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Health Law Journal

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

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PACE UNIVERSITY SCHOOL OF LAW
HEALTH LAW AND POLICY PROGRAM

A Message from the Section Chair

It was a pleasure to get together as a Section at our Annual Meeting. I hope that you found the program on the health care Internet engaging and informative.

The New York State Bar Association has just completed a survey to assess how well it is serving the needs and interests of its members, and how it can do a better job. I was one of the members called randomly to participate, and commend the Association for taking the pulse of its members. The 20-minute survey covered a host of member services ranging from access to information on the Association Web site to CLE programs and discount life insurance rates. While these no doubt are services valued by members, I realized as the call ended that none of the survey questions had addressed the principal reason I have enjoyed participating in the Association and the Section during these past five years. That reason is the opportunity to work with colleagues to advance public consideration of important health care issues in New York State. In fact, the Health Law Section has an extraordinary resource in the expertise represented in its membership and the Executive Committee to achieve this goal.

The Section has made a significant contribution in past years to consideration of legal and policy questions on the State's health care agenda, and we are in the process of doing so again in this legislative session. At its March 29, 2001 meeting, the Executive Committee approved recommendations developed by the Committee on Medical Information on pending privacy legislation. The Executive Committee also approved recommendations crafted by the Special Committee on Treatment Decisions for amendments to the Family Health Care Decisions Act that would simplify the Act and address issues that have proven controversial. The Family Health Care Decisions Act covers decisions about treatment, including life-sustaining treatment, for patients who have lost decision-making capacity and have not signed a health care proxy.

In addition, the Executive Committee agreed at its March meeting to rely on the Section's committees and the work of Executive Committee members to produce reports on legislative bills that address a host of policy questions: initiatives to control the spiraling costs of prescription drugs (A.1705-A/S.114-A; A.2098; A.5967; A.4167); licensure and standards for genetic counselors (A.2360/S.2471); increased mandatory reporting of medical errors (A.5550); oversight and incident reporting for office-based surgery (A.5549/S.3458; A.5548/S.3457); patient confidentiality (A.7185; A.4230/S.2330), and telemedicine (A.6712/S.3417).

The Health Law Section has developed legislation on the new reproductive technologies that was unanimously approved by the NYSBA Executive Committee in March 2001. Proposed by the Committee on Biotechnology, the legislation would amend Domestic Relations Law § 73 to create legal standards for determining the parentage of children born of assisted reproduction arrangements, including egg and embryo donation.

Existing law provides that when a married woman undergoes artificial insemination with her husband's consent and a physician performs the procedure, the wife's husband is the father of the child born for all legal purposes. The law is silent on the parentage of children born following egg and embryo donation. Parallel to the provisions of existing § 73, the proposed amendments would establish that any child born to a married woman by means of assisted reproduction, whether the genetic material is hers or provided by egg or embryo donation, would be the child of the woman and her husband for all legal purposes.

As discussed at the Section's Annual Meeting program on the health care Internet, New York and other states will increasingly face complex questions as the practice of medicine online becomes more prevalent. In the coming months, the Section will convene a special committee to recommend policy for New York State and nationally on the issue of licensure and oversight of professional practice across state lines. The special committee will examine regulatory alternatives that recognize the need for national standards and oversight as well as the advantages of local enforcement by state government of professional practice.

It has been a privilege and a pleasure to serve as Chairperson of the Section. I thank you for the opportunity, and look forward to working with Robert Abrams in the weeks ahead in the transition to his leadership of the Section.

Tracy E. Miller

In the New York State Courts

Restrictive Covenant Enforced Against Physician

North Shore Hematology/Oncology, et al. v. Zervos, 717 N.Y.S.2d 250 (2d Dep't 2000). After defendant Dr. Zervos left the employ of plaintiff North Shore Hematology/Oncology, plaintiff sued to enjoin Dr. Zervos from: (a) soliciting plaintiff's patients; (b) soliciting medical professionals who have referred patients to the plaintiff; (c) maintaining a hematology/oncology office within three miles of the plaintiff's office; and (d) retaining fees for professional services rendered by the plaintiff pending determination of this dispute. Relying on the general rule that covenants restricting a physician from competing with a former employer or associate are generally acceptable if reasonable as to time, area and the interests protected, the Appellate Division, Second Department affirmed the grant of plaintiff's motion for a preliminary injunction that enforced the terms of the restrictive covenant.

Hospital Is Not Required to Produce Information Collected as Part of Quality Assurance Review Investigation

VanBergen v. Long Beach Medical Center, et al., 717 N.Y.S.2d 191 (2d Dep't 2000). The plaintiff VanBergen filed suit against the defendant Long Beach Medical Center (the "Hospital") and several individuals for injuries sustained as a result of plaintiff's treatment at the Hospital. The plaintiff attempted to compel the Hospital to produce for deposition the employee who conducted the quality assurance investigation related to plaintiff's care at the Hospital. The trial court denied the motion.

The Appellate Division upheld the denial of plaintiff's motion to compel. First, the court clarified that the right to designate which of the Hospital's officers would be produced for purposes of the deposition belonged to the Hospital, and not the plaintiff. Thus, the Hospital could not be compelled to produce a designee not of its choosing. In addition, the court found that the employee who conducted the quality assurance investigation was immune from submitting to a deposition under New York Education Law § 6527(3), as the law "is designed to encourage peer review of physicians by guaranteeing confidentiality to those persons performing the review function." The court cautioned, however, that New York Education Law § 6527(3) did not extend protection to persons whose conduct was the subject of review. Thus, to the extent that statements made by a party to the action resulted from the quality control review process, such statements were not immune and were required to be disclosed to the plaintiff.

Hospital Not Liable for Sexual Assault of Patient by Medical Resident, as Conduct Is Deemed Outside the Scope of Physician's Employment and Not Reasonably Forseeable Absent History of Sexual Misconduct

N.X. v. Cabrini Medical Center, 719 N.Y.S.2d 60 (1st Dep't 2001). The plaintiff underwent a surgical procedure at defendant Cabrini Medical Center ("Cabrini"). While in the recovery room and still feeling the effects of anesthesia, the plaintiff was sexually assaulted by a surgical resident, Dr. Favara. Plaintiff claimed, and Cabrini did not dispute, that there were several nurses present in the recovery room at the time of the assault, and that these nurses were not aware that Dr. Favara was improperly touching the plaintiff. After the resident left the recovery room, however, the plaintiff informed one of the nurses of the assault. The nurse immediately investigated the incident, which led to Dr. Favara's immediate suspension and ultimately, his termination.

Plaintiff filed suit against both Dr. Favara and Cabrini. Plaintiff claimed that Cabrini was negligent in its hiring and supervision of Dr. Favara, and was vicariously liable for his conduct as it occurred within the scope of his employment.

The Appellate Division for the Second Department, over the dissent of two justices, held that Cabrini was not responsible for Dr. Favara's conduct under any legal theory asserted by the plaintiff. As a threshold matter, the court determined that Cabrini was not vicariously liable for the sexual assault by Dr. Favara, pursuant to the Court of Appeals ruling in *Judith M. v. Sisters of Charity Hosp.*, 93 N.Y.2d 932, 693 N.Y.S.2d 67 (1999) (reported in the Summer/Fall 1999 issue of NYSBA's *Health Law Journal*). The Appellate Division also cited the general rule that an employer is not vicariously liable for the tortious acts of employees unless those acts are committed in furtherance of the employer's business. The court found that "a sexual assault committed by a physician can never be considered a mere deviation from the physician's role as a provider of medical care." Thus, the court determined that the medical resident committed the sexual assault for his own satisfaction and not in furtherance of Cabrini's provision of medical treatment.

