Chapter 1

General Duty of Health Care Providers

1-1 INTRODUCTION

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

1-2 DUTY IN GENERAL

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

---

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

2. *Lodge v. Arett Sales Corp*., 246 Conn. 563, 571-85 (2003); *Murillo v. Seymour Ambulance Ass'n, Inc*., 264 Conn. 474, 478-79 (2003).

3. *Zamstein v. Marvasti*, 240 Conn. 549, 558 (1997).

Connecticut Medical Malpractice_Chapter 01.indd 1 6/18/2021 8:05:04 PM

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

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

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

---

4. *Pisel v. Stamford Hosp.*, 180 Conn. 314, 331-33 (1980).

5. *Murillo v. Seymour Ambulance Ass'n, Inc.*, 264 Conn. 474 (2003) (no duty to sister witnessing emergency medical procedure); *Fraser v. United States*, 236 Conn. 625, 634 (1996) (no duty to control noncustodial psychiatric patient to prevent harm to unidentifiable or unforeseeable third persons); *DiTeresi v. Stamford Health Sys., Inc.*, 142 Conn. App. 72 (2013) (hospital owed no duty to report on an alleged sexual assault of an elderly woman suffering from dementia to her daughter in less than seven hours). The split decision of the Supreme Court in *Ruiz v. Victory Properties, LLC*, 315 Conn. 320 (2015) (a non-medical malpractice case), contains a fascinating discussion of the policy aspects of the duty determination. *See* Charles D. Ray and Matthew Weiner, *Ruiz v. Victory Properties, LLC, 315 Conn. 320 (2015): How Narrowly Should the Foreseeability Inquiry Be Framed When Defining a Legal Duty of Care*, Connecticut Lawyer, Mar. 2015, at 30. For example, an emerging area of controversy is the degree to which duties may be imposed on physicians to provide medical care against their religious beliefs. This subject is covered in more detail in Chapter 12.

6. *Murillo v. Seymour Ambulance Ass'n, Inc.*, 264 Conn. 474, 480 (2003). In *Charette v. Malone*, No. HHBCV095014422S, 2012 WL 953373 (Conn. Super. Ct. Feb. 27, 2012), the court held that the physician was not relieved of duty on the ground that the patient committed a crime by lying about participating in a methadone program.

7. In *Guerri v. Fiengo*, 137 Conn. App. 437, *cert. denied*, 307 Conn. 920 (2012), the Appellate Court affirmed a refusal to submit to the jury a claim that a cardiologist had a duty to discuss every electrocardiogram with a treating physician when no critical value was present. In *Pirecca v. Koltchine*, 54 Conn. L. Rptr. 307 (Conn. Super. Ct. 2012), the court held that there is no independent cause of action for intentional alteration of a plaintiff's medical record.

8. *See Lodge v. Arett Sales Corp.*, 246 Conn. 563, 571 (2003); *Petriello v. Kalman*, 215 Conn. 377, 382-83 (1990).

Connecticut Medical Malpractice_Chapter 01.indd 2 6/18/2021 8:05:04 PM

1-3 STANDARD OF CARE

Medical malpractice is defined by the standard of care. A medical malpractice case generally requires that a similar health care provider testify on the plaintiff's behalf that the defendant's conduct deviated from the standard of care.[9]

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

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

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

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

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

---

9. *See* Conn. Gen. Stat. § 52-184c; *Pisel v. Stamford Hosp.*, 180 Conn. 314, 334 (1980). The generally held view in modern Connecticut cases is that foreseeability is relevant primarily to duty rather than causation. *Kumah v. Brown*, 130 Conn. App. 343, 349, *aff'd on other grounds*, 307 Conn. 620 (2013). Occasionally a negligence claim may be based on something other than a deviation from the standard of care. For example, in *Elnitsky v. Vodra*, No. CV065002902S, 2008 WL 2168803 (Conn. Super. Ct. May 1, 2008), the court held that a plaintiff who claimed that doctors misrepresented their skills adequately alleged a claim for negligent misrepresentation.

10. Conn. Gen. Stat. § 52-184c(a).

11. *See Levitt v. Etkind*, 158 Conn. 567, 576 (1969).

12. *Krattenstein v. Thomas*, 7 Conn. App. 604, 607, *cert. denied*, 201 Conn. 807 (1986), and cases cited therein. In *Logan v. Greenwich Hosp. Ass'n*, 191 Conn. 282, 299 (1983), the Court stated that it did not construe an earlier case as approval of the concept of a bona fide error in judgment as a definition of the standard of care.

Connecticut Medical Malpractice_Chapter 01.indd 3 6/18/2021 8:05:04 PM

selecting the one which, according to their best judgment, is best suited to the patient's needs.[13] However, a court may only instruct a jury that it can consider alternative methods of treatment to be within the standard of care when a qualified expert testifies that two or more methods are reasonable. Competing expert testimony regarding what method of treatment the standard of care requires does not, by itself, permit instructing the jury that it can consider both competing methods to be reasonable.[14]

Upon an appropriate evidentiary foundation, a court may instruct a jury that when distinct and different schools of thought exist, a physician should be judged only by the practice of his school of thought.[15]

A physician does not guaranty a good medical result and a poor result is not by itself evidence of wrongdoing.[16]

Violations of hospital policies, by-laws or work rules may be viewed as evidence of negligence but violations thereof do not necessarily by themselves establish the standard of care.[17] Similarly, "[s]tatutes, regulations, ordinances and other safety codes can be considered as some evidence of the standard of care . . . ."[18] However, "the standard of care in a medical malpractice case is not established merely by a regulation or a textbook, but is established as set forth in General

---

[13] *Wasfi v. Chadha*, 218 Conn. 200, 208 (1991) (upholding instruction that physician is not bound to use any particular method in diagnosing patient); *Nethercott v. Dukehart*, No. CV-095005205-S, 2011 WL 702977 (Conn. Super. Ct. Dec. 21, 2011) (*Wasfi* rule applied in denying motion to set aside and for new trial).

