COURT OF APPEALS OF THE STATE OF NEW YORK

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EDWIN DAVIS and DIANNA DAVIS,

Plaintiffs-Appellants,

APL-2014-00245

Supreme Court
Nassau County
Index No.: 1834/11

-against-

SOUTH NASSAU COMMUNTIES HOSPITAL, REGINA E. HAMMOCK, DO, CHRISTINE DeLUCA, RPA-C AND ISLAND MEDICAL PHYSICIANS, P.C.,

Defendants-Respondents.

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BRIEF OF AMICUS CURIAE

MEDICAL SOCIETY OF THE STATE OF NEW YORK AND

AMERICAN MEDICAL ASSOCIATION

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PRELIMINARY STATEMENT

This appeal raises the issue whether physicians and other health care professionals and hospitals owe a duty of care to a plaintiff such as Edwin Davis - an unidentified member of the public - to control the conduct of a patient following discharge from the hospital emergency room to the benefit of the plaintiff. The New York State Supreme Court, Appellate Division, Second Department affirmed the ruling of the Supreme Court, Nassau County on the basis that Defendants-Respondents owed no duty of care to the plaintiff Edwin Davis. Now Plaintiffs-Appellants ask this Court to reverse the ruling of the Appellate Division, Second Department and to hold that Defendants-Respondents owed a duty of care to the plaintiff.

A physician's duty of care is ordinarily owed to the patient and does not extend to the community at large. This Court has, in rare and limited circumstances, expanded a physician's duty of care to encompass non-patients who have a special relationship with either the physician or the patient. However, even in the rare circumstances where this Court has expanded the physician's duty of care to encompass a limited number of identifiable non-patients, the Court has articulated a reluctance to expand a doctor's duty of care except under the most carefully defined and narrow circumstances. A critical reason underlying the Court's reluctance to expand a doctor's duty of care is the recognition of the

potential profound harm to society that would result and that expanding a duty of care to non-patients would render doctors liable to a prohibitive number of possible plaintiffs.

The Plaintiffs-Appellants are now asking this Court to depart from the Court's precedent. The Plaintiffs-Appellants are asking this Court to hold that physicians owe a duty of care beyond their patients to an unidentified and practically limitless number of members of the public. Essentially, if physicians and hospitals are found to owe a duty of care to the plaintiff, Edwin Davis, who to the defendants was an unidentified member of the public, then physicians and hospitals will be subject to lawsuits from any member of the general public.

MSSNY and AMA respectfully request that this Court affirm the decision of the Appellate Division, Second Department.

INTEREST OF THE AMICI

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA House of Delegates, substantially all U.S. allopathic physicians, residents and medical students are represented in the AMA policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all states

and in all areas of medical specialization. A subsidiary of the AMA is AMA Insurance Agency, Inc.

The Medical Society of the State of New York ("MSSNY") is comprised of physicians, residents and medical students who practice in the State of New York. MSSNY is represented in the AMA House of Delegates and shares the objective of the AMA to promote the science and art of medicine and the betterment of public health. The primary purpose of MSSNY is to enhance the delivery of medical care of high quality to all people in the most economical manner and to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public. Together amici represent tens of thousands of physicians throughout New York and across the country.[1] Affiliate and subsidiary organizations of MSSNY include the Empire State Medical Scientific and Educational Foundation, Inc., and the Medical Educational and Scientific Foundation of New York, Inc.

FACTS

Walsh went to the emergency room of the Defendant-Respondent South Nassau Communities Hospital complaining of abdominal pain. At the hospital Walsh was examined by Defendants-Respondents Regina E. Hammock, D.O. and

[1] The AMA and MSSNY join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Christine DeLuca RPA-C. Walsh was given several medications including a narcotic medication. After she was discharged from the hospital, while driving her vehicle, it is alleged that Walsh became unconscious as the result of the medications administered to her at the hospital and her vehicle crossed a double yellow line and struck a bus operated by Plaintiff-Appellant Edwin Davis, which was traveling in the opposite direction.

