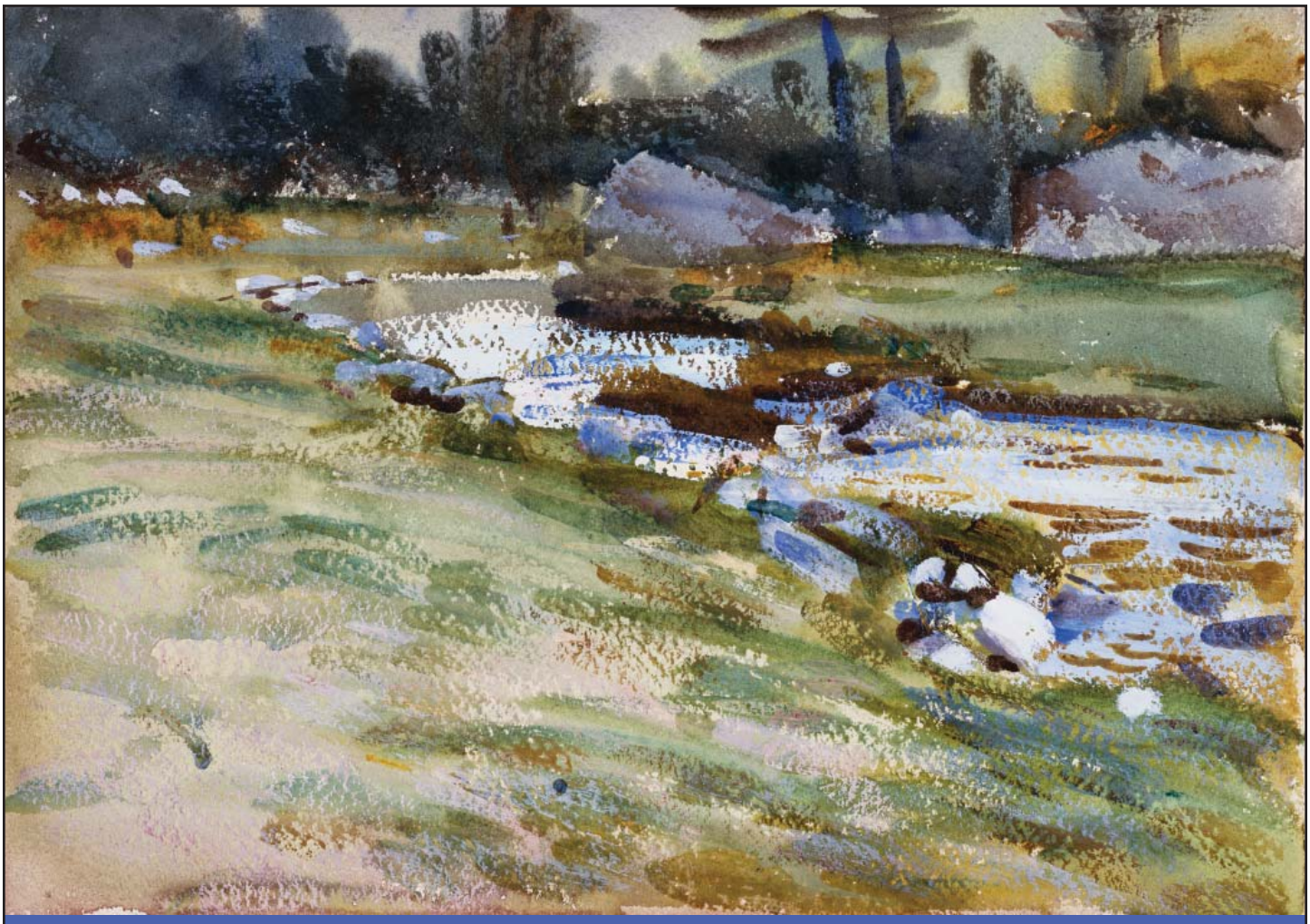
NYSBA WINTER 2008 | VOL.13 | NO.1

Health Law Journal

A publication of the Health Law Section of the New York State Bar Association



Special Edition: Selected Topics in Medical Malpractice Litigation

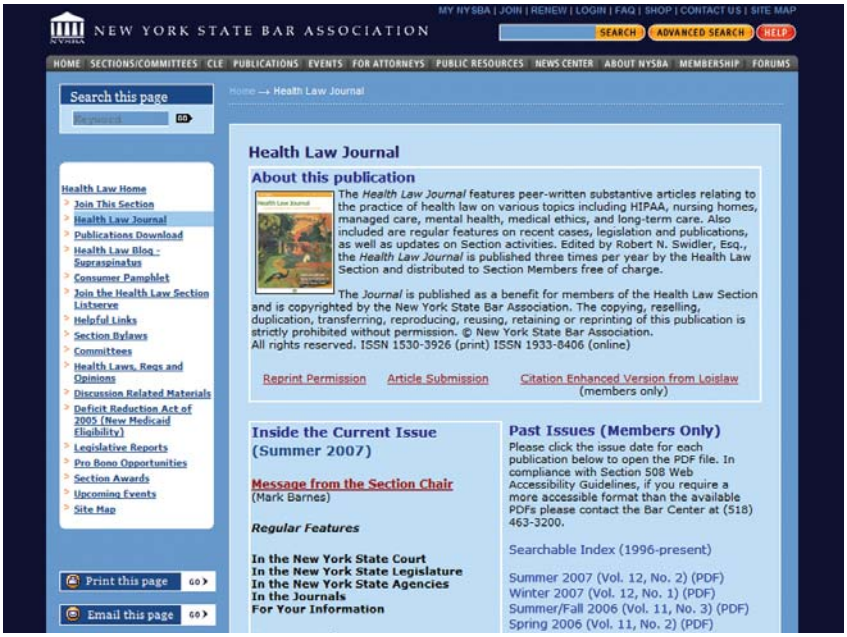
NYSBA

Your key to professional success…
A wealth of practical resources at www.nysba.org

- **Downloadable Forms organized into common practice areas**
- **Comprehensive practice management tools**
- **Forums/listserves for Sections and Committees**
- **More than 800 Ethics Opinions**
- **NYSBA Reports – the substantive work of the Association**
- **Legislative information with timely news feeds**
- **Online career services for job seekers and employers**
- **Free access to several case law libraries – exclusively for members**

The practical tools you need.
The resources you demand.
Available right now.
Our members deserve nothing less.

And now . . .
the *Health Law Journal* has a new online look!



Go to www.nysba.org/HealthLawJournal to access:

- Past Issues (1996-present) of the *Health Law Journal**
- *Health Law Journal* Searchable Index (1996-present)
- Searchable articles from the *Health Law Journal* that include links to cites and statutes. This service is provided by Loislaw and is an exclusive Section member benefit*

*You must be a Health Law Section member and logged in to access. Need password assistance? Visit our Web site at www.nysba.org/pwhelp. For questions or log-in help, call (518) 463-3200.

For more information on these and many other resources go to **www.nysba.org**

NYSBA

HEALTH LAW JOURNAL

Winter 2008

Vol. 13, No. 1

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

Table of Contents

Cover artwork: *The Brook* by John Singer Sargent (1856-1925)

A Message from the Section Chair

It is an honor to serve as Chair of the Health Law Section in 2007–2008. I follow Mark Barnes and nine other distinguished Chairs who have made the Section a vital component of the Bar Association. The past Chairs brought to the office a wealth of experience in private firms, health facilities and government. I will try to make a similar contribution.

One challenge we face is assuring that the composition of the Section reflects the diversity of the bar. We have made progress in bringing government lawyers into the Section. They now make up eight percent of the Section's members. We have been less successful in attracting minority lawyers. Only 32 of our members identify themselves as Asian, African American or Hispanic. One of my goals is to increase minority participation.

We all benefit from the outstanding work of several Section members in our legal education programs. The annual retreat in Cooperstown in November organized by Marcia Smith, Marge Davino and Ed Kornreich is the latest example. The program focused on health fraud and highlighted presentations by new top government officials: Jim Sheehan of OMIG, Heidi Wendel of MFCU, Deb Bachrach of DOH, and Hank Greenberg of the Attorney General's Office. The program was universally praised. The weekend was also a great opportunity to renew friendships and swap war stories.

Our educational programs have been characterized by their relevance and practical value to New York health lawyers of all kinds. I think we all come away from these programs with a bit more capacity to practice our profession well. In the case of the recent retreat, we also felt heightened anxiety for well-meaning clients.

Relevant also describes the Section's highly regarded *Health Law Journal* edited by Robert Swidler, the Section's frequently used listserv, and our most recent tool, the Blog, designed and named by Paul Gillan.

The core of the Section is its seventeen committees. Here we have enjoyed mixed success. Some committees have been very active. One recent example is a managed care contracting telephone seminar organized by the Committee for Long Term Care. Other committees are "less active."

The committees have a particularly important role in our Section because our focus covers all aspects of one "industry" and the problems we address as attorneys in this "industry" are incredibly diverse. Like every chair before me, I urge all of you to get involved in a committee.

We are all fortunate to be in a field that receives such a high portion of our GNP (of course, a very mixed blessing for our country) and encompasses so many tantalizing intellectual, ethical and policy issues. Apart from keeping us employed, the size and diversity of the health care field keeps our minds engaged and challenged, and provides much grist for the Section's mill.

I look forward to seeing all 1,200 of you at the Section's January 30 program at the Bar's Annual Meeting in New York City. Harold Iselin, Frank Serbaroli and Hermes Fernandez are putting together a program on policy developments in medical malpractice and quality of care. We hope that the state's report on medical malpractice policy options will have been released before we meet.

Peter J. Millock

In the New York State Courts

By Leonard M. Rosenberg

Children Conceived After Their Biological Father's Death Are Legally Included in Grantor's Trust as "Issue" and "Descendants"

In re Martin B., 17 Misc. 3d 198, 841 N.Y.S.2d 207 (Surr. Ct., N.Y. Co. 2007). Trustees for Martin B. (the "Grantor") sought judicial guidance on the novel question of whether the terms "issue" and "descendants" included grandchildren conceived by *in vitro* fertilization with the cryopreserved semen of the Grantor's son, who predeceased the artificial insemination and birth of his biological children. Finding that the laws of New York and the District of Columbia, which alternately governed the Grantor's seven trust instruments, failed to provide any statutory authority or judicial comment on the rights of post-conceived children, the Surrogate's Court (Renee R. Roth, J.) examined sister jurisdictions and authorities to make its determination.

The court first turned to the statutes of Louisiana, California, Florida, and those states that adopted the Uniform Parentage Act (Delaware, North Dakota, Oklahoma, Texas, Utah, Washington and Wyoming), which directly addressed the present issue. In each instance, the court concluded, the state legislatures attempted to balance all competing interests by requiring "written consent to the use of genetic material" and establishing "a cut-off date by which the child must be conceived." Thus, there could be "certainty and finality . . . in the orderly administration of estates" while recognizing the "human desire to have children" and the "rights of children born as a result of such scientific advances" to inherit from their respective estates. The court also noted that the courts of Massachusetts, New Jersey and Arizona have held that a post-conceived child qualified for benefits under the Social

Security Act. Here, the court specifically found that the Grantor's son had given written consent and that all of his cryopreserved sperm had been destroyed after the birth of his second son, thereby closing the class of his children.

The court then sought to determine the Grantor's intent by reading the face of the trust instruments. Although the court assumed that the Grantor could not have contemplated in 1969 that "issue" or "descendants" would include children conceived after the Grantor's son's death, the court nonetheless held that the absence of specific intent did not necessarily preclude a determination that such grandchildren were members of that class of issue. The court relied upon, among other supporting authorities, the rationale of the Restatement (Third) of Property § 14.8, which provides that "[u]nless the language or circumstances indicate that the transferor had a different intention, a child of assisted reproduction is treated for class-gift purposes as a child of a person who consented to function as a parent of the child and who functioned in that capacity or was prevented from doing so by an event such as death or incapacity." Thus, where the governing instrument is silent, the court held that children conceived with the consent of their parents are entitled to the same rights and are considered "for all purposes as those of a natural child."

Finally, recognizing the need for comprehensive legislative guidance in this evolving area of biotechnology, the court explicitly directed that its decision be sent to the New York State Senate and Assembly.

Supreme Court Holds That Emails Sent to a Personal Attorney Using an Employer's Email Address Are Not Privileged Under a Four-Part Test

Scott v. Beth Israel Medical Center, 2007 WL 3053351 (Oct. 17, 2007). Plaintiff, a physician, sued defendant hospital after being terminated from employment. The underlying dispute involved a suit for breach of contract regarding severance pay and counterclaims for breach of contract and fiduciary duty, recovery of money paid, tortious interference with contract, unfair competition, violation of the Lanham Act, and false and deceptive advertising.

Plaintiff sought a protective order requiring defendant to return to him certain email communications between himself and his personal attorney, which were sent from plaintiff's work email address and over defendant's server. He argued that the emails were privileged under both the attorney-client privilege and the work product doctrine.

