HEALTH LAW journal

Publication of the Health Law Section of the New York State Bar Association

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A Message from the Section Chair

The Health Law Section continues to be active, visible, and state-of-the-art. Our first official appearance at the NYSBA Annual Meeting offered a day filled with exciting events. Programs on "Physician-Assisted Suicide," chaired by Tracy Miller, and "Managed Care Liability," chaired by Peter Millock, included a distinguished set of panelists who presented their sometimes controversial views on topics that are as current as today's news. Many thanks to Tracy, Peter and Bob Abrams, our Legal Education Chair. The luncheon meeting was keynoted by Henry M. Greenberg, General Counsel to the Department of Health. Hank reviewed the activities of DOH during the past year and gave us a peek at the agency's priorities for the near future. We appreciate not only his willingness to meet with the Section, but also his cooperation in opening new channels of communication between public and private sector attorneys who deal with health law issues. The other effort in which the Section participated was entitled "Unrepresented and Meritorious." Co-sponsored with five other NYSBA Committees and Sections, this program focused on legal issues faced by people with disabilities.

Elections also took place at the Annual Meeting. I know that I speak for all of your officers in saying thanks for the vote of confidence in returning us to office.

The latest roster shows that our membership has grown to 700! This exceeds the expectations that your Executive Committee established a year ago. It reflects the fact that health law is one of the fastest-growing areas of practice. This increase also is due to the work done by Robert W. Corcoran, our Membership Committee Chair. Thanks, Bob! Please help us all by spreading the word about the Section. Remember, you don't have to be a health lawyer to join. Many attorneys who work in other fields, or who are generalists, find that their practices include health law issues. We welcome those individuals to the Section.

We're on the Internet

Robert Swidler, our Biotechnology and the Law Committee Chair, has also been working hard creating a Health Law Section Web site. Take a look at us after browsing through the New York State Bar Association site (http://www.nysba.org) or directly (http://www.nysba.org/sections/health/index.html). If anyone has suggestions for the site or would like to work with him on this project, please contact him at (518) 434-2163 (or RSwidler@aol.com).

INSIDE THIS ISSUE

Professional Discipline Committee

The new Professional Discipline Committee, with Joseph K. Gormley at the helm, is beginning to plan its year. If you are interested in joining, please contact him at (212) 349-7100. If e-mail is easier, just send me a note (healthlaw@juno.com) and you will be added to the membership list. OPMC has already provided a number of representatives to the Committee and we are reaching out to the Office of Professional Discipline. I anticipate that this Committee will be extremely active, reflecting the increased efforts that are currently being made by OPD and OPMC. It has already provided a "heads up" to attorneys who practice in this area, concerning very recent changes in the law that are not reflected in the McKinney's pocket part. That information is found elsewhere in the *Journal* and has been posted on our Web site. The amendment to the Public Health Law is important because a failure to follow the new procedure could result in your client having inadvertently admitted the charges.

The *Health Law Journal*

Please note the new name of our Section periodical. Your Executive Committee felt that the high quality of the this publication was not reflected in the old name, *Health Law Newsletter*. We all thank Professor Dale L. Moore, the Publications Chair and Editor, for her tireless work on this periodical. If anyone is interested in submitting an article, please contact her at (518) 445-2343 (or dmoor@mail.als.edu).

Health Care Delivery Systems Committee

I am sorry to report that, due to an overwhelmingly busy schedule, Eric Stonehill has resigned as Chair of the Health Care Delivery Systems Committee. Thanks a lot, Eric, for getting this Committee off the ground! On a positive note, I am pleased to announce that Robert A. Wild has agreed to assume the mantle of leadership. Many of us have enjoyed working with Bob over the years and look forward to his efforts with this important committee. He can be contacted at (516) 393-2200.

Legal Education Committee

Phil Rosenberg has been appointed Vice Chair of the Legal Education Committee. Most of you will remember Phil's vision and hard work in putting together the Health Law Primer series of programs that the Section presented last year. Welcome aboard!

In Conclusion

We live and practice in an era of change. The health care system is continuing its turbocharged evolution, while the rights of patients, professionals, health care facilities, and managed care entities are being explored and challenged from every direction. No matter whether you represent providers, patients, or government, this roller coaster is being ridden by all of us. We must keep our channels of communication open so that neither attorneys nor their clients lose track of the other participants in the health care system. Your Health Law Section is an ideal place for us to each provide "reality checks" for one another. Please participate in our activities. Finally, if you have any suggestions, criticisms, or thoughts on how to make the Section better, please let me know. I can be reached at (518) 455-9952 (or healthlaw@juno.com).

Barry A. Gold
Chair

From the Editor

Our second issue contains a mix of timely updates, announcements, and articles. An important announcement for those who handle cases before the Office for Professional Medical Conduct appears on page 8. Other announcements: the Commission on Quality of Care for the Mentally Disabled seeks volunteers to serve on surrogate decision making committees (see page 22), and the ABA is compiling a list of information about lawyers interested in disability issues (page 20). For information about the Health Law Section's Web site, which is provided by Robert Swidler, see page 26.

Legislative and elder law updates have been provided by David Daniels and Howard Krooks. One of the important matters mentioned in Mr. Krooks's update is further developed in the article by David Goldfarb on the criminalization of asset transfers in Medicaid planning, which is reprinted from the *Trusts and Estates Law Section Newsletter* with the editor's and the author's permission. In addition, Claudia Torrey updates us on another Medicare–managed-care concern.

The other articles in this issue include a case note by Robert Friedman, which discusses a Court of Appeals opinion important to professional health care providers. Edna Goldsmith and Barry Gold provide a thorough review of issues arising in connection with noncompetition clauses and health care professionals. Finally, Charlotte Buchanan's article provides a thorough review of, as well as commentary on the Scott Matthews case.

As always, I encourage you to submit articles, essays, and updates for future issues of our *Journal*. You may submit them to me at Albany Law School, 80 New Scotland Avenue, Albany, NY 12208.

Dale L. Moore
Editor

Noncompetition Clauses and the Health Care Professional

by Edna Goldsmith* and Barry A. Gold**

Competition is the guiding principle in today's ever-changing health care business environment. It is observed by the public in massive advertising campaigns, utilized by third-party payors as leverage for lowering costs, and felt by many health care professionals as they negotiate for jobs, partnerships, and shareholder status. In order to meet the challenges created by the new marketplace, many health care practices have merged, and the system's components have developed a multitude of relationships with one another. These new entities, as well as traditional practices, often feel financially threatened by the prospect of current employees, shareholders, or partners leaving to compete for the same pool of patients. While these fears may in some cases be exaggerated, they are nonetheless often manifested in contractual provisions limiting the ability of a departing professional to practice in the local geographic area.

As a consequence of the current climate, medical professionals considering a change in employment may wonder what their rights are, and those just signing on may want to know what these covenants not to compete bode for their future. Similarly, health care providers may desire clarification of their prerogatives and obligations in this area. This article offers a review of pertinent case law in the hope of clarifying the status of noncompetition agreements in the State of New York.

Introduction

It is well settled that the New York courts will enforce restrictive covenants against medical and dental professionals so long as the provisions are limited as to time and area, and if they protect a former employer from unfair competition without harming the public or unduly burdening the employee.[1] The context of the law in this regard is, however, interesting. Noncompetition clauses in employment or partnership agreements for attorneys run afoul of the Code of Professional Responsibility ("A lawyer shall not be a party to or participate in a partnership or employment agreement with another lawyer that restricts the right of a lawyer to practice law after the termination of a relationship created by the agreement, except as a condition to payment of retirement benefits." DR 2-108(a), 22 N.Y.C.R.R. § 1200.13) and are usually found to be unenforceable.[2] Some other states either prohibit[3] or restrict the use of such provisions.[4] In Louisiana, for example, the restriction may not last more than two years.[5]

A review of the reported decisions in New York reveals that the watchword of judicial determination is the "reasonableness" of the restriction as measured by the "circumstances and context" of each case.[6] In light of the fact-based nature of courts' analyses, it is helpful to look at the criteria governing judicial review, and how these have been applied. For purposes of discussion, this article focuses on the facts of *Karpinski v. Ingrasci*,[7] a contemporary linchpin case, and then examines how the judicial standards enunciated by the Court of Appeals have been applied both to *Karpinski* and its progeny.

Karpinski v. Ingrasci

In 1953, Dr. Joseph Karpinski, an oral surgeon with a solo office located in Auburn, New York, decided to expand his practice. Accordingly, he made a concerted effort to cultivate referrals from dentists in the nearby counties of Tompkins, Seneca, Cortland, and Ontario. By 1962, 20% of his practice consisted of patients referred to him by dentists in those counties.

In 1962, Dr. Karpinski opened a second office in Ithaca, New York, and hired Dr. Paul Ingrasci to staff it. Ingrasci was just completing his residency and had no previous familiarity with the region. The employment contract provided that Dr. Ingrasci never practice dentistry and/or oral surgery in Cayuga, Cortland, Seneca, Tompkins, or Ontario Counties unless in association with Dr. Karpinski or unless the latter terminated his contract and employed another oral surgeon. In addition, the young dentist agreed to execute a $40,000 note, payable to Dr. Karpinski in the event that he practiced dentistry or oral surgery within the five-county area in violation of the agreement.

When the employment contract expired, the two men engaged in protracted negotiations regarding the nature of their future association. They were unable to reach an agreement, and in 1968 Dr. Ingrasci established his own office in Ithaca. Area dentists began referring their patients to him and, within two months, Dr. Karpinski's practice in Ithaca dropped to almost nothing. As a result, he closed that office and brought an action seeking injunctive relief and judgment of $40,000 on the note, alleging breach of the covenant.[8]

Supreme Court decided in favor of the plaintiff and granted him both an injunction and damages. On appeal, however, the Appellate Division reversed the judgment and dismissed the complaint, holding that the restriction against the practice of both dentistry and oral surgery was impermissibly broad. The Court of Appeals: (i) upheld the covenant as it applied to oral surgery, but struck the portion relating to dentistry as overbroad; and (ii) in lieu of awarding Dr. Karpinski the full $40,000, held that he was entitled only to the actual damages suffered during the breach (i.e., the period of time Dr. Ingrasci practiced oral surgery in Ithaca after he left Dr. Karpinski's employ).[9]

The criteria used by the Court in this case, and employed by New York courts generally in similar cases, are described in further detail below.

Duration of the Covenant

In *Karpinski*, the Court stated that the perpetual nature of the covenant was not grounds to overturn it. Quoting *Foster v. White*, an earlier case involving the applicability of restrictive covenants to physicians, the Court in *Karpinski* wrote: "According to the weight of authority as applied to contracts by physicians, surgeons and others of kindred profession . . . relief for violation of these contracts will not be denied merely because the agreement is unlimited as to time, where as to area the restraint is limited and reasonable."[10] The implication here is that although permanence alone will not defeat a covenant, in concert with an objectionable geographic restraint it might. As indicated below, however, the Court in *Karpinski* found the territorial aspect of the restriction to be reasonable and, therefore, the unlimited duration of the restriction did not invalidate it.

