DOCKET NO. CV-22-5054100-S	:	STATE OF CONNECTICUT
WILLIAM PETAWAY	:	SUPERIOR COURT
	:	JUDICIAL DISTRICT OF NEW HAVEN
V.	:	AT NEW HAVEN
ADRIAN MAUNG, M.D., ET AL.	:	MAY 2, 2024

MEMORANDUM OF DECISION

STATEMENT OF CASE AND PROCEDURAL HISTORY

The self represented plaintiff, William Petaway, seeks damages from the defendants, Dr. Adrian Maung, Dr. Linda Maerz, Dr. Michael Hrycelak, and Yale-New Haven Hospital, for battery based on an alleged failure by the defendants to obtain the plaintiff's informed consent prior to rendering emergency medical treatment to the plaintiff. The plaintiff claims that the defendants failed to obtain his informed consent prior to ordering and performing a blood transfusion, performing surgery on him, and putting him under general anesthesia. In response, the defendants assert that they cannot be held liable on the grounds: (1) that the plaintiff arrived at the emergency department in a critical condition making it impractical to obtain his informed consent for the emergency medical treatment rendered to him and, therefore, the emergency exception to the doctrine of informed consent applies; (2) that substituted informed consent for the surgery was obtained by the plaintiff's wife; and (3) that the plaintiff failed to file his claim within the applicable statute of limitations, General Statutes § 52-584. The court heard evidence over a three day trial held on October 17, 2023, November 3, 2023, and December 8, 2023. At

the conclusion of the trial, the court ordered the parties to submit post-trial memoranda, to which both parties complied.[1]

STANDARD OF REVIEW

"The [fact-finding] function is vested in the trial court with its unique opportunity to view the evidence presented in a totality of circumstances, i.e., including its observations of the demeanor and conduct of the witnesses and parties . . . ." (Internal quotation marks omitted.) *Cavolick* v. *DeSimone*, 88 Conn. App. 638, 646, 870 A.2d 1147, cert. denied, 274 Conn. 906, 876 A.2d 1198 (2005). "It is the sole province of the trial court to weigh and interpret the evidence before it and to pass on the credibility of the witnesses." (Emphasis omitted; internal quotation marks omitted.) *Zahringer* v. *Zahringer*, 124 Conn. App. 672, 679-80, 6 A.3d 141 (2010).

FINDINGS OF FACTS

The court has considered testimony, and evidence presented and, accordingly, finds the following facts by a fair preponderance of the evidence. On October 17, 2023, the court first heard testimony from Adrian Maung, MD. Dr. Maung is an acute care surgeon whose practice consists of trauma surgery, general surgery and critical care medicine. He is board-certified in general surgery and surgical critical care. The court finds Dr. Maung's testimony credible.

At approximately 5:30 a.m. on June 16, 2018, the plaintiff, William Petaway, arrived at the Yale-New Haven Hospital emergency department (YNHH) with a stab wound to his back and an injury to his arm.[2] The plaintiff was brought in as an unidentified full trauma patient who was

[1] See #274.00 (Pl.'s Post-Trial Brief) and #275.00 (Defs.' Post-Trial Brief).

[2] The plaintiff was stabbed by his uncle, Herman Keen, in the early morning of June 16, 2018, at or near a Sam's Food Store.

answering minimal questions. Upon arrival, the plaintiff was examined by Dr. Maung, the on-call trauma surgeon working in the hospital's emergency department during the overnight shift. When Dr. Maung evaluated the plaintiff at approximately 5:42 a.m., the plaintiff had a critically low blood pressure at 84/37, also known as hypotension, due to significant amounts of blood loss. In addition, an alcohol panel performed using the plaintiff's urine demonstrated that he was intoxicated. As a result of the plaintiff's condition, he was assessed as being an acuity level one, meaning that his condition was among the most serious acuity of patients with potentially life-threatening injuries or conditions.

Due to the significant amounts of blood loss, the plaintiff required an emergency blood transfusion to save his life from the injuries sustained. Taking into account the plaintiff's critically low blood pressure, shock, altered mental status, and intoxication, along with Yale-New Haven Hospital's policy regarding emergency medical treatment, Dr. Maung assessed the plaintiff as not being in a condition to give consent to the blood transfusion.[3] Dr. Maung testified that it would have been "unethical" for him to try to have an informed consent discussion with the plaintiff because he was not "in a condition to make informed decisions." Consequently, an emergency blood transfusion was ordered, and the plaintiff received one unit of blood at 5:46 a.m. and a second unit at 5:49 a.m. The emergency blood transfusion protocol was ordered, and Dr. Maung documented in the chart that "a blood transfusion is needed urgently for the

[3]See Defs.' Exh. B, Yale-New Haven Hospital Policy and Procedures, p. 12 ("[i]n the event a patient is unable to consent and an Authorized Representative is not available despite reasonable efforts by the Hospital to locate, a Responsible Practitioner may perform an invasive procedure/treatment without written informed consent . . . [i]f an emergency exists, i.e., imminent threat to life or limb . . . ."), p. 14 ("if the patient has a life or health-threatening emergency and requires blood or blood product transfusion . . . no consent is required until the emergency has passed").

emergency care of this patient" and that "for this patient at this time, I believe that the benefits of an uncrossed transfusion outweigh the risks."[4] Within minutes of the transfusion, the plaintiff's blood pressure began to increase. A few minutes later, the plaintiff received fresh frozen plasma and, by 6:10 a.m., the plaintiff's blood pressure normalized to 102/64. This allowed a chest tube to be inserted to remove the collection of blood in the plaintiff's left chest cavity. The immediate blood output was approximately 800ccs, which does not include the unquantifiable amount of blood that the plaintiff lost prior to his arrival at the YNNH.

Following the transfusion, the plaintiff underwent a chest, abdomen, and pelvic CT scan with intravenous contrast which was necessary to identify the extent of his injuries. The chest CT scan impression was as follows: "1. Tiny left pneumothorax and chest tube in place. Left base consolidation may represent hematoma/aspiration or atelectasis. 2. Displaced 10th rib fracture likely secondary to stabbing. 3. Possible splenic injury without evidence of large hematoma. Tiny pneumoperitoneum is present."[5] The plaintiff was given 50 mcg of fentanyl to address his complaints of pain at 8 am followed by 2 mg of morphine at 8:15 am.[6] Dr. Maung's initial plan as documented in the record was as follows: "PTX (pneumothorax), HTX (hemothorax) after stab wound with likely diaphragmatic injury. The two foci are most likely from the PTX rather than bowel injury but will need to monitor abdominal exam. Plan would be for delayed laparoscopy and attempt at laparoscopic repair of diaphragm in 24 hours after

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[4]Defs.' Exh. A, Yale-New Haven Hospital Medical Records, p. 0609.