[14] *Kos v. Lawrence + Mem'l Hosp.*, 334 Conn. 823, 840-45 (2019) (Error to instruct jury that it could consider either of two competing methods of diagnosis to be "acceptable alternatives: when neither plaintiffs' nor defendants' standard of care experts testified that both methods were acceptable.").

[15] *Katsetos v. Nolan*, 170 Conn. 637, 652 (1976), and cases cited therein; *Savoie v. Daoud*, 101 Conn. App. 27 (2007) (adequate foundation for schools of thought charge).

[16] *Green v. Stone*, 119 Conn. 300, 304 (1934).

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

[18] *Considine v. Waterbury*, 279 Conn. 830, 864 (2006). *See DiMauro v. Conn. Hospice, Inc.*, No. NNHCV186083356S, 2019 WL 6736507 (Conn. Super. Ct. Nov. 20, 2019) (pleading hospice care regulation 42 C.F.R. § 418.52 as evidence of the standard of care); *Theroux-Acampora v. Saint Regis Health Ctr.*, No. CV-09-5029129-S 2010 Conn. Super. LEXIS 1508 (Conn. Super. Ct. June 14, 2010) ("It is permissible to plead a breach of a statutory or regulatory duty as evidence of negligence . . . .").

Connecticut Medical Malpractice_Chapter 01.indd 4 6/18/2021 8:05:04 PM

Statutes § 52-184c."[19] A Superior Court held it proper to plead a violation of a federal regulation "as evidence of negligence" even where the regulation did not provide for a private cause of action nor permit a negligence per se instruction.[20]

In the absence of an emergency, a physician is under a duty not to leave his patient at a critical stage without giving reasonable notice or making suitable arrangements for another physician to step in.[21]

Proof of the standard and the breach requires expert medical testimony.[22] This proof will vary with the facts of a case. Though the term may have acquired certain accepted meanings within the medical profession, the standard of care concept has great elasticity in the law.[23] Almost by definition, every case contested on liability involves a difference of opinion between experts over what is required by the standard of care and whether a physician's actions constituted a deviation.[24]

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

---

[19] *Williams v. Lawrence & Mem'l Hosp., Inc.*, 2020 Conn. Super. LEXIS 491 (Conn. Super. Ct. Mar. 6, 2020).

[20] *DiMauro v. Conn. Hospice, Inc.*, No NNHCV186083356S, 2019 WL 6736507 (Conn. Super. Ct. Nov. 20, 2019).

[21] *Katsetos v. Nolan*, 170 Conn. 637, 654 (1976).

[22] *Marchell v. Welchell*, 66 Conn. App. 574, 582-83 (2001); Conn. Gen. Stat. § 52-184c.

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

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

Connecticut Medical Malpractice_Chapter 01.indd 5 6/18/2021 8:05:04 PM

of a surgical procedure, failure to provide informed consent, and negligent failure to inform.[25]

Under common law, the standard of care was measured by the "locality rule." In other words, a physician was judged against his peers in the same "general neighborhood." This locality rule was later expanded throughout state of Connecticut.[26] In 1983, the Supreme Court broadened the geographical limitation to the entire nation.[27] However, the Appellate Court precluded the standard of care opinion of a podiatry expert whose opinion that a national standard of care governed podiatrists lacked sufficient foundation.[28]

Federal policy increasingly may impose certain metrics with respect to the practice of medicine. In early 2015, Congress passed and President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10), which provides that "the development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim."

---

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

26. *Fitzmaurice v. Flynn*, 167 Conn. 609, 617 (1975).

27. *Logan v. Greenwich Hosp. Ass'n*, 191 Conn. 282, 301 (1983). In *Smith v. Andrews*, 289 Conn. 61 (2008), the Supreme Court held that expert testimony establishing a local standard of care at a particular hospital is relevant only if it comports with an accepted national standard of care.

28. *Barnes v. Conn. Podiatry Grp., P.C.*, 195 Conn. App. 212 (2020).

Connecticut Medical Malpractice_Chapter 01.indd 6 6/18/2021 8:05:04 PM

1-4 DUTY TO NONPATIENTS

Traditionally, Connecticut courts have held that physicians generally owe no duty of care to non-patients.[29] In 2019, however, the Supreme Court carved out a narrow exception to this rule in the context of STD testing.[30]

"Under Connecticut law, a physician-patient relationship is created when the professional services of a physician are rendered to or accepted by another for the purposes of medical or surgical treatment."[31] "There can be no actionable negligence on the part of the physician unless there is a physician-patient relationship."[32] Generally, the physician-patient relationship does not exist if the physician is retained solely to examine an employee on behalf of an employer.[33] But if the

---

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

30. *Doe v. Cochran*, 332 Conn. 325 (2019). In *Cochran*, the plaintiff and her exclusive boyfriend underwent STD testing before engaging in a sexual relationship. The boyfriend's physician's office mistakenly reported to the boyfriend that he had tested negative for the herpes virus. The plaintiff-girlfriend later contracted the herpes virus and sued the physician. The physician argued that the plaintiff was not a patient and that he therefore had no duty to her. The Court disagreed, holding that the girlfriend was a foreseeable and identifiable victim of the physician's negligence. The Court limited its holding "only to identifiable third parties who are engaged in an exclusive romantic relationship with a patient at the time of testing, and, therefore, may foreseeably be exposed to any STD that a physician fails to diagnose or properly report."

31. *Wheelis v. Backus Hosp. Corp.*, No. KNLCV146022485S, 2017 WL 1484113 (Conn. Super. Ct. Mar. 31, 2007) (quoting *Proctor v. St. Francis Hosp.*, No. CV020815571S, 2006 WL 574218 (Conn. Super. Ct. Feb. 27, 2006)).

32. *Proctor v. St. Francis Hosp.*, No. CV020815571S, 2006 WL 574218, at *1 (Conn. Super. Ct. Feb. 27, 2006) (quoting D. Louisell and H. Williams, *Medical Malpractice*, § 8.03, p. 8-17 (2001)); *Jarmie v. Troncale*, No. CV085021176, 2008 WL 5663944 (Conn. Super. Ct. Dec. 31, 2008), *aff'd*, 306 Conn. 578 (2012).