Despite the free rein theoretically accorded time restrictions, most of the restrictive covenants drafted by New York attorneys have been of more limited duration. A sense of uneasiness about how long such lifetime prohibitions would remain enforceable and a desire not to sacrifice broad geographic restrictions on an altar of perpetual duration may be responsible for such caution. The cases surveyed involve definite time limits, most commonly ranging from one to five years.[11] While no case was found invalidating a covenant on the basis of time alone, in *Weintraub M.D., P.C. et al. v. Schwartz* a restriction for only one year was invalidated in part because it was felt to be overly broad geographically and unduly burdensome to the former employee.[12]

Geographic Scope of the Covenant

In *Karpinski*, the Court found the five-county scope of the restriction to be valid, but noted that "in some instances a restriction not to conduct a profession or a business in two counties or even in one, may exceed permissible limits."[13] Indeed, case law bears this assertion out. While, as in *Karpinski*, covenants embracing more than one municipality have been found reasonable,[14] a provision covering only portions of municipalities has been invalidated.[15]

In examining whether a territorial restriction is reasonable, a court may balance the interests of the employer against those of the employee. For example, in finding the five-county restriction to be valid, the *Karpinski* court focused on the size and character of the counties, as well as the congruence of the territorial restriction with the area of the plaintiff oral surgeon's practice: "The five small rural counties" encompassed by the restriction "comprise the very area from which the plaintiff obtained his patients and in which the defendant would be in direct competition with him. Thus, the covenant's coverage coincides precisely with the 'territory over which the practice extends,' and this is proper and permissible."[16]

Even where a restriction is not clearly co-extensive with the area of the employer's business, it may be upheld if found otherwise to be necessary to protect the employer's interests. In *Horne v. Radiological Health Services, P.C., et al*., where it was not possible to determine the exact area required for the employer, a professional corporation specializing in radiology, to protect itself against competition, a two-year restriction on practicing in any area located within a five-mile radius of any office, hospital, clinic, or other facility maintained by the corporation was found to be reasonable, because the practice of radiology was based on referrals.[17]

In *Weintraub, supra*, a similar restriction was found to be overbroad and unreasonable on the grounds that it would have significantly undermined the ability of the former employee to practice. There, a neurologist had signed an employment contract with two professional corporations furnishing neurological services in Westchester and Putnam counties. The agreement provided that, for one year after termination of employment, the physician could not practice neurology, open his own office or associate himself with another physician within a five-mile radius of the office of the two corporations or within a five-mile radius of any hospital at which the doctor had worked on behalf of the corporations. Although the court upheld the first part of the restriction, it invalidated the second on the grounds that it would have prevented the physician from practicing at or near the majority of hospitals in Westchester and Putnam counties and would have barred him from professional contacts with physicians at area hospitals that generally produced referrals.[18]

The difference in the outcomes of the previous two cases underscores the fact-based nature of judicial determination in this area. This point is also illustrated in *Gelder Medical Group v. Webber*, where the court found a covenant restricting competition by a former partner of a medicine and surgery partnership within a radius of 30 miles of a village to be reasonable.[19] It offered no specific reason for its determination except that the village, which had a population of 5,000, was small. The Court of Appeals noted generally that the physician who flouted the covenant had no roots in the village and had repeatedly changed professional associations within a range of thousands of miles, while during that same period of time the founding partner had put great effort and expense into building up the medical partnership.[20]

That a radial restriction under 30 miles will not automatically be given effect was made clear in *Metropolitan Medical Group v. Eaton*, where the court recognized that a 30-mile restriction had been upheld in *Gelder* but stated that further facts would be needed to determine whether a one-year restriction for a radius of 20 miles from the hospital where a psychologist had practiced could be sustained.[21]

Legitimate Interest of Employer

While the geographic scope of the covenant in *Karpinski* was valid, the scope of the employment restriction was deemed too broad because Dr. Karpinski practiced only oral surgery and the covenant proscribed the defendant, Dr. Ingrasci, from practicing both oral surgery and general dentistry. Agreeing with the Appellate Division, which had concluded that it was

not reasonable for an individual to be excluded from a profession when he does not compete with his former employer, the Court of Appeals stated: "[T]he plaintiff was not privileged to prevent the defendant from working in an area of dentistry in which he would not be in competition with him. The plaintiff would have all the protection he needs if the restriction were to be limited to the practice of oral surgery. . . ."[22] Although the Court's analysis of the dentistry restriction did not explicitly speak of the plaintiff oral surgeon as having a legitimate business interest, its discussion presupposed such a conclusion: "The hardship necessarily imposed on the defendant must be borne by him in view of the plaintiff's rightful interest in protecting the valuable practice of oral surgery which he built up over the course of many years."[23]

In other cases in which an employer has been in practice for a considerable length of time and has expended considerable time, money, and effort in building the practice, courts may find that a legitimate business interest exists. Sometimes this finding is explicit, as in the 1991 case of *Novendstern v. Mt. Kisco Medical Group*, in which the court found a prohibition on practicing obstetrics and gynecology for three years within a limited area in Westchester County reasonable, stating: "[T]he defendant's [medical group's] interest in protection from the competition of one who has been associated with the group's practice is legitimate. Established in 1947, the medical group developed and prospered as a result of the considerable time, money and efforts of its members. By including the restrictive covenants in the employment contracts, the members were validly protecting their interest in their investments from competition."[24]

At other times, the finding is implicit. For example, in *Gelder*, after stating that the medical group had spent a great amount of time, effort, and money in its development, the Court found that it was "not unreasonable, in admitting new members to the partnership, that voluntary withdrawal or involuntary expulsion should be coupled with a restrictive covenant."[25] Similarly, in *Millet v. Slocum*, in which a physician with no previous experience in New York State joined a practice in Utica, New York, that had been in existence for 11 years, the court found a legitimate interest, stating: "The partnership operating the clinic had been in operation since 1938 and earned a reputation for professional competence and had developed the good will of the community. It was inevitable that the plaintiff in the course of his duties as a partner in the clinic would serve patients of the clinic and would acquire their confidence and good will. It was foreseeable that if the plaintiff [the physician who had violated the covenant] be left free to compete with the clinic in the event that his connection with the partnership should be terminated at some time in the future, that the remaining partners would thereby suffer a loss of patients and good will. A profession partakes on its financial side of a commercial business and its good will is often a valuable asset."[26]

A court may find the protection of a specific contractual relationship to be a legitimate business interest, as demonstrated by *Ippolito v. NEEMA*. There, a professional corporation that provided medical personnel to hospital emergency rooms and had imposed a restrictive covenant barring such personnel from working for a designated hospital for three years, was found to have a legitimate interest in protecting its contractual relationship with its hospital clients.[27]

Harm to Public

The *Karpinski* case did not focus on the potential for harm to the public and, generally speaking, other courts' analyses either ignore this element altogether or mention it only in passing. Where courts do consider this aspect, however, they focus on whether enforcement of the covenant would deprive the public of sufficient access to medical care. Presumably a showing that the loss of the physician to the community would constitute a risk to its health would weigh heavily against a noncompetition agreement. In *Gelder*, *supra*, the Court upheld the agreement, noting that the defendant physician who had violated the covenant "is obviously not the only physician in Sidney [the village where he was prohibited from practicing]. . . . Even crediting his contention, which does not go unchallenged, that he is the village's only surgeon, there is every indication surgeons are available in nearby Binghamton and Oneonta, cities presumably capable of supporting surgical facilities more sophisticated than those of modest Sidney. Moreover, Dr. Webber [the defendant physician] points out in his affidavit that, by arrangement, surgeons came from Binghamton to Sidney."[28] Similarly, the court in *Horne, supra*, lacking facts on which to make an assessment whether the public would be harmed, indicated that the applicable question to consider was whether there was adequate coverage for the public.[29]

Employee Interest

As evidenced by *Karpinski*, a court's analysis of the burden on the former employee may be tied to its review of the legitimacy of the employer's interest. In upholding the geographic prohibition on practicing oral surgery, the Court in *Karpinski* noted that the defendant would be free to practice outside the area from which the plaintiff culled his patients. But in declining to enforce the "dentistry" prong of the restriction, the Court focused on the unreasonableness of preventing the defendant from practicing a specialty that did not pose competition to the plaintiff.[30]

Similarly, in *Weintraub, supra*, in which the court invalidated in part a territorial restriction, it noted the potentially harsh effect of enforcement on the employee and the absence of any evidence indicating harm to the former employer.[31]

Available Remedies

An injunction is often sought to enforce a covenant not to compete. Issuance, however, hinges on equitable principles such as "clean hands," the presence/absence of adequate remedies at law, timeliness, and whether it would be unreasonable,

unjust, or oppressive to the employee.[32] Thus, even if a covenant is valid, injunctive relief will not be automatically granted.[33] The court even maintains the authority to look beyond the words of the underlying agreement before determining how to exercise its powers in equity. It, therefore, will not be bound by contractual language stating that the departing physician's services are unique or that a breach would cause irreparable injury.[34] This often self-serving language is not uncommonly found in contemporary agreements prepared by the employer. Of course, where an injunction is denied on equitable principles despite the validity of a covenant, damages may still be awarded. In *Metropolitan, supra*, in which the court declined to enjoin preliminarily a psychologist from practicing within a 20-mile radius of the hospital where she had previously worked, the court pointed out that monetary relief would be available if the hospital ultimately prevailed in demonstrating the validity of the covenant.[35]

In *Karpinski*, the Court granted an injunction as to that part of the covenant deemed enforceable and also stated that the granting of injunctive relief did not preclude enforcement of the liquidated damages provision contained in the contract. However, the Court found that awarding the full amount of liquidated damages contemplated for a total breach of covenant would be unfair given that the injunction would prevent future violations. Therefore, the court held that the plaintiff oral surgeon was entitled only to the actual damages suffered on account of the breach.[36] Similarly, in *Novendstern v. Mt. Kisco Medical Group*, in which a permanent injunction issued, the court found that to award one year's gross medical fees as liquidated damages would be so disproportionate to the loss sustained by the former employer as to constitute a penalty.[37]

Liquidated damages clauses are not unusual in contracts that contain noncompetition clauses. They are often found to be enforceable if not so grossly disproportionate to the probable loss as to constitute a penalty, the damages anticipated from a breach are uncertain in amount, and there is an intent to liquidate the damages in advance.[38] In *Ryan v. Orris*, in which a gastroenterologist agreed to damages equal to one year's salary or $35,000 if he practiced within two years of termination in the Albany area, and no injunction was sought, liquidated damages were held to be enforceable. The court noted: "Considering the harm to Dr. Ryan's practice and the losses he would sustain by defendant's withdrawal from the corporation, the cost invested in training defendant and introducing him to the area and the similar costs to retrain defendant's substitute, the liquidated damages clause was particularly appropriate, for damages from breach of an employment contract are inherently incapable of accurate estimation, whether at the time of the contract's execution or after its breach."[39]

Conclusion

Noncompetition clauses will be given effect if reasonable. In crafting restrictive covenants that will be enforceable, legal practitioners must carefully tailor the restriction to the situation at hand, taking care to ensure that the covenant will protect his or her client without overreaching or violating the standard of reasonableness. In assessing their respective rights and obligations under a covenant, health care practitioners and providers alike must take into account all pertinent facts that could have a bearing on the covenant's validity.