[5]Defs.' Exh. A, pp. 0062-0063.

[6]Defs.' Exh. A, pp. 0039-0040.

monitoring for development of bowel injury. If his abdominal exam changes, will need operating room sooner."[7] The plaintiff's abdominal exam did change.

Care of the plaintiff was then transferred to Dr. Linda Maerz, the daytime trauma surgeon on call, who arrived to the plaintiff's bedside at approximately 9:42 a.m. Similar to Dr. Maung, Dr. Maerz is board-certified in general surgery and surgical critical care. The court finds Dr. Maerz's testimony credible. When Dr. Maerz arrived to evaluate the plaintiff, his wife, Georgia Francis, was present. In her documentation, Dr. Maerz noted the following: "The patient appears to be 30-to-40-year-old male who sustained a laceration (presumed stab wound) just to the left of the midline of the back, below the level of the scapula. He also sustained a laceration to the right upper extremity just superior to the antecubital fossa. In the emergency department, he was hypotensive, but responded to 2 units of blood and 1 unit of FFP. A left chest tube was placed and approximately 800 cc of blood was evacuated, along with air. Control of bleeding from the right upper extremity injury was achieved by the orthopedic trauma team and the wound was irrigated and bandaged with a pressure dressing. The patient stabilized and he was able to undergo CT imaging. This demonstrated an intrathoracic left chest tube as expected as well as a small amount of residual hemopneumothorax. A left 10th rib fracture was identified as well as a small left diaphragmatic injury. There were tiny locules of air below the diaphragm, consistent with punctate areas of pneumoperitoneum. It was elected to initially observe the patient with the thought that the pneumoperitoneum was tracking from the thoracic cavity, with a plan to perform a more semi-elective diaphragm repair. However, over the course of the subsequent couple of

[7]Defs.' Exh. A, pp. 0065-0066.

hours in the emergency department, the patient developed abdominal pain and mild distention. Therefore, he was taken to the operating room *urgently* for a trauma exploratory laparotomy."[8]

Ms. Georgia Francis' deposition was introduced into evidence. Dr. Maerz obtained informed consent for the plaintiff's emergency exploratory laparotomy from Ms. Francis. Dr. Maerz obtained informed consent from Ms. Francis because, in Dr. Maerz's assessment, the plaintiff was "too seriously ill" and "lacked capacity to sign the consent form." Ms. Francis' name and signature appears on the Consent for Operation Form. Ms. Francis gave consent to Dr. Maerz, "to save the life" of her daughter's father.[9]

Dr. Maerz discussed the nature and the risks of the emergency exploratory laparotomy with Ms. Francis in the presence of the plaintiff. Specifically, Dr. Maerz outlined the risks of infection, injury to internal organs, bleeding, and a potential colostomy which is when a portion of the bowel is removed and is brought out the abdominal area such that bowel movements then collect in a bag. In addition, Dr. Maerz broadly discussed the need for general anesthesia as a necessary component to the emergency procedure because such a procedure could not be performed without general anesthesia.

Michael Hrycelak, MD, was the anesthesiologist who attended the plaintiff's emergency exploratory laparotomy. The court finds Dr. Hrycelak's testimony credible. According to Dr. Hrycelak, the anesthesiology team was notified at approximately 9:42 am to mobilize for the emergency procedure. Dr. Hrycelak began documenting at approximately 9:45 am. This three-minute time lapse reflects the urgency of the clinical situation. According to the

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[8] Defs.' Exh. A, p. 0142.

[9] Pl. Ex. 4.

documentation, the anesthesia team was ready and in the operating room at 10:01 am and the plaintiff was brought to the operating room at 10:34 am. According to Dr. Hrycelak, generally it is not required for the anesthesia service to obtain a signed consent form separate from the one that is signed for the underlying procedure. Dr. Hrycelak also testified, and this court so finds, that in the circumstances of this particular case, informed consent could not be obtained from the plaintiff directly because he was unable to comprehend what would have been an informed consent discussion. In addition, informed consent could not be obtained from Ms. Francis because she was not in the immediate vicinity of the operating room in order to allow Dr. Hrycelak to have that substituted discussion.

Given the emergency circumstances, the gravity of the plaintiff's condition, and the urgent need for the surgical procedure, the emergency exploratory laparotomy was performed. The plaintiff went on to make a good recovery and was discharged from the hospital ten days later on June 26, 2018. The court will make additional findings of fact as necessary.

LEGAL ANALYSIS

A.

Doctrine of Informed Consent

Our Appellate Court provides a very thorough discussion on the history and application of the doctrine of informed consent in *Wood* v. *Rutherford*, 187 Conn. App. 61, 201 A.3d 1025 (2019), which this court finds instructive, and dispositive of the issues in this case.

"The doctrine of informed consent traces its origins to the common-law notion that an adult 'has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in

damages.' (Internal quotation marks omitted.) *Schmeltz* v. *Tracy*, [119 Conn. 492, 495-96, 177 A. 520 (1935)], quoting *Schloendorff* v. *New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914) (*Cardozo, J.*), overruled on other grounds by *Bing* v. *Thunig*, 2 N. Y. 2d 656, 143 N. E. 2d 3, 163 N. Y. S. 2d 3 (1957); see also *Union Pacific Railway Co.* v. *Botsford*, 141 U.S. 250, 251, 11 S. Ct. 1000, 35 L. Ed. 734 (1891) ('[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law'); *Abigail Alliance for Better Access to Developmental Drugs* v. *von Eschenbach*, 495 F. 3d 695, 717 (D.C. Cir. 2007) (en banc) (courts have long 'recognized with universal acquiescence that the free citizen's first and greatest right, which underlies all others, is the right to the inviolability of his person' [internal quotation marks omitted]), cert. denied, 552 U.S. 1159, 128 S. Ct. 1069, 169 L. Ed. 2d 839 (2008). As the United States Supreme Court has recognized, the 'notion of bodily integrity [is] embodied in the requirement that informed consent is generally required for medical treatment.' *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 269, 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990).