The Appellate Division, Second Department affirmed the ruling of the Supreme Court Nassau County holding that the complaint failed to state a cause of action alleging medical malpractice since only Walsh, and not Davis, had a doctor-patient relationship with the defendants. Furthermore, the Appellate Division, Second Department held that the Supreme Court appropriately exercised its discretion in denying plaintiff's motion to add a cause of action for simple negligence. In finding that Defendants-Respondents owed no duty of care to Davis, the Second Department quoted from this Court's decision in *Purdy v. Public Administrator of County of Westchester* 72 N.Y.2d 1, 530 N.Y.S.2d 513, 526 N.E.2d 4 (1988).

> "In the ordinary circumstance, common law in the State of New York does not impose a duty to control the conduct of third persons to prevent them from causing injury to others; liability for the negligent acts of third persons generally arises when the defendant has authority to control the actions of such third persons (citations omitted). This is so, we have said even where 'as a

practical matter' defendant could have exercised such control (citations omitted)".

"Of course, there exist special circumstances in which there is sufficient authority and ability to control the conduct of third persons so that we have identified a duty to do so. Thus, we have imposed a duty to control the conduct of others where there is a special relationship: a relationship between defendant and a third person whose actions expose plaintiff to harm such as would require the defendant to attempt to control the third person's conduct; or a relationship between the defendant to protect the plaintiff from the conduct of others." (citations omitted) 72 N.Y.2d at 8.

In the case at bar, the Appellate Division, Second Department held that plaintiff's proposed amendment failed to allege that Defendants-Respondents possessed sufficient authority and ability to control Walsh's conduct so as to give rise to a duty of care to protect Davis.

ARGUMENT

POINT I

There Was No Cause of Action for Medical Malpractice

The Appellate Division, Second Department correctly held that the complaint of Plaintiffs-Appellants failed to state a cause of action for medical malpractice. It has long been recognized that, as a general rule, the *sine qua non* of a medical malpractice action is the existence of a doctor-patient relationship. *Fox v. Marshall, 88 A.D.3d 131, 928 N.Y.S.2d 317 (App. Div. 2d Dept. 2011).* This Court stated as far back as in *Pike v. Honsiger, 155 N.Y. 201, 49 N.E. 760 (1898)*

that the law was well settled that the physician's duty of care is triggered upon the creation of a physician-patient relationship. As there was no physician-patient relationship between Plaintiff-Respondent Davis with the Defendants-Respondents, there could be no action for medical malpractice. The Court reiterated in *Purdy* that a physician's duty of care is ordinarily owed to his or her patient and not to an indeterminate class of persons. 72 N.Y.2d at 9.

POINT II

The Appellate Division, Second Department Correctly Applied The Court's Decision in Purdy.

It is submitted that the Appellate Division, Second Department correctly applied this Court's ruling in *Purdy* in denying plaintiff's motion for leave to amend the complaint to add a cause of action alleging simple negligence. The facts of this case are very similar to the facts in *Purdy*, where this Court held that the defendants owed no duty of care to the plaintiff.

In *Purdy*, Shaw was a 73 year old voluntary resident at defendant Bethel Methodist Home with a medical condition that made her susceptible to fainting spells and blackouts. Pursuant to her contract with Bethel, Shaw consented to routine medical treatment and inoculations and restraints ordered by her family physician, and agreed to allow Bethel to act in any emergency, but, insofar as when she was a voluntary resident, she did not relinquish general autonomy to Bethel. Shaw was examined by Bethel's medical director who issued an order authorizing

Shaw to leave Bethel unaccompanied. The plaintiff alleged that he was a customer at a gas station when he was struck by a speeding car that was driven by Shaw, while she was on leave from Bethel. The issue this Court addressed was whether the defendants Bethel and the admitting physician owed a duty to the plaintiff - a duty either to prevent Shaw from driving or to warn her of the dangers of driving given her medical condition. The Court concluded that defendants owed no duty of care to the plaintiff.

First, there was no special relationship between the plaintiff and defendants. The defendants did not know plaintiff as plaintiff to the defendants was an unidentified member of the public.

Thus, the Court stated if a duty was to be imposed on the defendants it would have to arise out of some special relationship between defendants and Shaw such as would require them to control Shaw's conduct for the benefit of plaintiff. The Court held, however, that neither Bethel nor the admitting physician had the necessary authority or ability to exercise control over Shaw's conduct so as to give rise to a duty on their part to protect plaintiff - a member of the general public.

