The issue of credentialing should be investigated in all cases where, for example, a patient is injured during the performance of a relatively new surgical procedure or while a surgeon is using special surgical instruments. The hospital and its credentialing staff may be liable for permitting a physician to perform surgery that the physician was not qualified or trained to perform.

The Supreme Court granted certification in *Jarrell v. Kaul*[386] on the question of whether the plaintiff could maintain a cause of action against a medical facility that allowed a doctor to perform in that facility procedures for which the doctor did not have malpractice insurance.

1-6:2 Duty of Employer/Respondeat Superior

1-6:2.1 Employment Relationship Required

A hospital is liable for the negligence of its employees, including physicians, pursuant to the doctrine of respondeat superior. However, most doctors are not employees of the hospital where they practice medicine, but rather are independent contractors with the privilege of seeing patients at the hospital. The imposition of liability based on the doctrine of respondeat superior requires proof of an employment relationship, as distinguished from an independent contractor relationship.[387] A discussion of such liability is found in

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384. *Suenram v. Soc'y of the Valley Hosp.*, 155 N.J. Super. 593, 599 (Law Div. 1977) (citing *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302 (Law Div. 1975)).

385. *Suenram v. Soc'y of the Valley Hosp.*, 155 N.J. Super. 593, 599 (Law Div. 1977); *see also President v. Jenkins*, 357 N.J. Super. 288 (App. Div. 2003) (a hospital may be liable for the "selection and appointment of an unqualified, unskilled or incompetent physician") (citing *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 308-09 (Law Div. 1975)), *rev'd on other grounds*, 180 N.J. 550 (2004)).

386. *Jarrell v. Kaul*, 223 N.J. 294 (2015).

387. *See generally Gil v. Clara Maass Med. Ctr.*, 450 N.J. Super. 368 (App. Div. 2017), where the court determined that an obstetrician working at the hospital pursuant to a

Tobia v. Cooper Hospital University Medical Center,[388] where plaintiff was admitted to the hospital at the age of 85 and was described as "in urgent need of medical care."[389] Plaintiff was left unattended on an unlocked stretcher with its side rails down and fell while attempting to get off the stretcher. The Court simply observed that "by reinstating the claims against the doctor and nurses the doctrine of respondeat superior requires us to reinstate the suit against Cooper Hospital."[390] Similarly, in *Corleto v. Shore Memorial Hospital*,[391] the court noted that a hospital is liable for the negligence of a doctor who is an employee of the hospital.[392]

1-6:2.2 Employee Need Not Be Party

In *Walker v. Choudhary*,[393] the appellate division examined the interaction between the liability of an employer, the statute of limitations and the 'relation-back' doctrine as provided by New Jersey Court Rule 4:9-3. In *Walker*, the plaintiff alleged that the negligence of the defendants during decedent's treatment at the hospital November 30, 2005 resulted in her decedent's death on December 5, 2005. On November 20, 2007, the plaintiff filed suit against a hospital, three doctors employed in the emergency department of the hospital, and the medical practice group that employed the physicians. On February 28, 2008, after learning that Dr. Kiger was the plaintiff's attending physician, plaintiff's attorney filed a motion to amend the complaint to add Dr. Kiger as a defendant, and on April 10, 2008, the plaintiff filed an amended complaint naming Dr. Kiger as a defendant.[394]

Dr. Kiger moved to dismiss based upon the statute of limitations, which motion was granted on August 1, 2008. The medical group that employed Dr. Kiger then successfully moved for to dismissal of the claim for vicarious liability for Dr. Kiger's negligence.[395]

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services agreement between his group and the hospital was not an employee or a leased worker falling under the umbrella of insurance coverage issued to the hospital.

388. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335 (1994).
389. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 339 (1994).
390. *Tobia v. Cooper Hosp. Univ. Med. Ctr.*, 136 N.J. 335, 345 (1994).
391. *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302 (Law Div. 1975).
392. *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 308 (Law Div. 1975).
393. *Walker v. Choudhary*, 425 N.J. Super. 135 (App. Div. 2012).
394. *Walker v. Choudhary*, 425 N.J. Super. 135, 139-41 (App. Div. 2012).
395. *Walker v. Choudhary*, 425 N.J. Super. 135, 141 (App. Div. 2012).

The appellate division reversed, explaining that the dismissal of Dr. Kiger on limitations grounds does not bar a "timely respondeat superior claim for vicarious liability against defendants" the hospital and Dr. Kiger's employer.[396]

> Because Healthcare and Physician Services were timely served within the statute of limitations period, plaintiff's action could have been prosecuted against them, even without Kiger being named as a defendant in the complaint. We note it would be incongruous to hold that plaintiff's claim against Physician Services must fail because Kiger was named and then dismissed because the claim was time-barred, while in the same breath observing that the same claim against Physician Services would survive if Kiger had not been named at all.[397]

The appellate court also rejected the hospital's and employer's arguments that the doctrine of res judicata bars the claims against the entities:

> Plaintiff's claims for malpractice and wrongful death were never adjudicated on the actual merits. The basis on which the summary judgment was granted, the statute of limitations, bears no relationship to the actual merits of the case. When summary judgment was granted, the merits were never examined. We agree to label such an order as an adjudication on the merits would be the embodiment of promoting form over substance.[398]

In sum:

> We conclude an employer can be subject to suit for the negligent actions of its employee under the principle of respondeat superior even though the employee is dismissed because the claims against her or him were filed outside the statute of limitations. Therefore, plaintiff's malpractice and

396. *Walker v. Choudhary*, 425 N.J. Super. 135, 148 (App. Div. 2012).
397. *Walker v. Choudhary*, 425 N.J. Super. 135, 150 (App. Div. 2012).
398. *Walker v. Choudhary*, 425 N.J. Super. 135, 154 (App. Div. 2012).

> wrongful death claims against Healthcare and Physicians Services are not barred by the doctrine of res judicata and are reinstated.[399]

In *McCormick v. State*,[400] Judge Sabatino explained the necessity for an affidavit of merit for unnamed employees when "the plaintiff's claim of vicarious liability hinges upon allegations of deviation from professional standards of care by licensed individuals who worked for the named defendant." However, *McCormick* specifically states, "[n]othing in the Tort Claims Act requires that the individuals whose negligent conduct creates the public entity's liability be names as co-defendants in the action."[401] Further, "[i]n cases such as this, where a plaintiff chooses to sue a public entity for medical malpractice on a theory of vicarious liability, the defendant entity is obligated to comply with *Rule* 4:5-3 by including in its answer the identities and specialties of the physicians, if any, involved in the defendant's care, along with whether the treatment the defendant received involved those specialties."[402]

1-6:2.3 Employer Not Liable for Employee Conduct Outside Scope of Employment

The liability of an employer for an intentional assault on a patient by an employee was discussed in *Davis v. Devereux Foundation*.[403] In *Davis*, defendant's employee had poured boiling water on the plaintiff, causing severe injuries. After the trial court dismissed the case as to the Devereux Foundation, the appellate division reversed, rejecting the plaintiff's argument that the duty of care owed by the institution was non-delegable, but holding that a jury might determine that the employer was be liable under the concept of "*respondeat superior*."[404] The Supreme Court agreed that imposition of a non-delegable duty was

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399. *Walker v. Choudhary*, 425 N.J. Super. 135, 154 (App. Div. 2012).

400. *McCormick v. State*, 446 N.J. Super. 603, 615 (App. Div. 2016).

401. *McCormick v. State*, 446 N.J. Super. 603, 615 (App. Div. 2016).

402. *McCormick v. State*, 446 N.J. Super. 603, 618 (App. Div. 2016).

403. *Davis v. Devereux Found.*, 414 N.J. Super. 1 (App. Div. 2010), *aff'd in part, rev'd in part*, 209 N.J. 269 (2012).

404. *Davis v. Devereux Found.*, 414 N.J. Super. 1, 3-4 (App. Div. 2010), *aff'd in part, rev'd in part*, 209 N.J. 269 (2012).

> not justified by the relationship among the relevant parties, required by the nature of the risk, warranted by the opportunity and ability to exercise care, or grounded in the public policy of our State. The imposition of liability for unexpected criminal acts of properly screened, trained and supervised employees would jeopardize charitable institutions that provide critical services for disabled citizens. We decline to expand New Jersey *respondeat superior* law beyond its traditional parameters.[405]

However, the appellate division had concluded that the plaintiff was entitled to pursue a claim under the doctrine of respondeat superior, asserting that the employee's intentional act was within the scope of employment.[406] The appellate panel concluded that a rational factfinder could find that "McClain's motives were at least mixed," and that the employee's intent was to serve the employer, the "employer is liable under *Gibson*," and therefore remanded the case for trial.[407] The Supreme Court reversed this conclusion, stating:

> McClain's conduct is clearly outside of the scope of her employment. McClain's decision to injure

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405. *Davis v. Devereux Found.*, 209 N.J. 269, 278 (2012).

406. *Davis v. Devereux Found.*, 414 N.J. Super. 1, 12-16 (App. Div. 2010) (relying on *Gibson v. Kennedy*, 23 N.J. 150 (1957)), *aff'd in part, rev'd in part*, 209 N.J. 269 (2012). The court explained:

> A jury might find that [the employee] assaulted Davis solely because of a preexisting personal grievance arising out of his prior assaults on her, or because she was angry about her boyfriend's death, either of which would free Devereux of liability. But a jury could also find that [the employee's] motives were at least mixed. When she went to get Davis out of bed, she was performing an assigned task. Her responsibilities included maintaining control of his behavior so that his tendency toward outbursts of violence did not cause harm to her or others. If avoidance of such an outburst to serve her employer was her intent, at least in part, her employer is liable under *Gibson*. Of course, her behavior was seriously reprehensible, but it was not substantially worse than the employee behavior in either *Gibson* (repeatedly striking a man in the head with a lantern) or *Nelson*, the main case on which *Gibson* relied, which involved a sudden punching followed by a severe beating.

Davis v. Devereux Found., 414 N.J. Super. 1, 15-16 (App. Div. 2010) (citing *Nelson v. Am.-West African Line, Inc.*, 86 F.2d 730 (2nd Cir. 1936)), *aff'd in part, rev'd in part*, 209 N.J. 269 (2012); *see also President v. Jenkins*, 357 N.J. Super. 288 (App. Div. 2003) (the Appellate Division observed that in some circumstances a hospital may be liable vicariously for the negligence of a staff physician) (citing *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 306 (Law Div. 1975)), *rev'd on other grounds*, 180 N.J. 550 (2004).

407. *Davis v. Devereux Found.*, 414 N.J. Super. 1, 16 (App. Div. 2010), *aff'd in part, rev'd in part*, 209 N.J. 269 (2012).

> Davis was not only inconsistent with Devereux's purpose in employing her, but directly contravened Devereux's mission to protect a resident for whom Devereux had cared since his childhood. While McClain's act was 'substantially within the authorized time and place limits' of her job, it was not by any measure 'actuated' by a purpose to serve Devereux. See Restatement, supra, § 228(1). McClain's act of violence, concealed from supervisors before and during the assault and denied thereafter, could not have been foreseen by Devereux.
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> In short, the Court finds that no rational factfinder could construe McClain's premeditated and unprovoked scalding of Davis to be an effort to serve Devereux. As a matter of law, McClain's assault was not within the scope of her employment. The trial court properly granted summary judgment dismissing plaintiff's claims against Devereux.
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> In summary, we affirm the Appellate Division's decision insofar as it rejected the imposition of a "non-delegable duty" upon Devereux. We reverse the Appellate Division's decision to the extent that it held that the trial court's grant of summary judgment was error.[408]

Similarly, in *Claus v. Brodhead*,[409] plaintiff filed suit against a physician and his union's medical clinic alleging fraud, negligence and assault and battery in connection with treatment of a hemorrhoid. The court held that "a corporate employer may not be held for the negligence of a physician employee in the absence of negligence in his selection."[410]

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408. *Davis v. Devereux Found.*, 209 N.J. 269, 307-08 (2012).
409. *Claus v. Brodhead*, 36 N.J. Super. 598 (Law Div. 1955).
410. *Claus v. Brodhead*, 36 N.J. Super. 598, 607 (Law Div. 1955).