"The doctrine of informed consent attempts to balance the autonomy of the patient with the professional obligations of the physician. In the seminal decision of *Canterbury* v. *Spence*, [464 F. 2d 772, 780 (1972)], the United States Court of Appeals for the District of Columbia Circuit explained that '[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach

an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.' . . . The court continued: 'A physician is under a duty to treat his patient skillfully but proficiency in diagnosis and therapy is not the full measure of his responsibility. . . . [T]he physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. . . . The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.'. . . For that reason, the court held that 'the physician's overall obligation to the patient [includes the] duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.' . . . Accordingly, a physician 'must seek and secure his patient's consent before commencing an operation or other course of treatment.'. . .

"The doctrine of informed consent 'is embedded firmly in American jurisprudence, now forming a recognizable basis for physician liability in the [fifty] [s]tates and the District of Columbia.' . . . In Connecticut, '[i]nformed consent requires a physician to provide the patient with the information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy.' (Internal quotation marks omitted.) *Janusauskas* v. *Fichman*, [264 Conn. 760, 810, 826 A.2d 1066 (2003)]; accord *Canterbury* v. *Spence*, supra, 464 F.2d at 787 ('[a] risk is . . . material when a reasonable person . . . would be

likely to attach significance to the risk . . . in deciding whether or not to forego the proposed therapy' [internal quotation marks omitted]). As our Supreme Court held in *Logan* v. *Greenwich Hospital Assn.*, [191 Conn. 282, 292, 465 A.2d 294 (1983)], 'the physician's disclosure should include: (1) the nature of the procedure, (2) the risks and hazards of the procedure, (3) the alternatives to the procedure, and (4) the anticipated benefits of the procedure.'. . .

"At the same time, our Supreme Court has emphasized that the doctrine of informed consent 'is a limited one' that requires 'something less than a full disclosure of all information which may have some bearing, however remote, upon the patient's decision.' (Internal quotation marks omitted.) *Duffy* v. *Flagg*, [279 Conn. 682, 692-93, 905 A.2d 15 (2006)]; see also *Munn* v. *Hotchkiss School*, 326 Conn. 540, 605, 165 A.3d 1167 (2017) (*Espinosa, J.*, concurring) ('a physician need not disclose to patients every remote risk potentially associated with a medical procedure but only those deemed sufficiently likely as to be material'); *Pedersen* v. *Vahidy*, 209 Conn. 510, 523, 552 A.2d 419 (1989) (disclosure generally unnecessary when 'the likelihood of such injury is remote'); *Precourt* v. *Frederick*, 395 Mass. 689, 694-95, 481 N. E. 2d 1144 (1985) ('The materiality of information about a potential injury is a function not only of the severity of the injury, but also of the likelihood that it will occur. Regardless of the severity of a potential injury, if the probability that the injury will occur is so small as to be practically nonexistent, then the possibility of that injury occurring cannot be considered a material factor in a rational assessment of whether to engage in the activity that exposes one to the potential injury.'). Furthermore, 'there is no need to disclose risks that are likely to be known by the average patient or that are in fact known to the patient usually because of a past experience with the procedure in

question.' (Internal quotation marks omitted.) *Logan* v. *Greenwich Hospital Assn.*, supra, 191 Conn. at 292, 465 A.2d 294. A physician nonetheless is obligated 'to advise a patient of feasible alternatives' . . . even when 'some involve more hazard than others.'. . .

"Under Connecticut law, application of the doctrine of informed consent is not confined to operations and surgical procedures. Rather, it concerns the physician's 'duty to provide patients with material information concerning a proposed course of treatment.' *Downs* v. *Trias*, 306 Conn. 81, 89, 49 A.3d 180 (2012); see also *Logan* v. *Greenwich Hospital Assn*., supra, 191 Conn. at 292-93, 465 A.2d 294 (physician obligated to provide patient with information 'material for making a decision whether to embark upon a contemplated course of therapy'). A contemplated course of therapy includes—but is not limited to—a particular procedure, operation, or surgery. See *Torres* v. *Carrese*, [149 Conn. App. 596, 622, 90 A.23d 256, cert. denied, 312 Conn. 912, 93 A.3d 595 (2014)]. For example, in *Curran* v. *Kroll*, 303 Conn. 845, 859-60, 37 A.3d 700 (2012), the patient sought medical treatment for menopausal issues. Our Supreme Court held that the failure of the defendant physician to advise the patient of 'any symptoms and risks associated' with the birth control medication that the physician had prescribed gave rise to 'a cause of action for lack of informed consent.' Id., at 858, 37 A.3d 700; see also *Johnson* v. *Rheumatology Associates, P.C.*, Superior Court, judicial district of Hartford, Docket No. CV-12-6031500-S (December 29, 2014) (59 Conn. L. Rptr. 549, 550) ('[o]bviously treatment of a condition by the prescribing of medication is no less a form of treatment than surgery for a condition'). Our Supreme Court likewise has held that the nonsurgical procedure of obtaining a blood transfusion constituted a course of therapy and, thus, properly could give rise to a cause of action for lack of informed consent. *Sherwood* v. *Danbury Hospital*, [278 Conn.

164, 180-82, 896 A.2d 777 (2006)]. Accordingly, the doctrine of informed consent applies to a course of medical treatment undertaken by a patient in consultation with a medical practitioner." (Footnotes omitted.) *Wood* v. *Rutherford*, supra, 187 Conn. App. 81-86.

In his amended complaint, filed on July 29, 2022, the plaintiff alleged that the defendants committed a battery through their intentional conduct by failing to obtain his informed consent for the blood transfusion ordered by Dr. Maung and for the surgery performed by Dr. Maerz.[10] At trial, the plaintiff also claimed that he did not give informed consent to undergo general anesthesia administered by Dr. Hrycelak, the attending anesthesiologist during the plaintiff's emergency exploratory surgery. Although the conduct of Dr. Hrycelak is not formally plead in the amended complaint, the issue was fully litigated at trial. The plaintiff seeks monetary damages in the amount of $22,000,000; $15,000,000 for the blood transfusion and $7,000,000 for the surgery.