Shaw was a voluntary resident at Bethel and there was no medical reason impeding her ability to leave Bethel unaccompanied. Shaw could come and go as she pleased. The Court stated that plaintiff did not assert any provision of the Public Health Law or regulation governing health-related facilities that either

authorized or required defendants to prevent Shaw – in non-emergency situations - - from leaving the premises or to control her conduct while she was off the premises.

In this case, as in *Purdy*, there was no special relationship between the plaintiff and the defendants. Just as in *Purdy*, in this case, the defendants had never met the plaintiff and the plaintiff to the defendants was an unidentified member of the public.

Thus, as in *Purdy*, in order to impose a duty on defendants, there had to be some special relationship between the defendants and Walsh as to require defendants - in non-emergency situations to prevent Walsh - from leaving the premises or to control her conduct while she was off the premises. In *Purdy*, the Court held that defendants had no duty of care because the defendants did not have authority and ability to control the conduct of Shaw. This Court in *Purdy* held that plaintiff could point to no provision in the Public Health Law or regulations governing health-related facilities that either authorized or required defendants to prevent Shaw - in non-emergency situations - from leaving the facility, or to control her conduct while she was away from the facility. Similarly, in this case, the plaintiff has not pointed to any provision in the Public Health Law or regulations governing the hospital that either authorized or required defendants to

prevent Walsh - once the emergency condition was treated - from leaving the hospital or to control her conduct while she was away from the premises.

For example, statutory provisions relating to the treatment of mental illness authorize the hospital or treating psychiatrist to retain a patient involuntarily under certain conditions where it is believed the patient has a mental illness and in need for involuntary treatment, Mental Hygiene Law sections 9.27 and 9.37. However, neither Shaw in *Purdy*, nor Walsh in this case, was suffering from any mental illness. Mental Hygiene Law sections 9.27 and 9.37 are inapplicable in the case at bar as they were inapplicable in *Purdy*.

Accordingly, just as defendants did not have authority and ability to control Shaw in *Purdy*, the defendants did not have authority and ability to control Walsh. It is, therefore, submitted that the Appellate Division, Second Department in this case correctly followed this Court's ruling in *Purdy*.

POINT III

A Finding of Duty of Care Owed to Indeterminate Members of the Community Would Cause Profound Hazards to Society.

In *Eiseman v. State of New York, 70 N.Y.2d 175, 518 N.Y.S.2d 608, 511 N.E.2d 1128 (1987)* this Court recognized that the Court must consider the larger social consequences in determining whether to extend a duty of care owed by one member of society to an indeterminate class of persons in the general community. In *Eiseman*, a prison inmate, anticipating a scheduled release from a State

correctional facility, applied for and was accepted into a special program at the State University College at Buffalo. The prison physician was asked to complete a health report which was part of the college acceptance package. The purpose of the form was to enable the college to offer follow-up care to students in the college. The prison physician inaccurately completed the health report, and failed to disclose any information regarding the prison inmate's emotional disability or prior treatments for mental disorder. Upon his release, the former inmate attended classes at the college and lived on campus. While attending college, the former inmate befriended some college students, and, one evening, murdered two students and seriously injured a third student at an off-campus apartment.

In a lawsuit brought by the estate of one of the deceased students and the injured student, the Court addressed whether the State was liable because of the prison physician's inaccurate health report. The Court held that even assuming that the physician's response was incomplete or inaccurate by reason of his failure to report the former prison inmate's medical history the physician did not owe a duty of care to all the students at the college. 70 N.Y.2d at 187. The Court analogized the situation to where a physician reports a physical examination for the benefit of a patient. In such situation, according to the Court, the physician owes a duty of care to the patient and does not undertake a duty to the community at large. 70 N.Y.2d at 188.