33. *See* James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician-Patient Relationship for Malpractice Purposes*, 17 A.L.R. 4th 132 (1982).

Connecticut Medical Malpractice_Chapter 01.indd 7 6/18/2021 8:05:04 PM

physician, during the course of the examination, affirmatively treats or affirmatively advises the employee, a physician-patient relationship may be created.[34]

Several Superior Court opinions have held that a physician does not have a duty in the case of a "fitness for duty" determination or an independent medical examination where the physician is acting at the request of an employer or an opposing litigant rather than the examinee.[35] The Supreme Court (applying New York law) held that there was no duty in the case of a fitness for duty determination but that a duty may arise if the physician affirmatively treated the examinee or affirmatively advised him as to treatment.[36]

Issues of fact may be presented over whether a doctor's conduct creates a physician-patient relationship.[37] There has been some division in authority on duties to patient's relatives. Just because harm was foreseeable does not necessarily mean legal duty exists.[38] See also Chapter 2, § 2-3:2.2 dealing with cases involving injury to third persons caused by the discharge of patients under the effects of medication.

---

34. *See Dugan v. Mobile Med. Testing Servs., Inc.*, 265 Conn. 791, 812 (2003) (construing New York law).

35. *See Cowan v. Warner-Lambert Co*., No. CV90 03 25 64S, 1993 WL 298885 (Conn. Super. Ct. July 28, 1993); *Pokorny v. Shafer*, No. CV93 052 83 75, 1994 WL 65213 (Conn. Super. Ct. Feb. 24, 1994).

36. *Dugan v. Mobile Med. Testing Servs., Inc.*, 265 Conn. 791, 813 (2003).

37. *See Proctor v. St. Francis Hosp.*, No. CV020815571S, 2006 WL 574218 (Conn. Super. Ct. Feb. 27, 2006) (where neurologist advises patient's physician to hold off on use of drug until after MRI and examination, and then fails to perform the procedure, question of fact exists as to whether neurologist assumed patient's care); *Wheelis v. Backus Hosp. Corp.*, No. KNLCV146022485S, 2017 WL 1484113 (Conn. Super. Ct. Mar. 31, 2017) (where physician 1 affirmatively rendered advice to physician 2 to start patient on heparin infusion, and that advice was followed, question of fact existed as to whether physician 1 and patient had physician-patient relationship).

38. *Murillo v. Seymour Ambulance Ass'n, Inc.*, 264 Conn. 474 (2003) (health care provider had no duty to a woman who was injured when she fainted after observing a medical procedure performed on her sister); *Desimini v. Bristol Hosp.*, 50 Conn. Supp. 344 (Conn. Super. Ct. Apr. 26, 2007) (physician has no duty to provide post discharge instructions to family members of a patient competent to understand instructions given directly to patient); *Pyshny v. Conn. Hospice, Inc.*, No. NNHCV136039612S, 2014 WL 929346 (Conn. Super. Ct. Feb. 3, 2014) (health care provider has no duty to patient's mother who holds a power of attorney); *DeVito v. Yale New Haven Hosp.*, No. CV156059315, 2015 WL 9242226 (Conn. Super. Ct. Nov. 23, 2015) (The exclusion of a sibling from the hospital room of a terminally ill patient does not by itself constitute intentional or negligent infliction of emotional distress.). *But see Valentin v. St. Francis Hosp.*, No. CV040832314, 2005 WL 3112881 (Conn. Super. Ct. Nov. 7, 2005) (physician has a common law duty to avoid emotional injury to next of kin when removing life support from patient).

Connecticut Medical Malpractice_Chapter 01.indd 8 6/18/2021 8:05:04 PM

1-5 FIDUCIARY DUTY

Fiduciary duty is the highest standard of behavior imposed by law.[39] The Connecticut Supreme Court quoted the famous phrase of Justice Cardozo in referring to fiduciary duty as "the punctilio of an honor the most sensitive."[40] The Court has also referred to a fiduciary duty as involving a unique degree of trust and confidence.[41]

Several appellate level cases strongly suggest that a fiduciary relationship exists between physician and patient.[42] Numerous superior court decisions hold, or strongly suggest, that physicians owe fiduciary duties to their patients.[43] Most other jurisdictions that have directly addressed the issue found a physician-patient relationship gives rise to fiduciary standards.[44]

In the case of hospitals, the fiduciary concept may be less applicable than in the case of physicians.[45]

Since the existence of a fiduciary relationship implicates a duty of loyalty and honesty, it is unlikely that pure acts of medical malpractice (e.g., negligent failure to diagnose), state a cause of action for breach of fiduciary duty. In the legal malpractice context, Connecticut courts have indicated causes of action for breach of fiduciary duty are more concerned with breaches of a duty of loyalty and honesty.[46]

---

39. Henry Campbell Black*, Black's Law Dictionary* 625 (6th ed. 1990); Ernest Weinrib, *The Fiduciary Obligation*, 25 U. Toronto L.J. 1, 5-6 (1975).

40. *Konover Dev. Corp. v. Zeller*, 228 Conn. 206, 218 n.9 (1994) (quoting *Meinhard v. Salmon*, 249 N.Y. 458, 464 (1928) (Cardozo, J.)).

41. *Dunham v. Dunham*, 204 Conn. 303, 322 (1987).

42. *Byrne v. Avery Ctr. for Obstetrics & Gynecology, P.C.*, 327 Conn. 540 (2018) (passim); *Konover Dev. Corp. v. Zeller*, 228 Conn. 206, 222, n.11 (1994); *Rosenfield v. Rogin, Nassau, Caplan, Lassman & Hirtle, P.C.*, 69 Conn. App. 151, 163 (2002); *see also Gager v. Mathewson*, 93 Conn. 539, 543-44 (1919).