In response, the defendants assert that they cannot be held liable on the grounds: (1) that the plaintiff arrived at the emergency department in a critical condition making it impractical to obtain his informed consent for the emergency medical treatment rendered to him and, therefore, the emergency exception to the doctrine of informed consent applies; (2) that substituted informed consent for the surgery was obtained by the plaintiff's wife; and (3) that the plaintiff failed to file his claim within the applicable statute of limitations, General Statutes § 52-584.

"In order to prevail on a cause of action for lack of informed consent, a plaintiff must prove both that there was a failure to disclose a known material risk of a proposed procedure and that such failure was a proximate cause of his injury. . . . [A] claim for lack of informed consent

[10]The plaintiff's initial complaint was filed on July 6, 2022.

is determined by a lay standard of materiality, rather than an expert medical standard of care which guides the trier of fact in its determination." *Shortell* v. *Cavanagh*, 300 Conn. 383, 388, 15 A.3d 1042 (2011). "[T]he lay standard of informed consent requires a physician to provide the patient with that information which a *reasonable* patient would have found material for making a decision whether to embark upon a contemplated course of therapy. . . . Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment." (Citation omitted; emphasis in original; internal quotation marks omitted.) *Torres* v. *Carrese*, supra, 149 Conn. App. 620. Put another way, "the question of causality is resolved in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance." (Internal quotation marks omitted.) *Hammer* v. *Mount Sinai Hospital*, supra, 25 Conn. App. 711-712 (concluding that objective test regarding proximate cause is preferred over subjective test).

"'Informed consent requires a physician to provide the patient with the information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy.'" (Internal quotation marks omitted.) *Janusauskas* v. *Fichman*, 264 Conn. 796, 810-11, 826 A.2d 1066 (2003). In previous cases in which [our Supreme Court has] considered an alleged lack of informed consent, [its] inquiry has been confined to whether the physician has disclosed: '(1) the nature of the procedure, (2) the risks and hazards of the procedure, (3) the alternatives to the procedure, and (4) the anticipated benefits of the procedure.' (Internal quotation marks omitted.) *Logan* v. *Greenwich Hospital Assn.*, supra, [191 Conn.] 292, 465 A.2d 294; accord *Alswanger* v. *Smego*, 257 Conn. 58, 67-68, 776 A.2d 444 (2001). Thus,

'[u]nlike the traditional action of [medical] negligence, a claim for lack of informed consent focuses not on the level of skill exercised in the performance of the procedure itself but on the adequacy of the explanation given by the physician in obtaining the patient's consent.' *Dingle* v. *Belin*, 358 Md. 354, 369-70, 749 A.2d 157 (2000), as cited in *Sherwood* v. *Danbury Hosp.*, 278 Conn. 163, 180, 896 A.2d 777, 788 (2006). The doctrine of informed consent 'clearly focuses on imparting information relative only to the surgery itself.' (Internal citations omitted). *Duffy* v. *Flagg*, 279 Conn. 682, 694, 905 A.2d 15 (2006). '[It] is an objective, rather than subjective analysis; its calculus does not shift depending on how inquisitive or passive the particular patient is.' Id." *Parsons* v. *Vorih*, Superior Court, judicial district of New London, Docket No. CV-22-5023193-S (May 19, 2023, *Jacobs, J.*). The standard is what a reasonably prudent person in the patient's position would have decided if suitably informed of all material risks.

LIABILITY

A.

Claims against Dr. Maung

The plaintiff first claims that the defendants committed a battery through their intentional conduct by failing to obtain his informed consent for the blood transfusion ordered by Dr. Maung.[11] Specifically, the plaintiff claims that his religion prohibits him from consenting to a blood transfusion, and that the defendants battered him when Dr. Maung failed to obtain his

[11]As previously discussed, our Supreme Court has held that the nonsurgical procedure of obtaining a blood transfusion constitutes a course of therapy and, thus, properly gives rise to a cause of action for lack of informed consent. See *Sherwood* v. *Danbury Hospital*, 278 Conn. 163, 181, 896 A.2d 777 (2006) (plaintiff's claim founded "on the defendant's failure to apprise the plaintiff about the condition of the blood and the options available to the plaintiff under the circumstances").

informed consent prior to ordering and performing a blood transfusion.[12] In response, the defendants argue that because the plaintiff arrived at the emergency department in a condition making it impractical to obtain his informed consent for the emergency medical treatment rendered to him, the emergency exception to the doctrine of informed consent applies and, therefore, the defendants cannot be held liable.

"In *Logan* v. *Greenwich Hospital Assn.*, supra, 191 Conn. 289, the Supreme Court clarified that a patient can recover on a theory of battery as a basis for recovery against a physician in three limited circumstances: (1) when a physician performs a procedure other than that for which consent was granted; (2) when a physician performs a procedure without obtaining any consent from the patient; and (3) when a physician realizes that the patient does not understand what the procedure entails. [The Appellate Court] similarly has observed that [o]ur courts have long adhered to the principle that the theory of intentional assault or battery is a basis for recovery against a physician who performs surgery without consent." (Internal quotation marks omitted.) *Wood* v. *Rutherford*, supra, 187 Conn. App. 74-75.

"[A]pplication of the doctrine of informed consent is not confined to operations and surgical procedures. Rather, it concerns the physician's duty to provide patients with material information concerning a proposed course of treatment. . . . A contemplated course of therapy includes–but is not limited to–a particular procedure, operation, or surgery. . . . Accordingly, the doctrine of informed consent applies to a course of medical treatment undertaken by a patient in consultation with a medical practitioner." (Citations omitted; footnotes omitted; internal quotation marks omitted.) Id., 85-86.

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[12] See Am. Compl. ¶ 12.

Circumstances arise, however, that "do not always lend themselves to such a dialogue between patient and physician. For that reason, a physician's duty to secure informed consent is not an absolute one, but rather is contingent on the particular context in which it arises. To accommodate the exigencies inherent in the practice of medicine, courts have crafted exceptions to the physician's general duty that excuse the failure to obtain such consent in certain circumstances. . . . [A] number of situations may be established by the defendant physician as a defense to an informed consent action, constituting exceptions to the duty to disclo[se]. These include . . . [s]ituations in which an emergency makes it impractical to obtain consent . . . ." (Citation omitted; footnotes omitted; internal quotation marks omitted.) Id., 90-91.