The Court held that limiting the duty of care to a "controllable degree" is based on public policy and a consideration of the social consequences of extending the duty of care to an indeterminate class. The Court stated in relevant part:

> "Embedded in the law of this State is the proposition that a duty of reasonable care owed by the tort-feasor to the plaintiff is elemental to any recovery in negligence (citations omitted). Unlike foreseeability and causation, both generally factual issues to be resolved on a case-by-case basis by the fact finder, the duty owed by one member of society to another is a legal duty for the courts (citations omitted). 'While moral and logical judgments are significant components of the analysis, we are also bound to consider the larger social consequences of our decisions and to tailor our notion of duty so that the legal consequences of wrongs (are limited) to a controllable degree'." (Citations omitted) 70 N.Y.2d at 187

Thus, this Court realized that if the duty of care is not limited to a "controllable degree", there could be severe social consequences. The Court then further observed:

> "We have limited the universe of permissible plaintiffs because a failure to do so would impose a duty of reasonable care enforceable by any member of an indeterminate class of persons, present and prospective, known and unknown, directly or indirectly injured by any negligence. 'The hazards of a business conducted on these terms are so extreme as to enkindle doubt whether a flaw may exist in the implication of a duty that exposes to these consequences'." (quoting from Judge Cardozo in Ultramares Corp. v. Touche, 255 N.Y. 170, 179-180) 70 N.Y.2d at 188.

Thus, the Court in *Eiseman* recognized that expanding the defendant's duty of care to an indeterminate and unidentified class of members of the general community would place the risk of profound harm to society, and accordingly, the Court rejected the request to expand the scope of the defendant's duty of care in this manner. It is submitted that the ruling that Plaintiffs-Appellants now request from this Court would risk the very harm that the Court sought to avoid in *Eiseman*. The Court in *Eiseman* recognized that it would be unreasonable to hold that defendant owed a duty of care to plaintiffs who were unidentified members of the public. This Court again decided that defendants did not owe a duty of care to the plaintiff in *Purdy*, who to the defendants was an unidentified member of the public. It is respectfully submitted that following the Court's ruling in *Eiseman* and *Purdy*, the Court should affirm the ruling of the Appellate Division, Second Department and hold that defendants did not owe a duty of care to *Davis* - an unidentified member of the public.

In *Pulka v Edelman, 40 N.Y.2d 781, 390 N.Y.S.2d 393, 358 N.E.2d 1019 (1976)* the Court held that the operator of a parking garage was not liable for an injury to a pedestrian struck by a car while it was driven out of the garage and across an adjacent sidewalk by a patron of the garage. While a garage obviously owes a duty to protect pedestrians from the acts of its own employees when driving a patron's vehicle across the path of pedestrians, the Court held it would be "most

unfair" to impose that duty on the garage operator with respect to acts of its patrons 40 N.Y.2d at 784. The Court held it was unfair to impose a duty on the garage operator because the garage operator has no control over the acts of its patrons. The Court refused to impose the duty on operators of a garage because the Court feared that imposing such a duty would expose the garage operator to limitless liability. The Court expressed the following concerns related to such liability.

> "If a rule of law were established so that liability would be imposed in an instance such as this, it is difficult to conceive of the bounds to which liability would flow. The liability potential would be all but limitless and the outside boundaries of that liability, both in respect to space and the extent of care to be exercised, particularly in the absence of control, would be difficult of definition. Consider a city like New York with its almost countless parking garages and lots. Think especially of those in the theater districts and around sporting stadiums and convention halls with mass exoduses that occur upon cessation of the events which draw the crowds. Think also of the parking facilities at some hotels, office building and shopping centers. The burden cast on the operators of these establishments in order to discharge their responsibilities in the respect to patron-operated vehicles beyond the confines of their properties would be an impractical and unbearable one. More importantly, there is no basis in the law for the imposition of this burden." 40 N.Y.2d at 786.

The Court appropriately recognized that it would be an unfair and unbearable burden to impose a duty of care on garage operators to protect pedestrians from vehicles driven by garage patrons out of the garage because the garage operator has no control over the patron, and, the Court recognized it would

be difficult to define the "bounds" of such liability. It is respectfully submitted that it would even be more unfair and unbearable to impose a similar duty of care on physicians and other health care professionals and require physicians and health care professionals to protect members of the general community, including motorists and pedestrians, from acts of patients driving away from a hospital or medical office after receiving treatment at these locations. Similar to the relationship between a garage operator and its patrons, physicians and other health care professionals have no authority and ability to control the conduct of their patients. As much as it would be difficult to define and limit the "bounds" were such liability to be imposed on garage operators, it would even be more difficult to define and limit the "bounds" of liability if such duty of care were to be imposed by this Court on physicians and other health care professionals. In *Pulka*, had the Court decided to impose a duty of care on garage operators to protect pedestrians, the Court could have limited such "bounds" of the duty of care to the immediate vicinity outside of the garage and across the adjacent sidewalk driven by the garage patron. However, the Court correctly recognized that even such bounds would be difficult to limit and the potential liability to garage operators could be limitless and unbearable. It is respectfully submitted that if such duty of care is imposed on physicians and other health care professionals to protect motorists and pedestrians from the driving of patients, it would be even more difficult, and likely impossible,