43. *Bobbin v. Sail the Sounds, L.L.C.*, No. CV020563884S, 2003 WL 22206799 (Conn. Super. Ct. Sept. 12, 2003); *Zabensky v. Lawrence & Mem'l Hosp.*, No. 545872, 1999 WL 608673 (Conn. Super. Ct. Aug. 5, 1999); *Starrett v. Spencer*, No. CV 940140926S, 1995 WL 749549 (Conn. Super. Ct. Nov. 27, 1995); *Villa Constr., Inc. v. Southington Sav. Bank*, No. CV-94-0540241S, 1995 WL 491295, at *2 (Conn. Super. Ct. Aug. 3, 1995); *Chemical Bank v. Exec. Mgmt. Co., Ltd.*, No. CV 930532083, 1995 WL 774526 (Conn. Super. Ct. Oct. 20, 1995).

44. *E.g.*, *Petrillo v. Syntex Labs.*, 148 Ill. 3d 581, 587 (1986); *Korper v. Weinstein*, 57 Mass. App. Ct. 433, 437-38 (2003); *Hoopes v. Hammargren*, 102 Nev. 425, 431 (1986); *Black v. Littlejohn*, 312 N.C. 626, 646 (1985); *State v. Henning*, 190 W. Va. 142 (1993); *Matter of Adoption of Bay Boy Irons*, 684 P.2d 332 (Kan. 1984).

45. *Sherwood v. Danbury Hosp.*, 278 Conn. 163, 195-97 (2006); *DiTeresi v. Stamford Health Sys., Inc.*, 142 Conn. App. 72, 93-96 (2013).

46. *Beverly Hills Concepts, Inc. v. Schatz & Schatz, Ribicoff Kotkin*, 247 Conn. 48, 56 (1998). ("Professional negligence alone . . . does not give rise automatically to a claim for breach of fiduciary duty. Although an attorney-client relationship imposes a fiduciary duty on the attorney . . . not every instance of professional negligence results in a breach of that fiduciary

Connecticut Medical Malpractice_Chapter 01.indd 9 6/18/2021 8:05:04 PM

Cases holding that a physician has violated a fiduciary duty usually concern breaches of loyalty (e.g., disclosing confidential information),[47] acts of dishonesty (e.g., concealing facts from patients, at times to hide acts of malpractice)[48] and immorality (e.g., sexual exploitation).[49]

The establishment of a fiduciary relationship may have profound litigation consequences because, upon a showing of such a relationship, the burden of proof shifts to the fiduciary to prove by "clear, convincing, and unequivocal evidence" that the fiduciary has dealt fairly with the plaintiff.[50]

1-6 SEXUAL EXPLOITATION CASES

The leading case in Connecticut exploring the concept of duty in the case of sexual exploitation is *Doe v. Saint Francis Hospital & Medical Center*,[51] a case involving the notorious Dr. Reardon who was found to have sexually exploited children during the course of what purported to be a research study. The plaintiffs' claim was that the hospital did not follow its own rules for conducting research. The Court found that it was not error to have failed to instruct the jury that it could not find for the plaintiffs unless the hospital knew or should have known that Dr. Reardon was a pedophile. The Court's opinions (majority and dissenting) are a treatise on the law of duty in this context.[52]

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

---

duty."). *See also Nosik v. Bowman*, No. CV000379089, 2002 WL 1842662 (Conn. Super. Ct. July 12, 2002) (quoting *Flexo Converters USA, Inc. v. Adleman*, No. X07CV990072553S, 2000 WL 1868232 (Conn. Super. Ct. Nov. 30, 2000)).

47. *E.g.*, *Byrne v. Avery Ctr. for Obstetrics & Gynecology, P.C.*, 327 Conn. 540 (2018) (passim); *Manion v. N.P.W. Med. Ctr. of N.E. Pa., Inc*., 676 F. Supp. 585, 594 (M.D. Pa. 1987); *Alston v. Greater Se. Cmty. Hosp*., 107 F.R.D. 35, 37 (D.D.C. 1985); *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96, 102 (N.D. Ohio 1965).

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

49. *E.g.*, *Hoopes v. Hammargren*, 102 Nev. 425, 431 (1986).

50. *Dunham v. Dunham*, 204 Conn. 303, 322-23 (1987). *But see Heaven v. Timber Hill, LLC*, 96 Conn. App. 294 (2006) (a nonmedical malpractice case where the Appellate Court held that the burden did not shift on particular facts).

51. *Doe v. St. Francis Hosp. & Med. Ctr.*, 309 Conn. 146 (2013).

52. *See* Carey Reilly, *'Duty of Care' Issues Mark Key Cases*, Conn. Law Trib., Oct. 14, 2013, at 14 (commenting on *Doe* and other cases).

Connecticut Medical Malpractice_Chapter 01.indd 10 6/18/2021 8:05:04 PM

a sexual relationship between patient and physician does not, ipso facto, result in a breach of fiduciary duty.[53] It is generally accepted that consensual sexual activity between a health care provider and patient does not constitute medical malpractice.[54]

Several cases in other jurisdictions held that a plaintiff can maintain a medical malpractice cause of action if "the sexual relationship was initiated by the physician under the guise of treatment of the patient."[55] Most of these cases involve psychiatrists and alleged mishandling of the "transference phenomenon." The majority view in other jurisdictions, however, appears to be that sexual exploitation does not constitute the rendering of professional health care services even in cases where the pretense of medical care is employed.[56] In these circumstances, the appropriate cause of action would be breach of fiduciary duty. That is because the action arises out of a breach of trust, not the negligent failure to comply with a recognized standard of care for rendering of medical services.[57]

On the other hand, a Connecticut Superior Court has held that a claim of sexual exploitation survives a motion to strike under theories of intentional infliction of emotional distress and medical malpractice.[58]

One case raises some question regarding whether Connecticut would follow the rule that sexual exploitation does not constitute the rendering of professional health care services even where the pretense of medical care is employed.[59] This insurance coverage case centered

---

53. *Hoopes v. Hammargren*, 102 Nev. 425, 431 (1986).