The Appellate Division rejected plaintiff's claim of privilege based on CPLR 4848, which provides that no communication loses its privilege merely because it was sent by electronic means. The court stated that "the holder of the privilege and his or her attorney must protect the privileged communication." To examine whether plaintiff's use of his employer's email for personal email communications rendered the communication not made in confidence, the court applied the test from *In re Asia Global Crossing*, 322 B.R. 247 (S.D.N.Y. 2005). In that case, the District Court for the Southern District of New York established that whether

or not personal emails sent using an employer's email were privileged is a case-by-case analysis of four factors: (1) the existence of a corporate policy banning personal or other objectionable use; (2) whether the employer monitors an employee's computer or emails; (3) whether third parties have a right of access to the computer or emails; and (4) whether the corporation notified the employee, or whether the employee was otherwise aware, of the use and monitoring policies. *See id.* at 257.

The *Scott* court found that plaintiff's emails with his personal attorney were not privileged under this test. Defendant had an email policy in place that specifically prohibited personal use and retained defendant's right to monitor and access materials on its computer systems without notice. The only third parties with regular access to the emails after plaintiff left were members of defendant's computer staff, whose access does not defeat privilege under CPLR 4848. Finally, plaintiff was charged with both constructive and actual knowledge of the policy. He had constructive knowledge because of his position as an administrator and because he required new doctors in his department to sign an acknowledgment form confirming that they were aware of the policy. He had actual knowledge because the policy was distributed to every employee in 2002 (despite the fact that he failed at that time to sign a required acknowledgment form confirming receipt).

The court also rejected plaintiff's arguments based on a privacy right implicit in his employment contract, because defendant had a right to monitor its own equipment. It further rejected plaintiff's argument that defendant does not have a right to monitor communications under HIPAA privacy laws, stating that the email did not relate to patients, and even if it did, a hospital has a clear right to access confidential information regarding its patients.

Finally, the court rejected plaintiff's contention that the emails were privileged under the work product doctrine because his personal attorneys tagged each email message with a notice about confidentiality and privilege. The court stated that a lawyer is responsible for using reasonable care when communicating with a client electronically, and that a *pro forma* email notice cannot undo an employer's policy, and is not a reasonable precaution against third party disclosure.

Southern District Dismisses Physician's Whistle-Blower Claims but Sustains Retaliation Claim

United States ex rel. Smith v. New York Presbyterian Hospital, No. 06 Civ. 4056 (NRB), 2007 WL 2142312 (S.D.N.Y. July 18, 2007). Relator brought this *qui tam* action under the federal False Claims Act ("FCA"), alleging fraud and retaliation against New York Presbyterian Hospital ("NYPH") and Cornell University ("Cornell"). Relator, a medical doctor, was an Associate Chair of Information Technology and Systems Administration in Cornell's Radiology Department, and was an Attending Radiologist at NYPH. Relator alleged that he observed NYPH and Cornell perpetrating a scheme to defraud Medicare/Medicaid in that NYPH billed for the technical component of radiological studies ordered by Cornell without waiting for Cornell to complete the professional component of those studies.

Relator further alleged that the employees of NYPH and Cornell retaliated against him in response to his investigation of the FCA fraud, in that he (1) lost access to some of NYPH's administrative computerized systems; (2) did not have his employment contracts with NYPH and Cornell renewed; and (3) received a threatening letter from an NYPH administrator.

This action was originally brought in the District of Connecticut against two Connecticut entities where relator worked prior to joining Cornell and NYPH. Relator named Cornell and NYPH as defendants in his Third Amended Complaint, and alleged the same FCA fraud against all of the defendants. The Connecticut entities successfully moved to dismiss the complaint as against them, and the action was transferred to the Southern District of New York. Specifically, the Connecticut District Court found that an entity can bill the technical component of a radiological study before the professional component is completed. Upon transfer to the Southern District, NYPH and Cornell moved to dismiss the complaint on multiple grounds.

The court ruled that relator did not plead the alleged fraud with the requisite particularity under Rule 9(b). The New York court agreed with the Connecticut court, finding that the fraud allegations were "fraught with assumptions and conclusions, which do not suffice to establish the essential facts of an FCA claim. . . ." Moreover, the court found that relator "does not list a single NYPH employee or hospital technician who is alleged to have been involved [in the alleged fraudulent billing]." Relator also failed to name one specific fraudulent claim. Accordingly, the court dismissed relator's FCA claim pursuant to Rule 9(b).

Although the court dismissed the FCA claim for lack of particularity, it performed an analysis of the same claim under Rule 12(b)(6). The court agreed with the Connecticut District Court in finding that relator cited no persuasive authority to support his argument that a hospital that has completed the technical component of a radiological study is required to wait for the professional component to be completed before billing the government. In fact, the court listed several examples where patient care would be adversely affected if a hospital could not bill for the technical component of a study until the professional component is done. Accordingly, the court held that relator's

FCA fraud claim should be dismissed under Rule 12(b)(6) as well.

Relator's retaliation claim, however, survived the motion to dismiss. The court found that both Cornell and NYPH were relator's "employer" and therefore relator had standing to bring an FCA retaliation claim against both entities. The court next found that an FCA retaliation claim is subject to New York's three-year statute of limitations for personal injury claims, and therefore relator's claim was timely. The court then held that relator met the standard for pleading an FCA retaliation claim in that he alleged that: (1) he was engaged in conduct protected under the FCA; (2) the defendants knew that he was engaged in such conduct; and (3) he was retaliated against because of the protected conduct. However, the court raised doubts that the retaliation claim would survive a summary judgment motion.

Second Circuit Finds That SUNY Stony Brook Physicians/Professors Cannot Bring Suit Against SUNY Stony Brook, Its Clinical Practice Management Plan or Its Union in Federal Court

Baumgart v. Stony Brook Children's Service, P.C., et al., 2007 WL 2908252 (2d Cir. Oct. 3, 2007). Plaintiffs-Appellants were physicians on the faculty of SUNY Stony Brook School of Medicine, and also worked as clinicians at the Stony Brook University Hospital. Their income as clinicians was managed and distributed by the Stony Brook Clinical Practice Management Plan ("CPMP"). Plaintiffs brought suit alleging breach of the collective bargaining agreement (the "CBA") entered into between the State and Plaintiffs' union, United University Professions ("UUP"). Plaintiffs named various SUNY and CPMP entities and officers, as well as UUP, as defendants, alleging, *inter alia,* that their maximum clinical income was set too low in violation of SUNY's Policies, and that UUP breached its duty of fair representation.

Plaintiffs brought the underlying action in the District Court for the Eastern District of New York ("EDNY"), asserting violation of the federal Labor Management Relations Act ("LMRA") as the basis for federal jurisdiction. The LMRA confers jurisdiction over "hybrid" claims where a plaintiff asserts both a breach of a collective bargaining agreement *and* a breach of a union's duty of fair representation. In this case, plaintiffs alleged that the SUNY Policies were made a part of the CBA by reference, and therefore a violation of the Policies constituted a breach of the CBA. Plaintiffs appealed from two orders entered in the EDNY dismissing their complaint for lack of subject matter jurisdiction, and denying their motion for reconsideration.

The Second Circuit held that "[t]he LMRA does not confer federal jurisdiction over labor disputes among states, their employees, and the unions who represent them" (*citing* 29 U.S.C. § 152(2)). Plaintiffs argued that SUNY Stony Brook, a public entity concededly exempt from the LMRA, was their joint employer with the CPMP entities. Plaintiffs argued that CPMP is a private entity, and that the joint employment removed SUNY Stony Brook's immunity from the LMRA. The Second Circuit, however, agreed with the District Court, finding that UUP is a public sector union that represents plaintiffs as public employees. Moreover, the Second Circuit found that "the collective bargaining agreement plaintiffs seek to enforce was negotiated and entered into exclusively by [UUP] and SUNY." Accordingly, UUP's duties under the CBA "arise from its representation of plaintiffs as public employees, and [UUP] thus does not constitute a 'labor organization' for purposes of the LMRA." The judgment of the District Court was therefore affirmed, and the action was dismissed for lack of subject matter jurisdiction. [Ed. note: Garfunkel, Wild & Travis represented CPMP in this case.]

Federal Court Dismisses Physician's Discrimination Claims Against Other Doctors, but Allows Antitrust Claims to Stand

Mahmud v. Kaufman, et al., 495 F. Supp. 2d 266 (S.D.N.Y. 2007). Plaintiff physician sued other doctors, all affiliated with Bon Secours Community Hospital (the "Hospital"), alleging that defendants caused the Hospital not to renew plaintiff's contract of affiliation and interfered with plaintiff's efforts to gain admitting privileges at Orange Regional Medical Center ("ORMC"), based on defendants' "racial animus" toward plaintiff, and their desire to limit competition with their medical practices. Plaintiff alleged violations of the Civil Rights Act, the Sherman and Clanton Antitrust Acts, the New York Human Executive Law (a/k/a Human Rights Law) ("NYHRL") and the General Business Law ("NYGBL").

Defendants moved under Fed. R. Civ. Proc. 12(b)(6) to dismiss each of plaintiff's claims. After the court sustained the majority of plaintiff's causes of action, defendants moved for reconsideration.

Defendants challenged the court's finding that plaintiff's first 42 U.S.C. § 1981 claim was not time barred. Plaintiff alleged that defendants, through their *de facto* control of the Hospital, influenced the Hospital to refuse to enter into a new contract of affiliation with her based on plaintiff's race. In its initial Decision and Order, the court found that the applicable statute of limitations was four years pursuant to 28 U.S.C. § 1658(a), which states that ". . . a civil action arising under an Act of Congress . . . may not be commenced later than four years after the cause of action accrues." The court allowed plaintiff's claim because the conduct complained of occurred through May 2002 and the action was commenced in September 2005.

On reconsideration, defendants argued that plaintiff's Section 1981 claim was subject to a three-year

statute of limitations and was, therefore, time barred. Defendants relied on the United States Supreme Court decision, *Jones v. Railroad Donnelly and Sons Company,* 51 U.S. 369, 382, 124 S. Ct. 1836, 158 L. Ed. 2d 645 (2004). In that case, the Supreme Court held that in Section 1981 actions addressing a litigant's right to make contracts, a three-year statute of limitations applies. The Southern District concluded that plaintiff's claim addressed her rights to make contracts with the Hospital and ORMC and, based on *Jones*, dismissed plaintiff's claim as untimely. However, the court declined to grant that portion of defendants' motion which sought to dismiss plaintiff's second Section 1981 claim for failure to state a cause of action. In that claim, plaintiff alleged that defendants prevented her from entering into a contract with OMRC (apparently, this action was not time barred although not discussed). The court concluded that, under liberal pleading standards, the cause of action was adequately pleaded.

As to plaintiff's claim under NYHRL § 296(i)(a), the court noted that the NYHRL only prohibits racial discrimination in the traditional employment context and that plaintiff failed to allege that she sought an employer/employee relationship with ORMC. In this case, plaintiff conceded that she applied for a contract of affiliation to gain admitting privileges at ORMC, not employment. Thus, the court concluded that defendants' alleged conduct did not cause ORMC to refuse to hire plaintiff, rendering the NYHRL inapplicable.

The court sustained plaintiff's Antitrust claims, which alleged that defendants conspired to interfere with plaintiff's contracts with the Hospital and ORMC, in order to eliminate competition. Defendants argued that plaintiff did not satisfy the element of concerted action because she claimed that defendants conspired "among themselves" and not with a third party. The court disagreed and found that a group of physicians may be legally capable of conspiring among themselves for purposes of the Sherman Antitrust Act. The court, however, dismissed plaintiff's claim under the NYGBL, because that statute does not apply to licensed physicians.

Appellate Division Affirms Reversal of Jury Verdict Finding Hospital Liable for Negligent Re-Credentialing of Surgeon

Ortiz v. Jaber and Lutheran Med. Ctr., 843 N.Y.S.2d 384 (2d Dep't, Oct. 2, 2007). Plaintiff and her husband filed a malpractice suit to recover for personal injuries following a laparoscopic surgery at the defendant hospital. The suit alleged that the hospital had violated its Bylaws and the Public Health Law by re-credentialing the doctor despite a history of 21 previous medical malpractice actions. Plaintiff alleged that the hospital should have considered the doctor's entire history of malpractice, and on that basis should have restricted or denied his privileges.

Following a jury verdict for plaintiff, the trial court granted the hospital's motion to set aside the verdict. The appellate court agreed that the hospital had not violated either its Bylaws or the Public Health Law, where defense experts testified that the hospital had conducted a review of the doctor's entire file, including malpractice claims, but was required by Public Health Law § 2805-k to consider only "pending" cases in deciding whether to grant the physician's most recent privileges application.

The appellate court therefore held that while a hospital is required to review an independent physician's qualifications before granting or renewing privileges (*citing*, *inter alia,* Public Health Law §§ 2805-j and 2805-k), in the absence of any evidence that the hospital violated its own Bylaws or the Public Health Law, "there was no valid line of reasoning and permissible inferences which could possibly lead rational persons to the conclusion reached by the jury."