Endnotes

1. *See Zellner v. Stephen D. Conrad, M.D. P.C.*, 183 A.D.2d 250 (2d Dep't 1992); *Gelder Med. Group v. Webber*, 41 N.Y.2d 680 (1977).
2. *Cohen v. Lord & Day*, 75 N.Y.2d 95 (1989).
3. ALM GL ch. 112 § 12X (Annotated Laws of Massachusetts).
4. *See* California Business and Professional Code, §§ 16,600-16,602.
5. LSA-R.S. 23:921 (Louisiana).
6. *E.g.*, *Gelder Med. Group v. Webber*, 41 N.Y.2d 680, 684 (1977).
7. 28 N.Y.2d 45 (1971).
8. *Id.*
9. *Id.* at 47-49, 51, 53.
10. *Id.* at 50.
11. One year — *Rifkinson v. Kasoff*, 641 N.Y.S.2d 102 (2d Dep't 1996). Two years — *Zellner v. Stephen D. Conrad, M.D. P.C.*, 183 A.D.2d 250 (2d Dep't 1992); *Budoff, P.C. v. Jenkins*, 143 A.D.2d 250 (2d Dep't 1988), *appeal dismissed*, 73 N.Y.2d 810 (1988). Three years — *Novendstern v. Mt. Kisco Medical Group*, 177 A.D.2d 623 (2d Dep't 1991), *appeal dismissed*, 80 N.Y.2d 826 (1992). Five years — *Gelder Med. Group v. Webber*, 41 N.Y.2d 680 (1977); *In the Matter of the Arbitration Between Pine Street Pediatric Associates, P.C. and Peter DeAgostini*, 174 A.D.2d 804 (3d Dep't 1991).
12. 131 A.D.2d 663 (2d Dep't 1987).
13. *Karpinski v. Ingrasci*, 28 N.Y.2d 45, 49 (1971).
14. *Millet v. Slocum*, 4 A.D.2d 528, 532, 534 (4th Dep't 1957), *aff'd*, 5 N.Y.2d 734 (1958) (covenant found valid, but unenforceable on other grounds); *Keen v. Schneider*, 202 Misc. 298, 303, *aff'd*, 280 A.D. 954 (2d Dep't 1952).
15. *Weintraub*, 131 A.D.2d at 665.
16. *Karpinski*, 28 N.Y.2d at 49-50.
17. *Horne v. Radiological Health Services, P.C.*, 83 Misc. 2d 446, 453 (Sup. Ct., Suffolk Co., 1975), *aff'd*, 51 A.D.2d 544 (2d Dep't 1976).
18. *Weintraub*, 131 A.D.2d at 665.
19. *Gelder Med. Group v. Webber*, 41 N.Y.2d 680, 685 (1977).
20. *Id*.
21. *Metropolitan Medical Group v. Eaton*, 154 A.D.2d 252, 254 (1st Dep't 1989).
22. *Karpinski v. Ingrasci*, 28 N.Y.2d 45, 51 (1971).
23. *Id.* at 53.
24. *Novendstern v. Mt. Kisco Medical Group*, 177 A.D.2d 623, 625 (2d Dep't 1991), *appeal dismissed*, 80 N.Y.2d 826 (1992).
25. *Gelder*, 41 N.Y.2d at 685.
26. *Millet v. Slocum*, 4 A.D.2d 528, 531 (4th Dep't 1957), *aff'd*, 5 N.Y.2d 734 (1958) (covenant found valid but unenforceable on other grounds).
27. *Ippolito v. NEEMA*, 127 A.D.2d 821, 822 (2d Dep't 1987).
28. *Gelder Med. Group v. Webber*, 41 N.Y.2d 680, 685 (1977).
29. *Horne v. Radiological Health Services, P.C.*, 83 Misc. 2d 446, 453 (Sup. Ct., Suffolk Co., 1975), *aff'd*, 51 A.D.2d 544 (2d Dep't 1976).
30. *Karpinski v. Ingrasci*, 28 N.Y.2d 45, 51 (1971).
31. *Weintraub M.D., P.C. et al v. Schwartz*, 131A.D.2d 663, 665 (2d Dep't 1987).

32. *See Horne*, 83 Misc. 2d 446 and *Millett v. Slocum*, 4 A.D.2d 528, 531 (4th Dep't 1957) (clean hands doctrine); *Keen v. Schneider*, 202 Misc. 298, *aff'd*, 280 A.D. 954 (2d Dep't 1952) (stating that issuance of an injunction must not be unjust or oppressive to the employee).

33. *Keen*, 202 Misc. 2d 298.

34. *Dockstander v. Reed*, 121 A.D. 846 (1st Dep't 1907) (preliminary injunction).

35. *Metropolitan Group v. Eaton*, 154 A.D.2d at 253.

36. *Karpinski v. Ingrasci*, 28 N.Y.2d 45, 52-53 (1971).

37. *Novendstern v. Mt. Kisco Medical Group*, 177 A.D.2d 623, 625 (2d Dep't 1991), *appeal dismissed*, 80 N.Y.2d 826 (1992).

38. *Ryan v. Orris*, 95 A.D.2d 879, 881 (2d Dep't 1983).

39. *Id.*

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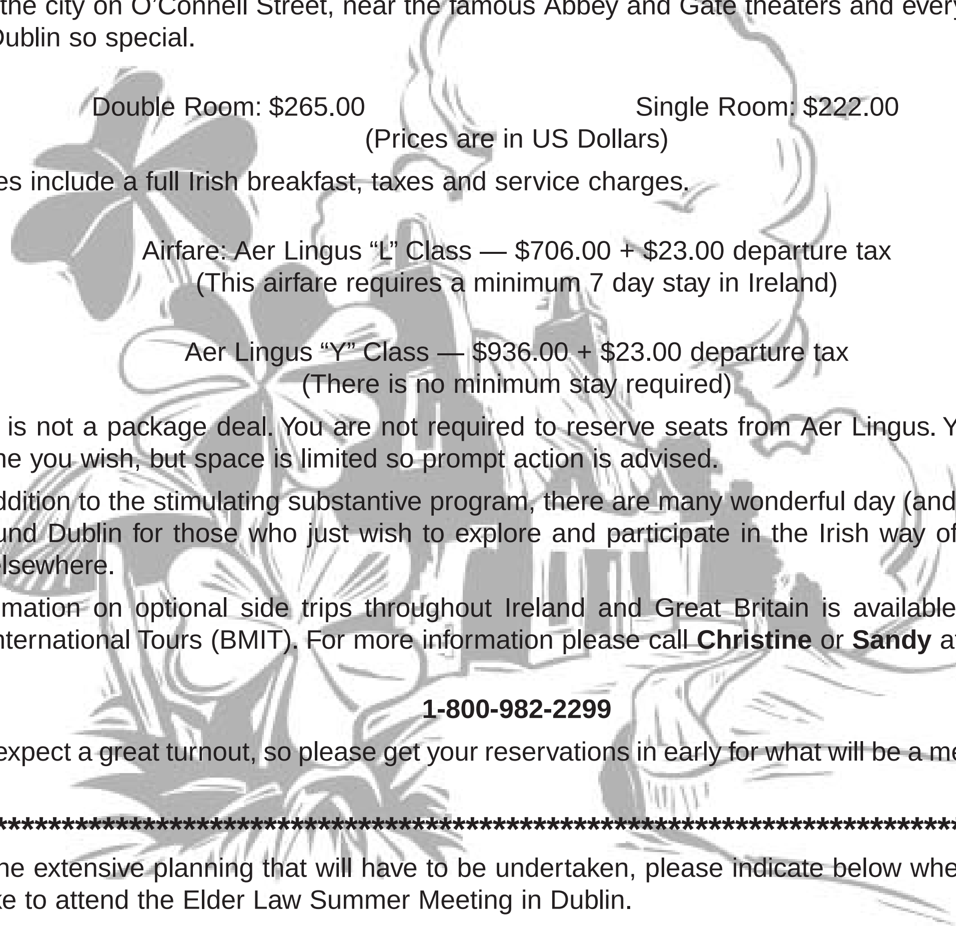
ELDER GO BRAGH!

August 6-11, 1997

Yes — it's Ireland for the ELDER LAW SECTION'S SUMMER MEETING. We'll be at the four-star Gresham Hotel, Dublin's oldest (1817) and one of its most charming lodging establishments, right in the heart of the city on O'Connell Street, near the famous Abbey and Gate theaters and everything else that makes Dublin so special.



Double Room: $265.00 Single Room: $222.00
(Prices are in US Dollars)

Prices include a full Irish breakfast, taxes and service charges.

Airfare: Aer Lingus "L" Class — $706.00 + $23.00 departure tax
(This airfare requires a minimum 7 day stay in Ireland)

Aer Lingus "Y" Class — $936.00 + $23.00 departure tax
(There is no minimum stay required)

This is not a package deal. You are not required to reserve seats from Aer Lingus. You can choose any airline you wish, but space is limited so prompt action is advised.

In addition to the stimulating substantive program, there are many wonderful day (and longer) trips in and around Dublin for those who just wish to explore and participate in the Irish way of life or want to extend elsewhere.

Information on optional side trips throughout Ireland and Great Britain is available through Brian Moore International Tours (BMIT). For more information please call **Christine** or **Sandy** at BMIT.

1-800-982-2299

We expect a great turnout, so please get your reservations in early for what will be a memorable experience.

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Due to the extensive planning that will have to be undertaken, please indicate below whether or not you would like to attend the Elder Law Summer Meeting in Dublin.

Please fax this sheet to Barbara Mahan at: 518-463-8527.

____ Will Attend

Name: ____Number of Guests __________

Important Notice for Attorneys Handling OPMC Cases

by James F. Horan

The Committee on Professional Misconduct wishes to advise the Section's members that the 1997 McKinney's supplement for the Public Health Law, the Education Law, and other statutes are current only to Chapter 599 of the Laws of 1996. The complete Session Laws run to Chapter 721. The supplement fails to reflect Public Health Law ("PHL") amendments that make significant changes in the physician disciplinary process. Chapter 627 amends:

- PHL sections 230(10)(c) & 230(10)(p) to require that respondents in professional medical conduct cases file answers to misconduct charges and to provide that *unanswered charges will be deemed admitted*;
- PHL section 230(12) to authorize the Health Commissioner to take summary action against a physician's license following a state or federal felony conviction or an administrative determination from another state; and
- PHL section 230-c(4)(a) to remove the automatic stay to hearing committee penalties during an administrative review, in cases in which the committee ordered license annulment, revocation, or suspension.

The Chapter Laws that do not appear in the supplement appear in West's Session Laws News Pamphlets and in WESTLAW's on-line service updates. The completely updated text for the Public Health Law appears in the version on LEXIS-NEXIS and the version available through the NYSBA Web site.

Decision Making About Health Care in New York: The Case of Scott Matthews

by Charlotte S. Buchanan*

The basis for requiring all life-sustaining treatment for anyone who has not left evidence of subjective wishes while a competent adult rests on the Court of Appeals' decision that "substituted judgment" is "unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another."[1] But, by stating that life-sustaining treatment must be applied in all life-threatening situations, the Court is, in fact, making a quality-of-life judgment. There is no way to make any judgment in a life-threatening situation without making a quality-of-life judgment. And yet even with this dictate from the Court, life-sustaining treatment is not always implemented. In cases in which feeding tubes are at issue, they may be inserted; but if one is talking about an organ transplant or very complicated surgeries or other intensive treatments that might prolong someone's life or process of dying, they are simply not done. Perhaps this is on the basis of a cost-benefit analysis or perhaps it is the maintenance of an older value that, ultimately, the physician decides, according to medically accepted standards, what is appropriate medical treatment.

Even though American society generally sees death as something always to avoid or as an evil, it is, in fact, part of, or the end of, everyone's life. One cannot avoid death; but with modern medicine sometimes death can be postponed. That means that someone must decide several things: who makes the decision to allow someone to die, when death is to be allowed, and on what bases the decision is made. When people talk about "playing God," they often seem to forget that every time a physician saves the life of someone who otherwise would have died naturally, the physician and perhaps society have "played God."

A Case in Point: *In the Matter of Scott Matthews*

A recent case in Albany County illustrates some of the difficulties with the way the law is applied in New York. The case involves Scott Matthews, a 28-year-old who has never weighed more than 55 pounds. Over the past year and six months his weight has fluctuated; in August he weighed about 45 pounds. He is profoundly retarded and has cerebral palsy with spastic quadriparesis. He has a medical history of epilepsy and respiratory infections. He has been hospitalized on five occasions in the last year for pneumonia or dehydration and malnutrition. He has a swallowing disorder and sometimes aspirates his food and saliva.[2]

For many years, Scott's natural parents, Kathleen Matthews and Gary Matthews, cared for their son. Since 1985, Scott has resided in a facility operated by the United Cerebral Palsy Association of the Capital District ("CP Association"). On October 13, 1995, Ms. Matthews and Mr. Matthews were appointed guardians of Scott.[3] According to Kathleen Matthews, her son is able to recognize people and voices although he cannot speak. She said his one apparent pleasure and only independence in life is eating, since he sometimes spits out food and sometimes readily takes other food.[4]

Scott is malnourished. His former physician, who was also a physician for the CP Association, Carl M. Shapiro, M.D., believes that Scott's feeding problems would be reduced if a feeding tube were inserted into him.[5] Against the wishes of the parents-guardians, the CP Association petitioned the Surrogate's Court for an order to insert a feeding tube. At one point, Dr. Shapiro testified that a successful insertion of a gastrostomy tube into Scott could extend Scott's life from years to decades,[6] although at another point he stated that he could not "even give . . . a guess" about Scott's life expectancy.[7]

The record at the Surrogate's Court was that Scott's "handicaps or problems with aspiration would not be alleviated by placement of a feeding tube and that its use was primarily recommended to prevent Scott from succumbing to malnutrition."[8] Conflicting evidence was presented by physicians as to whether the aspiration of Mr. Matthews's own salivary secretions was sufficient to negate any benefit from feeding through a tube. Despite the conflicting testimony, the Surrogate's Court, "regrettably constrained" by New York case law,[9] concluded that it had no choice but to find in favor of the CP Association and the Mental Hygiene Legal Services ("MHLS"), the co-petitioner.