In addressing the question of whether Cabrini negligently supervised Dr. Favara, the court framed the issue in terms of whether Cabrini's nurses in the recovery room were obligated to prevent the attack on plaintiff. Plaintiff contended that the nurses were required to stop the resident before he entered the recovery room to assess his intentions, reasoning that Cabrini had a "heightened duty" due to plaintiff's condition after surgery. The court rejected plaintiff's argument, reasoning that although a hospital has a duty to exercise reasonable care and diligence to protect its patients, this duty is not boundless—it extends only to harms that are "reasonably foreseeable." Since Dr. Favara had no history of sexual misconduct, the court found that the mere possibility that he would assault a patient was too remote to be considered reasonably foreseeable. Further, the court found that to require the nurses to supervise all interactions

between doctors and their patients was unmanageable, and would constitute a burden on the hospital that was disproportionate to the risk being addressed.

Life Insurance Company Has No Duty to Disclose Health Information to Prospective Insured

Petrosky v. Brasner, 718 N.Y.S.2d 340 (1st Dep't 2001). Plaintiff's husband died of a heart attack shortly after undergoing medical tests in connection with his application for life insurance. The plaintiff commenced a negligence action against the life insurance company, insurance agent, brokerage firm, and the independent medical examination service company, including the technician who performed the subject medical tests on behalf of the insurer. Her negligence claim was premised on the theory that all of these defendants had a duty to disclose the results of her husband's physical examination which allegedly would have revealed his heart abnormalities.

The motion court disagreed with this theory and granted summary judgment dismissing the complaint. The court held that an insurer and its agents do not have a duty to obtain or disclose to a prospective insured medical conditions discovered during a pre-insurance physical examination. The Appellate Division affirmed—refusing to assume the role of the Legislature by creating such a duty. The alleged foreseeability of her husband's death did not create the existence of a duty upon an insurer or its agents to disclose health information. Plaintiff's husband was specifically advised that the medical tests were being administered solely for purposes of the application process and not for purposes of treatment. Thus, plaintiff could not have reasonably relied upon the insurer or its agents for health information. However, had the defendants misled or induced him to forgo necessary treatment, liability may have been imposed upon them.

The court also rejected plaintiff's argument that Insurance Law § 2611(c) created a broad duty of disclosure, since that statute applies to discovery of HIV-related conditions, which were not present in this case.

Pharmacies May Have Fiduciary Duty to Maintain Confidentiality of Customer's Medical Information

Anonymous v. CVS Corp., New York County Index No. 604804/99, N.Y.L.J., Mar. 9, 2001, p. 19, col. 6 (Sup. Ct., New York Co.). Defendant Trio Drugs, a local pharmacy, ceased doing business and sold its customer medical profiles to CVS, a national drugstore chain. In fact, CVS had purchased the customer profiles of approximately 350 independent pharmacies through its "File Buy Program." Plaintiff, who filled his HIV-related prescriptions at Trio Drugs, commenced a class action asserting that the defendant pharmacies violated their statutory and fiduciary duty of confidentiality. Plaintiff alleges that the File Buy Program prevented individuals from being notified prior to the transfer of their medical profiles, and once the information was transferred, it was accessible to tens of thousands of CVS employees and the health care plans that contract with CVS.

Defendants moved to dismiss. The motion court (Ramos, J.) dismissed four counts of the complaint since these counts alleged violations of statutes that did not contemplate liability for the transfer of prescription and medical information between pharmacies. However, Justice Ramos ordered a trial on several issues.

The issue of whether a pharmacist owes a fiduciary duty of confidentiality is one of first impression in New York. A fiduciary duty arises, even in a commercial transaction, where one party reposes trust and confidence in another who exercises discretionary functions for the party's benefit or possesses superior expertise on which the party relied. The court found that such a duty may be implied from the circumstances, and thus the pharmacies' sale of customer's medical information without their consent raised a triable issue.

The court also found that the pharmacies' conduct in intentionally declining to give customers notice of an impending transfer of their critical prescription information, so as to increase the saleable value of the customer's file, appeared deceptive and stated a claim under New York's General Business Law § 349.

Persons Who Witness Negligent Treatment of Their Relatives by Hospice May Not Claim Damages for Emotional Distress

Yates v. Genesee County Hospice Foundation, Inc., 718 N.Y.S.2d 765 (4th Dep't 2000). An estate administrator brought an action seeking damages for emotional distress against a hospice care center and several of its staff and employees who treated the decedent. The plaintiff claimed that she suffered from emotional injuries as a result of witnessing allegedly negligent care provided by defendants.

The Court held that there was no common law or statutory duty to protect the plaintiff or any of the decedent's relatives from emotional injuries sustained as a result of witnessing negligent care. The court further held that no such duty may be fairly implied in the definition of hospice in Public Health Law § 4002(i), nor may it be implied in the rights of hospice patients and their relatives under 10 N.Y.C.R.R. § 794.1(a). Thus, plaintiff's claims for damages could not be maintained.

Exception to Employee-At-Will Doctrine Applies to Physician Fired by Non-Medical Entity

Horn v. New York Times, 2000 WL 187366 (Sup. Ct., New York Co. 2000). In *Weider v. Skala*, 80 N.Y.2d 628 (1992), the Court of Appeals endorsed a narrow exception to the employee-at-will doctrine. The Court permitted a wrongful discharge claim by an attorney allegedly fired by a law firm in retaliation for his insistence that the partners report professional misconduct by another associate. The Court reasoned that the nature of the legal profession's "self-regulation" and its requirement that its members report dishonesty "is nothing less than essential to the survival of the profession."

In *Horn v. New York Times*, a trial court in New York County ruled that the *Weider* exception applies to a physician employed on an at-will basis by a non-medical entity—*The New York Times.* The plaintiff physician alleged that the *Times* directed her to provide it with confidential medical records of *Times* employees, without the employees' knowledge or consent. The physician also alleged that the *Times* instructed her to misinform employees regarding their illnesses so as to reduce the volume of workers' compensation claims. After writing to the Department of Health and receiving advice that these actions would be contrary to her legal and ethical duties, the physician advised the *Times* of that conclusion and refused to comply with the *Times*'s directives. Shortly thereafter, her position was eliminated.

The court held that the physician had alleged sufficient facts for the court to find that her department at the *Times* could be treated as an "in-house" medical office. Thus, the court found that the mere fact that the *Times* was not a medical entity did not defeat application of the *Weider* analogy. Second, the court found that physicians have an ethical duty to protect patient confidentiality, and violation of that duty constitutes professional misconduct under Education Law § 6530. Significantly, the court ruled that "nothing in the law makes a physician's duty of confidentiality and honesty any different depending on whether the patients being treated are employees of the doctor's employer or are private patients." Because "no physician should be placed in the position of choosing between . . . retaining employment or violating ethical standards . . .," the court applied the *Weider* exception and permitted the physician to pursue a claim for breach of an implied contract of employment.

Hair Transplant Advertising Gives Rise to Consumer Fraud Claim Against Physician and Medical Practice

Abrams v. Handler, N.Y.L.J., Jan. 26, 2001, p. 26, col. 3 (Sup. Ct., New York Co.). This case arises from a patient's disappointment with a series of hair transplant treatments and the defendant physicians' alleged failures to live up to promises made in an infomercial and video promotion.

In 1978, two of the defendant physicians, Hitzig and Handler, formed a P.C. In 1996, the third physician defendant, Schwinning, joined the P.C., and the physicians began practicing under the name Long Island Medical Associates or LIMA. In 1997, Schwinning and Hitzig formed an LLC without Handler. The LLC did no business until May 1998, the date on which the P.C. declared Chapter 7 Bankruptcy. The LLC retained many of the same employees and purchased some but not all of the P.C.'s assets.