Court Upholds Revocation of Orthopedic Surgeon's License for False Statements and Omissions on Hospital Medical Staff Applications

Ross v. State Bd. for Prof'l Med. Conduct, 2007 WL 3196627 (3d Dep't, Nov. 1, 2007). Petitioner, an orthopedic surgeon, brought an Article 78 proceeding to challenge a determination by the Administrative Review Board for Professional Medical Conduct ("ARB"). The Office of Professional Medical Conduct ("OPMC") charged the surgeon with fraudulent practice, willful filing of false reports, violations of Public Health Law § 2805-k, and conduct evidencing moral unfitness to practice medicine in connection with his repeated provision of inaccurate information on hospital medical staff applications. Petitioner claimed that these inaccuracies, including those involving his disciplinary background, were inadvertent and inconsequential, and resulted when his original applications were prepared by his mother and unintentionally perpetuated by his office manager in subsequent applications.

A three-member Hearing Committee sustained all of the charges against petitioner except those pertaining to moral unfitness, and recommended a one-year license suspension, a two-year period of probation, and twenty hours of continuing medical education. The Committee also had directed that, during the probationary period, applications for renewal, appointment or insurance be submitted to the Department of Health. Both petitioner and the OPMC sought review of the Hearing Committee's decision. Upon review, the ARB sustained the charges and revoked the surgeon's license to practice medicine.

The Appellate Division upheld the ARB findings. The court found that despite petitioner's denials, he repeatedly omitted from applications information concerning disciplinary actions against him. Specifically, petitioner failed to disclose that *inter alia* he had: been suspended for four

weeks during his orthopedic residency training in 1988; been served with a statement of charges in 1988 and later censured and reprimanded, as well as sued for malpractice in connection with work during his residency in 1986; been the subject of an investigation by the OPMC in 2002; and been subjected to focused review at a hospital at which he had had privileges. Petitioner engaged in these omissions repeatedly despite correspondence by himself and his attorney in 1989 with hospitals to which he had submitted applications, and despite letters of admonishment from hospitals in 1989 and 1990.

The court dismissed petitioner's claims that his course of conduct resulted solely from inadvertent errors or the errors of others, stating that fraudulent practice could be inferred from the surrounding circumstances. Petitioner, who acknowledged his ultimate responsibility for the misinformation, perpetuated it on subsequent applications after clearly being notified of the errors and failed to undertake any effort whatsoever to correct them. Even though petitioner's conduct did not implicate patient care, the court decided that there was no reason to disturb the ARB's determination that petitioner's repeated, deliberate and false representations violated the public trust and demonstrated an overall lack of integrity. Finally, the court found that the penalty of revocation was not so disproportionate to the underlying offenses as to shock one's sense of fairness.

Federal Court in New York Accepts a New Theory of Discrimination Under New York Executive Law in Class Action Suit by Former Patients of a Psychiatric Treatment Facility

Romano et al. v. SLS Residential Inc., et al., 2007 WL 3145076 (S.D.N.Y. Oct. 10, 2007). Former patients of a psychiatric treatment facility sued the facility, its owners and several employees, under the New York Executive Law, the Rehabilitation Act of 1973, the Americans with Disabilities Act ("ADA"), and a variety of state law claims. Plaintiffs moved for class certification, and defendants moved to dismiss the claims and for a stay of the action pending the outcome of an administrative proceeding before the Office of Mental Health ("OMH").

The complaint alleged that defendants regularly assaulted, restrained, punished and isolated patients. Further, plaintiffs alleged that defendants fraudulently held themselves out as being experts in the care and rehabilitation of mentally ill patients, when in fact they failed to focus on rehabilitation and recovery.

Plaintiffs' claims under New York Executive Law § 296 brought an issue of first impression before the court. Under Section 296, a plaintiff must show he or she was disabled and that he or she was discriminated against by an owner, leasor/lessee, or operator of a place of public accommodation because of his or her disability. Plaintiffs made the novel argument that defendants' conduct amounted to discrimination because defendants "targeted, mistreated and profited off" plaintiffs based on their "vulnerability as a disabled person."

The court accepted plaintiffs' argument even though neither the parties nor the court found any case on point that recognized this theory of discrimination. The court held that, "where an entity targets a protected class for mistreatment because of its protected status . . . , such conduct constitutes discrimination." To hold otherwise would allow defendants to avoid liability under the discrimination laws if they only target disabled people, rather than also providing services, goods, or accommodations to others who would use defendants' services but for the fact they are not disabled. As such, plaintiffs stated a claim under the New York Executive Law.

In deciding defendants' motion to dismiss plaintiffs' ADA claim due to lack of standing, the court noted that standing requires a plaintiff to establish that an injury in fact was suffered, that there was a causal connection between the injury and a defendant's conduct, and that the injury would be redressed by a favorable decision. Further, the court stated that Title III of the ADA permits a plaintiff only injunctive relief—not damages—for discriminatory behavior against a disabled person in places of public accommodation.

To establish the injury in fact, the court stated plaintiffs had to demonstrate defendants' actions were causing an irreparable harm and that there was a real or immediate threat that plaintiffs would be injured again. There had to be a "continuing, present adverse effect" because of defendants' continued behavior. Because plaintiffs were no longer patients at the facility, and made no allegations that they intended to use the facility in the future or would use it but for defendants' conduct, the court found that any potential injury to plaintiffs was speculative and not actionable for injunctive relief under the ADA. Accordingly, the court dismissed the ADA claims.

Defendants' motion to dismiss plaintiffs' Rehabilitation Act claim was also granted for failure to state a claim. Section 504 of the Rehabilitation Act requires a showing that the plaintiff is disabled for purposes of the Act, the plaintiff was "otherwise qualified" for the benefit he or she was denied, the denial of the benefit was solely because of the disability, and the benefit is part of a program or activity that received funding from the Federal Government. The court stated that "the Act does not create a cause of action based on a handicap that is directly related to providing the very services at issue." Because plaintiffs' disability in this case—mental illness—was the basis for plaintiffs seeking defendants' services, plaintiffs failed to state a claim under the Rehabilitation Act.

In addressing plaintiffs' other state law claims, the court found that plaintiffs stated a claim of intentional

and negligent infliction of emotional distress because their allegations of defendants' behavior—which they allege included repeated acts of physical abuse—amounted to "outrageous conduct" that a civilized society would find "atrocious and intolerable."

The court granted plaintiffs' motion for class certification because plaintiffs met the four requirements of Rule 23(a), which are: (1) the claims are too numerous to individually join all plaintiffs; (2) the claims share common questions of law and fact; (3) the claims are typical of a class claim; and (4) the named plaintiffs will be fair and adequately represent all of the plaintiffs' rights. Further, under Rule 23(b), the court found that, although there would be individualized proof required for an individual plaintiff's claims, the generalized proof required to establish injury from the alleged systemic practices and policies of defendants outweighed any individual issues and the class should be certified.

Supreme Court Confirms That Under New York Law, a Physician Cannot Maintain a Cause of Action for Damages for the Alleged Wrongful Denial of Clinical Privileges

Frank M. Lobacz, M.D. v. North Shore LIJ Southside Hospital, Index No. 7153-07 (http://decisions.courts.state.ny.us; 51000715320071sciv.pdf) (October 31, 2007). Plaintiff is a physician with family practice privileges at defendant Southside Hospital. He brought suit for $10 million in compensatory damages stemming from multiple denials of his requests for clinical privileges to perform medical acupuncture. He claimed interference with his contractual rights with patients, and his licensed right to practice medicine. The hospital moved to dismiss the complaint with prejudice, on the grounds that New York does not recognize a cause of action for damages for the alleged wrongful denial of hospital privileges; because plaintiff failed to exhaust his administrative remedy with the New York State Public Health Council ("PHC"); and as barred by the statute of limitations. Plaintiff then sought to withdraw the complaint without prejudice, so that he could pursue his administrative remedy with the PHC, and then return to court to pursue his damage claim. Plaintiff argued that because he had not yet exhausted his administrative remedy, the court could not yet review the merits of his complaint.

The motion court granted the hospital's motion to dismiss plaintiff's complaint with prejudice to the extent that he requested damages, but also granted plaintiff's motion to discontinue the action without prejudice to the extent that plaintiff may pursue his administrative remedy and then seek only injunctive relief.

The court examined Public Health Law ("PHL") § 2801-b, which provides the criteria upon which hospitals must base decisions to grant or deny clinical privileges to physicians, and also provides for administrative review of hospital privileges decisions by the PHC. PHL § 2801-c also provides that the exclusive remedy for violations of PHL § 2801-b is an injunction. Upon review of these provisions, the court found that, as confirmed by New York case law, "[a]n aggrieved physician is limited to claims solely involving injunctive relief based upon wrongful denial of hospital privileges and cannot recover money damages based upon such claims." Since plaintiff's claim sought only money damages, he failed to state a viable cause of action. [Ed. note: Garfunkel, Wild & Travis, P.C. represented the hospital in this case.]

Appellate Division Rules That Commissioner of Health Must Refund Capital Value Fee Paid for the Proposed Construction of a Nursing Home.

Sbriglio v. Novello, 2007 WL 3104214 (3d Dep't 2007). In this Article 78 proceeding, nursing home developers sought review of the Commissioner of Health's refusal to refund capital value fees of approximately $78,000.

In 1993, the Public Health Council (the "PHC") contingently approved the petitioners' application for the establishment of a residential health care facility in Newburgh, Orange County. Shortly thereafter, the Department of Health contingently approved the petitioners' application setting forth the scope and concept for the facility's construction. At that time, the petitioners paid a capital value fee in satisfaction of one of the listed contingencies, and later paid an additional fee after obtaining approval to increase the proposed cost of the project. The petitioners later sought to amend their application.

In 2000, the respondent indicated that the original application was amended and superseded, issued a new application number, and announced a temporary moratorium on the review of applications that had not yet received approval to start construction. When the moratorium was lifted in October 2004, the PHC disapproved the petitioners' amended application. The petitioners sought a refund of the fee paid to the respondent in connection with the original application that had been approved, but the Department of Health refused to refund the fee. The petitioners commenced an Article 78 proceeding challenging the respondent's refusal to refund the fee. The Supreme Court, Albany County, dismissed the petition, concluding that the refusal was rational. The Appellate Division reversed, finding that the respondent's refusal was arbitrary, capricious, and contrary to law.

The Appellate Division applied its own statutory reading and analysis in arriving at a decision in the belief that the circumstances did not call for an agency's technical expertise. The court first distinguished between the Public Health Law § 2801-a, the mechanism by which the PHC approves the "establishment or

incorporation" of a nursing home, and Public Health Law § 2802, the mechanism by which the respondent approves the "construction" of a nursing home. The regulations implementing Section 2802 divide the construction application process into three levels of approval: (1) application, project scope and concept; (2) determination by the Commissioner; and (3) approval to start construction. The court concluded that the second level of approval (determination by the Commissioner) triggers payment of the 0.4% capital value fee, rejecting the respondent's argument that the first level (application, project scope and concept) is the "written approval" sufficient to trigger payment of the capital value fee under Public Health Law § 2802(7).

To support its conclusion, the court relied on case law stating that "contingent approval is not tantamount to final approval" because agencies have the power to re-evaluate their initial determination of public need for a facility. This initial determination has been long recognized by New York courts as tentative. Also, the court cited the Commissioner's regulation providing that the second approval level of the construction application process is the critical determination by the Commissioner. It is only after the Commissioner receives all documentation for the second level of approval and determines that all applicable outstanding contingencies have been satisfied that an application is approved or denied.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a Partner in the firm of Garfunkel, Wild & Travis, P.C., a full-service health care firm representing hospitals, health care systems, physician group practices, individual practitioners, nursing homes and other health-related businesses and organizations. Mr. Rosenberg is Chair of the firm's litigation group, and his practice includes advising clients concerning general health care law issues and litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation, contract, administrative and regulatory issues, professional discipline, and directors' and officers' liability claims.

In the New York State Legislature

By James W. Lytle

By the time this edition is published, the New York State Legislature is likely to have returned to Albany to resume its deliberations, now in the second year of the Spitzer Administration. While the relationships between the Governor and the legislative leaders have been the subject of much of the attention of late, the Governor's first year was a reasonably productive one, particularly in the health care arena. After a virtually unprecedented budget battle with the hospital industry and health care workers, the Governor's team managed to enact a half dozen or so of the bills sought by the Department of Health and the Governor's office—bills that addressed managed care regulation, the operation of dialysis clinics by publicly traded companies, immunization and infection control, regional perinatal data systems and a range of other bills.