1-6:2.4 Limitation of Liability

The relationship between the $250,000 limitation of liability provided to hospitals pursuant to N.J.S.A. 2A:53A-8 and the vicarious liability of a hospital is discussed in Chapter 8, § 8-7:2.2.

1-6:3 Apparent Employment of Medical Professionals

Hospitals are vicariously liable for the negligence of their actual employees, including physicians employed by hospitals. However, in a trilogy of cases, starting nearly 30 years ago with a law division decision, *Arthur v. St. Peter's Hospital*,[411] and concluding with the decisions in *Basil v. Wolf*,[412] and *Estate of Cordero v. Christ Hospital*,[413] the courts in New Jersey and elsewhere have established and reaffirmed the doctrine of "apparent employment." Pursuant to this doctrine, hospitals and other medical providers can be liable for the negligence of those hospital-based health care providers who are not actually employed by the hospital, but who appear to be employed by the hospital. Radiologists, pathologists, anesthesiologists, emergency department doctors and nurses are among those most likely to be involved, but health care professionals employed in clinics and private corporate health care providers are also potential "apparent employees."

The doctrine of apparent employment was first cited in a malpractice case in New Jersey in *Arthur v. St. Peter's Hospital*,[414] where the patient alleged that the defendant physicians failed to diagnose a fracture. The defendant hospital moved for summary judgment, contending that the physicians were independent contractors. The trial judge observed that hospitals are generally not liable for the acts of physicians who are not employees but rather independent contractors.[415] However, the court presciently concluded that where a hospital holds out a physician as its employee,

> plaintiff had a right to assume that the treatment that was being received was being rendered through hospital employees and that any negligence

411. *Arthur v. St. Peter's Hosp.*, 169 N.J. Super. 575 (Law Div. 1979).
412. *Basil v. Wolf*, 193 N.J. 38 (2007).
413. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306 (App. Div. 2008).
414. *Arthur v. St. Peter's Hosp.*, 169 N.J. Super. 575 (Law Div. 1979).
415. *Arthur v. St. Peter's Hosp.*, 169 N.J. Super. 575, 579 (Law Div. 1979).

> associated with that treatment would render the hospital responsible.[416]

In reaching this conclusion, *Arthur* relied upon the Restatement of Torts 2d § 429 and a seminal New York case, *Mduba v. Benedictine Hospital.*[417] In *Mduba*, a patient died after a physician failed to obtain a blood sample so that a transfusion could be ordered in a timely fashion. The *Mduba* court also relied upon the Restatement of Torts 2d § 429, and held that because the hospital held itself out to the public as furnishing emergency care, it was vicariously liable for the negligence of the doctors it assigned despite their status as independent contractors.[418] In reaching its conclusion, the *Mduba* Court noted that "[s]uch patients are not bound by secret limitations as are contained in a private contract between the hospital and the doctor."[419]

The rationale of *Mduba* has been widely followed, and majority of jurisdictions that have considered this issue have adopted the doctrine of apparent employment to impose liability on hospitals for the negligence of independent contractor physicians.[420]

However, despite the growing number of out-of-state decisions that recognized this doctrine, the vitality of the doctrine in New Jersey was limited by the fact that *Arthur* was an older Law Division decision. However, the doctrine of apparent employment was revitalized by the Court in *Basil v. Wolf*[421] and finally explicitly adopted in *Estate of Cordero v. Christ Hospital*.[422]

In *Basil*, the plaintiff was referred by his workers' compensation carrier to Dr. Wolf, who had closed his practice but still performed medical evaluations for insurance companies. Dr. Wolf failed to diagnose a sarcoma, and the plaintiff asserted that the compensation carrier should be vicariously liable for Dr. Wolf's negligence. The trial court dismissed the case as to the carrier, and the appellate division affirmed. The Supreme Court rejected Basil's claim

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416. *Arthur v. St. Peter's Hosp.*, 169 N.J. Super. 575, 584 (Law Div. 1979).

417. *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450 (3d Dept. 1976).

418. *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450, 453-54 (3d Dept. 1976).

419. *Mduba v. Benedictine Hosp.*, 52 A.D.2d 450, 453 (3d Dept. 1976).

420. *See, e.g.*, Note: *Hospital Vicarious Liability for Negligence by Independent Contractor Physicians: a New Rule for New Times*, 2005 U. Ill L. Rev. 1291, 1323 (2005).

421. *Basil v. Wolf*, 193 N.J. 38 (2007).

422. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306 (App. Div. 2008).

because the facts did not establish vicarious liability based upon apparent employment, but commented, in dicta:

> If a principal cloaks an independent contractor with apparent authority or agency, the principal can be held liable as if the contractor were its own employee if it held out the contractor to the plaintiff as its own servant or agent. *See Arthur v. St. Peters Hosp*., 169 N.J. Super. 575, 581 (Law Div. 1979).
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> . . . .
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> . . . Thus, in the context of a hospital and its independent contractor physicians, there would be apparent authority '[i]n those cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital.' Id. at 581.[423]

Nevertheless, the *Basil* Court concluded that there was no evidence to support the claim that the compensation carrier

> conveyed and intended to convey that Dr. Wolf was its treating physician for Basil, and that Basil acted in reliance on such a reasonable, but falsely created, impression to that effect.[424]

The Court therefore affirmed the dismissal.

The plaintiff successfully asserted a claim based upon apparent authority in *Estate of Cordero v. Christ Hospital*,[425] where the court explicitly approved the application of the doctrine of apparent employment to hospital-based physicians. The plaintiff therein was admitted to Christ Hospital for surgery. The defendant, an anesthesiologist, "was assigned, randomly" to the plaintiff. The court observed that the defendant "had one brief conversation with Cordero before the procedure . . . and did not tell Cordero that Christ Hospital assumed no responsibility for the care she

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423. *Basil v. Wolf*, 193 N.J. 38, 63-67 (2007).

424. *Basil v. Wolf*, 193 N.J. 38, 67 (2007).

425. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306 (App. Div. 2008).

would provide."[426] Additionally, Christ Hospital's website merely identified the defendant as "a member of its anesthesia department." After the plaintiff settled with the defendant, plaintiff contended that Christ Hospital was liable for the defendant's negligence under a theory of apparent employment. The trial court dismissed this claim, but the appellate division reversed, first reiterating that the doctrine of apparent employment applies when a

> hospital, by its actions, has held out a particular physician as its agent and/or employee and . . . a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital.[427]

The *Cordero* court then explained:

> [W]hen a hospital provides a doctor for a patient and the totality of the circumstances created by the hospital's action and inaction would lead a patient to reasonably believe the doctor's care is rendered in behalf of the hospital, the hospital has held out that doctor as its agent. We also hold that when a hospital patient accepts a doctor's care under such circumstances, the patient's acceptance in the reasonable belief the doctor is rendering treatment in behalf of the hospital may be presumed unless rebutted.[428]

The *Cordero* court reviewed the analysis of this issue in other jurisdictions and, placing reliance upon § 2.03 of the Restatement (Third) of Agency and § 429 of the Restatement (Second) of Torts, held

> when a hospital provides a doctor for its patient and the totality of the circumstances created by the hospital's action and inaction would lead a patient to reasonably believe that the doctor's care

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426. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 311 (App. Div. 2008).
427. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 313 (App. Div. 2008).
428. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 318 (App. Div. 2008).

> is rendered on behalf of the hospital, the hospital has held out that doctor as its agent.[429]

The *Cordero* court then outlined the factors that courts should consider when addressing this issue:

1. whether the hospital supplied the doctor;
2. the nature of the medical care and whether the specialty, like anesthesiology, radiology or emergency care, is typically provided in and an integral part of medical treatment received in a hospital;
3. any notice of the doctor's independence from the hospital or disclaimers of responsibility;
4. the patient's opportunity to reject the care or select a different doctor;
5. the patient's contacts with the doctor prior to the incident at issue; and
6. any special knowledge about the doctor's contractual arrangement with the hospital.[430]

Applying these five factors to the case, the *Cordero* court concluded that:

> Christ Hospital put in place a system under which [the defendant] arrived, without explanation, on the day of Cordero's surgery to provide specialized care in the hospital's operating room. The doctor had no prior contact with the patient. The totality of these circumstances would lead a reasonable patient in the same situation to assume that Christ Hospital furnished the services of the anesthesiologist along with those of other members of the operating room staff. Having created a misimpression of agency, Christ Hospital failed to take any action to correct it. There is no evidence that Christ Hospital issued, or required [the defendant] to issue, any disclaimer of its responsibility and no evidence that Cordero was

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429. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 310 (App. Div. 2008).
430. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 318-19 (App. Div. 2008).

> given an opportunity to reject [the defendant's] services or select a different doctor. Nothing suggests that Cordero had special knowledge about the administration of Christ Hospital or its relationship with [the defendant.] Under these circumstances, created by Christ Hospital's action and its inaction, a reasonable patient in Cordero's position would have every reason to believe and little reason to doubt that [the defendant] was rendering care in Christ Hospital's behalf . . . .
>
> Because Cordero accepted [the defendant's] care under circumstances that would lead a reasonable patient to believe the care was rendered in behalf of Christ Hospital, plaintiffs are entitled to a rebuttable presumption that Cordero accepted [the defendant's] care in that reasonable belief.[431]

Thus, when a health care provider selects or assigns a physician for a patient, the provider will generally be liable for the negligence of the physician, unless it gives the patient notice that the doctor was an independent contractor. This holding has been incorporated into the Model Jury Charges.[432]

The relationship between the $250,000 limitation of liability provided to hospitals pursuant to N.J.S.A. 2A:53A-8 and the vicarious liability of a hospital for the negligence of an apparent employee is discussed in Chapter 8, § 8-7 regarding charitable and other immunities.

1-6:4 Liability of Referring Physician

A physician who refers a patient to another doctor is not generally responsible for the latter's negligence. In *Tramutola v. Bortone*,[433] plaintiff sued a surgeon and the family doctor who referred her to the surgeon. The Supreme Court reversed the finding of liability against the family doctor, holding that he was not liable for recommending the surgeon and therefore was "not accountable for

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431. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 319-20 (App. Div. 2008).

432. *See* Model Jury Charge 5.50 Apparent Authority (Approved 6/10). *See* the Appendix for information on where to access the Model Jury Charge online.

433. *Tramutola v. Bortone*, 118 N.J. Super. 503 (App. Div. 1972), *aff'd*, 63 N.J. 9 (1973).

or chargeable with [the surgeon's] negligence in connection with the handling of the suturing needle."[434] A similar conclusion was reached in *Marek v. Professional Health Services, Inc.*,[435] where the court noted that a physician who engaged a specialist is not vicariously liable for the specialist's malpractice.[436] Indeed, it has been held that the duty of the initial doctor ends when the patient begins treatment with the next doctor.

A similar conclusion is found in *Brandt v. Grubin*,[437] which explained that:

> A general practitioner, when faced with a specialized problem, should not be faulted because he referred his patient to a specialist, or in this case, a clinic of specialists, in a situation where the patient presumably could not afford private psychiatric help. The duty of the initial doctor ends upon the patient's undergoing the subsequent treatment.[438]

This holding is consistent with the cases that discuss the liability of the supervisory or credentialing physician.