In 1995, plaintiff Abrams consulted with Dr. Handler (a shareholder with the P.C., but not the LLC) after viewing an infomercial promising, *inter alia*, a full natural head of hair. At his first visit, Abrams alleged he was shown a video which made even more promises about the results, including the promise that "he would never go bald again." Based on these statements, Abrams agreed to treatment by Dr. Handler. These treatments were performed between October 1995 and March 1997 at the P.C.'s offices.

Abrams was not happy with the treatments, and sought to hold liable the P.C., the LLC, and the physicians independently (and jointly and severally as partners) for, *inter alia*, medical malpractice, breach of contract, and violation of General Business Law §§ 349 and 350 (deceptive trade practices and false advertising). The court's decision stems from various motions and cross-motions directed at who is properly a defendant, and to dismiss various causes of action including the GBL causes of action.

The court allowed the LLC to remain as a defendant, holding that the plaintiff had alleged facts sufficient to demonstrate that it could be held as a "successor" entity to the P.C. The court made this finding based on the "de facto merger" exception to the general rule that a corporate entity which purchases the assets of another is not liable for the torts of its predecessor. On this issue, the court noted the timing of the cessation of the P.C.'s operations and the commencement of the LLCs, and the LLC's continued use of the P.C.'s phone number, indicated a de facto merger.

The court also refused to allow defendants Hitzig and Schwinning to be dismissed from the case. Although the court recognized that they could not be held liable by virtue of piercing the corporate veil, or under the theory that by practicing under the name LIMA they were holding themselves out as "partners" with Handler, the court did allow them to be held vicariously liable for their alleged failure to properly supervise the P.C.'s non-professional employees.

The court allowed plaintiff's breach of contract claim to proceed against the P.C. and Handler (but not against the LLC or the other individual defendants). The court held that the video and other promotional tools made express and special promises to effect a cure, and that these express and special promises were actionable separate and apart from medical malpractice claims. The court also allowed the plaintiff to proceed on his GBL claims, finding that the promotional tools used and the promises made fell directly within the Court of Appeals' holding in *Karlin v. IVF America, Inc.*, 93 N.Y.2d 282 (1999), that medical professionals who reach out to consumers at large can be held liable for deceptive trade practices and false advertising.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a partner at Garfunkel, Wild & Travis, P.C., a full-service health care firm representing hospitals, health care systems, physician group practices, individual practictioners, nursing homes and other health-related businesses and organizations. Mr. Rosenberg's practice is devoted primarily to litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation and directors' and officers' liability claims.

In the New York State Legislature

Legislative sessions, like some prize fights, begin with the principal combatants circling each other in the ring, assessing the intentions, skills and styles of the other party, keeping the ultimate strategy or fight plan to themselves as they wait for their opponents to commit themselves. As a result, legislative reports issued in the early months of the session—particularly those that focus on non-budgetary items—are notably weak on detail or, at least, on result.

Much of the Legislature's focus from January through at least April (if not May and June) is the Executive Budget. Proposed by the Governor in mid-January, budget recommendations form the basis for legislative hearings soon thereafter, internal budget subcommittee action, preparation and enactment of one-house budget resolutions and the convening of budget conference committees to iron out the budgetary differences. Health care and related fields occupy a large part of the Executive Budget—health spending accounts for over 29% of the Governor's proposed budget—and much of the health care legislative debate in the early months of the year concerns often recurring proposed cuts or restraints on Medicaid spending.

While the 2001-2002 Budget remains unresolved as of this writing (and may remain so long thereafter in what has been predicted to be an unusually contentious budget process), another set of health care issues, related to women's health and wellness, emerged as among the most significant controversies in the early stages of the 2001 legislative session.

Over the past several years, proposals have been advanced to augment or add health screening or treatment benefits of particular interest to women that would be required to be part of health insurance coverage. When other legislation was enacted to require coverage of prostate screening services before a number of these women's health initiatives were passed, these proposals took on increased political and legislative urgency and both houses readied legislation to be considered early in 2001 to address these concerns.

Two different proposals became the principal vehicles for each house to respond to the growing political and media attention to these issues: in the Assembly, A.2006, principally sponsored by Assembly members Glick, John, Gottfried, Grannis, among others, reflected the Assembly Democratic proposal; in the Senate, S.3, sponsored by Senate Majority Leader Joseph Bruno and Senators Bonacic, Rath, Hannon, Seward and others, represented the Senate position. Both Houses passed their bills in January. Soon thereafter, Assembly Speaker Sheldon Silver and Senate Majority Leader Bruno convened a conference committee—a relatively rare event for the State Legislature—to attempt to iron out the details of the proposal.

In general, the two versions of the legislation address many of the same issues, in relatively similar fashion. Both would mandate insurance coverage of bone density measurements, a critical screening test for evidence of osteoporosis: the major distinction, likely to be resolved, relates to the appropriate standards to be employed in determining the measures, drugs and devices to be employed in providing this coverage. Both would also expand coverage of mammography for breast cancer screening and detection, generally mandating coverage of annual mammograms at age 40 (at least if recommended by the primary care physician). Both would also mandate those plans that offer prescription drug coverage must provide coverage for contraceptive drugs and devices.

This last provision has, however, sparked the greatest debate and controversy and may result in a legislative stalemate over the legislation. In the Senate bill, the requirement is made subject to an exception, termed the "conscience clause," related to religious organizations. Pursuant to the Senate proposal, if the coverage is being offered on behalf of a group or entity that is "operated, supervised or controlled by or in connection with a religious organization, denominational group or entity" or is being covered by an insurer or HMO with such a religious affiliation, the mandate would not apply if such coverage would be contrary to the religious tenets of the organization.

Early in the debate over the provision, it appeared that there might be opportunities for compromise, through narrowing the definition of the "religious organization" along the lines adopted by other states facing the same political, legal and religious dilemma. The strong position taken by the newly installed Cardinal Egan of the New York Archdiocese, matched by equally strong positions taken by the Assembly sponsors of the legislation, leave the issue unresolved as of this writing, with opportunities for compromise diminishing. After a series of meetings of the conference committee, the fairly contentious and increasingly acrimonious discussions led to a decision to curtail the conference committee process, leaving the passage of an agreed-upon bill in doubt.

It would seem unlikely that the Legislature would conclude this session without an agreement on the issue, given the bipartisan support for so many of its provisions. Reading agreement on the "conscience clause" issue will, however, require an extraordinary degree of compromise and skill—and patience from the advocates on both sides of the issue.

Compiled by James W. Lytle, resident partner, and Ami Schnauber, Legislative Coordinator, from the Albany offices of Kalkines Arky Zall and Bernstein, LLP. The firm devotes a substantial part of its practice to health care and government relations.

In the New York State Agencies

Expanded Syringe Access

Amendment of §§ 80.131 and 80.137 of Title 10 N.Y.C.R.R. The Department of Health adopted these regulations on an emergency basis to protect the public health by allowing the sale and furnishing of hypodermic needles and syringes without a prescription. The amendments include definitions, requirements for registration of authorized providers, and guidelines for pharmacy sales of syringes and needles. Filing date: December 13, 2000. Effective date: January 1, 2001 through March 31, 2000. *See* N.Y. Register, December 27, 2000.

Medicaid Payments for Hospital Outpatient Programs, ACT

Pursuant to Public Health Law § 2807(11), the Department of Health proposed to amend Title XIX (Medicaid) State Plan for hospital outpatient services by developing, implementing, and operating a pilot reimbursement program for general hospital outpatient services that are prospective and associated to the resource use patterns in rendering ambulatory care services. The pilot reimbursement program will, for a period of three years, determine the efficacy of funding certain Hyperbaric Oxygen Therapy services provided by select hospitals. Six hospitals will be chosen for the program and will be expected to submit quarterly reports to the Department. Effective date: January 1, 2001. *See* N.Y. Register, December 27, 2000.