54. *Smith v. Njoku*, No. HHDCV125036064S, 2014 WL 1193319 (Conn. Super. Ct. Feb. 25, 2014). *See also Korper v. Weinstein*, 57 Mass. App. Ct. 433, 437-38 (2003); *R.W. v. Schrein*, 263 Neb. 708, 718-20 (2002); *Collins v. Covenant Mut. Ins. Co.*, 604 N.E.2d 1190, 1196 (Ind. App. 1992).

55. *Atienza v. Taub*, 194 Cal. App. 3d 388, 391 (Cal. Ct. App. 1987). *E.g.*, *Darnaby v. Davis*, 57 P.3d 100, 104-05 (Ct. App. Okla. 2002); *Korper v. Weinstein*, 57 Mass. App. Ct. 433, 437-38 (2003). *See Brown v. Njoku*, No. HHDCV136043835S, 2015 WL 2030935 (Conn. Super. Ct. Mar. 31, 2015), *aff'd per curiam*, 170 Conn. App. 329 (2017), where in a case involving unwanted sexual advances on the part of the defendant, the court held after a trial that the defendant's conduct constituted battery, negligent and intentional infliction of emotional distress.

56. *See New Mexico Physicians Mut. Liab. Co. v. LaMure*, 116 N.M. 92 (1993); *St. Paul Ins. Co. of Ill. v. Cromeans*, 771 F. Supp. 349, 353 (N.D. Ala. 1991).

57. Not all sexual exploitation cases in the medical context involve medical malpractice or even the pretense of medical care. *See Uyar v. Seli*, No. 3:16-cv-186, 2017 WL 886934 (D. Conn. Mar. 6, 2017) (action involving sexual relationship among faculty at Yale Medical School).

58. *Santos v. Bailey*, No. HHDCV156057532S, 2016 WL 1315372 (Conn. Super. Ct. Mar. 7, 2016).

59. *St. Paul Fire & Marine Ins. Co. v. Shernow*, 222 Conn. 823 (1992).

Connecticut Medical Malpractice_Chapter 01.indd 11 6/18/2021 8:05:04 PM

on whether a professional liability policy provided coverage when a dentist sexually molested a patient while administering nitrous oxide. In a controversial decision that included a vigorous dissent, the Supreme Court held that the policy provided coverage when the medically negligent procedure is inextricably intertwined and inseparable from the intentional conduct that served as the basis for the claim of sexual assault.[60]

Issues have arisen over whether sexual exploitation cases are governed by the statute of limitations for medical malpractice cases (§ 52-584) or the longer statute of limitations for sexual exploitation cases (§ 52-577d).[61]

1-7 RECKLESSNESS

Connecticut has defined recklessness as highly unreasonable conduct involving an extreme departure from ordinary care.[62] A finding of recklessness, instead of mere negligence, may entitle a plaintiff to punitive as well as compensatory damages.[63] Several Superior Court decisions have recognized a recklessness claim in the context of medical malpractice.[64]

---

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

61. *See Doe v. Rackliffe*, No. HHBCV145016102S, 2015 WL 9694357 (Conn. Super. Ct. Feb. 19, 2015) (§ 52-584 applied to claim sounding in medical malpractice). *See* Chapter 5 for a discussion of the statute of limitations.

62. *Shay v. Rossi*, 253 Conn. 134, 181 (2000) ("highly unreasonable conduct, involving an extreme departure from ordinary care, in a situation where a high degree of danger is apparent"), *overruled on other grounds by Miller v. Egan*, 265 Conn. 301 (2003); *see also Bishop v. Kelly*, 206 Conn. 608, 614-15 (1988); *Dubay v. Irish*, 207 Conn. 518, 533 (1988).

63. *See Seymour v. Careia*, 24 Conn. App. 446, 451 (1991).

64. *Hanes v. Solgar*, No. NHCV156054626S, 2017 WL 1238417, 63 Conn. L. Rptr. 728 (Conn. Super. Ct. Jan. 13, 2017) (allegations that patient's death was caused by defendants' knowing administration of unsafe and dangerous dietary supplement, their knowing inability to ensure that it was not contaminated and their failure to comply with federal regulations governing the formulation, and manufacture of the product stated an actionable claim of recklessness); *Anderson v. Montowese Health & Rehab. Ctr., Inc.*, No. CV146050792S, 2015 WL 2473193 (Conn. Super. Ct. May 1, 2015) (citing cases) (defendant was aware of a high degree of danger arising out of decedent's dementia, poor balance, and bladder dysfunction); *Wiseman v. Armstrong*, No. CV020821661S, 2005 WL 1867607 (Conn. Super. Ct. July 1, 2005) (allegations that defendant was deliberately indifferent and created policies and customs whereby inmates were deprived of adequate medical care states cause of action for recklessness); *Walsh v. Abbott Terrace Health Ctr., Inc.*, No. CV 990137269, 2000 WL 1429424 (Conn. Super. Ct. Sept. 18, 2000) (failure to prevent threats and assaultive behavior by a roommate against a 96-year-old resident of a health care facility); *Triano v. Fitzpatrick*, No. CV 000494828, 2000 WL 264292 (Conn. Super. Ct. Feb. 17, 2000) (performance of surgery on the wrong eye rendering the patient blind); *Hughes-Mason v. Wintonbury Care Ctr., LLC*, No. CV030823678S, 2008 WL 4853411 (Conn. Super. Ct. Oct. 17, 2008); *Diduca v. Longo*, No. CV095030747,

Connecticut Medical Malpractice_Chapter 01.indd 12 6/18/2021 8:05:05 PM

1-8 VICARIOUS LIABILITY

Under the theory of vicarious liability, a principal can be held liable for the negligent acts of its agent. "[T]he three elements required to show the existence of an agency relationship include: (1) a manifestation by the principal that the agent will work for him; (2) acceptance by the agent of the undertaking; and (3) an understanding between the parties that the principal will be in control of the undertaking."[65] The burden of proving agency is on the party asserting its existence.[66] If there is a finding that the allegedly negligent actor is not an employee or agent, the claim of vicarious liability must fail.