Among other facts, however, the Surrogate's Court found that "Scott is likely to succumb to a bacterial pneumonia within the next six months" without regard to whether a feeding tube were inserted.[10] The court also found that Scott's life could be shortened rather than prolonged if there were significant complications from the gastrostomy procedure.[11] Scott's mother and guardian has worked all of Scott's life to have him provided with the maximum quality of life and be treated as a human being. She fears that the insertion of tubes to prolong his life will take away his only independence and only pleasure, and that such a process is treating him as a machine rather than a human being.[12] Her fear is well-founded: Dr. Shapiro testified that if he were the physician of record, he would recommend that the staff not feed Mr. Matthews.[13]

In its conclusions of law, the Surrogate's Court read *In the Matter of Storar*[14] as requiring it to grant the CP Association the authority to have a gastrostomy or other medically appropriate feeding and hydration tube placed in Scott Matthews. The Surrogate's Court stated that the law of New York, as stat-

ed in *Storar*, allows relief from life-sustaining treatments only if a competent person has provided evidence of his or her subjective wishes.[15]

In companion cases (*In the Matter of John Storar* and *In the Matter of Philip K. Eichner)*,[16] the Court of Appeals determined that clear and convincing evidence of a competent person's wishes regarding health care would provide the basis for a decision to carry out that person's wishes. With regard to medical treatment for a child, that Court wrote:

> A parent or guardian has a right to consent to medical treatment on behalf of an infant. The parent, however, may not deprive a child of lifesaving treatment, however well intentioned. Even when the parents' decision to decline necessary treatment is based on constitutional grounds, such as religious beliefs, it must yield to the State's interests, as *parens patriae*, in protecting the health and welfare of the child. *Of course, it is not for the courts to determine the most "effective" treatment when the parents have chosen among reasonable alternatives* (*Matter of Hofbauer*, 47 N.Y.2d 648). But courts may not permit a parent to deny a child all treatment for a condition which threatens his life.[17]

The *Storar* court went on to state that, although the blood transfusions would not cure all of John Storar's conditions, the transfusions would allow him essentially the same quality of life he had before contracting cancer. In a footnote, however, the Court stated: "*Whether the presence or absence of excessive pain would be determinative with respect to the continuation of a life sustaining measure need not be reached under the facts of this case.*"[18]

Although the Surrogate's Court in the Scott Matthews case felt bound by the *Storar* case, it stated:

> [T]here should be some recognized legal process to address the use of life-sustaining measures for patients who, because of age or mental condition are unable to express their wishes. The absence of relief in New York under such circumstances undoubtedly inflicts needless suffering on many of our citizens and simple decency requires that a remedy be found. I would prefer that we provide relief by broadening our limited rules and joining in the majority of American jurisdictions that recognize some form of substitute judgment.[19]

The Arguments on Appeal

The parents and guardians of Scott appealed the decision and were opposed by both the CP Association and MHLS. The appellants argued that, under both the federal and the New York State Constitutions, Scott had been denied equal protection in that he had been denied an assessment of his individual best interests. The appellants argued that the clear-and-convincing-evidence standard derived from the *Storar* case may sensibly be applied only to persons who had at one time been competent; that, in fact, the Court of Appeals in *Storar* actually applied a best-interests test to John Storar in requiring blood transfusions that would provide him with a better quality of life for his remaining time. If the clear-and-convincing test is applied to someone who has never been competent, tautologically, there can never be a decision except to prolong life — or to prolong the dying process — of a person who has never been competent. "What the application of New York law has afforded Scott Matthews is a prejudged outcome, derived from the application of a standard that a person in his position will never be able to satisfy."[20]

The appellants cited New York's state constitution, article 80 of the Mental Hygiene Law, and case law to analogize Scott's situation to that of a never-competent patient who had neither guardian nor parents to make health care decisions. In such cases, a panel would be chosen to evaluate whether major medical treatment on behalf of the decisionally incapacitated individual is in that individual's best interests. The term "best interests" means "promoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment, taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical treatment and consistency with the personal beliefs and values known to be held by the patient."[21] While Scott would not be eligible for the decision-making *process* established under article 80 (use of a panel rather than a guardian or a court to make a health care decision), the decision-making *standard* recognized by the Legislature as appropriate for those who have never been competent should be applied to him. The appellants argued, accordingly, that New York law had operated in a discriminatory fashion by denying Scott the best-interests test that New York statutory and case law affords to others similarly[22] or even virtually identically[23] situated. Moreover, the appellants argued, Scott's parents' views should be given great weight in determining Scott's best interests.

The respondents countered that, no matter who — guardians, parents or panels — makes a health care decision for a decisionally incapacitated patient, *Storar* ultimately applies in any life-threatening situation and that "the courts may not permit a caring parent or guardian to deny a child medical treatment for a condition which threatens his life."[24]

> The court has clearly shown that when faced with making a life or death decision for an incompetent individual whose wishes are unascertainable (whether through lack of clear and convincing evidence, minority of age or incompetency from early childhood) they will not use a "best interest" or "substi-

tuted judgment" approach because it is inconsistent with the court's "fundamental commitment" to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another.[25]

The Decision on Appeal

On November 26, 1996, the New York Supreme Court, Appellate Division, Third Department, handed down its opinion and order. The court found for the appellants, declaring that "[i]nitially, it must be emphasized and made clear that this is not a 'right to die' case." The court found that all parties were "genuinely concerned about Scott"[26] but differed in their evaluations of Scott's best interests. The court discussed the conflicting evidence from the four medical experts: although the four physicians agreed that Scott has a swallowing disorder, they disagreed about the riskiness of the insertion and maintenance of a feeding tube, the degree of Scott's malnutrition and the appropriate method to assure adequate nutrition. Relying on court-appointed physician Richard Clift's testimony that Scott was obtaining sufficient nutrition for his physical needs, the court concluded that Scott was not being deprived of life-sustaining treatment. The opinion stated:

> In considering all of these principles together, it appears to us that in cases where there is a division of medical opinion as to the appropriate treatment for a life-threatening condition, deference should be given to the decision of the parents as long as the chosen course of treatment is a reasonable one within medical standards.[27]

> Had proof been presented clearly establishing that Scott's condition was deteriorating under Caulfield's care and that he was being deprived of life-sustaining treatment, we would have agreed with petitioner and granted its requested relief.[28]

> [I]t is apparent to this court that respondents cannot and should not be permitted to make a decision that would result in Scott starving to death, if such could be medically avoided, regardless of how soon he may or may not succumb from other causes.[29]

Because the court found the situation not now life threatening, it was able to avoid addressing the appellants' constitutional arguments while still ruling in their favor. In doing so, the court relied primarily on *Matter of Hofbauer*[30] and *Matter of Storar*[31] to conclude that a court should not interfere with parental choice among reasonable alternative treatments. So long as the denial of the treatment at issue is not life threatening, the court supported decisions made by the parents based on the criteria of the best interests of the incapacitated child (or patient who should be treated as a child). The court said: "Scott is no more capable of determining whether a feeding tube is warranted in his case than an infant would be in similar circumstances. . . . [T]he law relating to decisions as to life-sustaining treatment for infants is the only fair method by which Scott's rights can be assessed."[32] Indeed, the court noted that the Court of Appeals itself "never mentioned a clear and convincing standard in its discussion of John Storar's situation."[33]

Commentary

Although length and quality of life are different, they are always tied together. Any action or lack of action based on a decision at issue in the Scott Matthews case will result in one of the following:

1. Scott's life will be prolonged OR
2. Scott's life will be shortened OR
3. The length of Scott's life will not be changed

AND (by the action, in addition to the quantity of life)

1. Scott will suffer (in the extreme, the actions may be described as torture) OR
2. Scott will be comforted (the actions may be described as providing pleasure to him) OR
3. As with most human beings, Scott will suffer sometimes and be comforted at other times, but either pain or pleasure will dominate — sometimes to an extreme.

The subjective reality for Scott cannot be communicated in language, but the human experience does provide some commonality that allows us to objectify many of our personal experiences. Certain body movements, the quickness of them, the way they are made — particularly combined with audible sounds — provide a general indication of pain that is recognized by most human beings.

> [Another court] concluded that the following factors should be considered in order to determine whether the burdens to a particular patient in prolonging life markedly outweigh the benefits of continued life: age; life expectancy with, and without, the treatment or procedure; degree of present and future pain or suffering; the extent of the patient's physical and mental disability and the degree of helplessness; statements (if any) made by the patient which directly or impliedly manifest the patient's views on life-prolonging measures; the quality of the patient's life with, or without, the procedure; the risks to life or adverse side effects created by the contemplated procedure; patient's religious or ethical beliefs; the views of the patient's family and friends; the views of the

> physicians; the type of care which will be required if life is prolonged as contrasted with the availability of such care; and whether the state has any overriding *parens patriae* interests in sustaining life.[34]

When one looks at prolonging life and places a value on prolonging life, but chooses to ignore quality of life for another, the other may have to suffer in the extreme, needlessly. Sometimes to be allowed to die without medical intervention is in the best interests of an individual. The respondents on several occasions referred to cases in which the state has an interest in protecting the health and welfare of its citizens. What interest contrary to the best interests of Scott could the state possibly have? The way to achieve the best quantity and the best quality of life for Scott is to apply the best-interests test.

Justice Stevens, in his dissent in *Cruzan*,[35] quotes Judge Blackmar from the lower court:

> It is unrealistic to say that the preservation of life is an absolute, without regard to the quality of life. . . . It is appropriate to consider the quality of life in making decisions about the extraordinary medical treatment. Those who have made decisions about such matters without resort to the courts certainly consider the quality of life, and, balance this against the unpleasant consequences to the patient. There is evidence that Nancy [Cruzan] may react to pain stimuli. If she has any awareness of her surroundings, her life must be a living hell. She is unable to express herself or to do anything at all to alter her situation. Her parents, who are her closest relatives, are best able to feel for her and to decide what is best for her. The state should not substitute its decisions for theirs. Nor am I impressed with the crypto-philosophers cited in the principal opinion, who declaim about the sanctity of any life without regard to its quality. They dwell in ivory towers.

The argument of the slippery slope will always be raised in response to such a position; yet our courts, through the centuries, have been responsible for drawing lines. This is one of the reasons that it may seem absurd that one thing is permitted and something very similar is not because a hard line has been drawn to prevent something from going too far.

Applying the best-interests test is the best way to prevent the sacrifice of quality in the pursuit of quantity. If one will accept that the best interests of the affected individual are the best criteria to follow, then the remaining critical question is who should be in a position to apply them? Most people agree that applying a best-interests test to anyone is very difficult, particularly to someone who has never been competent to express subjective preferences. Who would be able to make the appropriate decision? Parents, guardians, physicians, institutional administrators, ethics committees, courts? Justice Brennan, in his dissent in *Cruzan v. Director, Missouri Dept. of Health*,[36] wrote:

> A State's legitimate interest in safeguarding a patient's choice cannot be furthered by simply appropriating it.
>
> The majority justifies its position by arguing, that, while close family members may have a strong feeling about the question, "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." I cannot quarrel with this observation. But it leads only to another question: Is there any reason to suppose that a State is *more* likely to make the choice that the patient would have made than someone who knew the patient intimately? To ask this is to answer it. As the New Jersey Supreme Court observed: "Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. . . . It is . . . they who treat the patient as a person, rather than a symbol of a cause." *In re Jobes*, l08 N. J. 394, 416, 529 A.2d 434, 445 (l987). The State, in contrast, is a stranger to the patient.