The Department of Health and the Office of Mental Health also proposed to amend Title XIX for ambulatory mental health services pursuant to Chapters 408 and 54 by making medical assistance reimbursement available for all Assertive Community Treatment Programs. The Office of Mental Health will provide program standards and detail Medicaid payment requirements, while the Department of Health will amend 18 N.Y.C.R.R. § 505.25 to conform to the Office's regulations. Effective date: January 1, 2001. *See* N.Y. Register, December 27, 2000.

External Appeal Program

Emergency rule making. The Department of Health renumbered Part 98 to Subpart 98-1 and added sub 98-2 to Title 10 N.Y.C.R.R. for the purpose of implementing an external appeals program. The proposed rules provide guidance to health care plans, enrollees of health care plans and external appeal agents in implementing the requirements of Chapter 586 of the Laws of 1998. The proposed rules include definitions, a standard description of the external appeal process, certification of the external appeals agents, and certification requirements. Filing date: December 5, 2000. Effective December 5, 2000 through February 14, 2001. *See* N.Y. Register, December 20, 2000.

New Fee Schedule for Radiation Protection Program

Proposed Action: Amendment of §§ 16.10, 16.21, 16.40, 16.41 and 16.50 of Title 10 N.Y.C.R.R. The Department of Health proposed this rule to support its regulatory program for x-ray registrants and radioactive materials licensees. The amendments aim to revise the schedules for fees to be charged to registered radiation equipment facilities and to institute new fees to be charged to licensed radioactive materials users. *See* N.Y. Register, January 24, 2001.

Adult Day Health Care Regulations

Emergency repealing of Parts 425, 426 and 427 and addition of new Part 425 to Title 10 N.Y.C.R.R. The Department of Health found that immediate adoption of this rule was necessary to preserve the public health and general welfare by establishing additional standards for operations of adult health care programs. The purpose of the emergency rules is to insure that individuals receive adult day health care when appropriate and that providers are accountable for providing necessary and appropriate care. The proposed regulations include expanded definitions, general minimum requirements for operation, and standards relating to general records and clinical records. Filing date: December 29, 2000. Effective date: December 29, 2000. *See* N.Y. Register, January 17, 2001.

External Appeals of Adverse Determination of Health Care Plans

Emergency rule making. The Insurance Department added Part 410 (Regulation 166) of Title 11 N.Y.C.R.R. in order to establish rules to assure an orderly implementation and ongoing operation of the external appeal program. The proposed regulation provides guidance to insurers, insureds, and external appeal agents for implementing the requirements of Chapter 586 of the Laws of 1998. Filing date: December 1, 2000. Effective date: December 1, 2000. *See* N.Y. Register, December 20, 2000.

Health Care Practitioner Referrals and Laboratory Business Practice

Proposed action to amend Part 34 of Title 10 N.Y.C.R.R. The Department of Health proposed this action in order to bring state regulation in compliance with federal rule and clarify state direct billing and anti-kickback laws. This amendment renumbered existing Part 34 and divides the part into Subpart 34-1, entitled Health Practitioner Referrals, and Subpart 34-2, entitled Laboratory Business Practices. *See* N.Y. Register, December 6, 2000.

Partial Filling of Prescriptions, Electronic Transmission of Prescription Data and Official Prescription Form

Proposed action by the Department of Health to amend §§ 80.46, 80.67, 80.68, and 80.71-80.75 of Title 10 N.Y.C.R.R. The purpose of the proposed amendments is to provide for the electronic transmission of prescription data by pharmacies, allow controlled substances to be prescribed on an official, single part departmental form, and permit partial filing of some prescriptions. *See* N.Y. Register, November 29, 2000.

Financial Risk Transfer Agreements between Insurers and Health Care Providers

Revised action by the Insurance Department. Addition of Part 101 (Regulation 164) to Title 11 N.Y.C.R.R. The purpose of the revised action is to assess the financial responsibility and capability of health care providers to perform their obligations under certain financial risk sharing agreements, and set forth standards pursuant to which providers may adequately demonstrate such responsibility and capability to insurers. The proposed revision sets forth standards pursuant to which health care providers may adequately demonstrate to their insurers their financial responsibility in risk transfer agreements, the type of insurers covered under this Part, requirements for risk transfer, and definitions. *See* N.Y. Register, November 8, 2000.

Tissue Banks and Non-Transplant Anatomic Banks

Notice of adoption. The Department of Health amended Part 52 of Title 10 N.Y.C.R.R. in order to change the standards for tissue banking. The amendment changes several definitions to reflect currently accepted nomenclature and provide needed clarification and consistency. Filing date: October 17, 2000. Effective date: November 1, 2000. *See* N.Y. Register, November 1, 2000.

Financial Statement Filings and Accounting Practices and Procedures

Emergency rule making. The Insurance Department added Part 83 (Regulation 172) to Title 11 N.Y.C.R.R. in order to enhance the consistency of accounting treatment of assets, liabilities, reserves, income and expenses by entities subject to regulation, by setting forth accounting practices and procedures to be followed in completing annual and quarterly financial statements required by law. Filing date: December 29, 2000. Effective date: December 29, 2000. *See* N.Y. Register, January 17, 2001.

Nursing Home Resident Discharge Appeals

Notice of proposed rule-making. The Department of Health gave notice of its intent to promulgate a rule to comply with the terms of an order of the Supreme Court, Monroe County. The court held that DOH regulations that establish an appeal process for nursing home residents who are faced with an involuntary discharge or transfer from the nursing home must be consistent with 42 C.F.R. Subpart E of Part 431 and 42 Part 483. This amendment will protect existing resident rights and mandate a new appeal process to comply with the federal regulations. Expiration date: April 12, 2001. *See* N.Y. Register, October 4, 2000.

Compiled by Francis J. Serbaroli, Esq. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft's 20-attorney health law department. He is the Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and serves on the Executive Committee of the New York State Bar Association's Health Law Committee. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care" published by BNA as part of its Business and Health Portfolio Series.

The assistance of Ms. Alison Heller, an associate at Cadwalader, Wickersham & Taft, in compiling this summary is gratefully acknowledged.

REQUEST FOR ARTICLES

If you have written an article and would like to have it published in the *Health Law Journal* please submit to:

Professor Barbara L. Atwell or Professor Audrey Rogers
Pace University School of Law
78 North Broadway
White Plains, NY 10603

Articles should be submitted on a 3 1/2" floppy disk, preferably in WordPerfect 5.1 or 6.1 or Microsoft Word, along with a printed original and biographical information, and should be spell checked and grammar checked.

For Your Information

By Claudia O. Torrey

On Wednesday, January 24, 2001, some illuminating topics regarding the new frontier of health care were put forth at the Annual Meeting (Meeting) of the New York State Bar Association/Health Law Section (Section). This new frontier was labeled the health care Internet, but is commonly known as "eHealth." One point that seemed to be the general consensus of all the Meeting speakers was that eHealth is partly the result of a more proactive, informed patient.

The Internet provides online health information, online physicians, online disease management, and much more—thus, eHealth. In a nutshell, eHealth describes those businesses or markets that use the Internet to provide health-oriented information, services, products, and new technologies. These four areas form the foundation for eHealth to be divided into four main categories: content, care, connectivity, and commerce.

Most scholars agree that: the *content* category includes those Internet sites that offer health/disease information and online communities; the *care* category represents Internet sites that record, deliver, monitor, and manage patient care; the *connectivity* category concerns the Internet-based management of health care networks, communications, and data transactions;[1] and, the *commerce* category pertains to companies that utilize Internet-based abilities to purchase, compare and research health care products.[2]

One of the Meeting speakers, Dr. George Lundberg, stated that a fifth "c" should be added to the foundation of eHealth—community. Dr. Lundberg opined that community necessarily encompasses morality, ethics, and law. These three components are so interwoven in the health arena, that, as a community, we must remember that the Internet is the medium, *not* the message! Dr. Lundberg suggested that this new frontier in health will challenge us all to operate at the highest ethical level(s). The ethics should follow the science.