Practice group corporations and hospitals that employ health care providers can be vicariously liable for the negligent acts of those employees.[67] However, the fact that a physician holds staff privileges at a hospital is not itself sufficient to support a finding that an agency relationship was created.[68]

2010 WL 2108461 (Conn. Super. Ct. Apr. 27, 2010) (removal of wrong teeth by maxillofacial surgeon constituted potential recklessness claim); *Gitelman v. Hughes Health & Rehab., Inc.*, No. CV-106013917-S, 2012 WL 432534, 53 Conn. L. Rptr., 337 (Conn. Super. Ct. Jan. 18, 2012) (failure to respond to symptoms of pneumonia in elderly patient). *But see Sands v. W. Conn. Health Network, Inc.*, No. DBDCV1960329025, 2020 WL 4341769 (Conn. Super. Ct. July 9, 2020) ("none of these allegations of recklessness amount to a sufficient basis to satisfy a reckless count. The plaintiff's allegation that the defendant was reckless because he did not follow protocols or perform a differential diagnosis even though she exhibited neurological issues is patently the same allegation as is his failure to perform his duties as a medical professional following the protocol for treatment."); *Gilman v. Shames*, 189 Conn. App. 736, 746 (2019) ("Simply using the word 'reckless' or 'recklessness' is not enough. A specific allegation setting out the conduct that is claimed to be reckless and wanton must be made."); *Wellons v. Bristol Hosp.*, No. CV095014713S, 2010 WL 4069530 (Conn. Super. Ct. Sept. 9, 2010) (declined to recognize a recklessness claim where the plaintiff alleged that a hospital failed to treat frostbite).

65. *Beckenstein v. Potter & Carrier, Inc.*, 191 Conn. 120, 132-33 (1983).

66. *L&V Contractors, LLC v. Heritage Warranty Ins. Risk Retention Grp.*, 136 Conn. App. 662, 667 (2012).

67. *See, e.g., Wilkins v. Conn. Childbirth & Women's Ctr.*, 314 Conn. 709 (2014) (plaintiff brought direct negligence claims against two nurse-midwives and vicarious liability claims against their employer); *Gagliano v. Advanced Specialty Care, P.C.*, No. CV106003939S, 2014 WL 7156739 (Conn. Super. Ct. Nov. 7, 2014) ("The Connecticut Supreme Court has recognized that a hospital or a medical corporation may be vicariously liable for the acts of its employees, including doctors.").

68. *Cefaratti v. Aranow*, 154 Conn. App. 1 (2014), *rev'd on other grounds*, 321 Conn. 593 (2016) (private attending general surgeon providing care and treatment to patients in his private office with medical staff privileges at hospital does not create agency relationship); *Griffin v. St. Vincent's Med. Ctr.*, No. CV065005220, 2011 WL 522024 (Conn. Super. Ct. Jan. 11, 2011) ("Agency is a fiduciary relationship which results from manifestation of consent by one person to another that the other shall act on his behalf and subject to his control and consent by the other so to act . . . . Performing administrative tasks or having staff privileges does not establish agency."); *see also Zbras v. St. Vincent's Med. Ctr.*, No. CV950323593, 2002 WL 31018547 (Conn. Super. Ct. Aug. 7, 2002).

Connecticut Medical Malpractice_Chapter 01.indd 13 6/18/2021 8:05:05 PM

There also exists an issue as to whether a hospital may be vicariously liable for acts or omissions of a physician practice group that has been retained to staff a hospital department.[69] When a patient sues a health care provider employed by a practice group that staffs a hospital department, he or she typically also sues the hospital under the law of agency, i.e., respondeat superior. Typically, hospitals attempt to contractually insulate themselves from such vicarious liability by including in the hospital/practice group agreements language tending to show that the hospital is not in control of the undertaking, i.e., (1) express acknowledgments that the physician group is an independent contractor; and (2) express provisions that the hospital shall not control the medical judgment exercised by the physician group.[70] This language is strongly indicative that the physician group is an independent contractor and, without evidence to the contrary, would be sufficient to conclude that it is not the agent of the hospital.[71]

However, in rebuttal, plaintiffs offer evidence of other language in the hospital/physician group agreement that requires the group physicians to comply with the hospitals' by-laws, rules, regulations, policies, directives, and codes of conduct; to work with the hospital to establish procedures and assure consistency of quality of services; to render medical care in a safe, effective, competent, and professional manner, consistent with quality improvement standards of the hospital; to participate in pre- or post-operative rounds in accordance with standards of the JCAHO or as may be designated or requested by the hospital from time to time.[72] Plaintiffs also offer evidence that the hospital supplies the instrumentalities, tools, and place of work. Given

---

[69] In Connecticut, there is a trend for hospitals to retain physician practice group to operate various hospital departments, including emergency, radiology, and anesthesiology. *See Bergwall v. Stamford Radiological Assocs.*, No. CV1260027331S, 2014 WL 4746760, 58 Conn. L. Rptr. 792 (Conn. Super. Ct. Aug. 15, 2014) (observing that there appears "to be a growing practice of Connecticut hospitals contracting with private entities to provide emergency department physicians").

[70] *E.g., Carano v. Kabadi*, No. CV116009251, 2014 WL 4413267 (Conn. Super. Ct. July 22, 2014); *Young Mi Joh v. Schmidt*, No. C09CV065006361, 2007 WL 4801435 (Conn. Super. Ct. Dec. 19, 2007).

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

[72] *See, e.g., Bordonaro v. Anesthesia Assocs. of Torrington*, No. LLICV106002739S, 2012 WL 5519632 (Conn. Super. Ct. Oct. 23, 2012); *Heath v. Day Kimball Hosp.*, No. HHDX04CV116026678S, 2013 WL 6989523 (Conn. Super. Ct. Dec. 16, 2013); *Young Mi Joh v. Schmidt*, No. C09CV065006361, 2007 WL 4801435 (Conn. Super. Ct. Dec. 19, 2007).