In light of the more contentious relationship that exists at least as of this writing, it is not yet clear whether that level of success is likely to continue in year two, particularly when members of the Legislature will be running for re-election and long-standing Republican control of the State Senate will be very seriously challenged. Whatever may be the outcome, the Administration shows no sign of diminishing its interest in reshaping health care policy, with a number of key initiatives likely to be on the legislative docket in 2008. Here is a review of what may prove to be the key issues:

Medicaid cost containment: While not unique to this Administration, the recurrent need to attempt to rein in expenditures in the Medicaid program is likely to be the focus of the early part of the legislative session, as the Governor attempts to close a projected $4.3 billion budget gap in the 2008–09 fiscal plan.

A recent State Comptroller report on state spending cited Medicaid costs—and prescription drug and home care expenditures, in particular—as major contributors to the growing gap between state revenues and state expenditures. With discouraging reports from Wall Street fueling expectations that state revenues (heavily dependent on the financial services industry and the end-of-year tax receipts on Wall Street bonuses) may not meet expectations, the cost containment pressure will be that much more intense. Last year's budget battles spawned a long and bitter battle, as noted, between the Governor and the hospital industry: both sides appear to be ready for a rematch.

Graduate medical education: As was apparent during last year's budget battles, Graduate Medical Education (GME) will again be at the center of next year's debate. In mid-June, Commissioner Richard Daines spelled out his concerns over the current $1.4 billion in Medicaid support for GME, principally asking whether New York is receiving a sufficient return on this investment.

Indigent care reform: Chapter 58 of the Laws of 2007 required the establishment of an Indigent Care Technical Advisory Committee to evaluate the current Hospital Indigent Care Pool, including its methodology, its purposes and the relationship between the current pool funding with the more recently enacted Hospital Patient Financial Aid Law, which requires hospitals to provide discounts to uninsured patients with incomes below specified levels. The Advisory Committee has met during the course of the summer and fall, held a series of public meetings, and significant changes in indigent care funding might be proposed by the Department as a result.

Medicaid reform: In addition to containing its costs, the program leadership at the Department have pledged to fundamentally change the way Medicaid pays for care. The expressed goals have been to leverage Medicaid's buying power (as the payor of nearly one-third of all state health care expenditures) to ensure continuity of coverage, to enhance value and to prevent waste and fraud. Wholesale reforms of how reimbursement is made for similar services—often dependent on the nature of the provider of care's license status and not on the care actually rendered—are expected at least over the next several years.

Universal health care coverage: Like several other states, New York appears poised to advance its own proposals to achieve universal health insurance coverage for its citizens, at least in the absence of any significant short-term prospects for progress at the federal level. Terming their effort "Partnership for Coverage," the Spitzer Administration has held hearings across the State on steps that might be taken to extend coverage to New Yorkers without health insurance coverage and has sought proposals from outside entities to evaluate proposals that might be advanced to achieve this goal. A deepening budgetary deficit may delay these efforts, but it is expected that proposals for universal coverage may begin to emerge from the Administration and the Legislature over the coming months and years.

Medical malpractice reform: For both fiscal and policy reasons, the reform of the medical liability

system is likely to be the subject of more consideration in 2008 than it has since the mid-1980s, the last time any significant medical malpractice reform was enacted. In late August, Insurance Superintendent Eric Dinallo and Commissioner Daines named a series of organizations to a Medical Malpractice Liability Task Force. Organizations representing consumers, business groups, hospital associations, physician and other provider associations, health insurers, malpractice carriers, and lawyers were invited to join legislators and regulators to discuss these issues. Whether the historically diametrically different perspectives brought by, say, the Trial Lawyers Association and the Medical Society of the State of New York might actually result in any significant and serious recommendations from the Task Force remains to be seen: observers of the Task Force meetings have confirmed that, thus far, somewhat more heat than light has been generated on the topic.

Home care aide registry: In an example of how the increasingly intense emphasis on Medicaid fraud and abuse may itself generate new policy initiatives, the Legislature is likely to consider proposals that will provide home care agencies with access to a state database to assess whether home health aides have the appropriate training and certification. Attorney General Andrew Cuomo and the Medicaid Fraud Control Unit launched an investigation known as "Operation Home Alone" that uncovered phony home care certification programs and other abusive practices that have already resulted in criminal charges and large Medicaid recoveries. The Legislature may consider proposals that will not only verify the qualifications of home health aides but may also provide access to their criminal history to facilitate home health agency reviews of prospective hires.

Physician ranking: Again as a result of an investigation by Attorney General Cuomo, legislation that may further regulate how health plans might utilize physician ranking systems may be under consideration by the 2008 Legislature. The Attorney General's Healthcare Bureau has obtained the agreement of several plans to either abandon their physician ranking programs or to adopt new approaches to the practice—and the Legislature may enact statutory provisions to conform current law to these new standards.

Mr. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP.

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

Hospice Residence Dually Certified Beds

Notice of adoption. The Department of Health amended Parts 700, 717, 790, 791 and 794 of Title 10 N.Y.C.R.R. to establish standards and procedures for hospice residence beds dually certified for residence care and inpatient care as well as updating general standards for hospice residence. Filing date: May 18, 2007. Effective date: June 6, 2007. *See* N.Y. Register, June 6, 2007.

Feeding Assistants in Nursing Homes

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 415.13 and add §§ 415.2(u) and 415.26(k) to Title 10 N.Y.C.R.R. to permit the use of paid feeding assistants in nursing facilities. *See* N.Y. Register, July 25, 2007.

Non-Prescription Emergency Contraceptive

Notice of emergency rulemaking. The Department of Health amended § 505.3(b)(1) of Title 18 N.Y.C.R.R. to allow access to Federal Drug Administration–approved non-prescription contraceptive drugs to be dispensed by a pharmacy without a fiscal order to women 18 years of age and older. Filing date: August 2, 2007. Effective date: August 2, 2007. *See* N.Y. Register, August 22, 2007.

Serialized Official New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended Parts 80 and 85 of Title 10 N.Y.C.R.R., and amended § 505.3 and repealed §§ 528.1 and 528.2 of Title 18 N.Y.C.R.R. to enact a serialized New York State prescription form to combat and prevent prescription fraud by curtailing theft or copying of prescriptions by individuals engaged in drug diversion. Filing date: August 6, 2007. Effective date: August 6, 2007. *See* N.Y. Register, August 22, 2007.

Payment of Nursing Services Provided to Medically Fragile Children

Notice of emergency rulemaking. The Department of Health amended § 505.8(g) of Title 18 N.Y.C.R.R. to authorize payment of Medicaid reimbursement for private duty nursing services at an enhanced rate when provided to medically fragile children in the community upon submission of a certification to the Department of Health that the provider is trained and experienced in caring for medically fragile children. Filing date: August 22, 2007. Effective date: August 22, 2007. *See* N.Y. Register, September 12, 2007.

Criminal History Record Check

Notice of emergency rulemaking. The Department of Health added Part 402 to Title 10 N.Y.C.R.R. to implement Chapter 769 of the Laws of 2006 and a chapter of the Laws of 2006 (Section 6630) by requiring nursing homes, certified home health agencies, licensed home care service agencies and long-term home health care programs to request criminal background checks of certain prospective employees that provide direct care or supervision to patients, residents or clients of such providers. Filing date: August 22, 2007. Effective date: August 22, 2007. *See* N.Y. Register, September 12, 2007.

Payment for Federally Qualified Health Centers ("FQHC") Psychotherapy and Offsite Services

Notice of emergency rulemaking. The Department of Health amended § 86-4.9 of Title 10 N.Y.C.R.R. to permit psychotherapy by certified social workers in an Article 28 FQHC as a billable service under certain circumstances. Filing date: September 10, 2007. Effective date: September 10, 2007. *See* N.Y. Register, September 26, 2007.

INSURANCE DEPARTMENT

Rules Governing Individual and Group Accident and Health Insurance Reserves

Notice of adoption. The Department of Insurance gave notice of its intent to repeal Part 94 and add a new Part 94 (Regulation 56) to Title 11 N.Y.C.R.R. to prescribe rules and regulations for valuation of minimum individual and group accident and health insurance reserves including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. Filing date: June 20, 2007. Effective date: July 11, 2007. *See* N.Y. Register, July 11, 2007.

High Deductible Health Plans

Notice of emergency rulemaking. The Department of Insurance added §§ 362-2.7(d), (e), and (f) and 362-2.8 to Title 11 N.Y.C.R.R. to create additional health insurance options for qualifying small employers and individuals by requiring health maintenance organizations and participating insurers to offer high deductible health plans in conjunction with the Healthy New York Program. Filing date: August 2, 2007. Effective date: August 2, 2007. *See* N.Y. Register, August 22, 2007.

Minimum Standards for the Form, Content and Sale of Health Insurance

Notice of emergency rulemaking. The Department of Insurance amended § 52.70 (Regulation 62) of Title 11 N.Y.C.R.R. to require insurers, Article 43 corporations and HMOs to send notices to their policy holders, certificate holders, and members describing Chapter 748 of the Laws of 2006. Filing date: August 7, 2007. Effective date: August 7, 2007. *See* N.Y. Register, August 22, 2007.

Healthy New York Program

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to add §§ 362-2.7(d), (e) and (f) and 362-2.8 to Title 11 N.Y.C.R.R. to offer high deductible health plans in conjunction with the Healthy New York Program and to add additional benefits to the program. *See* N.Y. Register, August 22, 2007.

Continuing Care Retirement Communities

Notice of revised rulemaking. The Department of Insurance amended Part 350 (Regulation 140) of Title 11 N.Y.C.R.R. to adopt revised standards pertaining to continuing care retirement communities authorized pursuant to Article 46 of the Public Health Law. *See* N.Y. Register, August 22, 2007.

Establishment of Industry Standard Rate

Notice of emergency rulemaking. The Department of Insurance amended Part 151 (Regulation 119) of Title 11 N.Y.C.R.R. to establish the interest rate applicable when Workers' Compensation insurers are required to deposit the present value of unpaid benefits for permanent partial disability cases into the aggregate trust fund. Filing date: September 19, 2007. Effective date: September 19, 2007. *See* N.Y. Register, October 10, 2007.

Term Life Issuance and Renewal Restriction

Notice of revised rulemaking. The Department of Insurance amended Part 42 (Regulation 149) of Title 11 N.Y.C.R.R. to modify the restrictions on issuance of term life insurance, bring basic policy anniversary nonforfeiture requirements into closer alignment with those of the rest of the states, and provide guidance on miscellaneous nonforfeiture issues. *See* N.Y. Register, October 10, 2007.

DEPARTMENT OF LAW

Investigations, Civil Enforcement Action and *Qui Tam* Actions Related to Fraud

Notion of emergency/proposed rulemaking. The Department of Law added Part 400 to Title 13 N.Y.C.R.R. to establish procedures for (1) investigating persons who defrauded the State or a local government and (2) the handling and processing of civil enforcement actions and *qui tam* actions under the New York State False Claim Act. Filing date: September 10, 2007. Effective date: September 10, 2007. *See* N.Y. Register, September 26, 2007.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft LLP's 17-attorney health law department. He is the Vice Chairman of the New York State Public Heath 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 Section. 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 Jared L. Facher and Eric Morrow of Cadwalader, Wickersham & Taft LLP in compiling this summary is gratefully acknowledged.

In the Journals

DePaul Journal of Health Care Law, Vol. 10, Issue 1

- *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law,* Vernellia R. Randall
- *An Examination of Variance in Risk Factors Associated with Diagnosis of Coronary Heart Disease,* Terry L. Mills
- *Perceptions and Beliefs About Type 2 Diabetes Among Non-Diabetic Black Women,* Mary Shaw-Perry
- *Mental Health Strategies to Eliminate Health Disparities: Towards The Creation of a Climate and Culture of Optimal Health from an African (Indigenous) American,* Linda James Myers
- *Lessons from African American History,* Lois E. Horton
- *Weaving the Tapestry of Healthier Cultures,* Gege Dimond
- *A Paradigm Shift in Health Communities of Color,* Chu Chu Onwauchi-Saunders
- *The Future of Health in Communities of Color out of Many, One: A Multicultural Action Plan to Achieve Health Parity,* Ruth T. Perot
- *Y.E.S. 4 Health: A Peer Education Approach to Prevention of Diabetes in African American Adolescents,* Imani Ma'at, K.A. Harris, G.A. Ogden, P. Rodne

Indiana Health Law Review, Vol. 4, No. 2

- *Of Doctors and Hospitals: Setting the Analytical Framework or Managing and Regulating the Relationship*, James F. Blumstein

Symposium: Hospital-Physician Joint Ventures: A Promising Partnership?