The Court of Appeals in *Storar* determined quality of life by requiring the sustaining of a life that would have ended more quickly without the intervention of medicine. The Court, however, had other alternatives. It could have allowed someone else to make the decision: the parent and the guardian.

Loving parents or other persons close to the patient are the most obvious potential decision makers. Those people, however, sometimes will not have had any training in ethical decision making, so they could be assisted in their decision by a small group of experts who would be able to help them in their analysis of the situation before or while applying subjective values.

Of course, such decision makers should be held to a fiduciary standard. Many people are in positions to observe and, if necessary, report breaches of duty by the decision makers. These observers include physicians and nurses, other relatives and friends.

New York is seriously harming many of its citizens who have never been competent to make their own health care decisions or who, for whatever reason, have not appointed health care agents to make decisions for them while they are inca-

pacitated. New York's Court of Appeals in *Storar* and in *O'Connor* has called upon the Legislature to act. The Legislature and Governor should act, but if they do not, the courts are our only hope for fashioning something more humane and acceptable than the current criteria in the *Storar* and *O'Connor* cases. The case law governing "right to die" in New York has come from sharply divided courts, from courts that, from time to time, have had to cite conflicting cases with their *stare decisis* citations. The whole line of "right to die" cases in New York has evolved from thin threads of law, from one federal case[37] and from dictum in an old New York case.[38] If we, in fact, can arrive at the law in *Storar* and *O'Connor* from that simple dictum "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body,"[39] surely the courts can use their powers to evolve the law a step further for the benefit of humanity.

Endnotes

1. *Matter of O'Connor*, 72 N.Y.2d 517, 530 (1988).
2. *In the Matter of Scott Matthews*, No. 77904, slip op. at 2 (N.Y. Sup. Ct., A.D. 3d Dep't, Nov. 26, 1996), *motion for leave to appeal denied* (Feb. 11, 1997).
3. *In the Matter of the Guardianship of Scott Matthews*, slip op. at 2, (N.Y. Sur. Ct. Oct. 4, 1996).
4. Private conversation with Ms. Matthews, September 1996.
5. *In the Matter of the Guardianship of Scott Matthews*, slip op. at 11-12 (N.Y. Sur. Ct. Oct. 4, 1996).
6. *Id.* at 13.
7. Record on Appeal at 234, *In the Matter of Scott Matthews*, No. 77904 (N.Y. Sup. Ct., A.D., 3d Dep't Nov. 26, 1996), *motion for leave to appeal denied* (Feb. 11, 1997).
8. *In the Matter of Scott Matthews*, No. 77904, slip op. at 4 (N.Y. Sup. Ct., A.D., 3d Dep't Nov. 26, 1996), *motion for leave to appeal denied* (Feb. 11, 1997) (hereinafter cited as "Matthews on Appeal").
9. *In the Matter of the Guardianship of Scott Matthews*, slip op. at 21 (N.Y. Sur. Ct. Oct. 4, 1996) (hereinafter cited as "Surrogate's Opinion").
10. Surrogate's Opinion, *supra* note 9, at 14.
11. *Id*.
12. Personal communication, September, 1996.
13. Brief for Respondents-Appellants at 25, *In the Matter of Scott Matthews*, No. 77904 (N.Y. Sup. Ct., A.D., 3d Dep't Nov. 26, 1996), *motion for leave to appeal denied* (Feb. 11, 1997) (hereinafter cited as "Appellants' Brief").
14. 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858 (1981).
15. Surrogate's Opinion, *supra* note 9, at 19.
16. 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858 (1991).
17. 52 N.Y.2d at 380-81 (emphasis added; most citations omitted).
18. *Id.* at 381 n.7 (emphasis added).
19. Surrogate's Opinion, *supra* note 9, at 19.
20. Appellants' Brief, *supra* note 13, at 21.
21. Appellants' Brief, *supra* note 13, at 19 (quoting N.Y. Mental Hyg. Law § 80.03(d) (McKinney 1996)).
22. *See Rivers v. Katz*, 67 N.Y.2d 485, *reconsideration denied*, 68 N.Y.2d 808 (1986); N.Y. Mental Hyg. Law article 81.
23. *See Matter of Hofbauer*, 47 N.Y.2d 648 (1979); *Matter of John Doe*, 104 A.D.2d 200 (4th Dep't 1984); N.Y. Mental Hyg. Law article 80.
24. Brief for Respondent CP Association at 15 (quoting *Matter of Storar*, 52 N.Y.2d at 381), *In the Matter of Scott Matthews*, No. 77904 (N.Y. Sup. Ct., A.D. 3d Dep't Nov. 26, 1996), *motion for leave to appeal denied* (Feb. 11, 1997) (hereinafter cited as "CP Association's Brief").
25. CP Association's Brief, *supra* note 24, at 17-18 (quoting *O'Connor*, 72 N.Y.2d at 530; *People v. Eulo*, 63 N.Y.2d at 357).
26. Matthews on Appeal, *supra* note 8, at 6.
27. *Id*. at 9.
28. *Id*. at 11.
29. *Id*. at 7.
30. 47 N.Y.2d 648.
31. 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858.
32. Matthews on Appeal, *supra* note 8, at 6-7.
33. *Id*. at 7 n.8.
34. Stephen C. Kenney, *Death and Life Decisions: Who is in Control?*, 23 Loyola of Los Angeles L. Rev. 791, 815 (1990).
35. *Cruzan, v. Director, Missouri Dep't of Health*, 497 U.S. 261, 337 (Stevens, J., dissenting).
36. *Id.* at 327-28 (1990) (Brennan, J., dissenting).
37. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891).
38. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125 (1918).
39. *Id.* at 129.

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The Criminalization of Asset Transfer in Medicaid Planning

by David Goldfarb*

Making Medicaid Planning a Crime

The Health Insurance Portability and Accountability Act (Kennedy-Kassebaum Bill), which was signed into law on August 21 and took effect on January 1, 1997, contains a provision which criminalizes certain transfers of assets for the purpose of qualifying for Medicaid.

The law adds to 42 U.S.C. § 1320a-7b(a) the following provision to the list of acts which constitute a federal crime:

> (6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c).

Section 1917(c) [42 U.S.C. § 1396p(c)] referred to in the statute describes the calculation of a period of Medicaid ineligibility if an individual or his/her spouse disposes of assets for less than fair market value during a look-back period.

Under current federal and state law, when someone applies for Medicaid, the Medicaid agency looks back at all transfers of assets made in the prior 36 months (60 months for transfers to or from a trust). New York has not opted to apply the look-back and consequent imposition of a penalty to community-based care but does apply the look-back and penalty period to institutional care (nursing homes and certain waivered programs). If a transfer of assets was done during the look-back period by either an applicant or his/her spouse and it doesn't fall within any stated exemption, then a period of ineligibility for Medicaid from the beginning of the month following the date of the transfer is calculated. The number of months of the penalty or waiting period is equal to the amount which was transferred, divided by the average monthly cost of nursing home care in the region. For example, if the regional rate is $5,000 per month and someone transferred immediately prior to January 1, 1996, $50,000, then he or she would not be eligible to be covered by Medicaid for nursing home care for ten months or until November 1, 1996.

Actions by the Section and the New York State Bar

The Elder Law Section and the Trusts & Estates Law Section of the New York State Bar Association have taken positions opposing the criminalization of Medicaid asset transfers. The New York State Bar Association Executive Committee has also supported this position opposing the criminalization of Medicaid asset transfers as an excessive and inappropriate approach.

Specific Problems with the Statute

The statute has been criticized as having been passed without sufficient public debate. It has also been criticized as inappropriate to criminalize civilly legal action. It contains a number of ambiguities which make it difficult to advise clients as to what is covered. The following is a discussion of some of the ambiguities in the statute.

The penalty provision in the statute was not amended, and the penalty section does not include the "transfers" referred to in the new provision. Furthermore, the statute provides in the penalty section for felonies and misdemeanors. The felony section is for acts "in connection with the furnishing [by that person] of items or services for which payment is or may be made under the program." This clearly does not cover "transfers" by a Medicaid applicant/recipient. However the conference committee report only refers to a "conviction of a program-related felony."

The statute refers to conduct which "results in the imposition of a period of ineligibility." There is clearly a lack of clarity as to what this covers. Among the alternative possibilities are the following:

(1) It applies only to transfers where the applicant applies for Medicaid before the calculated penalty period expired and the state agency imposes a period of ineligibility by denying Medicaid.

(2) It applies to any non-exempt transfer within a look-back period where either the applicant applies before the penalty period expires and the agency denies Medicaid or the applicant applies after the penalty period expires and Medicaid is granted.

(3) It applies to all non-exempt transfers, even beyond a look-back period.

(4) It applies to all transfers (exempt and non-exempt) which ultimately render a person eligible for Medicaid.

There is a separate issue as to whether the statute can criminalize transfers which took place before January 1, 1997, if the Medicaid application is made after that date. There is a question whether applications for Medicaid programs where the state has opted not to impose a penalty period (such as community based Medicaid in New York) are covered. There is a consensus among elder law practitioners (which will be discussed below) that the statute criminalizes item (2) above,

applies to transfers after January 1, 1997, and does not apply to Medicaid programs which do not have penalty periods for transfers.

There is some ambiguity in the statute as to who is the criminal. Does it include a person acting as an attorney-in-fact or a court-appointed guardian? 18 U.S.C. § 2 provides in part:

> (a) whoever commits an offense against the United States or aids, abets, counsels, commands, induces or procures its commission, is punishable as a principal;
>
> (b) whoever willfully causes an act to be done which if directly performed by him or another would be an offense against the United States, is punishable as a principal.

This provision would appear to be broad enough to cover family members and attorneys who are involved in transfer-of-asset planning.

This is a new law and there is obviously no court experience on how it will be interpreted and applied. However there appears to be a consensus among attorneys who practice in this area. A number of bulletins and articles have already appeared discussing these issues. These include:

> *Entitlement Bulletin*, Brookdale Center on Aging/Institute on Law and Rights of Older Adults. 96-LI-12 (September 1996).
>
> "Memorandum to Members of the Elder Law Section," from Vincent Russo, Chair (August 26, and October 4, 1996)
>
> *NAELA Legislative Alert and Update*, National Academy of Elder Law Attorneys (September 1996)
>
> *The Elder Law Report*, Harry S. Margolis, Editor, Vol. VIII, No. 2 (September 1996)
>
> "Criminal Penalties for Medicaid Motivated Transfers" by Daniel Fish, *The New York Law Journal* (September 23, 1996)

The consensus currently is that the criminal penalties do not apply to the following:

(a) Transfers prior to January 1, 1997.

(b) Transfers done exclusively for purposes other than to obtain Medicaid (such as $10,000 annual exclusion gifts to reduce estate taxes).

(c) Exempt transfers (such as transfers to or for the sole benefit of a spouse or disabled child, transfers of a homestead to a "care-taker" child, etc.).

(d) Transfers where the application for Medicaid is after the 36-month look-back period (or 60 months in the case of transfers to or from a trust).

(e) Transfers where the application is for Medicaid where there is no penalty period imposed under state law (such as community-based Medicaid in New York).

What is Being Done?

There are currently efforts being made to encourage Congress to make a technical amendment to the Kennedy-Kassebaum bill which would deal with some of the issues raised here. Discussions among advocacy groups include efforts to eliminate criminal penalties for civilly legal conduct. The New York State Bar Association has formed a task force with members from various sections including Trusts & Estates Law, Elder Law, Health Law, and Criminal Justice. The charge to the task force is to analyze and report to the membership on the statute and to work with advocacy groups and other organizations for the repeal of the law.