1-6:5 Liability of Workers' Compensation Carrier for Examining Physician's Negligence

A workers' compensation carrier is generally not liable for the negligence of a physician retained by the carrier to examine a worker. In *Basil v. Wolf*,[439] the plaintiff appealed from the dismissal of an action against her husband's workers' compensation carrier. Mr. Basil had been injured on the job and later died of a sarcoma. The plaintiff asserted that the cancer should have been discovered when Mr. Basil was treated for a workplace injury by a doctor assigned to him by the compensation carrier. The estate claimed that the compensation carrier was liable based on vicarious liability and negligent hiring of the physician. The estate also asserted

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434. *Tramutola v. Bortone*, 63 N.J. 9, 16-17 (1973).

435. *Marek v. Prof'l Health Servs., Inc.*, 179 N.J. Super. 433 (App. Div. 1981).

436. *Marek v. Prof'l Health Servs., Inc.*, 179 N.J. Super. 433, 443 n.3 (App. Div. 1981) (citing *Tramutola v. Bortone*, 63 N.J. 9, 16 (1973)).

437. *Brandt v. Grubin*, 131 N.J. Super. 182 (Law Div. 1974).

438. *Brandt v. Grubin*, 131 N.J. Super. 182, 190 (Law Div. 1974).

439. *Basil v. Wolf*, 193 N.J. 38 (2007).

that the compensation carrier's pre-approval process constituted the negligent provision of medical care. The trial court dismissed the case as to the compensation carrier and the Appellate Division and Supreme Court affirmed.

The Supreme Court rejected the argument that the compensation carrier's recommendation and provision of medical treatment created any liability.

> The facts do not provide a basis for concluding that TIC [the compensation carrier] shed its statutory immunity by performing, on behalf of the employer, the very tasks the employer is required by law to perform. We affirm the Appellate Division's judgment holding that, on these facts, there is no direct action available against TIC.[440]

The court distinguished *Mager v. United Hospitals of Newark*,[441] where "the insurer took it upon itself to directly and physically perform the services required under the Act by operating its own clinic."[442]

The Court noted that vicarious liability could be imposed if the principal: (1) controlled "the means and manner" of the contractor's performance, (2) created apparent authority of the contractor, or (3) negligently hired an incompetent contractor.[443] In rejecting the control test, the Court observed:

> when an insurer requests a contract physician to perform a physical examination and to report back the results of that exam, the insurer is not engaging in the sort of 'control' anticipated by the exception described in *Majestic Realty Assocs., Inc. v. Toti Contracting Co.*, 30 N.J. 425, 430-32 (1959).[444]

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440. *Basil v. Wolf*, 193 N.J. 38, 62 (2007).

441. *Mager v. United Hosps. of Newark*, 88 N.J. Super. 421 (App. Div. 1965), *aff'd o.b.*, 46 N.J. 398 (1966).

442. *Basil v. Wolf*, 193 N.J. 38, 59 (2007).

443. *Basil v. Wolf*, 193 N.J. 38, 63 (2007).

444. *Basil v. Wolf*, 193 N.J. 38, 65 (2007).

The Court also rejected any liability of the compensation carrier based upon the doctrine of apparent authority.[445] The Court explained the basis for liability based upon apparent authority:

> The key question 'is whether the principal has by his voluntary act placed the agent in such a situation that a person of ordinary prudence, conversant with business usages and the nature of the particular business, is justified in presuming that such agent has authority to perform the particular act in question.' *Ibid* . . . . Thus, in the context of a hospital and its independent contractor physicians, there would be apparent authority '[i]n those cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital.'[446]

In rejecting this claim of the estate of Basil, the Court concluded:

> The estate's extension of that rationale to a workers' compensation insurance carrier is novel and without precedent. In order to establish apparent authority in this case, the estate would have to show both that the insurer, in its communications to Basil, conveyed and intended to convey that Dr. Wolf was its treating physician for Basil, and that Basil acted in reliance on such a reasonable, but falsely created, impression to that effect. That showing simply does not exist in this record. The Appellate Division correctly affirmed the dismissal of that claim.[447]

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445. *Basil v. Wolf*, 193 N.J. 38, 58 (2007).

446. *Basil v. Wolf*, 193 N.J. 38, 67 (2007). *See also* § 1-6:3 regarding apparent employment of medical professionals.

447. *Basil v. Wolf*, 193 N.J. 38, 67 (2007).

The Court also rejected the negligent hiring claim.

> To prevail against the principal for hiring an incompetent contractor, a plaintiff must show that the contractor was, in fact, incompetent or unskilled to perform the job for which he/she was hired, that the harm that resulted arose out of that incompetence, and that the principal knew or should have known of the incompetence.[448]

The Court explained that such a showing was not made in the *Basil* case:

> We cannot conclude from the timing of the underlying events in this matter and of the enactment of the statute and its latter clarifying regulation that Dr. Wolf's lack of insurance rendered him, from the perspective of TIC, an 'incompetent contractor' as a matter of law.[449]

The Court added that because state regulations require practicing physicians to have medical malpractice insurance,

> an insurance company that engages an IME physician for evaluative purposes now must be aware that it is under a continuing duty of inquiry in respect of malpractice insurance requirements in order to ensure that the physicians it engages are qualified to practice.[450]

1-7 TERMINATION OF THE DUTY OF CARE

The duty of care is coterminous with the physician-patient relationship. In *Brandt v. Grubin*,[451] plaintiff sued a family physician asserting that the defendant improperly assessed her son who was in need of psychiatric care. The defendant examined plaintiff's son

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448. *Basil v. Wolf*, 193 N.J. 38, 69 (2007).

449. *Basil v. Wolf*, 193 N.J. 38, 72 (2007).

450. *Basil v. Wolf*, 193 N.J. 38, 73 (2007). *See also Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306 (App. Div. 2008), which held that the patient was entitled to a "rebuttable presumption" that an anesthesiologist was an apparent employee of a hospital. *Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306 (App. Div. 2008) (citing *Basil v. Wolf*, 193 N.J. 38, 67 (2007) and *Arthur v. St. Peter's Hosp.*, 169 N.J. Super. 575 (Law Div. 1979)).

451. *Brandt v. Grubin*, 131 N.J. Super. 182 (Law Div. 1974).

only once and diagnosed "anxiety, loneliness and insomnia."[452] The defendant gave him a prescription of thorazine and referred him to a mental hygiene clinic. The plaintiff's son did not see the defendant again. A month later, the plaintiff's son was treated in an emergency room and again advised to seek psychiatric help. Thereafter, he committed suicide. The court held that the defendant had satisfied his duty to the plaintiff's son as a matter of law and dismissed the case.

> A general practitioner, when faced with a specialized problem, should not be faulted because he referred his patient to a specialist, or in this case, a clinic of specialists, in a situation where the patient presumably could not afford private psychiatric help. The duty of the initial doctor ends upon the patient's undergoing the subsequent treatment.[453]

This holding should not be construed as permitting a physician to abandon the patient. However, where care has been transferred to another medical professional, the duty of the initial treating doctor is generally terminated.

Also, in *Couch v. Visiting Home Care Service of Ocean County*,[454] the court held that a medical provider has the right to withdraw from further treatment where the provider feels that the treatment is "inappropriate or unsafe."[455] However, the provider must obtain reasonable assurances that treatment and care will continue.

II OTHER RELATED DUTIES

1-8 THE DUTY OF CONFIDENTIALITY

1-8:1 Generally

The physician-patient privilege, found at N.J.S.A. 2A:84A-22.1 through -22.9 and New Jersey Rules of Evidence 506, imposes a duty of confidentiality upon a physician. Prior to enactment of the

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452. *Brandt v. Grubin*, 131 N.J. Super. 182, 185 (Law Div. 1974).

453. *Brandt v. Grubin*, 131 N.J. Super. 182, 190 (Law Div. 1974).

454. *Couch v. Visiting Home Care Serv. of Ocean Cty.*, 329 N.J. Super. 47 (App. Div. 2000).

455. *Couch v. Visiting Home Care Serv. of Ocean Cty.*, 329 N.J. Super. 47, 53 (App. Div. 2000).

statutory privilege, medical professionals had a common law duty not to disclose any information regarding their patients. This duty was acknowledged in *Hague v. Williams*,[456] where plaintiffs sued their pediatrician, alleging that he improperly disclosed medical information about their baby daughter to a life insurance company. The parents had stated in the application for the insurance that the baby was in good health. After the baby died, the insurance company contacted the pediatrician who advised the insurance company that the baby had heart trouble since birth. As a result of obtaining this information the insurance company refused to pay the proceeds of the life insurance policy.

Plaintiffs argued that the doctor was under a duty not to reply to the inquiry of the insurance company without their express authorization. The Supreme Court noted that there was no physician-patient privilege at common law, and that at the time of the disclosure New Jersey had not yet adopted a statutory physician-patient privilege. Nevertheless, the Court recognized the common law duty to maintain the confidentiality of information obtained about the patient and the public policy behind such a duty. The Court explained:

> We have, then, no expressed public policy pointing to a general prohibition against testimonial revelation of information acquired during the physician-patient relationship, but, on the contrary, our policy is to expose such information to view when it is relevant to the resolution of litigation . . . .
>
> . . . .
>
> However, the same philosophy does not apply with equal rigor to non-testimonial disclosure . . . . The benefits which inure to the relationship of physician-patient from the denial to a physician of any right to promiscuously disclose such information are self-evident. On the other hand, it is impossible to conceive of any countervailing

456. *Hague v. Williams*, 37 N.J. 328 (1962).

> benefits which would arise by according a physician the right to gossip about a patient's health.
>
> A patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled. So here, when the plaintiffs contracted with the defendant for services to be performed for their infant child, he was under a general duty not to disclose frivolously the information received from them, or from an examination of the patient.[457]

See also *B.R. v. Vaughan*,[458] in which the Appellate Division held that State agencies and their employees have no duty to notify a person of their partner's HIV/AIDS even if the infected person is a client or patient of that agency or employee, relying upon N.J.S.A. 26:5C-7 to -9 and N.J.S.A. 26:5C-14.

1-8:2 Exceptions to/Waiver of Confidentiality

1-8:2.1 Personal Injury Claim Waives Confidentiality

Despite recognizing a common law duty of confidentiality, the Court in *Hague v. Williams*[459] concluded that the plaintiff could not recover damages, and in so doing also recognized an exception to the duty of confidentiality.

> We conclude, therefore, that ordinarily a physician receives information relating to a patient's health in a confidential capacity and should not disclose such information without the patient's consent, except where the public interest or the private interest of the patient so demands . . . . One of these exceptions arises where, as here, the physical condition of the patient is made an element of a claim. While that claim had not yet been pressed to litigation,

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457. *Hague v. Williams*, 37 N.J. 328, 335-36 (1962).
458. *B.R. v. Vaughan*, 427 N.J. Super. 487 (Law Div. 2012).
459. *Hague v. Williams*, 37 N.J. 328 (1962).

> the same policy which during litigation permits, even demands, disclosure of information acquired during the course of the physician-patient relationship allows the disclosure thereof to the person against whom the claim is made, when recovery is sought prior to or without suit. At this point the public interest in an honest and just result assumes dominance over the individual's right of nondisclosure. When the plaintiffs made a claim involving the health of the patient, they lost any right to nondisclosure they may have had and defendant was justified in conveying the relevant information to the insurer upon its request.[460]

Thus, the filing of a suit for personal injuries results in the waiver of the privilege to keep medical records confidential. This holding has been incorporated into the statutory physician-patient privilege.