- *Introduction,* Eleanor D. Kinney
- *Transcript of Live Symposium Panel Discussion,* James F. Blumstein, Gregory L. Pemberton, Norman G. Table, Steven H. Pratt, Dennis L. Pippenger, M.D., Michael J. Finnerty
- *Hospital-Physician Joint Venture Relationships—A Useful Tool to Improve Hospital Services,* Steven H. Pratt
- *Move Over Managed Care—Health Savings Accounts, Small Businesses, and Low Wage Earners: Cost, Quality, and Access,* Russell B. Cate
- *Harvesting Organs from Minors and Incompetent Adults to Supply the Nation's Organ Drought: A Critical Review of the Substituted Judgment Doctrine and the Best Interest Standard,* Beth A. Schenberg
- *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment,* Rachel A. Scherer
- *Letting Lilliputians Sit at the Table: Providing Physicians with a Magnified Voice to Counter the Brobdingnagian HMO,* Brandt R. Voight

Indiana Health Law Review, Vol. 4, No.1 (2007)

- *Obesity, Public Health, and the Food Supply,* Barbara L. Atwell
- *No Fault, No Worries . . . Combining a No-Fault Medical Malpractice Act with a National Single-Payer Health Insurance Plan,* Jeremy Coylewright
- *Reforming FDA Policy for Pediatric Testing: Challenges and Changes in the Wake of Studies Using Antidepressant Drugs,* Joanna K. Sax
- *Policy, Plain Language, and Legislative Purpose: Applying State Medical Malpractice Caps on Damages to Federal EMTALA Claims,* Lauren N. Grattenthaler
- *Do the Benefits Outweigh the Risks? The Legal, Business, and Ethical Ramifications of Pulling a Blockbuster Drug Off the Market,* Neil F. Hazaray
- *The Patient Safety and Quality Improvement Act of 2005: An Invitation for Sham Peer Review in the Health Care Setting,* Leigh Ann Lauth
- *Nonprofit Hospital Billing of Uninsured Patients: Consumer Based Class Actions Move to State Courts,* David L. Nie

Houston Journal Health Law and Policy, Vol. 7, No. 2 (2007)

- *Symposium: The Role of Competition and Antitrust Laws in Healthcare*
- *Thirty Years of Solicitude: Antitrust Law and Physician Cartels,* Thomas (Tim) Greaney, J.D.
- *The Architecture of Health Care Markets: Economic Sociology and Antitrust Law,* Peter J. Hammer, J.D., Ph.D.
- *Hospital Mergers in an Era of Quality Improvement*, Kristin Madison, J.D.
- *The Nursing Shortage, Wage-Information Sharing Among Competing Hospitals, and the Antitrust Laws: The Nurse Wages Antitrust Litigation*, Jeff Miles, J.D.
- *Pharmaceutical Reformulation: The Growth of Life Cycle Management*, Rebecca S. Yoshitani, J.D., and Ellen S. Cooper, J.D., LL.M

Other Journals

- *Balancing Public and Private Interests in the Commercialization of Publicly Funded Medical Research: Is There a Role for Compulsory Government Royalty Fees?*, Ron A. Bouchard, 13 B.U. J. Sci. & Tech. L. 120 (Summer 2007)
- *The Blurred Line Between Nursing Homes and Assisted Living Facilities: How Limited Medicaid Funding of Assisted Living Facilities Can Save Tax Dollars While Improving the Quality of Life of the Elderly*, Jennifer Rae Fleming, 15 U. Miami Bus. L. Rev. 245 (2007)
- *The Criminalization of Treating End of Life Patients with Risky Pain Medication and the Role of the Extreme Emergency Situation*, Gina Castellano, 76 Fordham L. Rev. 203 (2007)
- *Defending Hospital Mergers After the FTC's Unorthodox Challenge to the Evanston Northwestern–Highland Park Transaction*, Tom Campbell, 16 Ann. Health L. 213 (2007)
- *The Dinosaur in the Office: A Consideration of the Technical and Ethical Issues Surrounding the Adoption of Digital Medical Data and the Extinction of the Paper Record*, Intro by Kristin E. Schleiter, 16 Ann. Health L. 353 (2007)
- *Disability Discrimination in Long-Term Care: Using the Fair Housing Act to Prevent Illegal Screening in Admissions to Nursing Homes and Assisted Living Facilities*, Eric M. Carlson, 21 N.D. J. L. Ethics & Pub Pol'y 363 (2007)
- *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, Sonja, 31 N.Y.U. Rev. L. & Soc. Change 361 (2007)
- *Electronic Healthcare Data Collection and Pay-for-Performance: Translating Theory into Practice*, Ramesh C. Sachdeva, M.D, 16 Ann. Health L. 291 (2007)
- *The Impact of Medicaid Reforms and False Claims Enforcement: Limiting Access by Discouraging Provider Participation in Medicaid Programs*, Christine M. Shaffer, 58 S.C. L. Rev. 995 (2007)
- *Influencing Physicians' Prescribing Behavior: Ethical Issues Related to Pharmaceutical Gifts*, Stephen A. Talmadge 11 Mich. St. J. Med. & Law 303 (2007)
- *Medicare's Coverage with Study Participation Policy: Clinical Trials or Tribulations*?, Sandra J. Carnahan, 7 Yale J. Health Pol'y L. & Ethics 229 (2007)
- *The New Medicare Part D Prescription Drug Benefit*, David Pratt, 17 Alb. L.J. Sci. & Tech. 337 (2007)
- *Pandora's Box: Can HIPAA Still Protect Patient Privacy Under A National Health Care Information Network?*, Sean T. McLaughlin, 42 Gonz. L. Rev. 29 (2006/2007)
- *The Politics of Health Law: Palliative Care in the U.S. Healthcare System: Constitutional Right or Criminal Act?*, Stephen Arons, 29 W. New Eng. L. Rev. 309 (2007)
- *A Proposal to Use Common Ground that Exists Between the Medical and Legal Professions to Promote a Culture of Safety*, Steven E. Pegalis, 51 N.Y.L. Sch. L. Rev. 1056 (2007)
- *Substituting an Iron Fist for the Invisible Hand: The False Claims Act and Nursing Home Quality of Care—A Legal and Economic Perspective*, James E. Utterback, 10 Quinnipiac Health L.J. 113 (2007)
- *Tackling the "Evils" of Interlocking Directorates in Healthcare Nonprofits*, Nicole Huberfeld, * 85 Neb. L. Rev. 681 (2007)
- *Telemedicine and the Commoditization of Medical Services*, Thomas R. McLean, 10 DePaul J. Health Care L. 131 (2007).

For Your Information

By Claudia O. Torrey

The following information highlights some of the recent "headlines" regarding medical malpractice issues:

- The use of pre-dispute binding arbitration is showing up more in agreements involving health plans, hospital admission materials, and statements of financial responsibility; as well as in cell phone bills and home mortgages.[1] Pre-dispute arbitration agreements are contracts in which both patients and physicians waive access to a jury trial and irrevocably commit to an arbitration process before either party has been harmed or any dispute has arisen.[2] This type of agreement calls into question concerns of: ethics, basic fairness, and the concept of a "legal end run" around the judicial system—in effect, bare minimum assent replacing true informed consent.[3] In 1998 the American Bar Association, the American Medical Association, and the American Arbitration Association created the Commission on Healthcare Dispute Resolution ("Commission") and completely rejected the use of pre-dispute binding arbitration in patient-physician contracts; however, the Commission did advocate using pre-dispute non-binding arbitration or post-dispute binding and non-binding arbitration.[4]

  The Motor Vehicle Franchise Contract Arbitration Act became law in 2002. The Act requires arbitration agreements between motor vehicle distributors and auto manufacturers to be signed by both parties after a dispute arises.[5] The Act also requires the arbitrators to provide a written account of their conclusions of law and facts.[6] "If owners of automobile dealerships, who are typically resource-rich and savvy, warrant protection, then how much more do patients in vulnerable positions seeking care from health providers?"[7]

- According to the October 22, 2007 issue of the *Archives of Internal Medicine*, approximately 80 percent of all United States medical malpractice claims from 2002 to 2004 (closed cases) covered four categories; and, 87 percent of the cases involved significant errors by medical residents.[8] The four categories are: medications, missed and delayed diagnoses, obstetrics, and surgical. While cognitive factors such as judgment and technical knowledge were strongly indicated, lack of teamwork and supervision also contributed significantly. The research sounded a clarion call that the "chain of communication" is sorely lacking in both the education and clinical work involving residents, fellows, and interns.[9] Research participants agreed upon the causal relationship of poor teamwork to preventable errors and quality of care. The question to be addressed is whether, with these facts, patients will soon be the beneficiaries of an improvement in graduate medical education?

- Current presidential candidate views on health care are, to say the least, quite nuanced; however, presidential candidate, lawyer, and former Sen. John Edwards of North Carolina has asserted that medical malpractice claims put enormous responsibilities on the backs of lawyers. Thus, "attorneys who seek to file malpractice lawsuits should have to obtain certification by two experts to prove that their cases have merit. In the event that attorneys fail to obtain certification, **they, not patients,** should have to cover the related legal costs. In the event that attorneys fail to obtain certification three times, they should lose the ability to file future malpractice lawsuits."[10] A novel approach to say the least!

Endnotes

1. Kenneth A. DeVille, The Jury Is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims, 28 *The Journal of Legal Medicine* 333–395 (2007).
2. *Id*. at 333.
3. *Id*. at 381.
4. *Id*. at 386.
5. *Id*. at 388.
6. *Id*.
7. Carl J. Chiappa & David Stoelting, Tip of the Iceberg? New Law Exempts Car Dealers from Federal Arbitration Act, 22 *Am. Bar Ass'n Franchise L.J.* 219, 221 (2003) (quoting Sen. Russ Feingold).
8. Medical Errors Involving Trainees: A Study of Closed Malpractice Claims from Five Insurers, http://www.medicalnewstoday.com/articles/86220.php (last visited Oct. 29, 2007).
9. *Id*.
10. http://www.kaisernetwork.org and www.health08.org .

Claudia O. Torrey is both a member of the Health Law Section and a Sustaining Member of the New York State Bar Association.

Must Hospital Vicarious Liability for Non-Employee Physicians Continue in the 21st Century?

By William D. Yoquinto and Mackenzie C. Monaco

> *Mduba* (madoobah), *n., adj., v.* —*n.* 1. Eddington Mduba, plaintiff and administrator of the estate of Regina Mduba, deceased emergency department patient. —*adj.* 2. of or pertaining to claims for vicarious liability of a hospital for the acts or omissions of non-employed physicians, i.e., "Mduba claim." —*v.* 3. to assign liability to a hospital for the acts or omissions of non-employed physicians to help a plaintiff who has not sued the physician or when there is inadequate insurance coverage for the doctor.

In the modern hospital an ever-expanding variety of medical services are delivered by an array of providers who, while members of the medical staff, are largely not employees of the facility and are not specifically sought after by the patient. Yet, in New York, many attorneys representing claimants believe that notwithstanding the absence of an employment relationship, a hospital where care has been provided may be held vicariously liable for these non-employees under agency principles. The reality of this form of agency liability has been more narrow than some would seem to think, with courts finding application of agency liability for some non-employed practitioners and not for others. It has been real enough, however, for the hospital either sued alone in the absence of the allegedly responsible physician, or in the catastrophic case where there does not seem to be enough available insurance coverage to satisfy the plaintiff in concert with the responsible physician. Two recent cases from the Appellate Division Third Department, while standing for the proposition that "*Mduba*" liability is not automatic and must be proven, also raise the interesting possibility that hospitals might be able to avoid this exposure to malpractice claims by careful disclosure of the physician relationship to the plaintiff at the time care is provided.

A. The Growth of the "*Mduba*" Doctrine in New York

Prior to the Court of Appeals decision in *Bing v. Thunig*, hospitals in New York State enjoyed charitable immunity, remaining immune from responsibility for the negligent acts of its employees. In *Bing*, the Court of Appeals, recognizing the significant control that a hospital exercises over its employees, held that a hospital is liable for the negligence of its employees while acting within the scope of their employment[1]—thereafter setting the precedent that the doctrine of *respondeat superior* shall apply to hold a hospital vicariously liable for the negligent acts of its employees.

"[I]n New York, many attorneys representing claimants believe that notwithstanding the absence of an employment relationship, a hospital where care has been provided may be held vicariously liable for . . . non-employees under agency principles."

But who is an employee? Even in the presence of a document purporting to categorize the physician as an independent contractor, courts have considered the level of control the facility exercises over the means and manner of the physician's practice in determining whether the physician can fairly be seen as an employee.[2] In considering the degree of control the facility exercises, courts have considered the following: whether the physician is guaranteed certain payment, who bills the patient for services provided, who schedules the physician's time, who supplies the materials needed by the physician, whether the physician is free to practice elsewhere, who determines the physician's fees and who is the custodian of the medical records.[3]

Not withstanding mantra-like repetition in cases that a hospital may not ordinarily be held vicariously liable for the negligent acts of a treating physician who is not an employee of the hospital, in extraordinary circumstances, liability can be found.[4] The courts of this state have recognized a distinct and heavily litigated exception to this general rule. That is, in New York, a hospital may be held liable for the acts of independent physicians under the doctrine of apparent or ostensible agency or agency by estoppel, terms which seem to consistently be used interchangeably.[5] Such has been a source of concern and increased liability exposure and, presumably, larger insurance premiums for hospitals.