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Private Dental Offices as "Public Accommodations" Under the Human Rights Law

by Robert Friedman*

The issue of health care providers as places of "public accommodation" under the Human Rights Law did not arise until the advent of the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS). Dental offices are places of public accommodation and, therefore, may not discriminate on the basis of disability. The Court of Appeals in *Cahill v. Rosa*[1] (decided on October 15, 1996) ruled that the term "places of public accommodation" under the Human Rights Law should be "liberally construed" to include all places that "provide service to the public." Although these decisions involved HIV-positive patients in dental offices, they will be applicable to all professional offices and all types of discrimination, according to the dissent.

In the *Cahill* case, the patient went to the dentist's office without an appointment for treatment of a cracked tooth. The dental assistant told him that the dentist would see him immediately. However, when the patient informed the assistant that he had been exposed to AIDS and was awaiting test results to determine if he was HIV-positive, he was told that the treatment would have to await the results of the test and that he would be treated only if the test result was negative. In the *Lasser* case, the patient, who had been treated by the dentist previously, was refused treatment after she became HIV-positive.

The State Division of Human Rights awarded the patients compensatory damages for mental anguish. The Appellate Division annulled the Commissioner's determination, concluding that dental practices could not be considered places of public accommodation within the meaning of the Human Rights Law because "dental offices" are not listed in Executive Law § 292 and because the dental practices were operated in privately owned premises and by "appointment only."

I. The Statute

The Human Rights Law provides that it shall be "an unlawful discriminatory practice for any person, being the owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation, resort or amusement, because of the . . . disability . . . of any person, . . . to refuse, withhold from or deny to such person any of the accommodations, advantages, facilities or privileges thereof."[3] Places that are and are not places of public accommodation are listed.[4] Since the statute does not expressly cite "dental offices" within either the included or exempt categories, it was the Court of Appeals' task to determine in which category such facilities fall.

II. The Dentists' Defenses

The dentists asserted three reasons why their offices are not "places of public accommodation." First, the dentists noted that since the statute does not expressly include dental offices in its list of public accommodations, the doctrine of *expressio unius est exclusio alterius* requires a finding that the Legislature must have intended such facilities to be excluded from the statutory definition. Second, they contended that the phrase "wholesale and retail" modifies the phrase "wholesale or retail establishments." Lastly, the dentists asserted that the only statutory reference that might incorporate dental offices is "clinics." They argued, however that they are not clinics because they are located in private premises and do not treat walk-in patients.

III. The Ruling

United States Power Squadrons v. State Human Rights Appeal Board[5] dealt exclusively with the interpretation of the statutory term "places of public accommodation" for purposes of the New York Human Rights Law. The Court reasoned that the Legislature intended the term "places of accommodation" to be interpreted broadly. However, the Court strictly construed the "distinctively private" exception and emphasized that the hallmarks of a distinctly private place are selectivity and exclusivity.[6]

Citing the *Power Squadrons* case, the Court in *Cahill* determined that the Human Rights Law must be construed liberally to achieve the goals of the statute and thus reasoned that the enumeration of examples of "places of public accommodation" in the definitional section of the Human Rights Law is not exclusive. The statutory lists of places of public accommodation is "illustrative, not specific."

Dentists' offices come within the definition of places of public accommodation because they provide services to the public. Although they may be conducted on private premises and by appointment, such places are "generally open to all comers." Patients may be drawn to the offices by an advertisement or telephone book listing, upon referral by other health care providers, or, as in the case of Dr. Cahill's patient, by a sign displayed on the premises. In the *Cahill* case, the patient originally was accepted for treatment after walking into the offices as a new patient, without an appointment.

Nor are dentists' offices one of the places of public accommodation exempt from the provisions of the statute. The nar-

row and restrictive language identifying such places and limiting the exemption stands in contrast to the expansive language identifying those included within the definition of "a place of accommodation." Only those places that are "hereinafter specified" are not included in the statutory definition.[7] The statute then identifies as exempt certain educational institutions and "any institution, club or place of accommodation which is in its nature distinctly private." Thus, while the Legislature intended that the inclusive list be broadly construed, it specified that exemptions were to be narrowly construed.

The dentists failed to sustain the burden of proving that they are exempt. Dr. Cahill established only that the premises in which his offices were located were privately owned and that patients were generally required to make appointments to be seen. Dr. Lasser offered no relevant evidence. Neither dentist offered evidence that his patient roster was selective or exclusive, or that his practice was not generally held open to the public.

IV. Health Issues

Although the Court recognized that potentially contagious blood-borne conditions may raise specific concerns in the health care community, the statute does not differentiate among types of disabilities. Nor did the Court perceive any conflict between its interpretation of the statute and modern dental and medical practice. The National Institute for Occupational Safety and Health in collaboration with the Center for Infectious Disease and Centers for Disease Control have published "Guidelines for the Prevention of HIV and Hepatitis B Virus to Health-Care and Public Safety Workers," and all licensed New York health care workers are required to use "universal precautions" in all situations in which there is potential for the transmission of viruses.[8]

Drs. Cahill and Lasser both testified that they and their staffs routinely employed universal precautions. Moreover, both the American Dental Association and the American Medical Association take the position that it is unethical to refuse to treat an HIV-positive patient solely because of that diagnosis.[9] The health care professions are generally in accord with the Human Rights Law with respect to the issue of treatment of HIV-positive patients, who may not be denied treatment solely because they have that disability.

V. The Dissent

According to the dissent, the majority's construction of "place of public accommodation, resort or amusement" to cover any provision of goods or services to any members of the public "empties the phrase of any substance content and will result in an explosive increase in the jurisdiction of the State Division of Human Rights." The dissent found no justification in either the language or legislative history of the statute or its amendments to support or compel this overly expansive interpretation. The holding will make into places of public accommodation all the practitioners of all of the professions, which includes 570,000 professionals licensed by the State Education Department plus some 164,000 attorneys registered to practice in this state.

VI. Federal Courts

Federal courts have ruled that a dental services provider is a place of public accommodation within the meaning of the Americans With Disabilities Act.[10] In order to qualify as disabled, however, a complainant must demonstrate either that (1) his or her HIV status has substantially impaired major life activities, (2) he or she has a record of such impairment, or (3) he or she is regarded as having such an impairment.[11] *Abbott v. Bragdon*[12] held that the reproductive function is a major life activity and HIV substantially impairs this function. *Doe v. Kohn Nast & Graf*[13] held that one year of HIV-positive status is not an adequate record of impairment to show a disability. *Kocsis v. Multi-Care Management, Inc.*[14] states that an employer's perception that an employee is HIV-positive may bring the employee within the scope of the Americans With Disabilities Act.

Endnotes

1. 89 N.Y.2d 14 (1996).
2. N. Y. Exec. Law § 296(2)(e).
3. N.Y. Exec. Law § 292(9).
4. 59 N.Y.2d 401, 410 (1983).
5. *Id.* at 410.
6. N.Y. Exec. Law § 292(9).
7. *E.g.*, N.Y. Comp. Code R. & Regs. tit. 8, § 29.2(a)(13) (member of health care profession engages in unprofessional conduct by failing to use appropriate scientifically accepted infection prevention techniques).
8. ADA Principles of Ethics and Code of Professional Conduct, Principle 1-A, Advisory Opinion (1996); Opinion 9.131 of the AMA's Code of Medical Ethics (1992).
9. 42 U.S.C. § 12101 (1990). *U.S. v. Morvant*, 898 F. Supp. 1157 (E.D. La. 1995); *D.B. v. Bloom*, 896 F. Supp. 166 (D.N.J. 1995).
10. 42 U.S.C. § 12102 (1990).
11. *Abbott v. Bragdon*, 912 F. Supp. 580 (D. Me. 1995).
12. *Doe v. Kohn Nast & Graf*, 862 F. Supp.1310 (E.D. Pa. 1994).
13. *Kocsis v. Multi-Care Management, Inc.*, 1996 U.S. App. LEXIS 26783 (6th Cir. 1996).

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Elder Law Update

by Howard S. Krooks*

Several pieces of recent legislation, on the federal and state level, have brought about significant changes in the field of elder law. Specifically, new legislation has been passed which a) criminalizes certain transfers of assets for Medicaid eligibility purposes, b) imposes new restrictions on Medicaid eligibility for legal immigrants, and c) revises New York's statutory short form power of attorney. In addition to discussing these legislative developments, I have included a synopsis of a recent case under article 81 of the Mental Hygiene Law.

Congress Criminalizes Certain Transfers of Assets

The Health Insurance Portability and Accountability Act of 1996 (also known as the Kassebaum-Kennedy bill) was signed into law by President Clinton on August 21, 1996 (the "Act"). As a result of this new legislation, certain transfers of assets made on or after January 1, 1997, for the purpose of qualifying for Medicaid benefits and which result in a penalty period (a period during which an individual does not qualify for nursing home Medicaid benefits) is a federal crime punishable by up to one year in prison and/or a fine of $10,000.

In order to understand the circumstances under which the Act might apply, it is important to first understand which transfers of assets are targeted by the Act (i.e., transfers which result in a penalty period). Medicaid, the joint federal-state program designed to cover the cost of medical care for individuals unable to afford such care, will cover nursing home expenses for qualified individuals, provided that certain financial eligibility criteria are met. In New York State, a person may not possess more than $3,350 in resources and a separate burial account with no more than $1,500. In addition, a Medicaid applicant/recipient may prepay certain funeral expense items which are exempt for Medicaid eligibility purposes.

Medicaid planning may involve the transferring of a portion of an individual's assets in order to accelerate the Medicaid eligibility date. When an individual applies for Medicaid benefits, the local Department of Social Services will review his/her financial documentation for the 36-month period preceding the Medicaid financial eligibility date. If any transfers of assets have been made by the applicant which are not made to a certain category of exempt individuals (discussed below), such transfers will result in a period of ineligibility, during which the individual will not qualify for Medicaid nursing home benefits. The period of ineligibility is determined by dividing the amount transferred by the average monthly cost of residing in a nursing home. The greater the value of the asset transferred, the longer the period of ineligibility will be.

Not all transfers of assets will result in a penalty period for Medicaid eligibility purposes. For example, the transfer of a homestead to a spouse, a child who is blind, disabled or under the age of 21, a sibling with an equity interest in the homestead, or a caretaker child constitutes an exempt transfer and no penalty period is imposed on such a transfer. In addition, transfers of assets between spouses are exempt transfers which do not result in a penalty period. Furthermore, under current New York State law, there is no penalty period imposed on transfers of assets by an individual who then applies for Medicaid home care benefits (as opposed to nursing home benefits). The wording of the statute is quite clear that only transfers of assets which result in the imposition of a period of ineligibility may create criminal liability. Thus, the exempt transfers described above should continue to be permissible (and not result in criminal sanctions) even after January 1, 1997, the effective date of the Act. Furthermore, merely transferring assets alone will not subject an individual to criminal liability under the Act, even if the transfer results in a period of ineligibility. It is the transferring of assets resulting in a period of ineligibility, combined with the subsequent application for Medicaid benefits, that may result in a fine and/or prison term.

The Act has been criticized by the elder law bar as being highly ambiguous and unclear. For example: Suppose that an individual transfers assets for estate planning purposes and not for the purpose of qualifying for Medicaid. Would such a transfer nevertheless be deemed to have been made for the purpose of qualifying for Medicaid should that individual subsequently apply for Medicaid benefits? Or, suppose that an individual submits a Medicaid application where a transfer occurred within the 36-month look-back period but after the penalty period has already expired. Does the Act apply to such a transfer? One of the major criticisms of the Act is that the Medicaid regulations already penalize transfers of assets, and it is unnecessary to take the further step of criminalizing such transfers. Notwithstanding the foregoing, the Act became effective on January 1, 1997. The Act is certain to have a chilling effect on seniors who might otherwise be eligible for Medicaid benefits but who are fearful of coming face-to-face with the criminalization aspect of the Act.