Connecticut Medical Malpractice_Chapter 01.indd 14 6/18/2021 8:05:05 PM

this conflicting evidence on the issue of control, Connecticut Superior Courts routinely decide that hospitals retain enough control over the physician group so as to create an issue of fact as to whether they should be vicariously liable for the acts or omissions of the group.[73]

1-8:1 Respondeat Superior

Under Connecticut law, the doctrine of respondeat superior in medical malpractice situations rests on common law agency principles of vicarious liability.[74] Under these principles, a master is responsible for the acts of his servant committed within the scope of employment and in the furtherance of the master's business.[75] The determination of whether someone is an employee or an independent contractor depends on the existence or nonexistence of the right to control the means and method of work.[76]

Agency law has elements of both a control test and a benefit test.[77] These factors can affect the analysis of cases. For example, a military physician participating in a residency program of a private hospital may render both the military and the private hospital liable under principles of vicarious liability.[78]

Connecticut has never adopted the "Captain of the Ship" doctrine under which physicians are automatically responsible for everything done under their supervision.[79]

1-8:2 Borrowed Servant Doctrine

Under the doctrine of respondent superior, a master (employer) is liable for the negligence of a servant (employee). But under the theory known as the "borrowed servant" rule, responsibility for the

---

73. *Young Mi Joh v. Schmidt*, No. C09CV065006361, 2007 WL 4801435 (Conn. Super. Ct. Dec. 19, 2007); *Carano v. Kabadi*, No. CV116009251, 2014 WL 4413267 (Conn. Super. Ct. July 22, 2014); *Heath v. Day Kimball Hosp.*, No. HHDX04CV116026678S, 2013 WL 6989523 (Conn. Super. Ct. Dec. 16, 2013); *Bordonaro v. Anesthesia Assocs. of Torrington*, No. LLICV106002739S, 2012 WL 5519632 (Conn. Super. Ct. Oct. 23, 2012).

74. *Garamella for Estate of Almonte v. N.Y. Med. Coll.*, 23 F. Supp. 2d 153, 165 (D. Conn. 1998).

75. *Larsen Chesley Realty Co. v. Larsen*, 232 Conn. 480, 500-01 (1995).

76. *Menzie v. Windham Cmty. Mem'l Hosp.*, 774 F. Supp. 91, 94 (D. Conn. 1991).

77. *See Bria v. St. Joseph's Hosp.*, 153 Conn. 626, 630 (1966) ("In the absence of assumption of control and direction by the doctor, the nurses did not become his servants."); *Larsen Chesley Realty Co. v. Larsen*, 232 Conn. 480, 501 (1995) ("But it must be the affairs of the principal, and not solely the affairs of the agent, which are being furthered in order for the doctrine to apply.").

78. *See Aldridge v. Hartford Hosp.*, 969 F. Supp. 816, 821 (D. Conn. 1996).

79. *See Sheriden v. Quarrier*, 127 Conn. 279 (1940) (operating surgeon not responsible for aftercare left in the hands of other health care providers).

Connecticut Medical Malpractice_Chapter 01.indd 15 6/18/2021 8:05:05 PM

employee can be transferred when the employee is loaned to another who assumes control over the employee's work.[80]

In medical malpractice context, the borrowed servant doctrine may be applied so that a surgeon supplants a hospital as the "master" of hospital employees (typically residents or nurses) by supervising, controlling, and directing the manner of their work during a surgical procedure. The borrowed servant doctrine makes the surgeon, rather than the hospital, liable for the actions of the residents or nurses. As a practical matter, the borrowed servant doctrine may amount to what is essentially a conflict between two financial institutions: the insurer for the physicians, and the insurer (or self-insured retention) of the hospital.

The law in Connecticut is somewhat varied on the application of the borrowed servant doctrine.[81]

1-8:3 Successor Liability

The trend toward physician group practice acquisitions and hospital mergers can give rise to questions of successor liability.[82] Normally an asset purchaser is not liable for the liabilities of the predecessor. There are exceptions to this rule (i.e., express or implied assumption of liability, consolidation or merger, fraudulent transaction, or mere continuation or reincarnation).[83]

---

80. *Bria v. St. Joseph's Hosp.*, 153 Conn. 626, 630 (1966). *See also Mather v. Griffin Hosp.*, 207 Conn. 125, 136 (1988).

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

82. *See* Eric Ofgang, "Hospital Wars," Conn. Magazine, Jan. 2015 (describing alliances, mergers, partnerships, and acquisitions in Connecticut's health care industry).

83. In *Robbins v. Physicians for Women's Health*, 311 Conn. 707 (2014), the Supreme Court held in a medical malpractice context that a settlement with a predecessor forecloses a successor

Connecticut Medical Malpractice_Chapter 01.indd 16 6/18/2021 8:05:05 PM

1-8:4 Apparent Authority

The Connecticut Supreme Court recognized the doctrine of apparent authority in *Cefaratti v. Aranow*.[84] A more complete discussion of the *Cefaratti* rule may be found at Chapter 7, § 7-4.

1-9 CONTRIBUTORY NEGLIGENCE

A patient in a medical malpractice setting may also have a duty, breach of which could lead to an affirmative defense of contributory negligence.[85] Pursuant to Connecticut law, a medical malpractice plaintiff would be completely barred from recovery if his negligence was found to be greater than the combined negligence of the defendants.[86] Contributory negligence must be affirmatively pleaded and the defendant retains the burden of proof.[87] A plaintiff is statutorily presumed to be in the exercise of reasonable care.[88]

A person's mental disability could impinge upon whether he is capable of exercising reasonable care, but a person's mental disability

---

liability claim against a successor. The Court articulated the rule of successor non-liability and its four exceptions. *See* Jeff White and Kate Dion, *Successor Liability, Retaliation, and Sanctions*, Conn. L. Trib., Sept. 22, 2014, at 17.

84. *Cefaratti v. Aranow,* 321 Conn. 593 (2016).