To state a viable claim based on ostensible agency, a plaintiff must set forth facts sufficient to support the conclusion that the hospital, as opposed to the physician, engaged in some misleading conduct upon which the plaintiff reasonably relied when he/she decided to accept medical services from the physician.[6] To establish the "holding out" element, the misleading words or conduct must be attributable to the principal. To establish the "reliance" element, the third party must accept the agent's services and submit to the agent's care *in reliance* on the belief that the agent was an employee of the principal.[7] In the context of a medical malpractice action, the patient must have reasonably believed that the physicians treating him or her were provided by the hospital or acted on the hospital's behalf.[8]

The Appellate Division Third Department applied the apparent agency principle in the oft-cited case of *Mduba v. Benedictine Hospital*. In *Mduba*, the Court established that when a hospital holds itself out to the public as an institution furnishing doctors, staff and emergency treatment, and a patient enters the hospital through the emergency room seeking treatment from the hospital, not from a particular physician, the hospital may be vicariously liable, if the patient reasonably believed that the physician was provided by the hospital or was acting on the hospital's behalf[9]—thereafter creating a two-prong test used by subsequent courts to determine if a hospital could be held liable for the negligent acts of non-employee physicians, consisting of: (1) Did the patient enter the hospital or facility through the emergency room seeking treatment from the hospital or facility generally, rather than from a specific physician? *and* (2) Did the patient reasonably believe the treating physician was provided by the hospital or facility or was acting on the hospital's behalf? This test has seen considerable recitation.[10]

The Court of Appeals in *Hill v. St. Clare's Hospital* allowed for extension of the apparent agency principles beyond the hospital emergency department, to treatment provided to a patient who presents to a clinic for treatment, not seeking treatment from a specific physician, to hold the clinic owner vicariously liable for the negligent actions of a non-employee physician.[11]

B. Treatment of the Apparent Agency Issue in Other States

Among other states there are two leading views on the issue of vicarious liability for non-employed physicians. Many courts have found hospitals liable for faulty emergency-room care or held the issue for jury determination, even where a treating physician's independent-contractor status was clear or, have relied upon the apparent-authority doctrine to hold hospitals liable for the acts of those whose independent-contractor status might otherwise preclude the hospital's liability.[12] Still some say that the hospital's liability could not be established because of the physician's independent-contractor status.[13] Yet, even in the cases where the physician's independent-contractor status served as a shield for the hospital, the courts focused on the fact that the hospital did not control the means and manner of the medical services provided—thereby looking beyond the title "independent-contractor" to the nature of the relationship and level of control exerted by the hospital.

C. New York Courts Grappling with the Evolution of *Mduba*

While the ostensible or apparent agency test seems clear, each case must be determined by an evaluation of the factual situation presented and there are myriad factors that can and are presented by both the patient and hospital in support of their case. As such, the precedential value of each case is arguably limited, and thus the issue continues to be heavily litigated. Until recently, the issue of control of the means and manner of the medical services provided appeared to have been lost; instead a more simplistic analysis was used related to the expectations of the plaintiff.

Recently, however, the issue of control has come back into view. For example, in *Thurman v. United Health Services Hospital, Inc.*, the Appellate Division Third Department considered whether a hospital could be held vicariously liable for the negligence of a non-employee radiologist.[14] In *Thurman*, the plaintiff's decedent presented to the emergency room of the defendant with abdominal pain and was thereafter admitted to the intensive care unit by the plaintiff's decedent's treating gastroenterologist, Dr. Marhaba. Dr. Marhaba ordered a CAT scan of the plaintiff's decedent to rule out sources of the abdominal bleeding. The CAT scan results were reviewed and interpreted by Dr. Ralston, the on-call radiologist at the defendant hospital. Dr. Ralston was not an employee of the defendant hospital, but instead an employee of an independent group of radiologists with an exclusive contract at the defendant hospital. Dr. Ralston was not known to plaintiff's decedent or Dr. Marhaba, nor was he personally requested by either.

In its decision, the Court reiterated the point, that to hold a hospital vicariously liable for the negligent acts of an independent contractor physician under an ostensible or apparent agency theory, there must be words or conduct on behalf of the hospital, communicated to the patient, that give rise to the appearance and belief that

the physician possesses authority to act on behalf of the hospital. The Court determined that a physician's affiliation with the defendant, his presence at the defendant's facility, his assumption of the role of reading and interpreting decedent's CAT scan, and the physician's use of the defendant's stationery for his report was insufficient to impute his negligence to defendant. Ultimately, the Court found that the plaintiff's decedent's treating physician had assumed the care of the patient and, as such, the hospital did not maintain control over the manner or means of treatment and, as such, the patient could not reasonably have believed that he was receiving medical care from the hospital in general rather than from a particular physician. Further, the Court found that Dr. Ralston's interpretation and reporting on the CAT scan did not occur in the emergency room setting or as part of the hospital's care, and as such his actions were not imputable vicariously to the hospital.

Moreover, the Appellate Division Third Department in *King v. Mitchell* considered the application of apparent or ostensible agency principles to impute the negligent acts of an anesthesiologist to a defendant hospital.[15] In *King*, plaintiff was admitted to Cayuga Medical Center for a planned surgery to remove a tumor in the plaintiff's chest cavity. The surgery was scheduled and performed by the plaintiff's treating general surgeon at Cayuga. Prior to the surgery, Dr. Mitchell introduced himself to the plaintiff as the anesthesiologist who would be providing anesthesia during the surgery. Dr. Mitchell was not an employee of Cayuga, but was a partner in an independent group of anesthesiologists who had privileges to practice at the hospital.

To support her claim that Cayuga had held out Dr. Mitchell as its agent or employee, the plaintiff alleged that 1) the questionnaire and consent forms related to the anesthesia were printed on forms with Cayuga's logo, 2) that the forms did not affirmatively state that Mitchell was not a Cayuga employee, and 3) Cayuga's web site describes Cayuga as having an anesthesiology department, and includes contact information for Mitchell at Cayuga. The Court was critical that there was no evidence presented that the plaintiff ever accessed the web site to obtain information on Mitchell and as such the same could not have reasonably relied on such information in making her decision. Further, the court confirmed that a hospital is not obligated to affirmatively disclaim the independent contractor physician as an employee in order to avoid the creation of ostensible agency. Lastly, the Court found that use of hospital stationery alone, without more, is insufficient to satisfy the holding out portion of the test.

The Court took pains to distinguish this case from the so-called "emergency" line of cases. In *King*, the plaintiff knowingly sought treatment from an independent surgeon who admitted her to the defendant. The plaintiff did not enter the hospital based on a proffer by the hospital to the public to provide anesthesiology services, but rather because her surgeon chose the hospital as the setting for her surgery. In finding that there was insufficient evidence to establish that the defendant hospital held out Dr. Mitchell as an agent or employee, the Court also advised that there was insufficient evidence to establish that the plaintiff relied upon a perceived employment relationship with Cayuga in accepting Mitchell's services, thereby defeating her claim based on ostensible agency theory on two separate and distinct grounds.

"Of the cases reviewed, there is not one where the hospital or clinic presented the patient with information relative to the employment/agency relationship between the treating physician and the hospital or clinic and thereafter the hospital was held vicariously liable."

D. A Potential Solution

The list of cases evaluating the myriad fact circumstances that can and have been presented is voluminous. The factually dependent nature of the "holding out" and "reasonable reliance" tests give practitioners and hospitals rare precedent upon which to rely. However, both facets of the test hinge on the perception of an employment relationship and the patient's reliance on this perception. It is when a patient seeks emergency care that the courts seem most to willing accept that there was a perception of employment.[16]

Notwithstanding whether the care by a non-employed provider is delivered in the emergency department or elsewhere in the hospital, concerns about "perception" and "holding out" might be dispelled with adequate, correct and prompt information being provided to the patient. The Court in both *Thurman* and *King* reiterates that a hospital does not have an obligation to affirmatively disclaim the independent contractor physicians as employees to avoid the creation of ostensible agency. Yet, the Court in *King* provides an insight into a potential escape for hospitals from this risky, fact driven, case evaluation. That is, if a hospital would clarify in their informational and consent forms the status of those phy-

sicians enjoying privileges at the hospital, neither prong of the test could be established.

Can it be that simple? Of the cases reviewed, there is not one where the hospital or clinic presented the patient with information relative to the employment/agency relationship between the treating physician and the hospital or clinic and thereafter the hospital was held vicariously liable. If the patient is properly informed of the relationship, the patient cannot fairly show that the hospital is "holding out" the physician as an agent or employee; in fact, all information would point to the contrary. Moreover, without a showing of "holding out," a patient could not establish that he/she relied on such actions in opting to accept the medical services. The result would be that a patient, with full information relative to the status of the physician providing the medical care, makes an informed decision to proceed with the treatment.

Ultimately, it is difficult to imagine how providing this information would change the decisions made by the patients or the actual delivery of health care. Moreover, in the interest of full disclosure and in avoiding the roulette of ostensible agency being applied to the hospitals, it would seem like a worthwhile and cost-effective solution to a long-standing problem for hospitals. Left for another day is consideration of potential personal exposure beyond insurance coverage to defendant physicians in malpractice claims if plaintiffs lose the deep pocket of the hospital made available under the *Mduba* doctrine. Although there could be a common law indemnity claim made against a physician by a hospital that finds itself liable solely by virtue of its relationship with the physician, in reality the relationships between physicians and hospital make this unlikely. Of course, a hospital could decide to forgo avoidance of *Mduba* type liability in favor of this concern for the medical staff. In that probably unlikely event, then, at least the institution would affirmatively accept the exposure inherent in the decision to provide company to those in misery rather than having the same thrust upon them by virtue of a legal fiction.

Endnotes

1. 2 N.Y.2d 656 (1957).
2. *See Mduba v. Benedictine Hospital*, 52 A.D.2d 450 (3d Dep't 1976).
3. *Id.*
4. *See Hill v. St. Clare's Hospital*, 67 N.Y.2d 72 (1986).
5. *See Hannon v. Siegel-Cooper Co.*, 167 N.Y. 244 (1901); *Hill v. St. Clare's Hospital*, *supra*.
6. *See King v. Mitchell*, 31 A.D.3d 958 (3d Dep't 2006); *Merrell-Benco Agency, LLC v. HSBC Bank USA*, 20 A.D.3d 605 (2005). *See also Ford v. Unity Hospital*, 32 N.Y.2d 464 (1973).
7. *See King v. Mitchell, supra*.
8. *Id.*
9. 52 A.D.2d 450 (3d Dep't 1986).
10. *See, e.g., Thurman v. United Health Services Hospitals, Inc.*, 39 A.D.3d 934 (3d Dep't 2007); *Citron v. Northern Dutchess Hospital*, 198 A.D.2d 618 (3d Dep't 1993); *Noble v. Porter*, 188 A.D.2d 1066 (4th Dep't 1992); *King v. Mitchell*, *supra*.
11. 67 N.Y.2d 72 (1986).
12. *See Dahan v. UHS of Bethesda, Inc.*, 295 III.App.3d 770 (III.App. 1 Dist. 1998); *Hodges v. Doctors Hospital*, 141 Ga.App. 649 (Ga.App. 1977); *Lindquist v. Scott Radiological Group, Inc.*, 168 S.W.3d 635 (Mo. App. E.D. 2005); *Willoughby v. Wilkins*, 65 N.C.App. 626 (N.C. App. 1983); *Roessler v. Novak*, 858 So.2d 1158 (Fla. App. 2d Dist. 2003).
13. *See Badeaus v. East Jefferson General Hospital*, 364 So.2d 1348 (La App. 1978); *Latham v. Ohio State Univ. Hosp.*, 71 Ohio App. 3d 535 (Ohio App. 10 Dist. 1991); *Baptist Memorial Hosp. System v. Sampson*, 969 S.W.2d 945 (Tex. 1998).
14. *See Thurman v. United Health Services Hospitals, Inc.*, *supra*.
15. *Id.*
16. *See Salvatore v. Winthrop Univ. Med. Ctr.*, 36 A.D.3d 887 (2d Dep't 2007); *Monostori v. Murphy*, 34 A.D.3d 882 (3d Dep't 2006); *Johnson v. Jamaica Hosp. Med. Ctr.*, 21 A.D.3d 881 (2d Dep't 2005); *Torns v. Samaritan Hosp.*, 305 A.D.2d 965 (3d Dep't 2003); *Cintron v. Northern Dutchess Hosp.*, *supra*. *See also McDonald v. Ambassador Constr. Co.*, 273 A.D.2d 108 (1st Dep't 2000); *Abraham v. Dulit*, 255 A.D.3d 345 (2d Dep't 1998); *Ryan v. New York City Health & Hosps. Corp.*, 220 A.D.2d 734 (2d Dep't 1995).

William D. Yoquinto is a member of the the firm of Carter, Conboy, Case, Blackmore, Maloney & Laird, P.C.

Mackenzie C. Monaco is an associate with Carter, Conboy, Case, Blackmore, Maloney & Laird, P.C. Both authors' practices largely involve medical malpractice defense, health care professional licensing and pharmacy defense litigation.