Welfare Act Restricts Medicaid Coverage for Legal Immigrants

Under the Personal Responsibility and Accountability Act of 1996 (the "Welfare Act"), which President Clinton signed into law on August 22, 1996, most legal immigrants who enter the United States will be denied Medicaid eligibility for five years. Under the Welfare Act, much of the responsibility of

administering the nation's welfare system will be transferred from the federal government to the states. While legal immigrants currently residing in the United States and receiving SSI or food stamps will be allowed to do so for up to one year, those legal immigrants presently receiving cash welfare and Medicaid benefits may be denied those benefits after January 1, 1997, at the option of the states. Future legal immigrants will be denied most federal benefits (including Medicaid and public housing) during their first five years in the United States. The Welfare Act further requires sponsors of new immigrants to repay to the federal and state governments any public benefits actually received by legal immigrants. Certain exemptions to the foregoing rules apply to legal immigrants who are veterans, who are currently in the military, or who have worked at least ten years without receiving federal benefits. Also, refugees who are granted asylum under applicable Immigration and Naturalization Service regulations are exempt from these rules. President Clinton has stated that he will try to change some of these restrictions and seek legislation to remedy immigrants' loss of Medicaid coverage and other benefits. However, with the Republicans controlling both houses of Congress, such reform legislation doesn't seem likely to be enacted anytime soon.

Significant Revisions Made to New York's Power of Attorney Statute

Chapter 694 of the Laws of 1994 resulted in significant changes in the statutory short form of general power of attorney under the General Obligations Law (§ 5-1501). These changes were designed to remedy perceived deficiencies in the existing form. For example, it was felt that principals paid little attention to the broad powers granted to attorneys-in-fact conferred by the principal, who merely had to execute the form before a notary public to confer such authority. Thus, one of the most significant changes effected by the 1994 legislation was the requirement that the principal place his/her initials in a box aligned to the right of the respective powers. In 1994, there were 14 different powers in the statutory short form. As many practitioners know, having an elderly person who may be suffering from Parkinson's disease or who may be legally blind place his/her initials in these small boxes can be quite a task. Add to this the practitioner's desire to have multiple originals executed, and you have one major fiasco on your hands as this individual attempts to place his/her initials in over 40 boxes. The 1994 changes were supposed to reduce abuse of the power of attorney and increase a principal's understanding of the form. If anything, the 1994 changes resulted in a more complicated form which was even more difficult to execute.

On August 8, 1996, Governor Pataki signed into law the latest revisions to New York's statutory short form power of attorney, which became effective on January 1, 1997. Some important changes enacted by this new legislation are as follows:

1. There are now three different statutory short forms: the Durable General Power of Attorney, the Non-Durable General Power of Attorney, and the Springing Power of Attorney. The new form in this group, the Non-Durable General Power of Attorney, allowed the legislature to eliminate paragraph "N" from the form, which until January 1, 1997, had to be initialed in order to have the power of attorney survive the subsequent incapacity of the principal.

2. After the 1994 legislation, much confusion surrounded the use of the word "jointly" and "separately" in conjunction with the words "and" and "or" when designating more than one attorney-in-fact. It was possible to specify that each attorney-in-fact could act separately; however, if the word "and" was used in between the designation of each agent, then joint action by both attorneys-in-fact was required, notwithstanding the use of the word "separately." The new legislation resolves this issue by providing two separate lines, one of which should be initialed by the principal: the first line states "each agent may act SEPARATELY," and the second line states "all agents must act TOGETHER."

3. The new legislation permits the principal to designate a successor attorney-in-fact in the event that the primary attorney-in-fact is unable or unwilling to serve.

4. With respect to the many boxes that must be initialed, the new legislation dealt with this problem by adding a catch-all paragraph in the statutory short-form (paragraph Q) which permits the principal to list all of the letters corresponding to the powers s/he wishes to grant on the line to the right of paragraph Q and initial just one box instead of the 14 previously required.

5. Three new powers have been added to the statutory short form: Retirement Benefit Transactions, Gift Transactions and Tax Matters. While it was possible to add these powers to the form prior to the new legislation, provided they conformed to the requirements of the General Obligations Law, the significance of having these powers as part of the standard form is demonstrated by the Gift Transactions power. Prior to the new legislation's taking effect on January 1, 1997, New York case law required that specific language be contained in the power of attorney in order for the attorney-in-fact to be able to make gifts of the principal's property. As of January 1, 1997, this power has been conferred, provided that the principal initials this power. However, the standard power limits the extent of the gifting to the $10,000 annual exclusion amount only to specified individuals, such as the principal's spouse, children, and more remote descendants and parents. Thus, if broader gifting is to be authorized, it still must be specifically stated in the power of attorney document.

Court Revokes Power of Attorney and Appoints Special Guardian for the Sole Purpose of Selling Co-op Shares to Preserve Medicaid Eligibility

Matter of Wingate, N.Y.L.J., August 30, 1996, p. 26, col. 4 (Sup. Ct., Queens County). Josephine Mascalone is a 95-year-old woman currently residing at the Bellhaven Nursing Center located in Suffolk County, having been admitted to Bellhaven in March 1992. Ms. Mascalone suffers from various ailments, including Alzheimer's disease and dementia. Bellhaven is paid from Ms. Mascalone's monthly income, with the remainder being paid by Medicaid. Ms. Mascalone's assets consist solely of shares in a cooperative apartment located in Queens County. On November 11, 1988, Ms. Mascalone executed a power of attorney in favor of her grandniece, Andrea O'Neill.

Petitioner, Suffolk County Department of Social Services, commenced this proceeding to have a special guardian appointed under article 81 of the Mental Hygiene Law with the authority to sell Ms. Mascalone's shares in the cooperative apartment so that she could remain Medicaid eligible. The petitioner contends that the attorney-in-fact is unwilling or unable to sell the cooperative apartment and, therefore has asked the court to revoke the power of attorney. At the hearing, it was established that the attorney-in-fact does not want to be involved in the sale of the cooperative apartment, citing the fact that she lives two counties away and stating that "it would be too much trouble for her."

The court found that Ms. O'Neill did not exercise good faith in her capacity as attorney-in-fact for Ms. Mascalone in that she was unwilling to sell the cooperative apartment, notwithstanding the fact that she was contacted by Medicaid regarding the sale. Thus, having found that Ms. O'Neill breached the fiduciary duty that she owed to Ms. Mascalone, the court revoked the power of attorney. Furthermore, having found the relevant requirements of article 81 satisfied, the court appointed a special guardian for the purpose of selling the cooperative apartment so that Medicaid benefits would not be denied to her.

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Notice From the American Bar Association

The American Bar Association's Commission on Mental and Physical Disability Law is initiating a voluntary campaign to assemble the names and addresses of lawyers who have a special interest in disability law by virtue of their legal practice or their own disabilities. The collected information will be used to form a disability law registry and a directory of lawyers, firms, organizations and agencies that specialize in disability law. This effort marks the first time any national organization has attempted to compile a comprehensive list of disability lawyers. To accomplish this goal, the ABA requests that attorneys who practice disability law and/or who have disabilities, mail, fax or e-mail their names, addresses, telephone numbers and areas of concentration, as well as any other pertinent information to the Commission.

For more information about this data collection effort or to contribute information you may have which will help this effort, please contact the ABA Commission on Mental and Physical Disability Law, 740 15th Street, N.W., Washington, D.C. 20005-1009; Attention Kristi Bleyer, CMPDL. Telephone (202) 662-1570; Fax (202) 662-1032; TTY (202) 662-1012; e-mail kbleyer@staff.abanet.org

Thank you in advance for your help with this effort.

Legislative Update From the Fall 1996 Section Meeting

by David E. Daniels*

As part of the Health Law Section's fall meeting, Section members provided a legislative update.

Joseph K. Gormley discussed Chapter 599 of the Laws of 1996, which makes certain corrections with respect to professional misconduct. This new law amends the Public Health Law to require that within 90 days of any interview of a licensee by the Office of Professional Medical Conduct ("OPMC"), an investigation committee be convened. The new law also provides that any penalty imposed by a hearing committee, other than a penalty of annulment, suspension without stay, or revocation, is stayed if an appeal is taken to the administrative review board. Prior law provided that *any penalty*, without exception, imposed by the hearing committee was stayed by the notice of review.

Ruth Lucas Scheuer discussed several new laws passed by the Legislature. Chapter 56 of the Laws of 1996 amends the Insurance Law and the Public Health Law to establish mandatory minimum maternity care and coverage. Every policy must include inpatient hospital coverage for mother and her newborn for at least 48 hours after a vaginal delivery and 96 hours following a caesarean section. If the mother chooses to be discharged earlier, the policy must cover at least one home care visit in addition to, rather than in lieu of, any home health care coverage available under the policy. The request for such coverage can be made within 48 hours of a vaginal delivery or within 96 hours of a caesarean section; the coverage must be provided within 25 hours after discharge or at the time of the mother's request, whichever is later. The law also covers education in breast or bottle feeding.

Chapter 220 of the Laws of 1996 requires regulations to establish and implement testing of newborns for antibodies to the human immunodeficiency virus (HIV) and requires that those results be provided to the mother or her legal representative. The proposed regulations have been distributed and comments were due by November 30, 1996.

Chapter 497 of the Laws of 1996 amends the Civil Rights Law and the Insurance Law relating to genetic testing. The new law requires that a prior written informed consent be obtained from the individual prior to genetic testing of that person's biological material. The statute sets forth the requirements of the written informed consent; a general waiver of the consent is not valid. The law also requires that the biological sample be destroyed within 60 days after the sample is taken. There is a limited exception for medical research. The results of the test may not be incorporated in the records of a nonconsenting individual genetically related, nor can the results be communicated to that individual.

Finally, Chapter 204 of the Laws of 1996 amends the Executive Law, prohibiting genetic testing by employers, labor organizations, and licensing agencies except where the test is directly related to the occupational environment, in that the employee or applicant with a particular genetic anomaly might be at an increased risk of disease.

David E. Daniels addressed the new legislation that replaced NYPHRM. The New York Health Care Reform Act of 1996 ("NYHCRA"), Chapter 639 of the Laws of 1996, implements a system of negotiated rates for all non-Medicare payors. Effective since January 1, 1997, Blue Cross, commercial insurers, HMOs, and self-insured plans must negotiate rates for inpatient services. Medicaid rates for inpatient services will continue to be set by the state until 1999.

NYHCRA also provides financing and allocation for public good programs, and three pools have been established for indigent care, health care initiatives, and graduate medical education. These pools are funded through Patient Services Payments, which require payors to pay a surcharge, based on net patient service revenues, of 8.18%, plus 24%, to designated providers of services, unless an election is made to pay the allowance directly to the Commissioner, in which case the total percentage allowance is reduced to 8.18%. Most payors are expected to elect direct payment in order to avoid the additional 24% surcharge.

NYHCRA also establishes Integrated Delivery Systems ("IDS"), which allows these entities to deliver a full array of health services to a defined population for a determined price and to accept risk. The statute defines who may set up an IDS, provides for Commissioner of Health and Commissioner of Insurance oversight, sets fiscal solvency standards, and defines the range of services to be provided.

Anne Maltz discussed Chapter 77 of the Laws of 1996. This new law amends the Public Health Law and the Insurance Law in order to regulate the delivery of managed health care by HMOs, insurance companies that use HMOs, and utilization review companies. It provides for the written disclosure of certain information to prospective subscribers concerning the benefits, exclusions, and limitations of the HMO's products, as well as information concerning the HMO's operations. The law also establishes minimum standards for HMO grievance procedures including time frames, reviewer qualifications, and appeal rights. In addition, the law establishes various protections for providers who are members of the HMO's provider network. It requires HMOs to give the provider notice of the reasons for an HMO's decision to terminate a contract and to allow the provider the opportunity to request a hearing or review of the decision. The law also prohibits HMOs from terminating or refusing to renew a contract solely because the provider advocated on behalf of a patient, filed a complaint, or requested a hearing. It also would prohibit HMOs and insurers from including "gag clauses" in their contracts with providers that prohibit or restrict providers from disclosing to enrollees or prospective enrollees information regarding their treatment,

or prohibit or restrict a provider from advocating on behalf of an enrollee. However, the law provides that an HMO's decision not to renew a provider's contract, in effect for at least one year, is not considered a termination and would not trigger a provider's right to a hearing. The legislation also standardizes the process by which HMOs determine whether treatment is for an "emergency condition" and gives patients the right to appeal such decisions. In addition, the law sets standards for the operation of utilization companies. Lastly, the law requires HMOs to report to the appropriate disciplinary agency any suspension, termination, or curtailment of employment or professional privileges of any licensed health care provider for reasons of impairment, incompetence, malpractice, or misconduct.