to defined reasonable "bounds" to such liability and physicians and other health care professionals would be exposed to the potential to limitless liability. At what point would the "bounds" of the physician's duty of care to motorists and pedestrians in the general community cease? Where would the demarcation point be drawn? After the patient has driven a mile, twenty miles, one hundred miles? After the patient has driven for one hour, ten hours, twenty-four hours? Would the Court need to define the bounds of the physician's duty of care in terms of geographic radius and the amount of time driven by the patient? Clearly, it would be impossible for the Courts to conceive the bounds of any such duty of care, and physicians and other health care professionals would assume an impractical and unbearable burden.

Just as the Court recognized that it would be impractical and unbearable to impose the duty of care on a garage operator, the Court should similarly find that the duty of care would be impractical and unbearable to impose on physicians and other health care professionals. More importantly, just as the Court found that there was no basis in the law for the imposition of this burden on garage operators, the Court should similarly conclude that there is no basis in the law to impose this burden on physicians and other health care professionals.

The Court has long recognized the need to be circumspect and wary in expanding a defendant's duty of care, and the need to draw a line between the

competing policy considerations of providing a remedy to everyone who is injured and of extending exposure to tort liability almost without liability. Recognizing that expanding duty of care results in concomitant liabilities, the Court emphasized in *DeAngelis v. Lutheran Medical Center, 58 N.Y.2d 1053, 462 N.Y.S.2d 626, 449 N.E. 2d406 (1983)* that in deciding whether to impose new duties, the Court needs to carefully consider the economic and social burden that would result from such duties and concomitant liabilities.

POINT IV

While the Court has Under Very Rare and Limited Circumstances Extended a Physician's Duty of Care to a Specific Non-Patient, Usually an Immediate Family Member, the Physician's Duty of Care Has Never Been Extended to the General Public.

In *Tenuto v. Lederle Laboratories, 90 N.Y.2d 606, 655 N.Y.S.2d 17, 687 N.E.2d 1300 (1997)*, this Court recognized that a doctor's duty can, in limited circumstances, encompass non-patients who have a special relationship either with the physician or the patient. The Court held that a doctor owed a duty of care to the parents of an infant vaccinated for paralytic poliomyelitis, which could be breached by a failure to warn the parents of the risk of contracting polio while tending to the child's basic needs. In *Tenuto*, the Court cited its ruling in *Purdy* and posited that one source of a limited expansion of a physician's duty of care is the existence of a special relationship either between the physician and the injured non-patient, or a special relationship between the injured non-patient and the

patient, where the physician knew or should have known that the non-patient was relying on the physician's exercise of due care. In *Tenuto*, the physician was a pediatrician who was engaged by the parents to provide medical services to their infant, and whose services, according to the Court, by necessity required advising the patient's parents. The Court held that the special relationship, in this case was "triangulated", involving interconnections of reliance running directly between the parents of the minor patient and the physician, and indirectly from their status and responsibility as the primary caretakers of the infant patient.

In *McNulty v. City of New York, 100 N.Y.2d227, 762 N.Y.S. 2d 12, 792 N.E.2d 162 (2003)*, this Court clarified its ruling in *Tenuto* to define the limited circumstances that courts would find a doctor's duty of care to encompass non-patients. In *McNulty*, the plaintiff, who was a nurse, was called to assist a sick friend. Before an ambulance arrived to take the friend to Jacobi Hospital, plaintiff was in close proximity to her friend who was later diagnosed with bacterial meningitis. The friend was later transferred to Albert Einstein Hospital. Plaintiff alleged that she asked defendant doctors at both hospitals whether she should be treated with any prophylactic medicine, since she was in close contact with her friend. Both doctors allegedly responded that no treatment was necessary, and plaintiff subsequently was diagnosed with bacterial meningitis. The Appellate Division, First Department ruled that the physicians owed a duty of care to

plaintiff, but the Court reversed the First Department and held that the physicians owed no duty of care to the plaintiff.