Numerous issues must be considered when operating in the eHealth arena. The obvious issues concern such areas as privacy, security/encryption, and reimbursement. Examples of issues that are not necessarily obvious are: whether or not the health information on a particular site constitutes the practice of medicine; whether or not the "hits" to a health site trigger the Children's Online Privacy Protection Act; whether or not electronic transactions between and among health care providers trigger the federal Stark II statute, as well as applicable state laws against self-referrals; and, whether or not appropriate liability insurance is in place for such catastrophes as computer system failure and data theft.

All of us will be, or have been, a patient. The new millennium presents unique opportunities and challenges in the eHealth frontier and in health law. Attorneys can attempt to be in the vanguard of this new health frontier by assisting with "navigational" concerns. To that end, the Section's Consumer/Patient Rights Committee is in the process of utilizing the Section Internet site to create a linking source of consumer friendly information. The information is slated to be categorized by state region (i.e., Downstate, Upstate, Western New York State, etc.) and health topic. Items to be included will be sources for: free health help, cancer issues, elder care issues, disability issues, health-related legal problems, and other topics as interest(s) dictate(s). It is hoped this information will be available later in the year.

Endnotes

1. It is this author's opinion that the new federal regulations pertaining to the privacy of individual, identifiable health information (65 Fed. Reg. 82461), as well as the federal regulations for health oriented electronic transactions (65 Fed. Reg. 50312), will greatly impact the eHealth connectivity market.
2. The primary company models under the commerce category are: business-to-business (B2B) and business–to-consumer (B2C).

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New York State Law Regulating Physician Referrals

By John D. Minehan

I. Introduction

The federal Stark, Anti-kickback and False Claims laws have generated an enormous amount of controversy in the health care industry over the last two decades. The federal government's aggressive enforcement of these laws has led to massive fines for some health care entities[1] and massive growth in the disciplines of health law[2] and compliance and regulatory consulting.[3] What is often forgotten is that the states *also* regulate these issues.

State and federal law in these areas is not, and is usually not intended to be, congruent.[4] The interests, needs and historical experiences of the states may prompt them to regulate different issues than the federal government does. The traditional police power interest the states have in regulating professional licenses has a strong influence on this area of law.[5] This article will examine the two main New York State laws that regulate physician referrals; § 238 of the Public Health Law and the "fee splitting" provisions of the Education Law (§§ 6530, Subdivisions 17, 18 and 19, 6531 and 6509-a).

II. Section 238 of the Public Health Law

In 1992, the New York State Legislature passed a law dealing with physician self-interested referrals to clinical laboratory, pharmacy, radiation therapy or imaging facilities. This law paralleled, but did not duplicate, the provisions of then-about-to-be-passed federal Stark II legislation. In some ways it was broader and in others narrower. Unlike Stark II which deals with clinical laboratory services, physical therapy services, occupational therapy services, radiology services (including magnetic resonance imaging, computerized axial tomography scans and ultrasound), radiation therapy, durable medical equipment, parenteral and enteral nutrients, prosthetics and orthotics, home health care services, outpatient prescription drugs and inpatient and outpatient hospital services,[6] § 238 deals only with clinical laboratory, pharmacy, radiation therapy and imaging services.[7] But the New York statute applies to all payment sources for these services,[8] unlike Stark II, which applies only to the Medicare and Medicaid programs.[9] Some of this legislation's safe harbors do not precisely dovetail with those of Stark II at this point.

This legislation was greeted with great trepidation.[10] There was concern that this would yield a vast quantity of litigation. However, this law has only generated one court case to date.[11] While this may be partly explained by the fact that referrals to imaging and clinical laboratory facilities prior to July 1, 1995 (where the interest was acquired prior to July 1, 1992) and for pharmacy services prior to July 1, 1995 (where the interest was acquired prior to March 1, 1993) are specifically excluded,[12] this may also turn on the fact that there are older state laws that regulate referrals.

Although the case law interpreting this law is sparse, there are some Advisory Opinions from the Department of Health (DOH) interpreting § 238. Under § 238, the DOH considers an independent contractor to potentially qualify as a member of a group practice or "similar association" talked about in the group practice exception to the statute.[13] However, the Health Care Financing Administration has proposed that independent contractors *not* be considered members of groups for Stark/Anti-kickback purposes.[14] While, as noted before, there is no general requirement that state and federal laws in this area be congruent, exceptions to § 238 are specifically intended to be "consistent with requirements imposed by regulations adopted pursuant to title XVIII of the federal social security act (Medicare) for clinical laboratory services."[15] This inconsistency does not yet appear to have been addressed.

While there is no equipment rental exception in § 238-a, as there is in the federal Stark II law, there is an advisory opinion that indicates that renting a facility that contains equipment also includes renting the equipment.[16] So, a physician could lease (or possibly lease part of) an MRI facility and could refer to that facility under § 238-a so long as he or a member of his group supervised the procedures. But, as the law stands, there is no safe harbor for a physician renting equipment for his own offices as there is under the equipment rental exception to the federal Stark and Anti-kickback statutes. Physician interests in business corporations which provide designated health care services also implicate § 238.[17]

One reason there has been little activity under § 238 is that the AG's office, which has responsibility for enforcing this law along with DOH, has a considerable amount on its plate. Additionally, many of the provisions of this law are duplicated by provisions of § 6530 of the Education Law. Among these are prohibitions on medically unnecessary referrals for "services, goods, appliances, or drugs" for financial gain (§ 17), direct or indirect fee splitting or kickbacks (§ 18), fee splitting with non-professionals and sham space and equipment leases or sales which are disguised sales of referrals (§ 19) and ordering of excessive tests, treatments or use of facilities (35).[18]

Using this law, rather than § 238, saves the AG's office time in several ways. These provisions are generally enforced by the Board for Professional Medical Conduct. The AG's office merely has to litigate appeals brought under Article 78 of the CPLR. Since the action by the Board of Professional Medical Conduct is an administrative proceeding, review under Article 78 is limited to ensuring that the determination had a "rational basis supported by fact"

and that the penalty is not "so incommensurate with the offense as to shock one's sense of fairness."[19]

Like § 238, § 6530 of the Education Law applies to all payment sources, unlike Stark which only applies to Medicare and Medicaid referrals for designated health care services or the Anti-kickback Statute which applies to Medicare, Medicaid and smaller federal programs such as Tri-Care and the Veteran's Administration.[20] Under § 6530, private third-party payors, both managed care organizations and indemnity insurers, can lodge complaints against providers with the Board for Professional Medical Conduct. This is in addition to any administrative rights they might enjoy to terminate a provider under their contract or to pursue a civil suit for fraud or conversion or press criminal charges for fraud, false pretenses or larceny.[21] Since recourse exists under these laws, there has been no great need for private sector payors to prompt the AG's office to pursue self-referring physicians under § 238.

Many of these cases involve Medicaid fraud, self-referral and kickbacks.[22] Although the federal health care statutes apply to Medicaid, New York has a logical interest. While Medicare is a purely federal program, Medicaid is a joint state-federal program where New York has its own dollars at risk.

None of this is a recommendation to ignore § 238. The kind of self-interested transactions prohibited by § 238 are also covered for Medicare and Medicaid patients by Stark, which applies to an even broader array of services, and (under certain circumstances) by the Anti-kickback Statute. Section 6530 of the Education Law provides sanctions against any of these and a wide variety of other prohibited practices, regardless of the funding source. Section 238 itself remains on the books, a trap for the unwary and a potential tool for attorneys general.