"The emergency exception has been recognized by courts across the country. . . . [T]he emergency exception comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it. . . . Put simply, a physician is not required to obtain the patient's consent in an emergency situation where the patient is in immediate danger. . . . Although our appellate courts have not had occasion to circumscribe the precise parameters of the emergency exception, it applies under our state regulations to medical treatment performed in hospitals throughout Connecticut." (Citations omitted; internal quotation marks omitted.) Id., 92.

"Application of the doctrine of informed consent, therefore, involves more than simply an examination of the communications, or lack thereof, between physician and patient. It also requires consideration of the context in which the physician's duty arose. That context is crucial

to the determination of whether an exception to that duty is implicated. Moreover, in an action predicated on an alleged lack of informed consent, the burden of proving an exception to [the] duty rests with the physician." (Internal quotation marks omitted.) Id., 95.

The defendants have established by a preponderance of the evidence that the emergency exception to the doctrine of informed consent is applicable to the present case with regard to the ordering and performance of the blood transfusion. The evidence presented at trial demonstrates that the plaintiff was incapable of consenting to the emergency blood transfusion, and the harm from the failure to treat the plaintiff was imminent and outweighed any harm threatened by the proposed treatment. Specifically, the evidence establishes that upon the plaintiff's arrival at the Yale-New Haven Hospital emergency department, the plaintiff was intoxicated, had a dangerously low blood pressure, and had an altered mental status which made it difficult for him to answer basic questions. Moreover, the evidence establishes that the plaintiff was not fully conscious and required stimulation to stay awake.[13] Indeed, the video at the scene where the plaintiff was found with stab wounds and bleeding, shows him lying on the ground in New Haven unable to move, unable to keep his eyes open as he lay in a pool of his blood and unable to answer a basic question such as his date of birth. Dr. Maung's documentation in the chart confirms his assessment of the plaintiff's mentation and initial physical appearance to be an "[i]nitially unknown age male (estimated 40s) brought in by EMS and police after stab to back and right arm. On arrival, wax and waning mental status. Would opens eyes to voice, withdraw and stated his name. Hypotensive with systolic to 80s. Exam significant for laceration to mid

[13] See Defs.' Exh. A, p. 0010 ("[n]arcan given"), p. 0067 ("[i]n the ED, [the plaintiff] was found to have a GCS of 13 [eyes only to command, intermittent verbal responses, responds to motor commands] . . . .").

thoracic back just left of midline as well as laceration right antecubital region with active bleeding."[14]

Taking all those circumstances together, Dr. Maung assessed that the plaintiff needed an emergency blood transfusion, but concluded that it would have been "unethical" for him to try to have an informed consent discussion with the plaintiff because the plaintiff was not "in a condition to make informed decisions." The evidence establishes that an emergency situation existed and Dr. Maung needed to act quickly to stabilize the plaintiff for further treatment of his injuries. Therefore, Dr. Maung exercised his medical judgment and ordered the emergency blood transfusion, specifically noting that "for this patient at this time, I believe that the benefits of an uncrossed transfusion outweigh the risks."[15] The court finds, based on the circumstances and context of this case a genuine emergency existed, such that the impracticality of conferring with the plaintiff dispensed with need for Dr. Maung obtaining his consent for the emergency blood transfusion. See *Canterbury* v. *Spence*, supra, 464 F.2d at 788-89. Put simply, "[Dr. Maung was] not required to obtain the [plaintiff's] consent in an emergency situation [such as here,] where [he was] in immediate danger." (Internal quotation marks omitted.) *Wood* v. *Rutherford*, supra, 187 Conn. App. 92.

The plaintiff argued at trial that he was conscious and capable of giving consent. The overwhelming credible evidence belies this. Other than his own testimony, the plaintiff offered no evidence to support his claim that he was capable of giving consent. As this court previously noted, the evidence clearly demonstrates that the plaintiff was incapable of consenting to any

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[14]Defs.' Exh. A, p. 0065.

[15]Defs.' Exh. A, p. 1029.

emergency treatment, as substantiated by the medical records and by the multiple physicians that treated him in the emergency department, and as clearly depicted in the police body camera video showing his inability to remain alert or answer basic questions.[16] Neither did the plaintiff offer evidence to support that he either provided informed refusal or that he had an advanced directive on file indicating that he declined to consent to receiving blood.[17] Indeed, the evidence establishes that this was an emergency situation; the plaintiff arrived at the emergency department in critical condition, he needed an emergency blood transfusion, he was incapable of providing informed consent, and the physicians acted according to emergency protocol. Therefore, because this was an emergency situation where the patient was in immediate danger, the court concludes that the emergency exception to the doctrine of informed consent applied and Dr. Maung did not need to obtain the plaintiff's informed consent prior to ordering and performing the blood transfusion. Accordingly, the court finds in favor of the defendant as to plaintiff's claim of lack of informed consent regarding the blood transfusion.

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[16]The court reviewed body camera footage from the New Haven police officers who found the plaintiff laying on the ground in New Haven wherein the plaintiff was unable to answer basic questions such as "what is your birthday" or "what happened." Consistent with the testimony of the medical providers, and the medical records, the video demonstrates that the plaintiff was in critical condition.

[17]See Defs.' Exh. B, p. 12 ("[i]n the event a patient is unable to consent and an Authorized Representative is not available despite reasonable efforts by the Hospital to locate, a Responsible Practitioner may perform an invasive procedure/treatment without written informed consent . . . [i]f an emergency exists, i.e., imminent threat to life or limb"), p. 14 ("if the patient has a life or health-threatening emergency and requires blood or blood product transfusion, except in case where patient has provided informed refusal or has an advanced directive on file which indicates he/she declines consent to blood products, no consent is required until the emergency has passed").

B.

Claims against Dr. Maerz and Dr. Hrycelak

The plaintiff next claims that the defendants committed a battery through their intentional conduct by failing to obtain his informed consent prior to the surgery performed by Dr. Maerz and the administration of general anesthesia by Dr. Hrycelak. In response, the defendants argue that substituted informed consent was obtained from Ms. Francis and, moreover, that the situation remained an emergency where the plaintiff was incapable of providing his own informed consent. Furthermore, the defendants argue that because the plaintiff failed to present evidence as to what risks the defendants failed to disclose that would have prevented the plaintiff from consenting to the surgery, the plaintiff has failed to satisfy the elements of a claim for lack of informed consent.