The Court explained that in the limited circumstances that it has expanded a doctor's duty to a non-patient third party, the third party's injury resulted from the physician's performance of the duty of care owed to the patient. Thus in *Tenuto*, the physician's very act in administering the polio vaccine to the infant created the serious risk of harm to the parent who contracted polio. In contrast, in *McNulty*, the performance of medical service to the patient did not result in the harm complained of by the plaintiff. The Court held, in addition, that there was no special relationship between the plaintiff and the doctors in *McNulty*. Unlike *Tenuto* where the parents had hired the physician and relied exclusively on his medical advice, the doctors in *McNulty* had never met the plaintiff when she approached them.

Thus, under *Tenuto*, the special relationship that existed and extended the doctor's duty of care to the parents of the infant patient included the following three critical factors: (1) the parent had engaged the physician and relied exclusively on his professional services; (2) it was the physician's acts in administering the vaccination to the infant patient that created the serious risk of harm to the parent and (3) the physician knew or should have known that the failure to warn the parent of the serious peril heightened the risk.

In *Cohen v. Cabrini Medical Center 94 N.Y.2d 639, 709 N.Y.S.2d 151, 730 N.E.2d 949 (2000)* the Court emphasized that although in *Tenuto* the Court recognized limited circumstances to extend a physician's duty of care to a patient's family members, the courts "have been especially circumspect in doing so". 94 N.Y.2d at 642. In *Cohen*, the Court affirmed an Appellate court ruling that dismissed the medical malpractice lawsuit brought by the wife of a patient, alleging that the negligent performance of a procedure to increase the patient's fertility caused the wife to suffer psychological harm. The Court held that recognizing the legal duty of care running from the physician to the non-patient wife in these circumstances would be an unwarranted extension of the Court's "narrowly drawn jurisprudence" with respect to malpractice liability to a patient's family member. 94 N.Y.2d at 643.

The Court in *Cohen* took notice that appellate courts have extended physician liability to the wife of a patient for her physical injuries due to an unwanted pregnancy after a negligently performed vasectomy, *Miller v. Rivard, 180 A.D.2d 331, 585 N.Y.S.2d 523 (App. Div. 3rd Dept. 1992). Weintraub v Brown, 98 A.D.2d 339, 470 N.Y.S.2d 634 (App. Div. 2nd Dept. 1983); Sorkin v Lee, 78 A.D.2d 180, 434 N.Y.S.2d 300 (App. Div. 4th Dept. 1980).* The Court noted that in these cases, a special relationship existed between the physician and wife of the patient, and the factors similar to the factors in *Tenuto*, were present: (1) the

procedure undertaken by patient husband was specifically and expressly to prevent the wife's pregnancy, and consequential physical harm, (2) both patient and patient's wife relied upon the proper performance of the procedure and (3) the physical harm from the pregnancy was the direct outcome of the negligently performed procedure. In contrast, the Court held that three factors did not apply to the wife of the patient in *Cohen*, and, accordingly, there was no special relationship between the physician and the patient's wife.

This Court has denied leave to appeal decisions of the appellate courts that held that a physician owed no duty of care to the immediate family members of a patient. In *Conboy v. Mogeloff, 172 A.D.2d 912, 567 N.Y.S.2d 960 (App. Div. 3d Dept. 1991) leave denied 78 N.Y.2d 862, 576 N.Y.S.2d 220, 582 N.E.2d 603 (1991)*, it was held that defendant physician owed no legal duty to the children of the plaintiff patient, who alleged that she lost consciousness while driving her car and collided with a bridge abutment, causing injuries to her children. The plaintiff commenced a lawsuit on behalf of her children and alleged that when she complained of headaches, the defendant physician prescribed a medication that had a sedative effect, and, in response to plaintiff's question, the physician advised her that she could drive while taking the medication. The appellate court, citing *Purdy*, held that the defendant physician lacked sufficient ability and authority to

control the conduct of the patient so as to give rise to a legal duty on the part of the physician to protect the patient's children.