85. *Schleidt v. State*, No. 54205, 1991 WL 257273 (Conn. Super. Ct. Nov. 25, 1991) (contributory negligence is a valid defense to a claim of medical malpractice); *Teixeira v. Yale New Haven Hosp.*, No. CV09503067S, 49 Conn. L. Rptr. 443 (Conn. Super. Ct. Mar. 5, 2010) ("the negligent conduct of a patient which furnishes the occasion for medical treatment will be legally sufficient to support a special defense of comparative negligence where the negligence alleged of the plaintiff is connected or contemporaneous with the alleged negligence of the physician"). *But see Newlan v. State*, No. 564396, 2003 WL 21321849, 34 Conn. L. Rptr. 681 (Conn. Super. Ct. May 27, 2003) (defense of contributory negligence held not valid where the decedent's suicide is the foreseeable result of the physician's tortious act).

86. Conn. Gen. Stat. § 52-572h(b).

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

88. Conn. Gen. Stat. § 52-114. In *Juchniewicz v. Bridgeport Hosp.*, 281 Conn. 29 (2007), the Court held that Conn. Gen. Stat. § 52-114 did not entitle the plaintiff to an instruction that the plaintiff's decedent was presumed to be in the exercise of reasonable care.

Connecticut Medical Malpractice_Chapter 01.indd 17 6/18/2021 8:05:05 PM

is not an automatic bar to that person's contributory negligence liability.[89]

A defendant being sued for medical malpractice stemming from a patient suicide ordinarily may assert a special defense of contributory negligence.[90] However, in circumstances where a healthcare provider admits or takes custody of a patient to prevent that patient from committing suicide, and the patient succeeds in doing so, the healthcare provider may not plead contributory negligence as an affirmative defense.[91]

As a matter of trial strategy, a physician being sued for medical malpractice may be reluctant to assert a defense of contributory negligence because it could put the physician in the unpalatable position of appearing to blame the patient. In such circumstances, a physician may prefer to simply assert a defense that his actions were not a proximate cause of the injury because the patient did not provide complete information or follow directions.[92] Evidence of a plaintiff's contribution to his own injury is generally admissible under a general denial of causation.

1-10 THE WRONGFUL CONDUCT RULE

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

---

89. *Badrijian v. Elmcrest Psychiatric Inst., Inc.*, 6 Conn. App. 383, 389 (1986).

90. *See, e.g., Lavoie v. Manoharan*, No. HHBCV146027376S, 2020 WL 853633 (Conn. Super. Ct. Jan. 23, 2020); *Corello v. Whitney*, No. CV970156438S, 1999 WL 701829 (Conn. Super. Ct. Aug. 24, 1999).

91. *McKeever v. Hartford Hosp.*, 66 Conn. L. Rptr. 629 (2018) ("When a hospital admits a person into its custody who the hospital knows is actively suicidal, and when the admission is for the purpose of preventing that person's self-destructive behavior, the hospital assumes a duty to use reasonable care in preventing the patient from engaging in such behavior."); *Newlan v. State*, No. 564396, 2003 WL 21321849, 34 Conn. L. Rptr. 681 (Conn. Super. Ct. May 27, 2003) (in case involving an incarcerated individual admitted to a mental health medical unit within a correctional facility, the court held "the defense of contributory negligence is not valid where the decedent's suicide is the foreseeable consequence of the physician's tortious act").

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

Connecticut Medical Malpractice_Chapter 01.indd 18 6/18/2021 8:05:05 PM

This principle found expression in *Greenwald v. Van Handel*,[93] an unusual case in which a plaintiff alleged that his social worker's failure to treat his predilection to internet child pornography led to emotional distress arising from fear of prosecution. While declining to adopt a sweeping rule or exceptions thereto, the Court held that in these narrow circumstances, it would violate public policy to allow the plaintiff to profit from his own wrong in this manner.[94] The Court emphasized that it did not hold that the defendant did not have a duty to exercise care in the treatment of the patient and that the wrongful conduct rule would not apply if the patient sustained injuries independent of the legal consequences of his criminal acts as a result of the defendant's negligent treatment of his underlying condition.

1-11 PRENATAL DUTY OF CARE

Connecticut law acknowledges "that a physician rendering prenatal care to a mother also has a physician-patient relationship with the fetus."[95] "And, although medical interventions may, at times, be directed more particularly to either the mother or her fetus, 'the welfare of each is intertwined and inseparable.'"[96] It has been held that "the physician-patient relationship between the defendants and [the child], while in utero, was not extinguished because the medical judgment at issue related to the termination of the pregnancy. The defendants' professional relationship with [the unborn child] gave rise to a duty to conform to professional standards with regard to an appropriate abortion technique."[97] Therefore, the defendants would be liable to the child (born alive) for prenatal injuries caused by a negligently performed abortion.

---

93. *Greenwald v. Van Handel*, 311 Conn. 370 (2014).

94. *See* Christian Nolan, *Profiting From 'Wrongful Conduct'*, Conn. L. Trib., Oct. 21, 2013, at 1.

95. *Vasquez v. Roy*, No. CV146024908S, 2018 WL 3403410, 66 Conn. L. Rptr. 602 (Conn. Super. Ct. June 18, 2018) (citing *Neuhaus v. DeCholnoky*, 280 Conn. 190, 219 (2006)) ("In short, prior to delivery, a clear physician-patient relationship between [the physician] and [the fetus] had been established."); *Gorke v. Le Clerc*, 23 Conn. Supp. 256, 261 (1962).

96. *Vasquez v. Roy*, No. CV146024908S, 2018 WL 3403410, 66 Conn. L. Rptr. 602 (Conn. Super. Ct. June 18, 2018) (quoting *Vrzivoli v. Women's Health Assocs.*, No. CV085014640, 2011 WL 1106214 (Conn. Super. Ct. Mar. 7, 2011)).

97. *Vasquez v. Roy*, No. CV146024908S, 2018 WL 3403410, 66 Conn. L. Rptr. 602 (Conn. Super. Ct. June 18, 2018).

Connecticut Medical Malpractice_Chapter 01.indd 19 6/18/2021 8:05:05 PM