Indeed, the filing of suit permits a defendant to interview the plaintiff's treating doctors. This is of special significance given the Supreme Court's decision in *Stigliano v. Connaught Laboratories*,[461] holding that a subsequent treating doctor may be called to testify as to causation against the wishes of the patient.[462]

In *Stempler v. Speidell*,[463] the Court established a procedure by which defense counsel may conduct interviews of the plaintiff's treating doctors. In *Stempler*, counsel for the defendant requested that plaintiff sign authorizations permitting defense counsel to interview plaintiff's treating physicians. The plaintiff refused and the trial court ordered plaintiff to execute authorizations permitting ex parte interviews. The Appellate Division denied leave to appeal, but the Supreme Court granted plaintiff's motion for leave to appeal.

The Court began its analysis by noting that a physician has "a professional obligation to maintain the confidentiality of his

460. *Hague v. Williams*, 37 N.J. 328, 336-37 (1962).
461. *Stigliano v. Connaught Labs.*, 140 N.J. 305 (1995).
462. *See* Chapter 9, § 9-14, particularly § 9-14:3.2.
463. *Stempler v. Speidell*, 100 N.J. 368 (1985).

patient's communications."[464] The Court explained that the filing of suit "extinguishes" the patient-physician privilege to the extent that plaintiff's medical condition is at issue.[465] The Court then recalled that in *Hague,* it held that patients have a qualified, but not absolute, right to confidentiality of records.[466] The Court ratified the holding in *Lazorick v. Brown*,[467] where the Appellate Division upheld the defendant's right to conduct ex parte interviews of plaintiff's treating physicians.[468] After analyzing the conflicting interests of the parties, *i.e.*, the defendant's desire to interview the treating physicians and obtain beneficial testimony, against the plaintiff's interest in protecting disclosure of damaging or confidential information not relevant to the litigation, the Court concluded:

> In our view, these competing interests can be respected adequately without requiring the formality of depositions in every case. The Rules regulating pre-trial discovery do not purport to set forth the only methods by which information pertinent to the litigation may be obtained. Personal interviews, although not expressly referred to in our Rules, are an accepted, informal method of assembling facts and documents in preparation for trial. Their use should be encouraged as should other informal means of discovery that reduce the cost and time of trial preparation.[469]

The Court therefore instructed that plaintiffs were required to sign authorizations permitting the defense counsel to interview their treating physicians. However, the Court also held that defense counsel must provide plaintiff's counsel with reasonable notice of the time and place of the interview. Finally, the Court held:

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464. *Stempler v. Speidell*, 100 N.J. 368, 375 (1985). *See* American Medical Ass'n, Principles of Medical Ethics § 9 (1957).

465. *Stempler v. Speidell*, 100 N.J. 368, 373 (1985).

466. *Stempler v. Speidell*, 100 N.J. 368, 377 (1985).

467. *Lazorick v. Brown*, 195 N.J. Super. 444, 447-48 (App. Div. 1984).

468. *Stempler v. Speidell*, 100 N.J. 368, 379 (1985).

469. *Stempler v. Speidell*, 100 N.J. 368, 382 (1985).

> Additionally, the authorizations or orders should require that defendant's counsel provide the physician with a description of the anticipated scope of the interview, and communicate with unmistakable clarity the fact that the physician's participation in an *ex parte* interview is voluntary. This procedure will afford plaintiff's counsel the opportunity to communicate with the physician, if necessary, in order to express any appropriate concerns as to the proper scope of the interview, and the extent to which plaintiff continues to assert the patient-physician privilege with respect to that physician.[470]

The Court noted that plaintiff may move for a protective order seeking the supervision of the trial court, granting plaintiff's counsel the opportunity to be present during the interview or even requiring that defense counsel proceed by deposition of the treating physician.

1-8:2.2 Use and Misuse of a Subpoena

Medical records may be the subject of a subpoena, but the use of a subpoena is subject to strict rules. The penalty for the misuse of subpoena power to obtain medical information was discussed in *Crescenzo v. Crane*,[471] In *Crescenzo*, the plaintiff was in the process of divorcing her husband when his attorney served a subpoena duces tecum on the plaintiff's personal physician, Dr. Crane, requiring production of the plaintiff's medical records. The subpoena was accompanied by a letter that stated that if the medical records were sent by mail there would be no need for Dr. Crane to appear on the return date of the subpoena.[472] Counsel for the husband did not provide an authorization from the wife consenting to the release of her medical records. Furthermore, the husband's attorney did not even provide notice of the subpoena to either the plaintiff or her attorney.[473] In response to the subpoena, the plaintiff's physician released her medical records to the husband's

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470. *Stempler v. Speidell*, 100 N.J. 368, 382 (1985).
471. *Crescenzo v. Crane*, 350 N.J. Super. 531 (App. Div. 2002).
472. *Crescenzo v. Crane*, 350 N.J. Super. 531, 536 (App. Div. 2002).
473. *Crescenzo v. Crane*, 350 N.J. Super. 531, 536 (App. Div. 2002).

attorney, who provided the medical records to third parties. The wife filed suit against her doctor alleging a breach of the duty of confidentiality. The trial court dismissed the complaint against the doctor, concluding that even if the wrong procedures were utilized, the records would have inevitably been discoverable.[474]

When reversing, the Appellate Division first explained that the purpose of the rule of court that grants subpoena power, New Jersey Court Rule 4:14-7(c), is to permit discovery from non-parties, while providing notice and the opportunity for parties to challenge the propriety of the subpoena. The court then observed that New Jersey Court Rule 4:14-7(c) has five essential requirements:

(1) the subpoena must be served with a deposition notice;

(2) the subpoena must state that the records shall not be released until the date of the deposition;

(3) the subpoena must notify the deponent that if a motion to quash the subpoena is filed the deponent shall not release the records;

(4) the subpoena must be served on all parties; and

(5) if evidence is produced by a deponent who does not attend the deposition, the party issuing the subpoena must provide notice and make the evidence available to all parties.

The court observed that the husband's attorney had actually managed to violate each of these five requirements.[475]

The Appellate Division then explained that the wife had a viable claim against the doctor for breach of the physician-patient privilege, relying on *Runyon v. Smith*.[476] The *Crescenzo* panel explicitly rejected the contention that since the records were ultimately discoverable, this was a case of "no harm, no foul" as stated by the trial judge.[477] The court therefore reversed and

474. *Crescenzo v. Crane*, 350 N.J. Super. 531, 537 (App. Div. 2002).
475. *Crescenzo v. Crane*, 350 N.J. Super. 531, 539 (App. Div. 2002).
476. *Runyon v. Smith*, 322 N.J. Super. 236 (App. Div. 1999), *aff'd*, 163 N.J. 439 (2000).
477. *Crescenzo v. Crane*, 350 N.J. Super. 531, 543 (App. Div. 2002).

remanded, adding that it would not address the issue of the scope of the plaintiff's damages.[478]

The improper use of a subpoena to obtain medical information resulted in disqualification of defense counsel in *Cavallaro v. Jamco Property Management*.[479] In *Cavallaro*, the defendant's attorney served subpoenas on numerous medical providers with a cover letter stating that if the medical records were provided prior to the date of the deposition the appearance of the medical providers at the deposition would not be required.[480] Although counsel for plaintiff was provided with a copy of the subpoena, the defense counsel did not provide a copy of the cover letter to the plaintiff's attorney. When counsel for the plaintiff contacted one of the plaintiff's medical providers, a psychologist, in connection with a motion to quash the subpoena, the plaintiff's attorney was advised that the records had already been sent to defense counsel. The plaintiff moved for a protective order and the trial court ruled that plaintiff's mental health treatment records were privileged pursuant to New Jersey Rules of Evidence 505 and N.J.S.A. 45:14B-28,[481] and that counsel for the defendant had failed to satisfy the requirements of *Kinsella v. Kinsella*,[482] regarding waiver of the privilege for mental health records. The trial court also found that the subpoena violated the Rules of Civil Procedure and the Code of Professional Responsibility. The trial court therefore ordered the return of the mental health records and disqualified the defense counsel.[483] The Appellate Division affirmed the holding that the mental health records were privileged pursuant to N.J.S.A. 45:14B-28 and New Jersey Rules of Evidence 505, and also affirmed the trial court's disqualification of defense counsel.[484]

In The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[485] has created new safeguards to protect the

478. *Crescenzo v. Crane*, 350 N.J. Super. 531, 544 (App. Div. 2002).
479. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557 (App. Div. 2000).
480. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 562 (App. Div. 2000).
481. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 565 (App. Div. 2000).
482. *Kinsella v. Kinsella*, 150 N.J. 276 (1997).
483. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 572 (App. Div. 2000).
484. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 572-73 (App. Div. 2000).
485. 42 U.S.C. 201, et seq.

security and confidentiality of health information. The regulations promulgated by the Department of Health and Human Services (HHS) permit patients to obtain copies of their medical records and control how their medical records and history information may be used and disclosed to third parties. Most health care providers, insurers, and pharmacies were required to comply with these federal standards beginning April 14, 2003.[486]

In *Kinsella v. NYT Television*,[487] the Appellate Division held that the names of hospital patients are protected from disclosure by the Hospital Patients Bill of Rights Act,[488] and the Physician-Patient Privilege.[489] In *Kinsella*, the plaintiff was a patient at a trauma center when a television program called "Trauma: Life in the ER" was being videotaped by the defendant. Although the plaintiff signed a consent, he alleged that the consent was invalid because of the fact that he was in great pain from his injuries and he was under the influence of pain medication. The plaintiff served the subpoena upon the treating hospital compelling production of the names and addresses of all the patients who were videotaped but the hospital refused to disclose the names of certain patients, citing the patients' "confidentiality interest in their admission to the trauma center that was protected from disclosure by the Hospital Patients Bill of Rights Act and the Physician-Patient privilege."[490]

The Appellate Division noted that the Hospital Patient's Bill of Rights Act confers a right of "patient privacy and confidentiality" that includes protection "from a hospital's disclosure of his or her admittance to the hospital." The court explained that there are many reasons why admission to a hospital may involve very confidential matters, such a seeking treatment for drug overdoses, attempted suicide, or sexual assault.[491] The Appellate Division also noted that the physician-patient privilege also protects against disclosure of an admission to the hospital. The court specifically held "this obligation of confidentiality . . . applies not only to

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486. A thorough discussion of the HIPAA regulations available at http://www.hhs.gov/ocr/hipaa/ (last visited Apr. 13, 2022).

487. *Kinsella v. NYT Television*, 382 N.J. Super. 102 (App. Div. 2005).

488. N.J.S.A. 26:2H-12.7 to -12.11.

489. N.J.S.A. 2A:84A-22.1 to -22.7.

490. *Kinsella v. NYT Television*, 382 N.J. Super. 102, 105 (App. Div. 2005).

491. *Kinsella v. NYT Television*, 382 N.J. Super. 102, 107-08 (App. Div. 2005).

physicians but also to hospitals as well."[492] The Appellate Division was careful to point out that these statutes do not "preclude discussion of a patient's case or examination of a patient by appropriate health care personnel,"[493] and that even the physician-patient privilege may be pierced when the patient puts his or her medical condition in issue in litigation.[494] The court therefore reversed an order compelling disclosure of the names of persons who are admitted to the hospital.