In *Ellis v. Peter, 211 A.D.2d 353, 627 N.Y.S.2d 707 (App. Div. 2d Dept 1995); leave denied 86 N.Y.2d 885; 635 N.Y.S.2d 950, 659 N.E.2d 773 (1995)*, the wife of a tuberculosis patient brought an action against her husband's physician alleging that she was stricken with tuberculosis as the result of the physician's failure to timely diagnose and treat her husband's tuberculosis. The Second Department held that the physician owed no duty of care to the wife, who was not the physician's patient. The Second Department held that the fact that the wife was in close proximity to her husband and could be exposed to tuberculosis as the result of such proximity did not provide sufficient basis to extend the physician's duty of care to the non-patient wife as the appellate court could perceive of no "demarcation of the point where the duty would end". 211 A.D.2d at 356. The Second Department recognized that if the physician's duty of care were extended to the patient's spouse, such duty would likely be extended to other individuals with whom the patient was in close contact, such as the patient's children and other relatives, co-workers, and even fellow commuters. Clearly, such individuals represent the community at large, to whom a physician owed no duty of care. The Second Department concluded that "the imposition of a common-law duty upon the defendant herein with respect to the wife could expand traditional tort concepts

beyond manageable bounds and create an almost infinite universe of potential plaintiffs' " (citations omitted). 211 A.D.2d at 356.

The physician's duty of care was not extended to the patient's immediate family members in *Conboy* and *Ellis* because there was no special relationship between the defendant physician and the family members in these cases. The three critical factors required to establish the finding of a special relationship, as enunciated in *Tenuto and McNulty*, were not present in *Conboy* and *Ellis*.

Thus, this Court and appellate courts have rarely extended the physician's duty of legal care beyond the patient. Even in the rare cases that a physician's duty of care was extended to the patient's immediate family member, this Court in *Tenuto* and *Cohen* has limited the narrow circumstances where a physician's duty of care can be extended to an immediate family member of the patient, and noted that the courts "have been especially circumspect in doing so" 94 N.Y.2d at 642. Clearly, if the courts in New York have rarely and only upon limited and narrow circumstances extended a physician's duty of care to a specific and foreseeable non-patient who is an immediate family member of the patient, the courts have never recognized that a physician, lacking authority and ability to control the conduct of the patient, owes a legal duty to unidentified members of the general public.

POINT V

Public Policy Considerations

The Court stated in *Eiseman* that in determining whether to expand the duty of legal care one member of society owes to other members of society, the Court is bound to consider the larger issue of social consequences of its decisions so that the legal consequences are limited to a "controllable degree". 70 N.Y.2d at 187. It is respectfully submitted that the ruling of the Appellate Division, Second Department should be affirmed because, if the Second Department ruling is reversed, and a physician is held to owe a duty of care to an indeterminate number of members of the community at large, the medical profession and the health care system would be exposed to profoundly adverse and unforeseeable hazards. The medical profession would be subject to a legal duty of care "beyond manageable bounds" and exposed to the foreseeable and unforeseeable consequences, "most especially for vast, uncircumscribed liability" *Ellis v. Peter 211 A.D.2d 353 at 357.*

According to the AMA report "Medical Liability Reform Now!"[2], physicians practice under the constant threat of medical malpractice suits. A 2007-2008 AMA survey found that 61% of physicians aged 55 and older have been sued at some point in their careers. Nearly 40% had been sued two or more times. Among surgeons age 55 and older, nine out of ten had been sued. The data

[2] Medical Liability Reform Now! The facts you need to know to address the broken medical liability system (2013 ed) available at http://www.ama-assn.org/ama/pub/advocacy/topics/medical-liability-reform.page.

does not show that physicians are practicing bad medicine. Data from the Physicians Insurers Association of America (PIAA), an insurance industry trade association of liability insurers shows that most liability claims are without merit. Sixty-five percent of claims that were closed in 2012 were dropped, withdrawn or dismissed. A little more than eight percent of claims were decided by a trial verdict, the vast majority - 89% - of which were won by the physician defendant in the case.[3]

From a number of perspectives the current liability system is extremely costly. PIAA data shows that the median indemnity payment on settlement claims that closed was $194,375. For tried claims decided in plaintiff's favor, the median payment was $500,000. In addition to the costs generated by the amounts paid out to plaintiffs, the claims are also costly to defend. The average defense cost for claims settled in 2012 was $70,480. For tried claims it was $135,747 when there was a defendant victory and $253,920 for a plaintiff victory. For dropped claims, the average was $28,777.[4]