III. The Fee Splitting Statutes

In addition to § 6530, New York has two other fee splitting laws, one applying to health professionals such as nurses, chiropractors, dentists and podiatrists (§ 6509-a) and the other to physicians and physician's (or specialist's) assistants (PA) (§ 6531).[23] Nurse Practitioners are covered by the article of the Education Law dealing with nursing and, therefore, by § 6509-a.[24]

These sections apply to the "furnishing of professional care or services,"particularly noting x-ray services and interpretation, clinical laboratory services, inhalation therapy services, ambulance services, hospital or medical supplies, physiotherapy and other therapy services, artificial eyes, limbs or teeth, orthopedic or surgical appliances and "any other goods, services, or supplies prescribed for medical diagnosis, care or treatment."[25]

Under both the fee splitting laws, professionals are prohibited from sharing fees with non-professionals.[26] This applies even to non-professional employees of physicians.[27] Both sections specifically allow professionals to practice "as partners, in groups, or as a professional corporation, university faculty practice corporations or groups"[28] and allow "the professionals constituting the partnership, corporation or group"[29] to divide income received from professional services rendered by members or employees "in accordance with a partnership or other agreement."[30] Each section restricts the division of fees received from Workers' Compensation.[31]

There are many nuances to the fee splitting laws. For example, physicians can give collection agencies a percentage of in-arrears fees earned by the doctors independently of the collection agency's efforts.[32] Paying a billing company/management services company or its employees, as opposed to an outside collection agency, a *percentage* of bills collected *would* implicate the fee splitting statute.[33]

Otherwise, non-licensed individuals

> can be paid only for the fair market value of the services provided in an arms length transaction. Not every situation in which payments approximate a percentage of the fee for professional services . . . constitutes unprofessional conduct. For example, if the unlicensed provider of goods or services charges "X" for each item provided and the licensee's fee for such services approximates a multiple of "X," it would not constitute unprofessional conduct if it can be demonstrated that the amount charged by the unlicensed provider is equal to the provider's cost plus some established profit margin which the provider wishes to receive from the goods or services provided or rendered to the license.[34]

Even between similarly licensed individuals, related issues may be implicated. For example, while an independent contractor relationship between two doctors is not fee splitting with a non-professional, it may be considered "brokering of services." Care must be taken in structuring these arrangements, especially insuring that the doctor retaining the contractor does not charge the contractor a fee for matching them with payors or patients.[35] Related to this issue in contracts between doctors are the requirements of Education Law § 6530(17) which prohibit licensees from exercising "undue influence" over patients, in areas such as "the promotion of the sale of services, goods, appliances, or drugs in such a manner as to exploit the patient for the financial gain of the licensee or of a third party."[36] Compensation arrangements with contractors should be set up to avoid giving them an incentive to provide unnecessary services. This is a consideration that probably often gets neglected.

IV. Conclusion

Although the federal Stark II and Anti-kickback laws receive the lion's share of attention and analysis among

health care lawyers, New York law on this issue should not be ignored. Enough inconsistencies exist between the two bodies of law that an arrangement, which complies under the federal statutes, may not apply under New York law and vice versa. Although § 238 of the Public Health Law is intended to be congruent with Stark, these two laws have diverged with the proposed changes in the Stark II Law in recent years, especially in terms of safe harbors.

Endnotes

1. *See United States v. Lorenzo*, 768 F. Supp. 1127 (E.D.Pa. 1991) (imposing $18,807,157.30 in fines as a result of $130,719.10 in claims); *Chapman v. United States Dep't of Health and Human Servs*., 821 F.2d 523 (10th Cir. 1987) (imposing fines of $156,318 for filing 10 false claims); *Mayers v. United States Dep't of Health and Human Servs*., 806 F.2d 995 (imposing fines of $1,791,100 for filing 2,702 false claims and holding that a penalty of *70 times* what was collected in false claims was constitutional).
2. *See, e.g.*, *The Health Law Section of the New York State Bar Association* (visited April 21, 2000) <http://www.nysba.org/sections/health> ("The Health Law Section is the New York State Bar Association's youngest and fastest growing Section.").
3. *See, e.g.*, *Readers' Salaries Lower Than Experts Expect, Survey Finds*, Corporate Compliance Officer (December 1998) at 1 (indicating that many Corporate Compliance Officers are not receiving executive level salaries, which indicates that there is an expectation that they should due to the growth of their duties over recent years).
4. *See* Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule, 64 Fed. Reg. at 63538-9 (Nov. 19, 1999).
5. For example, § 6530 of the Education Law regulates not only fee splitting and other physician referral offenses in Subdivisions (17), (18), (19) but also things more directly related to licensing such as practicing beyond the scope of a physician's license in Subdivision 24.
6. *See* 42 U.S.C.A. § 1395nn(h)(6). Since final implementing instructions have not yet been published for Stark II, it has not appeared to be a major enforcement priority for OIG. *See* Kevin J. Darken, *Defending and Preventing Healthcare Fraud Cases; An Attorney's Guide* (1999) at 4-1:41. However, the publication of proposed rules may indicate that this will change. *See* Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 63 Fed. Reg. 1659 (Jan. 9, 1998)
7. *See* N.Y. Pub. Health Law § 238-a(1)(a) (McKinney 1990 and Supp. 2000). Regulations implementing this section appear at 10 N.Y.C.R.R. Part 34.
8. *See* N.Y. Pub. Health Law § 238-a(1)(b) (McKinney 1990 and Supp. 2000). However, since so many providers participate in these programs, especially Medicare, this may amount to a distinction without a difference.
9. *See* 42 U.S.C.A. § 1395nn(a)(1).
10. *See, e.g.*, Melvyn B. Ruskin & Ellen F. Kessler, *Health Care Anti-referral Laws Effective in 1995*, 213 N.Y.L.J. 1 (Jan. 5, 1995); Francis J. Serbaroli, *Should Patients and Insurers Pay for Professional Misconduct*? 214 N.Y.L.J. 3 (July 26, 1995).
11. *See Ozone Park Med. v. All State*, 180 Misc. 2d 105, 689 N.Y.S.2d 616 (App.T. 1999) (dealing tangentially with factual issues of whether an organization met the parameters of the group practice exception).
12. *See* 10 N.Y.C.R.R. § 34.3.
13. DOH Ad. Op., April 19, 1996 (dealing with PHL § 238-a).
14. *See* 63 Fed. Reg at 1696 (Jan. 9, 1998).
15. N.Y. Public Health Law § 238-a(5)(b)(vii) (McKinney 1999 and Supp. 2000).
16. *See* DOH Ad. Op., April 19, 1996 (dealing with PHL § 238-a).
17. *See* DOH Ad. Op., May 2, 1995 (dealing with PHL § 238-a).
18. N.Y. Educ. Law §§ (17), (18), (19), (35) (McKinney 1985 and Supp. 2000). Implementing regulations appear at 8 N.Y.C.R.R. §§ 29.1 (General Provisions), 29.2 (Health Professions), 29.4 (Medicine), 29.5 (Dentistry), 29.7 (Pharmacy), 29.8 (Optometry), 29.9 (Opthalmic Dispensing), 29.12 (Psychology).
19. *In re of Balmir v. DeBuono*, 237 A.D.2d 648, 649, 655 N.Y.S.2d 113 (3d Dep't 1997) *citing In re of Adler v. Bureau of Professional Med. Conduct*, 211 A.D.2d 990, 993, 622 N.Y.S.2d 609 (3d Dep't 1995).
20. *See* 42 U.S.C.A. § 1320a-7b(b).
21. *See Sokol v. New York St. Dept. of Hlt.*, 223 A.D.2d 809, 636 N.Y.S.2d 450 (3d Dep't 1983) (concerning § 6530 action taken after "conviction of one count of grand larceny in the second degree for defrauding Medicaid of more than $ 1,000,000"); *Schankman v. DeBuono*, 237 A.D.2d 751, 655 N.Y.S.2d 164 (3d Dep't 1997) (describing a § 6530 action after conviction of Medicaid fraud in California).
22. *See Larkins v. DeBuono*, 257 A.D.2d 714, 682 N.Y.S.2d 732 (3d Dep't 1999); *Capote v. DeBuono*, 241 A.D.2d 570, 659 N.Y.S.2d 357 (3d Dep't 1997) (billing Medicaid for unnecessary lab tests and non-existent services); *Supris v. St. of New York*, 203 A.D.2d 670, 671, 610 N.Y.S.2d 373 (3d Dep't 1994) ("submitting over 1,600 claims for services that were never rendered"). *See also Dahl v. New York State Dep't of Health*, 274 A.D.2d 619, 710 N.Y.S.2d 193 (3d Dep't 2000).
23. *See* N.Y. Educ. Law § 6509-a (McKinney 1985 and Supp. 2000) (dealing with nurses, dentists, etc.); § 6531 (dealing with doctors and PAs).
24. *See* N.Y. Educ. Law § 6910 (McKinney 1985 and Supp. 2000) (describing the process for certifying NPs).
25. *See* N.Y. Educ. Law § 6509-a (McKinney 1985 and Supp. 2000) (dealing with nurses, dentists, etc.); § 6531 (dealing with doctors and PAs).
26. *See United Calender Manufacturing Corp. v. Huang*, 94 A.D.2d 176, 179-80, 463 N.Y.S.2d 499, 499-500 (2d Dep't 1983); *Artache v. Goldin*, 133 A.D.2d 596, 519 N.Y.S.2d 702 (2d Dep't 1987); *Sachs v. Saloshin*, 138 A.D.2d 586, 586-7, 526 N.Y.S.2d 168, 169-70 (2d Dep't 1988).
27. *See Okereke v. State*, 129 A.D.2d 373, 518 N.Y.S.2d 210, 211-2 (3d Dep't 1987).
28. *See also Albany Medical College v. McShane*, 66 N.Y.2d 982, 499 N.Y.S.2d 376, 489 N.E.2d 1278, *re-argument denied*, 67 N.Y.2d 757, 500 N.Y.S.2d 1028, 490 N.E.2d 1234 (1985).
29. N.Y. Educ. Law § 6509-a (McKinney 1985 and Supp. 2000); § 6531.
30. *Id*.
31. *See* N.Y. Educ. Law § 6509-a (McKinney 1985 and Supp. 2000); § 6531.
32. *See* DOH Ad. Op., May 7, 1992 (contracts with collection agencies and fee splitting).
33. *See* DOH Ad.Op. April 17, 1997 (collections and billing/management companies).
34. DOH Ad. Op., March 22, 1994 (concerning payment of non-licenced individuals).
35. DOH Ad. Op., July 11, 1994 (dealing with independent contractors and "brokering").
36. N.Y. Educ. Law § 6530(17) (McKinney 1985 and Supp. 2000); DOH Ad. Op., August 14, 1995 (concerning independent contractors and "undue influence").