1-8:3 Duty to Keep AIDS Diagnosis Confidential

The issues involving Acquired Immune Deficiency Syndrome (AIDS) have created additional confidentiality concerns. The extent to which a medical professional must keep the diagnosis of AIDS confidential was discussed in *Estate of Behringer v. Medical Center at Princeton*,[495] where plaintiff, a physician and member of the medical staff of the Princeton Medical Center, was diagnosed as HIV-positive while a patient in the hospital. The plaintiff was so concerned that others would find out about the diagnosis that he refused a wheelchair and insisted on walking out of the hospital when he was discharged. Nevertheless, by the time plaintiff returned home, he had received telephone calls about his condition from numerous doctors who were social friends but not involved in the treatment of plaintiff. As word of the plaintiff's diagnosis spread to his patients, "cancellations continued at an exceedingly high rate."[496] Plaintiff sued the Medical Center, asserting a breach of the duty of confidentiality. The court agreed that plaintiff had a cause of action, stating:

> The physician-patient privilege has a strong tradition in New Jersey. The privilege imposes an obligation on a physician to maintain the confidentiality of a patient's communications. *Stempler v. Speidell*, 100

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492. *Kinsella v. NYT Television*, 382 N.J. Super. 102, 109 (App. Div. 2005) (quoting *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 632 (Law Div. 1991)).

493. *Kinsella v. NYT Television*, 382 N.J. Super. 102, 110 (App. Div. 2005).

494. *Kinsella v. NYT Television*, 382 N.J. Super. 102, 110 (App. Div. 2005). *See also* N.J.S.A. 26:4-15 and N.J.A.C. 8:57-1.3, that impose a statutory duty to report certain crimes and diseases.

495. *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597 (Law Div. 1991).

496. *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 609 (Law Div. 1991).

> *N.J.* 368 (1985). This obligation of confidentiality applies to patients, records, and information and applies not only to physicians, but hospitals as well. *Unick v. Kessler Memorial Hospital*, 107 *N.J. Super.* 121 (Law Div. 1969). This duty of confidentiality has been the subject of legislative codification which reflects the public policy of the state. *N.J.S.A.* 2A:84A-22.1 *et seq*. The patient must be able to secure medical services without fear of betrayal and unwarranted embarrassment and detrimental disclosure . . . *Piller v. Kovarsky*, 194 *N.J. Super.* 392, 396 (Law Div. 1984).[497]

The court noted that there are exceptions to the duty of confidentiality, including when the plaintiff puts his medical condition at issue in civil litigation, a duty to warn third-parties at risk for harm, and a duty to report communicable diseases pursuant to N.J.S.A. 26:4-15 and N.J.A.C. 8:57-1.3. Nevertheless, the court ruled that the hospital breached its duty to keep the plaintiff's medical chart secure and was therefore liable for the damages which were reasonably foreseeable as a result of the breach of this duty.

Estate of Behringer v. Medical Center at Princeton[498] was further solidified by *Smith v. Datla*.[499] The Appellate Division held that the improper disclosure of a plaintiff's HIV-positive status to a third-party without the plaintiff's prior informed consent triggered several different claims: invasion of privacy, violation of the AIDS-assistance Act, and medical malpractice.[500]

Invasion of privacy has four classifications: (1) intrusion; (2) public disclosure of private facts; (3) placing plaintiff in a false light in the public eye; and (4) appropriation of plaintiff's name or likeness for defendant's benefit.[501] Therefore, the Appellate

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497. *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 632 (Law Div. 1991). *Smith v. Datla*, 451 N.J. Super. 82, 103 (App. Div. 2017), positively cites this exact quote.

498. *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 632 (Law Div. 1991).

499. *Smith v. Datla*, 451 N.J. Super. 82 (App. Div. 2017).

500. *Smith v. Datla*, 451 N.J. Super. 82, 104-05 (App. Div. 2017).

501. *Smith v. Datla*, 451 N.J. Super. 82, 95 (App. Div. 2017).

Division set a two-year statute of limitation on the claims by determining that the unauthorized disclosure of plaintiff's status fell within invasion of privacy by public disclosure of private facts.[502] The two-year statute of limitations was selected because the type of invasion of privacy tort is more like an injury to the person rather than defamation.[503] "Plaintiffs have a privacy right in their medical records and medical information."[504]

The Appellate Division reiterated the requirements to protect a patient's personal medical information from unauthorized disclosure by citing to HIPAA, the AIDS Assistance Act, and the common law duty to maintain the confidentiality of patients' records and information.[505] They further cite the Hospital Patients Bill of Rights Act as incorporating the privilege and rights of privacy and confidentiality of their medical records.[506]

"Medical records revealing a patient's HIV-positive status are afforded heightened confidentiality."[507] "The breach of a physician's duty to maintain the confidentiality of his patient's medical records is a deviation from the standard of care, giving rise to a personal injury claim based upon negligence, not defamation or placing plaintiff in a false light."[508] "[P]laintiff's claim for medical malpractice is most analogous to the category of invasion of privacy claims that are grounded on an allegation that defendant improperly disclosed private facts concerning the plaintiff to a third party."[509]

At the heart of the decision, the Appellate Division stated that the disclosure "struck directly at the personhood of the patient" and defendant's conduct "cuts most deeply at the personal level."[510]

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502. *Smith v. Datla*, 451 N.J. Super. 82, 100 (App. Div. 2017).

503. *Smith v. Datla*, 451 N.J. Super. 82, 96-100 (App. Div. 2017) (Defamation assumes facts that are untrue or in a false light and, in the present matter, the disseminated information was true.).

504. *Smith v. Datla*, 451 N.J. Super. 82, 99 (App. Div. 2017) (citing *United States v. Westinghouse*, 638 F.2d 570, 577 (3d Cir. 1980)).

505. *Smith v. Datla*, 451 N.J. Super. 82, 102 (App. Div. 2017).

506. *Smith v. Datla*, 451 N.J. Super. 82, 103 (App. Div. 2017) (citing N.J.S.A. 26:2H-12.8(f), (g)).

507. *Smith v. Datla*, 451 N.J. Super. 82, 103 (App. Div. 2017).

508. *Smith v. Datla*, 451 N.J. Super. 82, 103 (App. Div. 2017).

509. *Smith v. Datla*, 451 N.J. Super. 82, 103 (App. Div. 2017).

510. *Smith v. Datla*, 451 N.J. Super. 82, 104-05 (App. Div. 2017).

1-8:4 Duty to Keep Psychiatric Records Confidential

1-8:4.1 Privilege Akin to Attorney-Client Privilege

The New Jersey Supreme Court enacted a unified and comprehensive privilege for mental-health providers in 2016. The new rule of evidence, N.J.R.E. 534, Mental Health Service Provider-Patient Privilege, defines "confidential communications" as "such information transmitted between a mental-health service provider and patient in the course of treatment of or related to that individual's condition of mental or emotional health including information obtained by an examination of the patient, that is transmitted in confidence, and is not intended to be disclosed to third persons." The new evidence role defines "mental-health service provider" as "a person authorized or reasonably believed by the patient to be authorized to engage in the diagnosis or treatment of a mental or emotional condition" and is specifically intended to include psychologists, physicians, marriage and family therapists, social workers, alcohol and drug counselors, nurses, professional counselors, associate counselors or rehabilitation counselors, psychoanalysts, midwives, physician assistants, and pharmacists.

The new rule of evidence provides that a patient "has a privilege to refuse to disclose in a proceeding, and to prevent any other person from disclosing confidential communications."[511] There are of course several exceptions to the rule of confidentiality. Communications relevant to proceedings to commit a patient, to establish mental competence, or to recover damages when the conduct of the patient constitutes a crime are not protected from disclosure. Similarly, such communications are not protected in proceedings related to the validity of a will of a patient, an investigation ordered by the court, the patient's insurance, prior testimony by the health provider at the request of the patient, medical services obtained in the commission of a crime or fraud, a claim against the mental health provider, or an application to purchase a firearm.

The new rule of evidence also permits disclosure which is required to be made in compliance with the statutory duty to report, including but not limited to reports of child or elder abuse. Additionally, nothing in the new rule shall prevent a court from

[511] N.J.R.E. 534.

compelling disclosure where the patient has waived the privilege or exercise of the privilege would violate a constitutional right.

The confidentiality of psychiatric records comes under attack from several sources, including persons involved in litigation with the patient and persons who are at risk of being harmed by the patient. N.J.S.A. 2A:84A-22.4 states that there is no privilege

> in an action in which the condition of the patient is an element or factor of the claim or defense of the patient or of any party claiming through or under the patient or claiming as a beneficiary of the patient through a contract to which the patient is or was a party or under which the patient is or was insured.

In *Arena v. Saphier*,[512] plaintiff alleged that the defendant negligently failed to diagnose and treat an ectopic pregnancy resulting in the loss of her fallopian tubes and inability to conceive. Plaintiff sought damages for emotional distress and acute depression, and defendant moved to compel production of the notes of plaintiff's treating psychologist. The trial court barred production of the notes but the Appellate Division reversed. The appellate court instructed that the special nature of communications to a psychotherapist justify the protection of an *in camera* review by the trial court to determine whether anything in the record was relevant:

> We hold that a psychologist may be compelled to reveal relevant confidences of treatment when a patient renders her mental or emotional condition in issue during the course of litigation. Under such circumstances, the patient's communications to her psychotherapist should not be enshrouded in the veil of absolute privilege. Rather, important public policy considerations favoring liberal pretrial discovery compelled disclosure of all relevant information. Nevertheless, we are not insensitive to the countervailing necessity of protecting the patient from needless humiliation, harassment, and exposure. In our view, these antithetical interests

[512] *Arena v. Saphier*, 201 N.J. Super. 79 (App. Div. 1985).

> can be best accommodated by the trial court's thorough *in camera* inspection of the consultation notes to determine their relevance.[513]

In reaching this conclusion, the *Arena* court held that the communications between a patient and a psychologist are privileged despite the provisions of N.J.S.A. 2A:84A-22.4. The court explained that this statute was designed to "continue the policy which existed prior to enactment of the physician-patient privilege which allowed disclosure of a patient's medical condition when placed in issue in a legal action."[514] The court noted that a separate privilege for the psychotherapist is found at N.J.S.A. 45:14B-28, that was created

> as part of a comprehensive statutory scheme designed to license and regulate practicing psychologists. This legislation and the subsequent enactment pertaining to the physician-patient privilege are wholly distinct and cannot clearly be read *in pari materia*.[515]

The court also noted that there is a significant distinction between a physician treating a disease and a psychologist treating a mental problem.

> The nature of psychotherapy might well justify a greater degree of confidentiality and protection than is generally afforded medical treatment of a physical condition. The nature of the psychotherapeutic process is such that full disclosure to the therapist of the patient's most intimate emotions, fears, and fantasies is required. The patient rightfully expects that his personal revelations will not generally be subject to public scrutiny or exposure.[516]

The court also observed that the psychotherapist privilege was "coterminous with that provided under the attorney-client

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513. *Arena v. Saphier*, 201 N.J. Super. 79, 81 (App. Div. 1985).

514. *Arena v. Saphier*, 201 N.J. Super. 79, 85 (App. Div. 1985) (citing *Hague v. Williams*, 37 N.J. 328, 334 (1962)).

515. *Arena v. Saphier*, 201 N.J. Super. 79, 85 (App. Div. 1985).

516. *Arena v. Saphier*, 201 N.J. Super. 79. 86 (App. Div. 1985).

privilege."[517] Therefore, the court held that the exemption provided by N.J.S.A. 2A:84A-22.4 does not apply to communications between a patient and psychotherapist. Nevertheless, psychological records are not absolutely protected from disclosure.