The lawsuit environment exacts a heavy toll for physicians and our health care system: rising professional liability insurance premiums for physicians; rising health care costs for patients; overly defensive (and thus more expensive) medical practices; early retirement for physicians; and physician relocations to states that

[3] Id at p. 6.
[4] Id p. 6

have adopted effective medical malpractice reforms. The problems have been even more pronounced in New York. New York is identified as among the states in crisis during the medical malpractice crisis of the mid 2000s, with increasing premiums, patients losing access to health care, and many physicians struggling to stay in practice.[5] The crisis in the mid-2000s was very detrimental to patients and their physicians. The stability of New York's health care system remains fragile, and it is the concern of AMA and MSSNY that if the Appellate Division, Second Department is reversed, and the Court expands physicians' duty of care to unidentified and indeterminate number of members of the general public, the health care system in the state can be in crisis again, if not subjected to even a greater crisis than the mid-2000s.

The fear of lawsuits affects the way in which physicians practice, and the medical liability system causes health care expenditures to be higher, as physicians are forced to practice "defensive medicine". According to a 2003 U.S. Department of Health and Human Services Report issued during the last medical liability crisis the cost of defensive medicine is estimated to range between $70 and $126 billion per year.[6] It is not possible to calculate the impact to overall defensive medicine costs if physicians' legal duty of care is expanded to indeterminate members of the general community.

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[5] Id p. 10.
[6] Id at pp. 8-9.

Moreover, if a physician's duty of care is expanded beyond the patient to unidentified and indeterminate number of members of the general community, there may be circumstances, where a physician may perceive that his or her legal duty to the patient may be in conflict with the "duty" to the general community. Within the physician-patient relationship, a physician is ethically required to use sound medical judgment holding the best interest of the patient paramount. Section 10.015 of the AMA Principles of Medical Ethics. If, however, a physician may be exposed to liability to members of the public for medical treatment that the physician provides to a patient, physicians may be reluctant to provide certain types of medical treatment to patients if it is believed that such treatment could expose the physician to lawsuits by members of the general community. For example, a physician may believe that certain medication therapy may be in the best interest of the patient, but may be concerned that even with full disclosure to the patient regarding the benefits and potential risks of the medication therapy, the physician many be exposed to lawsuits from members of the community if it is alleged that the patient caused injuries to other persons because the medication, directly or indirectly, contributed to the patient's negligence. The chilling effect caused by such lawsuits may lead physicians to hesitate providing patients with treatments that have inherent risks and potential side effects. As the result of

physician fear of being exposed to liability from individuals in the general public, patients may have reduced access to medically beneficial treatment.

If non-patients are allowed to sue a physician for the care the physician provided to a patient, and the non-patient alleges that the physician neglected to caution the patient about the side effects associated with the prescribed medications (e.g., drowsiness), the physician should have the opportunity to prove that the physician gave the patient the necessary warnings. To make this defense, the physician would need to disclose otherwise confidential physician-patient communications. Such disclosures would weaken the bond of trust between the patient and physician needed to foster effective medical care. Allowing lawsuits by non-patients would frequently involve such a consequence. MSSNY and AMA are deeply concerned that non-patient lawsuits against physicians would weaken the bond of trust between the patient and physician would have a profound adverse effect impact on the ability of the physician to provide quality care to the patient.

CONCLUSION

The Defendants-Respondents owed no duty of legal care to Davis, who to the Defendants-Respondents, was an unidentified member of the general public. There was no physician-patient relationship between Davis and the Defendants-Respondents. The Defendants-Respondents did not know Davis and had never met

Davis. There was no special relationship. Defendants-Respondents did not have the authority or ability to exercise control over the conduct of the patient.

This Court and the courts in New York have already established that only under rare and limited circumstances will a physician's duty of care be extended to a specific and identifiable non-patient, usually an immediate family member, and this Court and the courts have never extended a physician's duty of care to unidentified members of the general public.

It is respectfully submitted that the Second Department correctly applied the ruling of this Court in *Purdy* and other decisions of this Court, and correctly held that Defendants-Respondents owed no duty of care to Davis. It is respectfully submitted that decision of the Second Department should be affirmed.

Respectfully submitted,

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