Thomas G. Smith, Chair of the Section's Committee on Payment Issues and a health care litigator with the Rochester-based firm of Harter, Secrest & Emery, examined "The Right of Health Care Providers to Adequate Medicaid Reimbursement — Today and Tomorrow." The current debate about financing care for the poor — and the enormous political pressure to slash Medicaid budgets at the state and federal levels — threatens providers as never before. As Congress moves to repeal the Boren Amendment, the federal statute that protects institutional providers from inadequate reimbursement, it is uncertain what legal recourse providers may have to hold states accountable for the cost of caring for the indigent.

In his presentation, Tom Smith explored how the courts historically have enforced the Boren Amendment and related rate-setting standards under state law to ensure that providers are not short-changed in their reimbursement rates. He then explored how the state and federal constitutions may need to be employed to prevent the government from foisting a disproportionate social and economic burden upon providers by forcing them — via deficient reimbursement — to subsidize care for the poor. While recognizing that the Fifth Amendment right to just compensation for the government's taking of private property has not yet been extended to those who "voluntarily" participate in the Medicaid program, Mr. Smith examined how that provision may offer the only recourse if the government removes its statutory duty to pay adequately for Medicaid care. Based upon its reasoning in "takings" decisions over the past ten years, the United States Supreme Court may be receptive to a challenge of this nature.

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Volunteers Sought

The Surrogate Decision-Making Committee Program ("SDMC" or "the Program"), an innovative program authorized by New York State Mental Hygiene Law article 80 and administered by the New York State Commission on Quality of Care for the Mentally Disabled, is seeking volunteers. The Program is an award-winning, quasi-judicial alternative to the courts to provide consent or refusal for major medical treatment on behalf of mental hygiene facility residents who are unable to provide their own informed consent and who have no family or guardian to provide surrogate consent on their behalf.

An attorney is required to be one member of a four-member decision-making body. The Program also needs medical professionals (medical doctors, nurses, clinical social workers, and other licensed health care professionals), family (persons who have been consumers of mental hygiene services or who have family members who have been consumers), or advocate members (persons with expertise or demonstrated interest in the care of the mentally disabled). Attorneys are encouraged to share this information with colleagues, family, and friends who may qualify as SDMC panelists.

Travel expenses for participation are reimbursed by the Program, and panel members, as "public officers," automatically are provided defense and indemnification under state law. The Executive Committee of the New York State Bar Association has not only endorsed participation in this program by attorneys, but it has also recognized the *pro bono* nature of such service since January 31, 1989.

One day of training is required and provided by the Commission. All cases to be reviewed by the panelists are analyzed by Commission staff and panel members in advance of the hearing held pursuant to the Mental Hygiene Law article 80. Panel determinations are, in most cases, made immediately after the hearing. The nature of these procedures allows the panel member to select the amount of participation which is conducive to his or her other obligations during a specific period of time.

SDMC panels are currently authorized in the following counties: New York, Kings, Queens, Richmond, Bronx, Rockland, Albany, Schenectady, Rensselaer, Schoharie, Columbia, Greene, Dutchess, Ulster, Putnam, Fulton, Montgomery, Warren, Washington, and Saratoga.

For more information or for a complete package of informative materials and an application, interested persons should contact: Surrogate Decision-Making Program, New York State Commission on Quality of Care for the Mentally Disabled, 99 Washington Avenue, Suite 1002, Albany, New York, 12210, (518) 473-8683. The next training is scheduled for March 27, 1997 in Albany and a training in New York City in May is contemplated.

For Your Information

by Claudia O. Torrey*

The federal government is keeping a close watch on Health Maintenance Organizations ("HMOs") that contract with Medicare. In October 1996, the Department of Health and Human Services' Office of Inspector General and the Health Care Financing Administration's Office of Managed Care produced a Medicare beneficiary advisory manual. The manual,[1] entitled "What Medicare Beneficiaries Need to Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights," is designed for consumers in order to give them an idea of the type of managed care practices/abuses the federal government will investigate, and perhaps prosecute.

According to the manual, there are two types of Medicare-contracting HMOs — risk HMOs and cost HMOs. The manual concerns itself exclusively with risk HMOs. A risk HMO plan requires subscribers to receive all of their health care through the plan's physicians, hospitals, home health agencies, etc. Thus, subscribers are "locked-in" to their HMO for all of their medical care needs. Of course, emergency/urgent care, in or out of one's HMO area, can be provided by non-plan providers. In fact, the manual states that some plans may offer a point-of-service option that allows members to use non-plan providers in certain cases.

The manual covers enrollment, disenrollment, Medicare HMO medical services rights, and complaint procedures. The clear message emanating from the manual is that Medicare-contracting HMOs should not attempt to "cherry pick" the healthiest customers. Medicare-contracting HMOs that choose to delve into this type of activity do so at their own peril.

Some of the manual warnings given to enrollees and potential enrollees of Medicare-contracting HMOs include:

- Pre-enrollment health screenings or questions about one's health or physical status are against the law. Exceptions to this rule are questions concerning receipt of a kidney transplant, kidney dialysis, and/or hospice services.
- It is improper for a Medicare-contracting HMO to offer free physical exams before enrollment, or free screening/diagnostic tests at health fairs or at marketing presentations.
- It is illegal for an HMO to offer people free gifts or incentives to get them or anyone else to enroll in an HMO. It is legal for the HMO to offer promotional materials worth less than $10, as well as light refreshments at a marketing presentation, so long as such items are given to everyone regardless of their decision to enroll.
- A Medicare-contracting HMO *must not* encourage subscribers to disenroll by delaying or denying expensive medical care, or by telling subscribers that they can re-enroll in the HMO after they receive their necessary expensive services outside of the HMO.
- A Medicare-contracting HMO *must* pay for emergency care and for unforeseen, urgently needed, out-of-area care a subscriber receives from non-HMO health care providers, including necessary follow-up care.
- Medicare-contracting HMOs *must* have written procedures, including time frames, for investigating complaints.
- Subscribers have a right to appeal if they believe that medically necessary care has been reduced, denied or inappropriately terminated.

The manual also includes important telephone numbers for Medicare recipients, and a quiz on the information within the manual.

We, in the legal community, will probably see more and more advisory bulletins/manuals from the government as managed care continues to flourish. To coin a cliché, to be forewarned is to be forearmed. Medicare-contracting HMOs that are concerned about governmental compliance issues may want to consider hiring a neutral, outside expert for guidance.

Endnote

1. U.S. Department of Health and Human Services/Office of Inspector General Publication OIG 96-02, Health Care Financing Administration Publication HCFA 10934, *What Medicare Beneficiaries Need to Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights* (1996).

***Claudia O. Torrey can be reached at P.O. Box 150234, Nashville, Tennessee 37215. She previously served in the New York State Senate as an Assistant Counsel covering several legislative committees, including Aging and Health.**

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Representing People with Disabilities, 2d Edition

This newly organized and updated second edition of *Representing People with Disabilities* is a comprehensive reference encompassing the myriad legal concerns of people with disabilities. The general practitioner, the specialist and the nonlawyer advocate all will benefit from the extensive coverage on topics such as special education, government benefits for the disabled, substituted decision making, community residences, AIDS legal issues, substance and alcohol abuse, and the criminal justice system.

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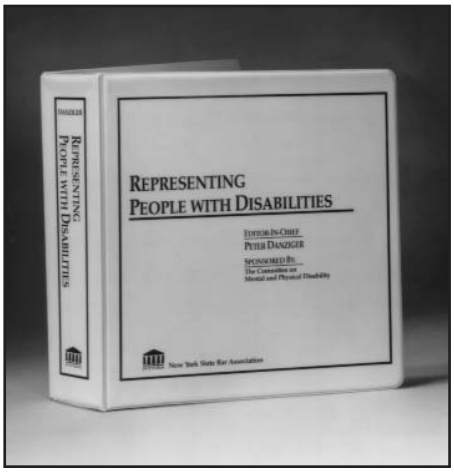

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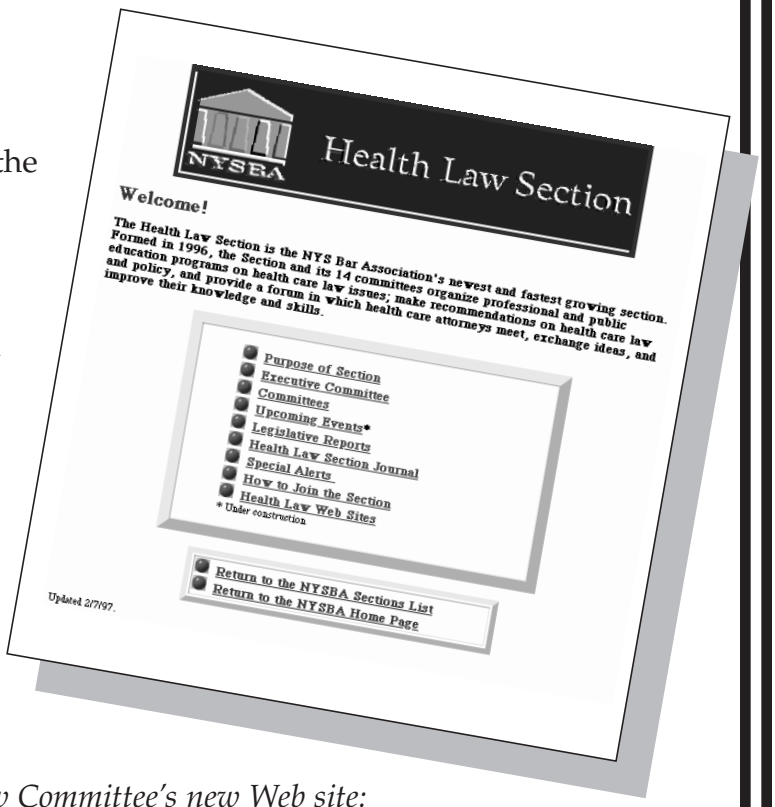

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Reception to Follow — Matthew Bender Classroom

Agenda

3:00 p.m. Introductory Remarks

Jonathan Rosen, M.D.
Albany Medical College

3:20 p.m. Palliative Care & Pain Management

Moderator: Benita Zahn
Health Reporter, WNYT Channel 13

Speakers to be announced

4:00 p.m. Legal and Medical Issues

Moderator: Professor Dale L. Moore
Albany Law School

Peter J. Millock, Esq.
Nixon, Hargrave, Devans & Doyle, LLP

Carl H. Coleman, Esq.
Executive Director
New York Task Force on Life and the Law

Carolyn Shearer, Esq.
Deputy Counsel
Albany Medical Center

5:00 p.m. Coffee Break

5:15 p.m. Panel on Bioethics

Moderator: Professor David A. Pratt
Albany Law School

Bonnie Steinbock, Ph.D.
Professor, University at Albany/
State University of New York

John A. Balint, M.D.
Professor of Medicine & Director
Center for Medical Ethics
Albany Medical College

Wayne Shelton, Ph.D.
Associate Professor & Associate Director
Center for Medical Ethics
Albany Medical College

6:00 p.m. Policy Alternatives for New York

Honorable Richard N. Gottfried
State Assemblyman
Chair, Assembly Committee on Health

Georgia Nucci, Esq.
Assistant Counsel
Office of State Senator Roy M. Goodman

Richard E. Barnes, Esq.
Legislative Counsel
New York State Catholic Conference

H. William Batt, Ph.D.
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7:00 p.m. Reception, Matthew Bender Classroom

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