Communication Breakdowns That Lead to Lawsuits: A Plaintiff's Attorney's View Toward Reducing Malpractice Claims

By Timothy J. Higgins

I. Introduction

No two in-patient hospitalizations are the same, but a common occurrence in many, if not most, such hospital stays is the consult by a specialty physician. Typically, the consult is done at the request of the physician by whose order the patient was admitted to the hospital. The admitting physician, in most circumstances, will be the patient's primary care doctor or a hospital-based physician. If the patient's case is complicated, or the cause of the patient's ailments is not easily identified, additional specialty physician consults frequently follow. In this setting, clear, concise and complete communication may be the key, not only to a better outcome for the patient, but also to each physician's best chance to avoid being sued when the patient's outcome is bad.

The first setting in which regular and complete communication is needed is among the physicians and health care providers involved in the patient's case. The second setting, which may or may not be a part of the first setting, is between the physician(s) and the patient (or the patient's family/health care proxy).

This article will examine New York case law that establishes the parameters of a physician's duty and legal responsibility to his patient within the attending vs. consulting framework. We will also offer anecdotal evidence and hypothetical, but foreseeable, fact patterns in which communication failures can result and have resulted in bad outcomes for the patient, leading to medical malpractice litigation and exposure to suit for health care providers.

II. Communication Among Medical Providers

Physicians owe a duty of care to their patients, but the duty "may be limited to those medical functions undertaken by the physician and relied on by the patient."[1] The case of *Wasserman v. Staten Island Radiological Associates* offers a fact pattern common to many doctor-patient relationships in which the attending physician enlists the assistance and opinions of consulting medical specialists. The plaintiff (patient) alleged that the defendant radiologist (and his medical practice), the defendant internist and three defendant surgeons committed medical malpractice by failing to diagnose Reflex Sympathetic Dystrophy[2] ("RSD") in her ankle. On appeal, the case against the internist and three surgeons was dismissed based on evidence that they deferred to orthopedic specialists for assessment and treatment of the plaintiff's ankle, and that since they were not involved in that aspect of the patient's care, they had no duty to diagnose RSD. The plaintiff's claims against the defendant radiologist and his medical group were also thrown out upon a showing that the radiologist's involvement in the case was limited to interpretation of ankle x-rays, that the films were properly read, and that the patient (as is customary) was never examined by the radiologist.[3] Although the appellate opinion does not indicate for certain, it is reasonable to assume that the plaintiff's attorney also sued the patient's orthopedist, given the reliance of the defendant internist and surgeons on the argument that diagnosis and treatment of RSD is outside of the scope of their specialty (and arguably within the scope of what would be expected from an orthopedic specialist).

In winning dismissal of the lawsuit against their clients, it appears that defense counsel in *Wasserman* effectively showed that there was little or no connection between the medical care provided by their clients and the ultimate harm (RSD) alleged by the patient. Further emphasizing the absence of a connection is that the specialty fields of the defendant physicians (radiology, internal medicine, surgery) are not typically associated with assessment and care of a patient with RSD, who would more likely be cared for by a neurologist or orthopedist. Physicians involved in caring for a patient in such a multiple-specialist setting, with an eye on avoiding entanglement in a malpractice claim, would be well-served by communicating to the patient the scope of what their medical care entails, followed by documentation in the patient's chart that those parameters were explained to and acknowledged by the patient. Why? Because documentation, especially when done at or near the time of medical treatment (and before the patient has a bad outcome), is effective and influential in at least three settings: with the jury deciding the case at trial; the judge deciding a pre-trial motion for dismissal;[4] and the attorney reviewing the potential case (prior to suit) for the would-be plaintiff.

For example, consider this hypothetical documentation applied to the facts of the *Wasserman* case as reported in the appellate opinion. The patient is seen by her internist for evaluation after twisting her ankle and falling, complaining of pain and exhibiting swelling in the ankle. X-rays indicate

no ankle fracture or dislocation, but the patient's pain and swelling persist over a period of a few weeks. The internist, perhaps considering RSD as a differential diagnosis, arranges for consults by specialists, first orthopedists and, later, surgeons. The surgical consult shows no obvious injury or deformity to the ankle, supporting the interpretation of the original x-rays and leading the surgeons to conclude that surgery is neither indicated nor likely to lessen plaintiff's complaints of pain, swelling and sensitivity to touch. The consulting surgeon discusses his findings and opinions with the patient and then prepares an office note and/or a letter to the attending internist that includes the following: *"I told the patient that based on our findings and earlier medical records, her pain and discomfort is more likely neurologic in origin and not anything we can help with by surgical intervention. There is no indication for any surgical treatment and we will not be seeing the patient again unless requested to do so. Patient indicates she understands and was instructed to return to her attending for further work-up."*

Those three sentences, or words to the same effect, would be hard for a judge or jury to ignore (to the benefit of the doctor) when considering whether the physician's duty extended to diagnosing RSD and whether the patient relied on the doctor to make the diagnosis. For an attorney whose law firm limits its practice to plaintiff's personal injury cases, at least half of which are medical malpractice claims, the hypothetical note written by the surgeon would be very significant if our law firm was considering whether to represent the patient with RSD. The hypothetical note makes crystal clear the line of communication between the doctor and the patient, as well as the line drawn by the surgeon, who distances himself from diagnosing the cause of the patient's ailments—it can't be treated or cured with surgery, and the patient is being returned to her primary care physician for further handling. Furthermore, sending a copy of the note to the attending physician puts that doctor on notice that the specialist is of the opinion that this patient's condition (as well as diagnosis and treatment) is outside the scope of the consultant's specialty field, and that no further appointments have been scheduled with the specialist. In basketball parlance, the surgeon/specialist has bounced the ball (the patient) back into the court of the attending/primary care physician.

When medicine and civil liability intersect, medical specialty invites greater scrutiny. An office note or letter like the hypothetical one above could very well provide insulation from suit or damages for the specialist who is held to a higher standard of care than is a general practice physician.[5] In considering whom to name as defendants when the lawsuit is commenced, the plaintiff's lawyer would be foolish to ignore or underestimate the value of such medical documentation that provides an obvious defense to the surgeon. Despite what may be conventional wisdom that plaintiff's lawyers prefer to "sue everyone" so as to keep all contingencies open, there is little benefit to picking a fight unlikely to be won. Doing so makes the litigation experience more costly, more time-consuming and may decrease the plaintiff's chances of winning at trial. Any attorney who has litigated and tried more than a few medical malpractice cases will acknowledge the difficulty of convincing a jury that even one doctor was negligent. Having two or three physicians as defendants in the same courtroom simply adds to the plaintiff's already-high burden of proof, and might give the jury the impression that if the case fails against one doctor, it must fail against all.

Another appellate court decision demonstrates how simple documentation by a consulting specialist might have allowed him to escape trial of a medical malpractice case.[6] In *Campbell v. Haber, M.D.*, the plaintiff-patient went to the defendant hospital's emergency room with a complaint of chest pain. Work-up by the defendant emergency room physician (Dr. Haber) yielded test results that indicated the possibility of heart muscle damage, leading the ER doctor to consult, by telephone, with the defendant cardiologist. Dr. Haber testified at deposition that he informed the cardiologist (Dr. Kelberman) of the patient's symptoms and test results and that Dr. Kelberman voiced an opinion that the test results were inconsistent with a cardiac event as the cause of the patient's chest pain. The ER physician communicated to the patient the consultation with the cardiologist and, in reliance on Dr. Kelberman's opinion, discharged the patient from the hospital. (Although not reported in the opinion, the patient presumably suffered an adverse outcome of cardiac origin.) The defendant cardiologist's motion to dismiss all malpractice claims against him was denied by the trial court and again on appeal. There was no evidence that the cardiologist ever examined or spoke to the patient, or read the patient's hospital chart. But the cardiologist's opinion and advice was relayed to the patient, albeit through the ER doctor, which the appellate court found sufficient to establish the possibility of an "implied physician-patient relationship," deferring to a trial jury the question of whether the cardiologist owed a duty of care to the patient. A dissenting judge felt Dr. Kelberman was entitled to summary judgment dismissing all claims, noting that while the cardiologist may have told Dr. Haber his opinion, "he did not render treatment, diagnosis, instructions or advice to the patient." Predicating liability on such informal consultations between doctors, wrote the dissenting judge, would serve to discourage the practice, resulting in impairment instead of improvement of "the state of medical knowledge and the quality of patient care."[7]

Would documentation in the hospital chart by the cardiologist defining his involvement in the case have led to dismissal of the case against him? It is difficult to say for certain, but even if the motion or appeal failed, a jury hearing all of the evidence at trial would likely give strong

consideration to finding no fault on the part of a doctor who (hypothetically) wrote a note as follows: *"I was called at home at 2:00 a.m. by Dr. Haber who gave me the patient's presenting symptoms and the results of tests done in the E.R. I was available to examine the patient myself but it was not requested. I did offer my opinion regarding a cardiac cause of the patient's chest pain. I was not asked whether the patient should be admitted for observation and did not offer any opinion on the topic."*

In the setting of a seriously ill patient whose care involves multiple physicians, a consulting specialist should seize the opportunity to document his involvement in the case by entering a timely and signed note in the patient's hospital chart. In *Malki v. Krieger*,[8] a jury awarded $12 million (later reduced to $4 million) to the plaintiff, who alleged that post-operative negligence resulted in the loss of his esophagus. On appeal, that part of the judgment against the defendant cardiologist was reversed and the complaint dismissed. The patient had come into the hospital through the emergency department with a complaint of chest pain, and the defendant cardiologist (Dr. Gerling) recommended coronary bypass surgery, which was performed by the defendant surgeon. While Dr. Gerling continued to see the patient daily, her role was that of a consultant, and the surgeon, designated as attending physician, assumed ultimate authority over the patient's care. The evidence at trial, including the patient's voluminous hospital record, showed that the cardiologist played no role and made no recommendation to the attending doctor about post-operative medications, which the proof at trial showed was a significant contributing factor leading to necrosis of the esophageal tissue. The appellate court found that while "Dr. Gerling had a duty of care as a consultant to advise and make appropriate recommendations to the plaintiff's treating physician" (defendant surgeon), there was no proof that the cardiologist breached that duty.[9] As *Malki* shows, the distinctions among physicians in the hospital setting (i.e., attending vs. consulting) can be a significant consideration for judges and juries assessing responsibility for a patient's bad outcome. If indicated, specialty medical providers would be wise to make note of those distinctions within the framework of their own charting and communicate their opinions and plan for further care, if any, to the patient, nursing staff and fellow physicians, especially the attending doctor. In this setting, New York law is clear that there is no negligence on the part of a physician who, after determining he is unable to care for the patient, makes arrangements to transfer the duty of care to another well-qualified physician.[10]

When creating a record detailing their respective involvement in a patient's care, physicians would benefit by making specific reference to the timing of their consultation, including the date, time of day and, perhaps most importantly, the relationship between the time of the consult and the condition of the patient. A medical malpractice case recently concluded by my law firm is illustrative. The patient was a 58-year-old woman who was initially assessed in the emergency department complaining of chest pain. The admitting physician was a cardiologist, but the consult and workup (including catheterization) did not identify a cardiac cause of the pain. A surgical consult was obtained, after which (day five of the hospital stay) the patient went to the operating room for repair of a chronic hiatal hernia. It was at this point that the surgeon became the patient's attending physician. As sometimes happens after surgery, the patient became feverish and developed an infection. The crux of the malpractice case, which eventually focused on the surgeon who assumed the role of attending physician, was a failure to respond quickly enough to the patient's deteriorating condition. The patient's hospital chart suggested that while the surgeon did order scanning that ruled out a leak or any other defect of the actual surgical procedure, the search for the cause of the infectious process, and interim treatment of the infection, was lacking. For example, antibiotic therapy commenced four days after surgery. An infectious disease consult was obtained, but not until the day before the patient died due to septic shock. The case settled prior to trial, where plaintiff's proof would have been that the post-operative infection was entirely treatable had the response been timely, and had the medical care been better coordinated and better communicated amongst physicians and the hospital staff. Helpful to the plaintiff's case was the opinion of the infectious disease consultant whose examination note in the hospital chart indicated that it was probably too late for antibiotic therapy to be effective.

The case appeared to show, sadly, that sometimes patients really do "fall through the cracks." The involvement of multiple physicians in the scheme of care and treatment seemed to work to the patient's disadvantage, perhaps based on the assumption of one or more of the doctors that some other physician was in charge and would order basics such as laboratory studies and antibiotics. In a malpractice case arising out of a hospital stay where multiple specialty consults are obtained, the plaintiff's attorney will always look closely at the actions of the attending physician. The title carries with it the responsibility to oversee and/or coordinate the patient's care, with the scope of the duty interpreted to extend as far as ensuring that the physician's orders are carried out.[11]

III. Communication with Patients and Their Family

The quality of the doctor-patient relationship can be an important factor in determining who does, and does not, get sued in a medical malpractice case. Communication with the patient and the patient's spouse and/or family members is at the core of the doctor-patient relationship.