> We are satisfied that a sensible accommodation of these mutually competing values requires limited pretrial disclosure of the communications between plaintiff and her treating psychologist to the extent that they are relevant to her present mental and emotional condition and its cause. Further, plaintiff should not be permitted to invoke the privilege to render conclusive [her] own evaluation of the nature and character of the materials in question . . . . Because the qualified or limited waiver of the privilege recognized here depends upon the content of the communications, we believe that the consultation notes and letters should be submitted to the trial judge for his *in camera* inspection to determine their relevance.[518]

The issue arose again in *Runyon v. Smith*,[519] where plaintiff alleged that her husband committed an act of domestic violence. The husband called the defendant, a psychologist, at the hearing on the domestic violence claim. The psychologist testified that the plaintiff was "an absentee mother" and that the mother was physically and verbally abusive to her child. The family part judge found the psychologist's testimony persuasive and modified the temporary restraining order to grant temporary custody of the children to the father. The psychologist then submitted a written report to the court which again criticized plaintiff. Thereafter, plaintiff filed suit against the psychologist alleging violation of the psychologist-patient privilege pursuant to N.J.S.A. 45:14B-28 and -29.

The defendant moved for summary judgment, arguing that the testimony adverse to the plaintiff at the hearing was required by the best interests of the children. The plaintiff cross moved for summary judgment arguing that there was no immunity and

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517. *Arena v. Saphier*, 201 N.J. Super. 79. 87 (App. Div. 1985).
518. *Arena v. Saphier*, 201 N.J. Super. 79. 90 (App. Div. 1985).
519. *Runyon v. Smith*, 322 N.J. Super. 236 (App. Div. 1999), *aff'd*, 163 N.J. 439 (2000).

certainly no immunity to make false or inaccurate statements to the court. The trial court granted the psychologist's motion for summary judgment. The Appellate Division reversed, reiterating that the psychologist-patient privilege is similar to the lawyer-client privilege, citing *Kinsella v. Kinsella*.[520] The court explained that the public benefits from a psychologist privilege that "protects the individual from public revelation of inner most thoughts and feelings that were never meant to be heard beyond the walls of the therapist's office."[521]

1-8:4.2 Exceptions to Confidentiality of Psychiatric Records

1-8:4.2a Defense to Crime/Mental State at Issue/Best Interests of Children

The Appellate Division then noted in *Runyon* that the privilege may be pierced where a party places her emotional or mental state in issue, to allow the defendant to present exculpatory evidence in a criminal proceeding, or where the best interests of the children mandate the disclosure. The Appellate Division recognized that the court should first generally rely upon independent experts appointed by the courts or hired by the parties and pierce the privilege only if the independent experts are unable to provide adequate information.

The *Runyon* court revisited *Arena*, which noted that the psychologist privilege must yield, at least to a limited extent, where the patient places her mental or emotional problems at issue. However, the *Runyon* panel held that in such a case the documents should be submitted to the trial judge for an in camera review.[522]

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520. *Kinsella v. Kinsella*, 150 N.J. 276, 297 (1997).

521. *Runyon v. Smith*, 322 N.J. Super. 236 (App. Div. 1999), *aff'd*, 163 N.J. 439 (2000). *See also Correia v. Sherry*, 335 N.J. Super. 60 (Law Div. 2000), where the plaintiffs' son died in a motor vehicle accident, and the plaintiffs provided the defendant with the decedent's academic records but would not authorize release of the decedent's Child Study Team records. The trial court held that the psychologist-patient privilege set forth in N.J.S.A. 45:14B-28 and New Jersey Rules of Evidence 505 survives the death of a person. *Correia v. Sherry*, 335 N.J. Super. 60, 66-67 (Law Div. 2000). The trial court therefore conducted an *in camera* review of the Child Study Team records and concluded that the need for confidentiality outweighed the need for disclosure. *Correia v. Sherry*, 335 N.J. Super. 60, 72 (Law Div. 2000). The defense had sought the records with regard to proof of pecuniary damages in the wrongful death action.

522. *Runyon v. Smith*, 322 N.J. Super. 236, 244 (App. Div. 1999), *aff'd*, 163 N.J. 439 (2000).

The *Runyon* court relied on *In re Kozlow*,[523] to support the creation of a three-pronged test before piercing the privilege:

1) "[T]here must be a legitimate need for the evidence;"
2) "[T]he evidence must be relevant and material to the issue;" and
3) "[T]he information sought cannot be secured from any less intrusive force."[524]

Application of this test compelled the *Runyon* court to conclude that the defendant had breached the psychologist-patient privilege.

The *Runyon* court then analyzed the nature of the damages available in the case of the breach of the duty to keep psychological records confidential. The court recalled that in *Hague v. Williams*,[525] the Supreme Court held that the duty to uphold the physician-patient privilege must yield when the information is relevant to litigation. The *Runyon* court then observed that in *Stempler v. Speidell*,[526] the Supreme Court recognized that a patient was permitted to sue a doctor for money damages arising from the unauthorized disclosure of confidential information. The *Runyon* court concluded:

> With this background, we are satisfied that our Supreme Court would extend the same judicial recognition to a patient seeking damages against a psychologist as a patient seeking damages against a physician for unauthorized disclosure of confidential information.[527]

The Appellate Division therefore concluded that the patient may sue the psychologist for money damages.

The Supreme Court affirmed.[528] The Court specifically stated that a psychotherapist who breaches the duty of confidentiality may be liable in damages. However, the Court also observed that it may be difficult to prove damages or to prove that the

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523. *In re Kozlow*, 79 N.J. 232 (1979).
524. *Runyon v. Smith*, 322 N.J. Super. 236, 242-43 (App. Div. 1999), *aff'd*, 163 N.J. 439 (2000).
525. *Hague v. Williams*, 37 N.J. 328 (1962).
526. *Stempler v. Speidell*, 100 N.J. 368 (1985).
527. *Runyon v. Smith*, 322 N.J. Super. 236, 249 (App. Div. 1999), *aff'd*, 163. N.J. 439 (2000).
528. *Runyon v. Smith*, 163 N.J. 439 (2000).

psychotherapist would not have been required to breach the privilege for other reasons.

1-8:4.2b Persons at Risk of Harm

Persons at risk of being harmed by psychiatric patients have also claimed an exception to the duty of confidentiality. A therapist may also have a duty to warn an identifiable third person that a patient of the therapist poses a risk of harm.[529] In *McIntosh v. Milano*,[530] plaintiff alleged that the defendant, a psychiatrist, breached a duty to warn plaintiff's daughter that a patient of the psychiatrist intended to kill her. The psychiatrist had treated the patient since the age of 15 for an "adjustment reaction of adolescence." The patient had also expressed numerous fantasies about plaintiff's daughter, and had expressed feelings of anger and jealousy regarding her dating other men.

Plaintiff brought suit against the psychiatrist alleging that the doctor had a duty to warn either the plaintiff or his daughter that the patient posed a threat of physical harm to her. The defendant moved for summary judgment, arguing that he had no duty to the plaintiff or his daughter. Plaintiff supplied the report of an expert who stated that the "defendant committed a 'gross deviation' from accepted medical practice by failing to warn or protect decedent under the factual circumstances."[531] Plaintiff's expert relied upon the fact that the defendant was aware that the patient had, on at least one occasion, fired a BB gun at the plaintiff's car, forged a prescription, verbalized threats toward the decedent and her boyfriends, and that the patient had exhibited a knife to the defendant.

The court noted that at common law a person has no duty to prevent harm to a third person absent a special relationship between the two people. The court cited the comment to § 314 of the *Restatement of Torts* that states:

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529. Social workers enjoy a similar privilege, which is found at N.J.S.A. 45:15BB-13 and New Jersey Rules of Evidence 518. This statute provides a privilege to a licensed or certified social worker except where disclosure is required by state law, failure to disclose presents a clear and present danger to the health and safety of another for certain litigation purposes, or where the patient agrees to waive a privilege.

530. *McIntosh v. Milano*, 168 N.J. Super. 466 (Law Div. 1979).

531. *McIntosh v. Milano*, 168 N.J. Super. 466, 477 (Law Div. 1979).

> One human being, seeing a fellow man in dire peril, is under no obligation to aid him, but may sit on the dock, smoke a cigar, and watch the other drown.[532]

However, the court noted that in *Tarasoff v. Regents of the University of California*,[533] the California Supreme Court held that the relationship between a therapist and his patient created a duty to warn third persons when the therapist determines that the patient presents a serious threat of harm to another. The *McIntosh* court therefore concluded that under certain circumstances a psychiatrist does have a duty to warn a third person of the threat of violence and that the jury should determine whether the defendant breached this duty:

> [A] psychiatrist or therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine, in the appropriate factual setting and in accordance with the standards of his profession established at trial, that the patient is or may present a probability of danger to that person.[534]

1-8:4.3 Improper Use of Subpoena for Psychiatric Records

As noted above, the improper use of a subpoena to obtain psychiatric records resulted in the disqualification of defense counsel in *Cavallaro v. Jamco Property Management*.[535] In *Cavallaro*, the defendant's attorney served subpoenas on numerous medical providers with a cover letter stating that if the medical records were provided prior to the date of the deposition, the appearance of the medical providers at the deposition would not be required.[536] Although counsel for the plaintiff was provided with a copy of the subpoena, the defense counsel did not provide a copy of the cover letter to the plaintiff's attorney. When counsel for the plaintiff

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532. *McIntosh v. Milano*, 168 N.J. Super. 466, 484 (Law Div. 1979).
533. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal.3d 425, 551 P.2d 334 (Sup. Ct. 1976).
534. *McIntosh v. Milano*, 168 N.J. Super. 466, 489 (Law Div. 1979).
535. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557 (App. Div. 2000).
536. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557 (App. Div. 2000).

contacted one of the plaintiff's medical providers, a psychologist, in connection with a motion to quash the subpoena, the plaintiff's attorney was advised that the records had already been sent to defense counsel.

The plaintiff moved for a protective order and the trial court ruled that plaintiff's mental health treatment records were privileged pursuant to New Jersey Rules of Evidence 505 and N.J.S.A. 45:14B-28, and that counsel for the defendant had failed to satisfy the requirements of *Kinsella v. Kinsella*,[537] regarding waiver of the privilege for mental health records.[538] The trial court also found that the subpoena violated the Rules of Civil Procedure and the Code of Professional Responsibility. The trial court therefore ordered the return of the mental health records and disqualified the defense counsel.[539] The Appellate Division affirmed the holding that the mental health records were privileged pursuant to N.J.S.A. 45:14B-28 and New Jersey Rules of Evidence 505, and also affirmed the trial court's disqualification of defense counsel.[540]

1-9 THE DUTY TO PROVIDE GENETIC COUNSELING

There is a duty to provide genetic counseling in certain circumstances. This duty was discussed in *Schroeder v. Perkel*,[541] where plaintiffs alleged that the defendants negligently failed to diagnose their daughter's cystic fibrosis during four years of treatment. The parents had not been advised that they were carriers of the cystic fibrosis gene, and as a result were deprived of the opportunity to avoid having a second child who also suffered from cystic fibrosis. The defendants argued that the child was the patient and therefore they had no duty to the parents. The Supreme Court disagreed, calling the defendant's position "myopic," and concluded that the scope of the defendant's duty was "coextensive with the reasonable foreseeability of the consequences of a negligent act."[542]

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537. *Kinsella v. Kinsella*, 150 N.J. 276 (1997).
538. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 565 (App. Div. 2000).
539. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 572 (App. Div. 2000).
540. *Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 572-73 (App. Div. 2000).
541. *Schroeder v. Perkel*, 87 N.J. 53 (1981).
542. *Schroeder v. Perkel*, 87 N.J. 53, 63 (1981).