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An Idea Whose Time Has Come: ADR and Health Care Disputes

By Chris Stern Hyman

The fact is that for some time now there has been a need for a better dispute resolution process for the health care community. ADR, as most of you know, refers to "alternative dispute resolution" but as Carrie Menkel-Meadow explains it should more precisely refer to "appropriate dispute resolution." Most disputes are settled outside of a trial, so a litigated resolution is the true "alternative."[1] In any case, ADR comes primarily in three forms: negotiation, mediation, and arbitration.

All three forms of ADR provide an advantage by shifting the efforts to resolve the dispute from the battle mode of litigation to an effort to talk through the differences and find common ground, in addition to saving the costs of litigation and reaching a final decision more quickly. Negotiation is what many of us do all the time in our daily lives and what lawyers frequently do on behalf of their clients: bargaining with the other parties and their representatives in an attempt to resolve the dispute.[2]

When negotiations reach an impasse, mediation provides for the inclusion of a neutral third party who is skilled in facilitating negotiations, who assists the parties in generating options, and who changes the tone of the communication to help the parties resolve the dispute. The parties in mediation are the decision-makers, deciding voluntarily on a mutually acceptable resolution of the issues. The decision they reach is not limited to the narrow legal remedies that can be awarded by a judge or jury, but can address the specific concerns of the aggrieved party, e.g., a letter of apology, a change in procedure or any other appropriate act agreed to by the parties. (If they cannot reach a mutually acceptable resolution, they can always return to litigation.) Parties are bound by confidentiality as part of the agreement to mediate, so that the information disclosed during the mediation cannot be disclosed outside the mediation, unless it is information that would otherwise have been admissible as evidence.

Arbitration also involves a neutral third party agreed to by the disputants, but in contrast to mediation, the arbitrator or panel of three arbitrators decides the disputed issues for the parties. Arbitration is better known than mediation to most lawyers and members of the public, but increasingly it is criticized for failing to deliver on its promise of informality, brevity, and economy.[3] Mediation is favored by many because it allows the parties to retain control over their dispute and does not mimic adjudication by having the neutral decide the case. (Also included in lists of non-binding ADR are early neutral evaluation, mini-trial, summary jury trial, and non-binding arbitration.) With this thumbnail sketch of ADR, we can look at some logical applications to health care disputes, keeping in mind that ADR is not appropriate for every case, particularly if legal precedent must be established, but it is always worth considering.

Managed care organizations would seem to be logical candidates,[4] but they have not embraced ADR. The regulatory constraints on how "appeals" and "grievances" must be processed mean that realistically ADR would have to be an adjunct to these statutorily mandated procedures. Arbitration is used occasionally to resolve disputes between managed care organizations and their vendors, providers and enrollees, but consumer advocates accurately caution that pre-dispute arbitration can compromise an enrollees' legal rights and there has been some unfavorable decisions from managed care's perspective resulting from arbitration clauses.[5] Generally, as a mechanism for resolving its disputes, mediation is used minimally by managed care organizations at the present time.[6]

In New York, there was a recent settlement of an arbitration brought in 1998 by 15 county medical societies and numerous individual physicians against Oxford Health Plans, Inc. for nonpayment of several million dollars in fees owed the physicians. According to Scott Einiger, Esq., of Fager & Amsler, one of the law firms initiating the arbitration, a mediation clause was included in the Memorandum of Understanding settling the dispute. The provision for mediation was ultimately moot because all the physicians participating in the settlement accepted the lump sum payment for their individual disputes. However, had any of the physicians not accepted their payments and if a subsequent review procedure between Oxford and the eligible physician had not resulted in a satisfactory settlement, then that physician would have been entitled to request mediation. According to Mr. Einiger, Oxford agreed to pay the first $2,500 for the mediation and thereafter each party would share any additional cost of the mediation equally.

Although mediation of health care disputes is in its nascent stage, the range of mediated disputes covers a wide spectrum. At Montefiore Medical Center in the Bronx, bioethical disputes about clinical decision making are mediated by a member of the Bioethics Consul-

tation Service, consisting of an attorney, a philosopher and a nurse/attorney. These consultations are a blend of traditional mediation, clinical consultation and bioethics analysis. The basic principles and skills of mediation are applied within the constraints imposed by the clinical setting and the imperatives of the patient's changing condition. The process consists of fact gathering, identification of the parties and their interests, clarification of the issues, and exploration of the therapeutic options and their benefits, burdens and risks. The consultant/mediator, although a member of the hospital staff, remains neutral throughout the process. Ethical and legal principles inform discussion of the issues and frame the outcome, but the ultimate resolution is determined by the parties, not the mediator.[7]

There are medical malpractice claims that are being mediated in New York City. FOJP Service Corporation (FOJP) which administers the medical malpractice insurance program for five hospitals, 1,300 voluntary attending physicians, numerous long term care facilities, and thousands of resident and employed physicians at these facilities, began a pilot mediation project in January, 2000. What is new about the pilot project is the introduction of mediation early in the litigation process. Lisa Kramer, President and CEO of FOJP, is an attorney who in 1982 was involved in setting up the ADR program as part of the litigation management practice at CIGNA. She remains a strong proponent of early mediation under appropriate circumstances. As she explains, medical malpractice cases can often be effectively mediated where a settlement is likely. According to Ms. Kramer, many medical malpractice cases will not settle because they are completely defensible, but for the cases in which payment is going to be made and if there are additional compelling reasons not to have the case go to trial, mediation early on is particularly helpful. FOJP is continuing its mediation program.