(i)

Substituted Consent

The defendants argue that they are entitled to judgment on the grounds that Dr. Maerz obtained substituted consent from Ms. Francis for the surgery performed by Dr. Maerz and the administration of general anesthesia by Dr. Hrycelak. Yale-New Haven Hospital's policy regarding consent for procedures and treatment provides that "[i]f a patient is incapable of giving consent and there is no emergency which removes the need for consent, 'substituted consent' may be obtained."[18] "If no conservator exists with the authority to consent to medical or surgical treatment, consent to non-emergency procedures may be obtained from the patient's next of kin

[18]See Defs.' Exh. B, p. 3.

in the following order of preference: (a) [s]pouse or domestic partner . . . ."[19] The evidence established at trial demonstrates that Dr. Maerz was able to obtain substituted informed consent from Ms. Francis for the emergency exploratory laparotomy.[20] This is confirmed by Ms. Francis' deposition testimony, wherein she testified that Dr. Maerz explained to her the risks of infection, bleeding, and injury to internal organs, that she consented to the possibility of a blood transfusion, that she signed the consent form on her own free will, and that she gave Dr. Maerz consent "to save the father of [her] daughter's life."[21] Moreover, in discussing the nature and risks of the procedure, the evidence established at trial demonstrates that Dr. Maerz explained to Ms. Francis that the emergency exploratory laparotomy would be performed while the plaintiff was under general anesthesia. The evidence further demonstrates that a consent form for general anesthesia separate from a consent form for the underlying procedure was not required. Moreover, even if a separate form was required, the testimony of Dr. Maerz and Dr. Hrycelak establish that the plaintiff was incapable of giving his informed consent at that time. Therefore, the defendants cannot be held liable because Dr. Maerz received substituted consent from Ms. Francis for the plaintiff's surgery and for the administration of anesthesia.

(ii)

Emergency

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[19]See Defs.' Exh. B, p. 8.

[20]See Defs.' Exh. A, p. 0142 ("[c]onsent was obtained from the patient and his wife and the form was signed by his wife"); see also Defs.' Exh. C, Yale-New Haven Hospital Consent for Operation or Special Procedure (signed by Ms. Francis).

[21]See Pl.'s Exh. 4, Georgia Francis Dep. 42-44, 68.

The defendants further argue that even though Dr. Maerz obtained substituted informed consent from Ms. Francis for the surgery and administration of anesthesia, the situation nonetheless remained an emergency under the emergency exception. The medical record demonstrates that the initial surgical plan by Dr. Maung was a delayed laparoscopy after 24 hours of monitoring. However, Dr. Maung factored in the possibility that they may not be able to wait that long given the seriousness of the injuries and he further documented that "if abdominal exam changes, will need operating room sooner."[22] Indeed, when Dr. Maerz assumed care of the plaintiff, his abdominal exam did change and, in her assessment, he needed an emergency exploratory laparotomy. According to Dr. Maerz, as a trauma surgeon, there are circumstances that call upon her to perform an emergency surgery on a patient without obtaining informed consent. Some of those circumstances "include the patient either being mentally or physically incapable of giving consent and/or if there is not a patient representative in lieu of the patient being able to do so."[23]

At 9:42 a.m., Dr. Maerz examined the plaintiff and documented that while observation was the initial plan, "the patient has since developed abdominal tenderness and some degree of distension on abdominal examination."[24] The surgical in-house booking form identified the priority level of the procedure as "1," which is the most acute level and, under time preferred, Dr. Maerz indicated "ASAP."[25] This form demonstrates that the surgery was as emergent. Dr. Maerz

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[22]Defs.' Exh. A, p. 0066.

[23]Trial Testimony of Dr. Maerz, p. 36.

[24]Defs.' Exh. A, p. 0142.

[25]Defs.' Exh. A, p. 1039.

then notified Dr. Hrycelak and the anesthesia team to get the operating room ready. Dr. Hrycelak's documentation indicates that anesthesia received the call at approximately 9:45 a.m.—three minutes after Dr. Maerz examined the plaintiff—and that the anesthesia team was ready by 10:01 a.m., sixteen minutes later. Within that sixteen minute time period, the operating room was ready for a major emergency abdominal surgery. By the time Dr. Maerz mobilized the operating room for surgery, the plaintiff was relying heavily on narcotics for pain control. He had been given morphine and fentanyl throughout his stay in the emergency department and at 9:45 a.m., he received an additional fifty mcg of fentanyl.

According to Dr. Maerz, the plaintiff was "in critical condition" when she evaluated him and that even though he was not unconscious, he was "not readily responsive." Dr. Maerz assessed the plaintiff as not having "capacity"—meaning, "he did not have the ability to understand and reason through what was being told to him."[26] Furthermore, according to Dr. Maerz, a medical emergency is not defined by whether a physician can obtain informed consent. According to Dr. Maerz, "an emergency situation under the circumstances that we're talking about here [is] when a patient's life is at risk."[27] Based on the plaintiff's critical condition and need for emergency surgery, Dr. Maerz assessed the situation as emergent. The fact that Dr. Maerz obtained substituted consent does not remove the emergency nature of the clinical situation. The YNHH medical records and testimony from the attending physicians, clearly establish that plaintiff's condition remained an emergency situation. Therefore, the defendants

[26]Trial Testimony of Dr. Maerz, p. 8.

[27]Trial Testimony of Dr. Maerz, p. 37.

cannot be held liable because the situation remained an emergency wherein Dr. Maerz was not required to obtain informed consent.

Even if the situation did not remain an emergency, the defendants still cannot be held liable because, as previously discussed, Dr. Maerz did in fact obtain proper substituted informed consent from Ms. Francis in accordance with YNHH's policy regarding consent for procedures and treatment. Indeed, the evidence at trial establishes that Dr. Maerz had the consent discussion with Ms. Francis in the presence of the plaintiff, and that Ms. Francis signed the consent form because the plaintiff was incapable of giving his informed consent at that time.