> The foreseeability of injury to members of the family other than one immediately injured by the wrongdoing of another must be viewed in light of the legal relationships among family members. A family is woven of the fibers of life; if one strand is damaged the whole structure may suffer. The filaments of family life, although individually spun, create a web of interconnected legal interests.[543]

The Supreme Court concluded in language relevant to the duty to third parties:

> A physician's duty thus may extend beyond the interests of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty. Here, the physicians had not only a duty to Ann, but an independent duty to Mr. & Mrs. Schroeder to disclose to them that Ann suffered from cystic fibrosis. The wrong allegedly committed by the defendants was the failure to disclose material information.[544]

The duty to provide genetic counseling to the patient's children was addressed in *Safer v. Estate of Pack.*[545] In *Safer*, plaintiff filed suit against her father's treating physician, asserting that the doctor failed to advise her that she was genetically predisposed to develop multiple polyposis, a hereditary condition that invariably results in cancer of the colon. Plaintiff's father died as a result of this disease in 1964 when plaintiff was 10 years old. In 1990, plaintiff was diagnosed as suffering from the type of colon cancer associated with polyposis. Plaintiff asserted that her father's doctor owed her a duty to warn of the probability that she would develop cancer and of the need for medical monitoring. The trial court granted summary judgment, concluding that "the physician had no legal duty to warn a child of a patient of a genetic risk."[546] The trial court based its conclusion on the absence of a physician-patient relationship between the plaintiff and the defendant. The

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543. *Schroeder v. Perkel*, 87 N.J. 53, 63-64 (1981).
544. *Schroeder v. Perkel*, 87 N.J. 53, 65 (1981).
545. *Safer v. Estate of Pack*, 291 N.J. Super. 619 (App. Div. 1996).
546. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 623 (App. Div. 1996).

Appellate Division reversed, holding that the defendant had a duty to warn of the genetic threat.

> Whether a legal duty exists is, however, a matter of law . . . . We see no impediment, legal or otherwise, to recognizing a physician's duty to warn those known to be at risk of avoidable harm from a genetically transmissible condition. In terms of foreseeability especially, there is no essential difference between the type of genetic threat at issue here and the menace of infection, contagion or a threat of physical harm.[547]

The court emphasized that the person at risk was "easily identified, and substantial future harm may be averted or minimized by a timely and effective warning."[548] In these circumstances, public policy required imposition of a duty since "[e]arly monitoring of those at risk can effectively avert some of the more serious consequences a person with multiple polyposis might otherwise experience."[549] The court therefore instructed that there is a "duty to warn of avertible risk from genetic causes" and that the duty is not only to the patient but also members of the immediately family who might be at risk.[550]

The court avoided resolution of the issue of how one is to discharge the duty to a ten-year-old child "except to require that reasonable steps be taken to assure that the information reaches those likely to be affected or is made available for their benefit."[551] The court noted there was no evidence with regard to what information the physician provided the plaintiff's father and implied that providing such information to plaintiff's father would probably satisfy the duty owed to plaintiff.[552] The court refused to

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547. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 625 (App. Div. 1996) (citing *McIntosh v. Milano*, 168 N.J. Super. 466, 483-85 (Law Div. 1979)).

548. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 626 (App. Div. 1996).

549. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 626 (App. Div. 1996).

550. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 626-27 (App. Div. 1996) (citing *Fosgate v. Corona*, 66 N.J. 268, 274 (1974), where a patient's daughter-in-law and grandchildren were permitted to recover against a physician who failed to diagnose the patient's tuberculosis).

551. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 627 (App. Div. 1996).

552. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 627 (App. Div. 1996).

consider the confidentiality issues, noting that at some later date it may be necessary to resolve "a conflict between the physician's broader duty to warn and his fidelity to an expressed preference of the patient that nothing be said to family members about the details of the disease."[553] This issue will be significant in cases involving AIDS or other communicable diseases.

1-10 THE DUTY TO TERMINATE CARE

There are cases that discuss whether a physician has an affirmative duty to terminate care at the patient's instruction. In *McVey v. Englewood Hospital Ass'n*,[554] plaintiffs' mother suffered a severe stroke at the age of 91 and was being maintained on a respirator. Plaintiffs demanded that their mother be removed from the respirator because she had expressed that she would never want to be maintained on life support. The doctors refused to terminate life support because plaintiffs' mother was not brain dead. Plaintiffs sued the doctors, and in denying the plaintiffs' cause of action, the Appellate Division held:

> Hospital and medical personnel are charged with the heavy responsibility of saving lives and endeavoring to restore bodily function. The decision to turn off a respirator is ordinarily a medical one for which the attending physician must take responsibility . . . . Medical professionals are not now, and should not be, charged with the non-medical *duty* to determine the existence, veracity and effect of an incompetent's orally expressed wishes.[555]

Nevertheless, the court noted that medical professionals may consider the wishes of relatives and reports of the wishes of the patient.

> It is a very different thing, however, to assert that failure to comply with such undocumented requests, and absent the appointment of a guardian, constitutes an actionable breach of a duty

553. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 627 (App. Div. 1996).
554. *McVey v. Englewood Hosp. Ass'n*, 216 N.J. Super. 502 (App. Div. 1987).
555. *McVey v. Englewood Hosp. Ass'n*, 216 N.J. Super. 502, 506 (App. Div. 1987).

> owed to the patient and family. That time has not come in New Jersey.[556]

1-11 THE DUTY OF TREATING PHYSICIAN TO TESTIFY OR PROVIDE LITIGATION SUPPORT

A physician has a duty to assist the patient in litigation related to the treatment rendered by the doctor. This duty was discussed in *Spaulding v. Hussain*,[557] where plaintiff sued a doctor who refused to testify at plaintiff's trial in a claim against another party. The plaintiff's initial suit alleged that he sustained serious injuries when he slipped and fell on grease on the premises of a recycling corporation. Plaintiff's treating physician, Dr. Hussain, agreed to testify as an expert witness on behalf of plaintiff. However, when the trial started, the physician failed to come to court despite every effort by the trial court to accommodate his schedule. The court noted:

> when it became clear to [plaintiff's attorney] that Hussain would not appear, he began, so he testified, to weigh his options which he regarded as threefold: seeking a further continuance, moving for a mistrial, or accepting [the insurance company's] inadequate settlement offer of $75,000.00 and looking to Hussain thereafter to make plaintiff whole.[558]

The plaintiff accepted the $75,000 and sued the non-testifying physician for breach of contract and for various torts, including fraud. The trial court instructed the jury that:

> unless otherwise agreed when a doctor treats an accident victim, the physician impliedly agrees to appear and testify on behalf of his patient on

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556. *McVey v. Englewood Hosp. Ass'n*, 216 N.J. Super. 502, 507 (App. Div. 1987); *see also In re Quinlan*, 70 N.J. 10 (1976), *cert. denied, sub. nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *In re Conroy*, 98 N.J. 321 (1985).

557. *Spaulding v. Hussain*, 229 N.J. Super. 430 (App. Div. 1988).

558. *Spaulding v. Hussain*, 229 N.J. Super. 430, 435 (App. Div. 1988).

> issues such as the nature, extent and causality of his patient's injuries.[559]

The jury awarded $250,000 against the doctor. In affirming the verdict, the Appellate Division held:

> [W]e are satisfied that a treating physician has a duty to render reasonably required litigation assistance to his patient. But whether that assistance unequivocally and invariably requires the physician to testify in court is a question we need not here address. Clearly, a physician who tells his patient from the outset that he will not testify is not thereby absolved from rendering other litigation assistance, including the rendering of reports, consultation with counsel and forensic witnesses, and the like. By the same token, we are not prepared to say that a physician who does not make such an early disclaimer has any choice but to testify. He may, under particular circumstances, be able to fulfill his duty to render litigation assistance in like manner or by submitting to videotape depositions pursuant to *R*. 4:14-9.[560]

However, the Appellate Division noted that a treating physician "is not at liberty to ignore with impunity the basic obligation of rendering a reasonable modicum of litigation assistance."[561] The failure of a physician to fulfill the duty to the patient in this regard is actionable.

The duty of a physician to issue accurate reports was discussed in *Illiano v. Seaview Orthopedics*,[562] where plaintiff alleged that the defendant, an orthopedist, negligently attributed the plaintiff's injury to a work-related accident as opposed to a motor vehicle accident. The defendant moved to dismiss, asserting, *inter alia*,

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559. *Spaulding v. Hussain*, 229 N.J. Super. 430, 437 (App. Div. 1988).

560. *Spaulding v. Hussain*, 229 N.J. Super. 430, 440-41 (App. Div. 1988).

561. *Spaulding v. Hussain*, 229 N.J. Super. 430, 441 (App. Div. 1988); *see also Smith v. Farber*, 307 N.J. Super. 107, 112 (App. Div. 1997) (holding that the Entire Controversy Doctrine does not bar a party from pursuing a claim against his experts in a case "subsequent to disposition of the underlying tort action") (citing *Illiano v. Seaview Orthopedics*, 299 N.J. Super. 99 (App. Div. 1997); *Kranz v. Tiger*, 390 N.J. Super. 135 (App. Div. 2007) (regarding the duty of an expert to testify).

562. *Illiano v. Seaview Orthopedics*, 299 N.J. Super. 99 (App. Div. 1997).

that the complaint failed to state a cause of action. The trial court dismissed due to the entire controversy doctrine. The Appellate Division reversed and stated in a footnote:

> As to the cognizability of the cause of action, *see, e.g., Spaulding v. Hussain*, 229 N.J. Super. 430, 551 A.2d 1022 (App. Div. 1988), regarding a treating physician's litigation obligation to his patient. *See also*, as to the cause of action for negligent misrepresentation, *Restatement (2d) of Torts*, Section 552 (1977). *See also Petrillo v. Bachenberg*, 139 N.J. 472, 655 A.2d 1354 (1995); *Rosenblum v. Adler*, 93 N.J. 324, 334, 461 A.2d (1983). *And see*, as to the concealment of material evidence, *Fox v. Mercedes-Benz Credit Corp.*, 281 N.J. Super. 476, 482, 658 A.2d 732 (App. Div. 1995); *Viviano v. CBS, Inc.*, 251 N.J. Super. 113, 597 A.2d 543 (App. Div. 1991), *certif. denied*, 127 N.J. 565, 606 A.2d 375 (1992).[563]

The manner of proving damages in a case involving an inaccurate medical report was discussed in *Kelly v. Berlin*.[564] In *Kelly*, the plaintiff's orthopedist sent X-rays taken of the plaintiff to a radiologist for evaluation but in fact mistakenly sent the X-rays of another patient's lumbar spine. The radiologist did not notice that the films of the lumbar spine contained the name of another patient and issued a report stating that the lumbar spine was normal. Plaintiff then settled a pending case for $70,000. Thereafter, plaintiff was treated by another orthopedist who diagnosed spondylolisthesis of the lumbar vertebrae. Plaintiff sued the initial orthopedist, the radiologist, and the hospital, asserting that he settled the initial case for an inadequate sum because of the lack of knowledge of the spondylolisthesis. The court held that plaintiff could prove his damages through expert testimony as to the settlement value of the case with knowledge of the spondylolisthesis, versus the settlement value without knowledge of spondylolisthesis. The court explained:

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563. *Illiano v. Seaview Orthopedics*, 299 N.J. Super. 99, 105 (App. Div. 1997).
564. *Kelly v. Berlin*, 300 N.J. Super. 256 (App. Div. 1997).