From the vantage point of a mediator of several of the FOJP mediations, there was considerable skepticism on the part of some attorneys, both plaintiff and defense, that it would be worthwhile mediating before extensive discovery had been conducted. Interestingly, many became converts after the first mediation session. Their shift in attitude resulted from an awareness that without the mediation, the parties would never have sat down together at this early juncture, explored their views of the case, their interests and the settlement options. For those claims in which both sides had virtually identical views about the theory and value of the case, settlement was quickly accomplished. In other cases, the mediation produced expedited discovery by facilitating the exchange of records and reports and the next steps. Settlement was not the only constructive outcome of the mediations.[8]

The Combined Coordinating Council, Inc. (CCC) which administers a medical malpractice insurance and claims program for its eight hospital members in New York City, according to Ronald B. Milch, President & CEO, is in the process of developing a mediation program as well.

The benefits of mediation have spawned additional initiatives in a variety of states and countries. For example, in Oklahoma and Texas, long-term care ombudsmen have been trained as mediators and are using mediation to resolve disputes in long-term care facilities between residents and between a resident and a family member or guardian.[9] In Australia, there is a provision for mediation in the Aged Care Act, which covers people who live in nursing homes and hostels.[10]

In the field of physician misconduct, mediation has been used to resolve disciplinary cases against physicians by the College of Physicians and Surgeons of Ontario. From 1992 to 1997, 266 cases of alleged misconduct were referred for mediation between the physician and the complainant. Eighty-four percent of the cases in this pilot project were successfully resolved.[11] Similarly in 1992, the Massachusetts Board of Registration in Medicine created a pilot mediation program for complaints against physicians, although the complaints in this program did not rise to the level of misconduct, and therefore, would have been dismissed. Of the first ten cases referred to mediation, nine were mediated and successfully resolved with only four cases involving money as part of the resolution.[12]

According to Alexander F. Fleming, former Executive Director of the Massachusetts Board of Registration in Medicine, the process of bringing the physician to the table with the complainant, having the physician listen to the aggrieved person, having each person's version of the issue heard by a neutral third party, and reaching an agreement satisfactory to both sides, resulted in real change in the physician's behavior. Often during these mediations the physician understood the significance of a communication skill that could improve her practice. Prior to the pilot project, the physician's reaction to dismissal of a complaint typically was exoneration, when in fact her conduct needed to change, and the dismissal was highly unsatisfactory to the complainant.[13] Massachusetts' project continues with 40 mediations having been completed and the Board of Registration in Medicine currently considering expansion of the project.[14]

The motivation to change the status quo has to be compelling enough to overcome the inertia of the established and the familiar. In the initiatives described

above, the motivation to expand the traditional ways of resolving health care disputes to include mediation appears to be two-fold: a desire for a more effective and less costly resolution. The former relies on several factors: the nature of the process and the participants, the decision makers, and their commitment to the resolution reached. Residents in a nursing home, whose complaints have been heard and who have been part of deciding the resolution, are much more likely to abide by their agreement than one imposed by an administrator. Physicians who participate in mediation and understand, often for the first time, how their conduct is flawed, may change their conduct and the beneficiaries will be numerous present and future patients. Also embedded in every effective resolution are savings: economic, in that an early resolution invariably costs less than one arrived at later on, and emotional, in that parties have often been able to express their feelings, have often heard a differing perspective, have agreed to a resolution that they each think is fundamentally fair, and have been spared participation in litigation. The richness and flexibility of a decision-making process that evolves from the disputants and is not imposed by edict benefits all the participants. In ever increasing numbers, people involved in conflict are recognizing the value of a non-litigation approach, and the health care community is included among the beneficiaries.

Endnotes

1. Carrie Menkel-Meadow, *Mothers and Fathers of Invention: The Intellectual Founders of ADR*, 16 Ohio St. J. On Disp. Resol. 1, 2 (2000)

1. The seminal book on negotiation and dispute resolution is Roger Fisher, et al., *Getting to Yes: Negotiating Agreement Without Giving In* (Bruce Patton ed., 2d ed. 1991).

2. For a discussion of mediation and arbitration and ways in which arbitration is becoming more like litigation see Leonard L. Riskin and James E. Westbrook, *Dispute Resolution and Lawyers*, 585-588 (2d ed. 1997).

3. *See, e.g.*, American Arbitration Association, American Bar Association, and American Medical Association, *Health Care Due Process Protocol: A Due Process Protocol for Mediation and Arbitration of Health Care Disputes* (June 1998).

4. *Engalla v. Permanente Medical Group*, 938 P.2d 903 (Cal. 1997).

5. Naomi Karp and Erica Wood, *Understanding Health Plan Dispute Resolution Practices*, 111-115 (April 2000). This report of the ABA's Commission on Legal Problems of the Elderly studied the internal practices for resolving enrollee-plan disputes of 50 health plans in 27 states and found that ADR is used infrequently.

6. *See* Nancy Neveloff Dubler, *Heroic Care Cases*, Dispute Resolution Magazine, 7-8 (Spring 1999) and Nancy Neveloff Dubler and Leonard J. Marcus, *Mediating Bioethical Disputes* (April 1994) for a more detailed discussion of the mediation of bioethical disputes. This description of the Bioethics Consultation Service is based on an e-mail dated 2/16/01 from Linda Farber Post, J.D., B.S.N., M.A., who is a member of the service.

7. Medical Mediation Group LLC, in which Marc Fleisher, J.D., and I are partners, is one of the four mediation organizations used by FOJP.

8. E-mail dated 1/8/01 from E. Kurtz and C. Gesell on file with author.

9. E-mail dated 1/8/01 from K. Marchant on file with author.

10. Lisa Feld and Peter A. Simm, *Mediating Professional Misconduct Complaints*, 6-7 (1998).

11. *See* Edward A. Dauer and Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 Law & Contemp. Probs., 185 (1997) for a more detailed description of the mediation project.

12. Based on a conversation with Mr. Fleming on 12/3/98.

13. Based on a telephone conversation with Dawn Effron, J.D., formerly Complaint Counsel at the Massachusetts Board of Registration in Medicine and currently an independent mediator.

Chris Hyman is a professional mediator with an extensive background as a health care attorney. From 1980 until 1995, she was the Chief Counsel of the Bureau of Professional Medical Conduct in the New York State Department of Health and supervised the 25 lawyers who prosecuted physicians for professional misconduct throughout the state. In 1998 she founded with Marc Fleisher the Medical Mediation Group LLC to resolve disputes in the health care community through mediation. In addition to health care disputes, she mediates child visitation and custody cases referred from the Family Court, *pro se* cases referred by Civil Court, New York County and attorney disciplinary cases.

Newsflash offers Section members a way to keep up on the comings and goings of their colleagues and upcoming events of interest. Has there been a change in your practice? Any recent or forthcoming articles or lecture presentations? Won any awards recently? Please send submissions to Professor Barbara Atwell or Professor Audrey Rogers, Pace University School of Law, 78 North Broadway, White Plains, NY 10603.

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