(iii)

Failure to Disclose Material Risks

The defendants further argue that they are entitled to judgment because the plaintiff has presented no evidence demonstrating what material risks Dr. Maerz and Dr. Hrycelak failed to disclose that would have prevented him from consenting to the emergency surgery. "In order to prevail on a cause of action for lack of informed consent, a plaintiff must prove both that there was a failure to disclose a known material risk of a proposed procedure and that such failure was a proximate cause of his injury." *Shortell* v. *Cavanagh*, supra, 300 Conn. 388. The plaintiff did not articulate any of the material risks that were not made known to him which would have caused him to withhold consent. Indeed, the plaintiff did not testify that he would have withheld consent. The plaintiff asserts that Dr. Hrycelak failed to disclose the risks of anesthesia to himself or Ms. Francis. The plaintiff's only concern, however, was that Dr. Hrycelak did not speak with him before administering anesthesia and so he did not know if the plaintiff had eaten or drank anything in the hours before. This risk is not material because a reasonable person likely would

not attach significance to the risk in deciding whether or not to forego the procedure. "There is no bright line separating the significant from the insignificant; the answer in any case must abide a rule of reason. Some dangers–infection, for example–are inherent in any operation; there is no obligation to communicate those of which persons of average sophistication are aware. Even more clearly, the physician bears no responsibility for discussion of hazards the patient has already discovered, or those having no apparent materiality to patients' decision on therapy. The disclosure doctrine, like others marking lines between permissible and impermissible behavior in medical practice, is in essence a requirement of conduct prudent under the circumstances. Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts." (Footnotes omitted.) *Canterbury* v. *Spence*, supra, 464 F.2d 787. Moreover, even if it was a material risk, the evidence established at trial demonstrates that because the plaintiff arrived at the emergency department in such a critical condition, Dr. Hrycelak assumed that the plaintiff had eaten or drank and, therefore, treated him in accordance with standard medical practice and procedure. According to Dr. Hrycelak: "Rapid sequence induction is a technique that is used when there's a concern for a possible aspiration from a full stomach. Basically means that we give all of the medications, including a muscle relaxant, which we use as part of the induction process, that we give them all in sequence without testing ventilation first . . . it is something that is often done in trauma, A, because sometimes we don't actually know when the last time a patient may have eaten or had something to drink. . . ." Trial Testimony, Dr. Hrycrelak.

Similarly, with regard to the emergency blood transfusion, setting aside the emergency exception, the plaintiff did not put forth any evidence that there were material risks that were not

made known to him which would have caused him not to consent to the emergency blood transfusion. The plaintiff testified both at his deposition and at trial that he would only be accepting of blood from a devout black Muslim or practicing Jew. This is contrary to his allegation in the amended complaint that his "religion" prohibits him from accepting any blood transfusion. Applying the required elements of an informed consent claim, the plaintiff has failed to prove that the risk that he would receive blood from a non-devout black Muslim or non-practicing Jew is a "material risk that a reasonably prudent person" in his situation would have found significant in deciding whether or not to accept the blood transfusion. He would also need to prove that receiving the blood of a non-devout black Muslim or non-practicing Jew is considered to be a risk of any blood transfusion. See *Canterbury* v. *Spence*, supra, 464 F.2d 787. The plaintiff testified that his concern regarding a blood transfusion was that he did not want to receive blood from any homosexual or anyone who had taken drugs. He also testified that he would not be accepting of any male Hispanic blood because they had homosexual tendencies. This testimony does not fall within the realm of a reasonable patient. The plaintiff has offered no credible evidence that these considerations are valid, material risks of a blood transfusion.

As the court previously discussed, the defendants have satisfied their burden that the surgical treatment rendered to the plaintiff, including anesthesia care, was under emergency circumstances and therefore fall within the emergency exception. However, despite the emergency nature of the surgery, the evidence established at trial demonstrates that Dr. Maerz indeed disclosed the material risks of surgery to Ms. Francis in the presence of the plaintiff, including the risks of infection, bleeding, and injury to internal organs. As this court also previously discussed, the fact that Dr. Maerz obtained substitute consent did not negate the

emergency nature of the plaintiff's clinical situation. As Dr. Maerz testified at trial, a medical emergency is not defined by whether a physician can obtain informed consent. Dr. Maerz testified that "an emergency situation under the circumstances that we're talking about here [is] when a patient's life is at risk."

It is clear in looking at the totality of the evidence that the plaintiff is unable to overcome the emergency exception to the doctrine of informed consent as it relates to the surgical/anesthesia care as well as the blood transfusion to make out a claim for lack of informed consent. Even setting aside the emergency nature of the plaintiff's situation, he failed to articulate any of the material risks that were not made known to him which would have caused him to withhold consent. Therefore, the plaintiff has failed to establish a claim based on lack of informed consent against Dr. Maung, Dr. Maerz and Dr. Hrycelak and, accordingly, the defendants are entitled to judgment in their favor.

(iv)

Proximate Cause

The defendants further argue that they are entitled to judgment because the plaintiff has presented no evidence demonstrating that Dr. Maerz's and Dr. Hrycelak's failure to obtain his informed consent was a proximate cause of any injury that he allegedly sustained. "[T]he lay standard of informed consent requires a physician to provide the patient with that information which a *reasonable* patient would have found material for making a decision whether to embark upon a contemplated course of therapy. . . . Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or

treatment." (Citation omitted; emphasis in original; internal quotation marks omitted.) *Torres* v. *Carrese*, supra, 149 Conn. App. 620. Put another way, "the question of causality is resolved in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance." (Internal quotation marks omitted.) *Hammer* v. *Mount Sinai Hospital*, supra, 25 Conn. App. 711-712.

In the present case, the court need not reach the issue of proximate cause because the plaintiff has not put forth any evidence that the defendants failed to disclose a material risk of the emergency surgery and administration of general anesthesia that the plaintiff would have objected to and which therefore resulted in injury. Therefore, the defendants are further entitled to judgment because the plaintiff failed to demonstrate that "a prudent person in the [plaintiff's] position would have decided [differently] if suitably informed of all perils bearing significance." See *Hammer* v. *Mount Sinai Hospital*, supra, 25 Conn. App. 711.

C.