> Expert testimony was necessary to determine the fair settlement value of plaintiff's motor vehicle accident claim had plaintiff been aware of his spondylolisthesis condition. Without expert testimony, a jury simply does not have the knowledge, training or experience to decide the settlement value of plaintiff's claim. While juries may generally determine damages in the ordinary case, the trial court properly concluded that laypersons do not have the knowledge, from their common experience, to evaluate and determine damages in a case of this kind, that is, to determine the difference between the amount plaintiff actually received in his settlement and the amount he would have received had his lower back condition been made known prior to the settlement. The many factors that go into a settlement are not within the knowledge of the average juror. An expert in the settlement of claims, such as an experienced torts attorney or an experienced claims adjuster, is necessary to explain the various factors which are taken into consideration in the settlement of a case of this kind. Such an expert could explain which factors are relevant and how they affected this matter to enable the jury to determine whether the defendant doctor's negligence caused plaintiff to settle for a lower amount than he would have, and, if so, the amount of damages plaintiff sustained as a result. For example, such an expert could render a comparison of similar claims in the area, an analysis of how plaintiff's other injuries would have affected the settlement of his lower back injury, an opinion as to the value of plaintiff's lower back injury in light of its projected severity when the case settled, and an analysis of how legal issues would have affected the settlement amount.[565]

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[565] *Kelly v. Berlin*, 300 N.J. Super. 256, 269 (App. Div. 1997).

1-12 THE DUTY TO MAINTAIN INSURANCE

In 2004, the Legislature enacted N.J.S.A. 45:9-19.17, which requires that:

> A physician who maintains a professional medical practice in this state and has responsibility for patient care is required to be covered by medical malpractice liability insurance issued by a carrier authorized to write medical malpractice insurance policies in this State, in the sum of $1,000,000 per occurrence and $3,000,000 per policy year . . . or, if such liability coverage is not available, by a letter of credit for at least $500,000.[566]

Johnson v. Braddy,[567] held that "the holder of an insurance policy with limits in excess of the Guaranty Association's $300,000 maximum liability is liable for the amount of any judgment in excess of that amount." *Shaler v. Toms River Obstetrics*,[568] discussed operations of the New Jersey Property Liability Guaranty Association ("PLIGA"). *Smith v. Moustiatse*,[569] held that the tortfeasor was liable for pre-judgment interest above the statutory limit of the guaranty fund.

However, in *Jarrell v. Kaul*,[570] the court denied plaintiff a private cause of action against a physician who didn't maintain insurance:

> We [] conclude that *N.J.S.A.* 45:9-19.17 does not expressly, and cannot be read to implicitly, recognize a direct cause of action by an injured patient against a physician who fails to obtain the statutorily required medical malpractice liability insurance or letter of credit.[571]

Although the New Jersey Supreme Court held that there is no private cause of action against a physician who fails to maintain

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566. N.J.S.A. 45:9-19.17(a).

567. *Johnson v. Braddy*, 376 N.J. Super. 215, 222-23 (App. Div. 2005), *aff'd*, 186 N.J. 40 (2006), *overruling Flaherty v. Safran*, 367 N.J. Super. 565 (Law Div. 2003).

568. *Shaler v. Toms River Obstetrics*, 383 N.J. Super. 650 (App. Div. 2006).

569. *Smith v. Moustiatse*, 388 N.J. Super. 274 (Law Div. 2006) (citing *Johnson v. Braddy*, 376 N.J. Super. 215 (App. Div. 2005), *aff'd*, 186 N.J. 40 (2006)).

570. *Jarrell v. Kaul*, 223 N.J. 294 (2015).

571. *Jarrell v. Kaul*, 223 N.J. 294, 309-10 (2015).

the required insurance coverage, the employer of the physician may be independently liable for hiring such an incompetent contractor:

> [W]e hold that a cause of action for negligent hiring may be asserted against a health care facility that grants privileges to a physician who has not complied with the statutorily required insurance. A health care facility that grants privileges to physicians to use its facility has a continuing duty to ensure that any physician granted privileges maintains the required insurance, which is a condition of obtaining and maintaining a license to practice medicine in this State.[572]

When a physician makes a material misrepresentation, an insurer owed neither a duty to defend nor a duty to indemnify its insured.[573] In *DeMarco v. Stoddard*,[574] a podiatrist misled the Rhode Island Medical Malpractice Underwriting Association by stating that the insured podiatrist maintained his primary practice in Rhode Island when, in fact, his primary practice was housed in New Jersey. The Court addressed whether to permit rescission of the policy or require molding of the policy, similar to the motor vehicle case law, to the statutorily mandated minimum level, which for medical malpractice would be the $500,000 limit required by a letter of credit.

Ultimately, in a 4-2 decision, Judge Cuff wrote:

> [I]t is well established in this State that a professional who has made a misrepresentation of material fact in an application for professional liability insurance can expect that the policy may be rescinded on application of the insurer. A professional in that position can also expect that claims that arose prior to discovery of the misrepresentation will be excluded from coverage. In other words, once the policy has been rescinded, the professional

572. *Jarrell v. Kaul*, 223 N.J. 294 (2015).
573. *DeMarco v. Stoddard*, 223 N.J. 363 (2015).
574. *DeMarco v. Stoddard,* 223 N.J. 363 (2015).

> responds to any claim from injured third parties without coverage.[575]

In the dissenting opinion, Justice Albin wrote:

> I disagree that under this State's law, the medical-malpractice carrier in this case can retroactively cancer malpractice insurance to deny an innocent patient coverage for a physician's professional negligence. The approach taken by the majority is at complete odds with our State's public policy, which finds expression in our compulsory medical malpractice insurance law.[576]

The dissent explained that "the purpose of this compulsory insurance law is to ensure that patients can secure financial compensation in the event of a doctor's professional negligence. Every patient has a right to presume that his physician is in compliance with the law."[577]

Whereas *Jarrell v. Kaul* preserved a cause of action against a facility for employing a physician who failed to maintain the statutorily required liability insurance or letter of credit due to the facility's independent failure to verify the requirement, *DeMarco* relieves the insurance company of providing any amount of coverage due to a material misrepresentation that could have been identified by exercising due diligence to verify.

1-13 PRACTICE POINTERS

1. **Prepare the case from the initial interview though the verdict sheet with the Model Jury Charges in mind.** One should prepare a case for trial with the Model Jury charges in mind, since this is what the Court will instruct the jury at the end of the case.[578]

2. **Define the term "standard of care" for all experts.** The term "standard of care" should be carefully

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575. *DeMarco v. Stoddard*, 223 N.J. 363, 378-79 (2015).

576. *DeMarco v. Stoddard*, 223 N.J. 363, 385 (2015).

577. *DeMarco v. Stoddard*, 223 N.J. 363, 384 (2015).

578. *See, e.g.*, Model Jury Charge 5.50, Apparent Authority, through Model Jury Charge 5.50I, Fraudulent Concealment of Medical Records.

explained and defined for all experts before every deposition and all trial testimony. Medical malpractice is generally defined as a deviation from the generally accepted standard of care. Model Jury Charge 5.50A, Duty and Negligence, states that two elements of proof are essential (1) standards that are generally recognized and accepted by the branch of the profession to which he belongs as the customary and proper methods of diagnosis or treatment of the physical or mental condition concerned in the inquiry and (2) a departure from such standards under circumstances justifying the conclusion of want of the requisite degree of care. The expert's ability to state and support with competent evidence, as opposed to personal opinion, the standard of care is critical to the case. The standard of care is most often defined as what a reasonable practitioner would do under the same or similar circumstances. It does not necessarily mean the best care or the "gold standard" but is best considered the average. All testifying physicians should be familiar with this definition.

3. **Distinguish the "standard of care" and "medical judgment" for all experts.** The term "medical judgment" should be carefully explained and defined for all experts before every deposition and all trial testimony. Model Jury Charge 5.50G, Medical Judgment, instructs that the issue of medical judgment must be distinguished from the standard of care. It is not malpractice for a physician to exercise reasonable judgment in choosing one of two or more generally accepted courses of action. The expert's failure to understand the difference between these two concepts is critical to the case.

4. **Adapt the jury charge to the facts of the case.** If a case involves judgment issues on some theories of

liability, but not on others, the charge should be tailored to those facts.[579]

5. **Be certain that all experts testify as to generally accepted standards, not personal practices or standards.** An expert witness must testify that the physician deviated from a "generally accepted standard of care," not the standard personal to the expert. The expert must testify that the opinions expressed represent the opinions "generally accepted in the profession."[580]

6. **Be certain the jury understands that a specialist owes a higher duty of care.** A specialist must comply with a higher standard of care and provide a higher level of skill or knowledge than a general practitioner.[581]

7. **Be aware of the standard of care to be applied to hospital residents.** Hospital residents are generally to be held to the standard of care of a general practitioner, although a hybrid charge may be warranted, depending on the circumstances of the case. Prepare your expert so as not to confuse this issue with testimony with respect to the specialty involved.[582]

8. **Be aware of the doctrine of vicarious liability and apparent employment.** A health care provider is liable for the negligence of its employees, including physicians, pursuant to the doctrine of respondeat superior. Additionally, when a health care entity selects or assigns a physician for a patient, the provider will generally be

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[579] *See Velazquez v. Portadin*, 163 N.J. 677 (2000), where the Supreme Court instructed that the judgment charge should be "limited to cases in which the physician exercised judgment in selecting among acceptable courses of action." *Velazquez v. Portadin*, 163 N.J. 677, 687 (2000); *see Patton v. Amblo*, 314 N.J. Super. 1 (App. Div. 1998) (trial judge committed reversible error when he failed to separate out what aspects of care involved judgment and which did not.)

[580] *Fernandez v. Baruch*, 52 N.J. 127, 131 (1968).

[581] *See* Model Jury Charge 5.50, Duty and Negligence.

[582] *See Clark v. Univ. Hosp./UMDNJ*, 390 N.J. Super. 108, 113 (App. Div. 2007).

liable for the negligence of the physician, unless it informs the patient that the doctor is an independent contractor.[583] However, one must be aware of the relationship between the $250,000 limitation of liability provided to hospitals pursuant to N.J.S.A. 2A:53A-8 and a hospital's vicarious liability, that is discussed in Chapter 8 of this text. This is becoming a much more significant issue as hospital systems have been purchasing entire practice groups at a rapidly increasing pace.

9. **Be aware of the duties imposed by EMTALA**. The duties of an emergency department are controlled by the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), 42 U.S.C. § 1395dd.

10. **Be aware of the duties imposed by the Nursing Home Responsibilities and Rights of Residents Act and *Ptaszynski*'s construction of this statute.** The duties of a nursing home are defined by the Nursing Home Responsibilities and Rights of Residents Act.[584]

11. **Be careful using a subpoena to obtain medical records.** Medical records may be the subject of a subpoena, but the use of a subpoena is subject to strict rules. The misuse of a subpoena can result in harsh penalties, including disqualification of counsel.[585]

12. **Carefully compare all versions of the same set of medical records.** With electronic medical records becoming the norm, all versions produced of the

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583. *See* Model Jury Charge 5.50, Apparent Authority. *See also Estate of Cordero v. Christ Hosp.*, 403 N.J. Super. 306, 310-11 (App. Div. 2008).

584. N.J.S.A. 30:13-1 to -17. *But see Ptaszynski v. Atl. Health Sys., Inc.*, 440 N.J. Super. 24 (App. Div. 2015).

585. *See Crescenzo v. Crane*, 350 N.J. Super. 531, 539 (App. Div. 2002). *See also Cavallaro v. Jamco Prop. Mgmt.*, 334 N.J. Super. 557, 572-73 (App. Div. 2000).

same set of records should be reviewed carefully for any changes, additions or deletions between versions. Likewise, a copy of the audit trail can and should be sought if any issues or discrepancies are identified.