Statute of Limitations

The defendants raised in their special defense and asserted at trial that they are further entitled to judgment because the plaintiff's claims are barred by the two year statute of limitations set forth in General Statutes § 52-584. General Statutes § 52-584 provides in relevant part: "No action to recover damages for injury to the person, or to real or personal property, caused by negligence, or by reckless or wanton misconduct, or by malpractice of a physician, surgeon, dentist, podiatrist, chiropractor, advanced practice registered nurse, hospital or sanatorium, shall be brought but within two years from the date when the injury is first sustained or discovered or in the exercise of reasonable care should have been discovered . . . ." See also

Ligouri v. *Sabbarese*, Superior Court, judicial district of Danbury, Docket No. CV-18-6026710-S (October 1, 2020, *D'Andrea, J.*) (70 Conn. L. Rptr. 356) (applying two year statute of limitations set forth in § 52-584 to claim based on lack of informed consent); *Provost-Daar* v. *Merz Aesthetics, Inc.*, Superior Court, judicial district of New Haven, Docket No. CV-13-6037872-S (April 6, 2016, *Wilson, J.*) (62 Conn. L. Rptr. 64) (same).

In response to the COVID-19 pandemic, Governor Lamont issued several executive orders, including Executive Order No. 7G. That order, in relevant part, suspended "all statutory . . . time requirements, statutes of limitation or other limitations or deadlines relating to service of process, court proceedings or court filings . . . " beginning on March 19, 2020. That suspension was lifted by Executive Order No. 10A beginning on March 1, 2021.

A number of Superior Courts have considered the effect of these executive orders. These courts generally conclude: (1) "that [Executive Order No.] 7G temporarily suspended all statutory deadlines relating to service of process, court proceedings, or filings until the suspension was lifted by [Executive Order No.] 10A"; and (2) that "any time limitations that were suspended during that nearly one-year period resumed from the point where they had been paused by [Executive Order No.] 7G." *Krzeminski* v. *Duby*, Superior Court, judicial district of Hartford, Docket No. CV-21-6140073-S (January 24, 2022, *Rosen, J.*). See also *Komoroski* v. *Columbia Dental, P.C.*, Superior Court, Docket No. CV-21-6113578-S (June 13, 2022, *Wilson, J.*) (concluding "that Executive Order No. 7G interrupted the running of the two-year statute of limitations applicable to the plaintiff's negligence claim such that, when the suspension terminated as of March 1, 2021, the plaintiff had some 348 days [from March 19, 2020 to March 1, 2021], within which to seek an amendment, thus creating a new statute of limitations

expiration date . . ."); *Capua* v. *Hill*, Superior Court, judicial district of Hartford, Docket No. CV-21-6140492-S (September 24, 2021, *Sicilian, J.*) (concluding that Executive Order No. 7G "acted to interrupt the running of the applicable time period, leaving the time remaining when the suspension took effect to run after the date that the suspension terminated").

In the present case, the plaintiff received the subject emergency medical treatment from the defendants on June 16, 2018, and, therefore, the statute of limitations on his claims expired on June 16, 2020. As of March 19, 2020, the effective date of Executive Order No. 7G, the plaintiff had 89 days remaining on the two year statute of limitations and, thus, had 89 days remaining as of March 1, 2021, when the suspension expired. Therefore, the plaintiff had until May 29, 2021, to file his claims against the defendants. Because May 29, 2021 was a Saturday, and May 31, 2021 was a holiday, the plaintiff had until Tuesday, June 1, 2021 to commence the action against the defendants. According to the marshal's return, the plaintiff, however, did not commence the action against Dr. Maung until June 21, 2022, and against YNHH until June 22, 2022. Accordingly, the defendants are further entitled to judgment on the ground that the plaintiff failed to commence the action against the defendants within the applicable two year statute of limitations.

Even if the court were to apply the continuing course of conduct doctrine, and therefore look to the date of the plaintiff's discharge from Yale-New Haven Hospital, the plaintiff's claims would still be barred by the two year statute of limitations set forth in General Statutes § 52-584. "'In certain circumstances [our Supreme Court has] recognized the applicability of the continuing course of conduct doctrine to toll a statute of limitations. Tolling does not enlarge the period in which to sue that is imposed by a statute of limitations, but it operates to suspend or interrupt its

running while certain activity takes place.' *Flannery* v. *Singer Asset Finance Co., LLC*, 312 Conn. 286, 311, 94 A.3d 553 (2014), citing *Romprey* v. *Safeco Ins. Co. of America*, 310 Conn. 304, 330-31, 77 A.3d 726 (2013) (*McDonald, J.*, dissenting). 'Consistent with that notion, [w]hen the wrong sued upon consists of a continuing course of conduct, the statute does not begin to run until that course of conduct is completed.' (Citation omitted; internal quotation marks omitted.) *Flannery* v. *Singer Asset Finance Co., LLC*, supra, 311. In *State* v. *Ali*, 233 Conn. 403, 413 n.8, 660 A.2d 337 (1995), the court noted that 'the traditional meaning of the term toll within the parlance of statutes of limitations [is] as a synonym for suspend . . . .' (Internal quotation marks omitted.). 'A tolling statute is defined as '[a] law that interrupts the running of a statute of limitations in certain circumstances . . . .' Black's Law Dictionary (9th Ed. 2009). In other words, tolling suspends the limitations period.' *Romprey* v. *Safeco Ins. Co. of Am.*, 310 Conn. 304, 330, 77 A.3d 726 (2013) (*McDonald, J.*, dissenting). See also, *Artis* v. *D.C., U.S.*, 138 S.Ct. 594, 601-02, 199 L.Ed.2d 473 (2018) ('Our decisions employ the terms 'toll' and 'suspend' interchangeably.')." *Capua* v. *Hill*, supra, Superior Court, Docket No. CV-21-6140492-S.

Applying the continuing course of conduct doctrine to the present case, the plaintiff was discharged from Yale-New Haven Hospital on June 26, 2018. As of March 19, 2020, the effective date of Executive Order No. 7G, the plaintiff had 99 days remaining on the two year statute of limitations and, thus, had 99 days remaining as of March 1, 2021, when the suspension expired. Therefore, the plaintiff had until Tuesday, June 8, 2021, to file his claims against the defendants. As previously noted, the plaintiff did not commence the action against Dr. Maung until June 21, 2022, and against YNHH until June 22, 2022. Therefore, even if the court were to

apply the continuing course of conduct doctrine, the plaintiff's claims are still barred by the two year statute of limitations. Accordingly, the defendants are entitled to judgment in their favor.[28]

CONCLUSION

For the foregoing reasons, the court renders judgment in favor of the defendants as to all of the plaintiff's claims.

Juris No. 421279
Wilson, J.

[28]Because the court has found in favor of the defendants on the issue of liability it need not address the issue of damages.