An extremely common complaint heard in our law office from plaintiffs and would-be plaintiffs is that the potential defendant physician never took the time or made an effort to explain what happened to the patient. Patients or their family members, curious about the cause of a bad medical outcome, rarely know the full truth that a medical record presumably contains, and whether those facts might constitute a deviation from good and accepted medical practice. But, the patient and family do know if their doctor was rude or arrogant, "too busy" to talk to them, failed to return telephone calls or simply lacked common courtesy. To act in this manner is not medical negligence. But treating a patient like a file instead of a human being can be the "last straw" that makes the patient pick up a phone and call a lawyer who sues doctors for a living. At that point, the physician's opportunity to avoid a lawsuit based on his relationship with the patient is probably lost.

You need not take the word of a plaintiff's lawyer on this. A study at Vanderbilt University School of Medicine that analyzed patient complaints and risk management activity concluded that a doctor's malpractice experience is most closely related not to patient volume or specialty field, but, rather, to the physician's ability to effectively communicate with their patients, establish rapport and provide care and treatment consistent with what the patient expects.[12]

The benefit of a better bedside manner in helping a physician avoid complaints and litigation was further borne out in research done at McGill University in Montreal.[13] Researchers tracked over 3,400 physicians who, between 1993 and 1996, took the clinical skills examination administered by the Medical Council of Canada, and then went on to practice medicine in the provinces of Ontario and Quebec. The results showed a strong correlation between the doctors' ability to communicate well with patients and the number of complaints filed against them in their first two to twelve years of practice. Physicians with the highest numbers of patient complaints registered against them were, more often than not, found among those who scored low when their communication skills were tested (actors portrayed patients) in the clinical skills examination.[14]

Patients who talk to plaintiff's attorneys seem to understand that bad outcomes happen and that not all are caused by medical negligence. In our experience, however, they do not understand, and feel most angry about, a physician who, in the face of a bad outcome for the patient, makes things worse by neglecting or refusing to pay attention to the patient's need for personal attention, time, and sympathy. "I'm sorry" are two powerful words. Physicians, perhaps unwisely cautioned by their own lawyers or risk managers who hear the phrase as "I'm responsible," would be well served by using those words sincerely and more often in their doctor-patient relationships. More often than not, patients go to the office of the medical malpractice lawyer looking for the truth about what happened, and not because the lawyer may have the ability and means to start a lawsuit. No physician would deny that such an explanation is something to which every patient is entitled. Physicians should take the time to give that explanation to the patient or the patient's family, even if the truth may not reflect well on all of the medical care providers. To do so in a setting that the doctor can control, making time for the patient and his family in a friendly and sympathetic manner, is a better option than giving the same answers in response to the deposition questions of the patient's attorney.

Endnotes

1. *Wasserman v. Staten Island Radiological Associates*, 2 A.D.3d 713, 770 N.Y.S.2d 108 (2d Dep't 2003).
2. Also known as Complex Regional Pain Syndrome (CRPS), a chronic neurological syndrome characterized by severe burning pain, pathological changes in bone and skin, excessive sweating, tissue swelling and extreme sensitivity to touch. *Reflex Sympathetic Dystrophy Syndrome Association.*
3. *Wasserman*, 770 N.Y.S.2d at 109-110.
4. *Markley v. Albany Medical Center Hospital*, 163 A.D.2d 639, 558 N.Y.S.2d 688, 689-690 (3d Dep't 1990) (defendant pediatricians not responsible for infant's chemotherapy overdose where treatment regimen was defined by oncologists and pediatricians exercised no control over therapy); *Yasin v. Manhattan Eye, Ear & Throat Hospital*, 254 A.D.2d 281, 678 N.Y.S.2d 112, 114 (2d Dep't 1998) (Defendant urologist who admitted patient to hospital and ordered testing that ruled out urological problems entitled to summary judgment, as was defendant surgeon who properly diagnosed patient's bacterial infection and then referred patient for follow-up care by specialist).
5. *Toth v. Community Hospital*, 22 N.Y.2d 255, 292 N.Y.S.2d 440, 447 (1968).
6. *Campbell v. Haber, M.D.*, 274 A.D.2d 946, 710 N.Y.S.2d 495 (4th Dep't 2000).
7. *Id*. at 496-497.
8. *Malki v. Krieger*, 213 A.D.2d 331, 624 N.Y.S.2d 167 (1st Dep't 1995).
9. *Id*. at 168-169.
10. *Brown v. Bauman*, 2007 Slip Op. 06251 (1st Dep't 2007).
11. *Kless v. Lee, M.D., P.C.*, 19 A.D.3d 1083, 796 N.Y.S.2d 502, 503 (4th Dep't 2005).
12. "*Patient Complaints and Malpractice Risk*," Journal of the American Medical Association, Vol. 287, No. 22, June 12, 2002.
13. "*Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities,*" Journal of the American Medical Association, Vol. 298, No. 9, September 5, 2007.
14. *Id.*

Tim Higgins is a partner with the law firm of Powers & Santola, LLP, in Albany, which limits its practice to plaintiff's personal injury litigation. He graduated from the State University of New York's Empire State College and earned his law degree from Albany Law School.

At Long Last: The Court of Appeals Authorizes Ex Parte Interviews of Treating Physicians

By Nancy May-Skinner

After decades of silence on the issue, the Court of Appeals weighed in to the ex parte interview debate and confirmed that an attorney may privately interview an adverse party's treating physician when the adverse party has placed his or her medical condition in controversy.[1] In order to address the procedural requirements of HIPAA (Health Insurance Portability and Accountability Act of 1996), the Court ruled that upon request, plaintiffs must provide a HIPAA authorization permitting the defendant to *request* an ex parte interview. It remains the treating physician's prerogative to accept or reject the request.

A. Historical Background

Over the past four decades, the lower courts had grappled with the propriety of ex parte interviews. During the 1970s, the courts were asked to decide whether ex parte interviews should be permitted during the discovery phase of personal injury actions.[2] The courts answered in the negative based upon the absence of any authority in the local rules or the Civil Practice Law and Rules ("CPLR") expressly authorizing them.[3] Subsequently, in the late 1980s and early 1990s the appellate courts revisited the issue and limited their prior holdings to ex parte interviews sought during discovery.[4]

After this judicial distinction was drawn between pre– and post–Note of Issue ex parte interviews, defense counsel began routinely seeking and conducting interviews of plaintiff's treating physicians after discovery was concluded. The interviews remained voluntary on the part of the treating physician and were initiated by the service of a non-party subpoena and request to meet informally. Neither the court nor the plaintiff's attorney was involved in requesting or conducting the interview. In fact, the interviews were typically conducted without notice to either.

This informal practice came to a screeching halt with the enactment of HIPAA and the associated Privacy Standards, enforced effective 2003.[5] While neither HIPAA nor the Privacy Standards expressly addressed this practice, they presented a practical obstacle to ex parte interviews by requiring physicians to obtain HIPAA authorization before making any disclosures. Treating physicians began to refuse defense counsel's requests for ex parte interviews absent provision of a HIPAA authorization. Not surprisingly, when defense counsel requested authorizations from the plaintiffs, they were not inclined to voluntarily comply. As a consequence, defendants were forced to involve the courts, and a flurry of motions to compel provision of HIPAA authorizations followed.

The Supreme Court decisions addressing these motions yielded a variety of outcomes, leaving counsel with no consistent guidance regarding the permissibility, scope or method for obtaining ex parte interviews under HIPAA.[6] Some courts allowed pre-HIPAA type ex parte interviews while others completely denied them.[7] Not surprisingly, the bulk of the decisions struck a balance between the two extremes, allowing ex parte interviews with certain limiting conditions.[8]

B. The Appellate Courts Weighed In

After two years of conflicting Supreme Court–level decisions, the Second and Fourth Departments of the Appellate Division took on the ex parte interview issue. Relying upon long-standing provisions or the Civil Practice Law & Rules ("CPLR") and not HIPAA, each court ruled that the absence of statutory authority for ex parte interviews precluded the courts from compelling plaintiffs to provide HIPAA authorizations for ex parte interviews. As a practical matter then, ex parte interviews were history.

1. The *Arons* Case

In December of 2006, the Second Department became the first appellate court to rule on the effect of HIPAA, if any, on ex parte interviews.[9] The court noted that this was an ". . . issue of first impression regarding the interplay of . . . HIPAA . . . and the defense bar's informal practice of privately interviewing plaintiffs' non-party treating physicians after a Note of Issue has been filed."[10] The Second Department started with the premise that prior to HIPAA, it had *not declared* that defendants had a right to ex parte interviews.[11] Rather, it had *merely allowed* the testimony of treating physicians who had voluntarily submitted to these interviews. The Court noted that while the enactment of HIPAA did not alter the precedent allowing ex parte interviews, it did present a practical obstacle to defense counsel, who were now being asked to provide HIPAA authorizations before subsequent treating physicians would participate in the interviews.[12] Not surprisingly, insofar as plaintiffs were not willing to authorize

these ex parte interviews, defendants were required to move to compel provision of HIPAA authorizations allowing the interviews.[13] In this case, the Supreme Court had granted the motion requiring provision of authorization.

The Second Department reversed, finding that there was no authority for conducting ex parte interviews under CPLR Article 31.[14] In the absence of this statutory authority, the ". . . courts should not become involved in post–Note of Issue trial preparation matters and should not dictate to plaintiffs or defense counsel the terms under which interviews with non-party witnesses may be conducted."[15] Finally, in recognition of the unsettled nature of the law regarding ex parte interviews, the appellate division granted the defendants leave to move for permission to conduct pre-trial discovery regarding the treating physician.[16]

2. The *Webb* Case

Following *Arons*, the Second Department revisited the ex parte interview issue in *Webb v. New York Methodist Hospital*.[17] In *Webb*, the court referred to the *Arons* decision and granted the same relief.

3. The *Kish* Case

Becoming the second appellate court to consider the ex parte interview issue, the Fourth Department of the Appellate Division followed suit and denied the defendant's motion to compel plaintiff's production of HIPAA authorizations to conduct ex parte interviews.[18] The court concurred with the Second Department's analysis, finding that the absence of authority for interviews in CPLR Article 31 precluded the relief sought by defendants. It then went on to identify four "compelling reasons for prohibiting such interviews."[19] First, there was no statutory authority for the interviews.[20] Second, other discovery procedures were available to obtain records and non-party depositions.[21] These procedures provided for the presence of opposing counsel and as such, guarded against privileged disclosures.[22] Third, the information sought was subject to the doctor-patient privilege; and fourth, there was no reason to allow interviews after the filing of the Note of Issue that were not permitted before the filing of the Note of Issue.[23]

In a spirited dissent, two justices of the Fourth Department argued that the order compelling plaintiff to provide HIPAA compliant authorizations should have been affirmed. The dissenters argued that the rationale for permitting ex parte interviews and the case law supporting them were still valid after HIPAA. The rationale cited was fairness and equal access to the evidence.

> [A] rule disallowing ex parte communications with a plaintiff's treating physicians attempts to ensure the confidentiality of the physician-patient relationship at the expense of the defendant. Allowing a plaintiff to have free access to potentially important facts and/or expert witnesses, while requiring the defendant to use more expensive, inconvenient, and burdensome formal discovery methods tilts the litigation playing field in favor of the plaintiff (*Conning the IADC Newsletters*, 71 Def. Couns. J. at 210, quoting Jennings, *The Physician-Patient Relationship: The Permissibility of Ex Parte Communications between Plaintiff's Treating Physicians and Defense Counsel*, 59 Mo. L. Rev. 441, 475 [1994]).

The dissenters distinguished *Arons*, holding that post–Note of Issue interviews constituted trial preparation, not discovery.[24] Consequently, the absence of statutory authority in CPLR Article 31 was not determinative.[25] Rather, as with any other non-party fact witness, interviews were permissible trial preparation.[26]

The dissenters then responded to the majority's four compelling reasons. First, the absence of statutory authority in the CPLR permitting ex parte interviews was irrelevant as there were no such rules for any non-party interviews.[27] Second and fourth, formal discovery techniques were more expensive, inconvenient and burdensome than ex parte interviews.[28] The resulting interruption in the practice of physicians was particularly burdensome.[29] Third and finally, authorizations for ex parte interviews could be limited in scope and the plaintiff waived the physician-patient privilege by raising his/her medical condition as an issue.[30]

Finally, the dissenters cited to out-of-state and in-state precedents supporting their determination that HIPAA had not changed the law in New York permitting ex parte interviews.[31] Accordingly, the Supreme Court's order compelling the provision of HIPAA authorizations should have been affirmed.

C. Appeal to the Court of Appeals

Motions for leave to appeal to the Court of Appeals were granted by the Second and Fourth Departments pursuant to CPLR 5602(b)(1). The cases were joined for purposes of the appeal and oral argument. In addition to the briefs filed by the five appellants and three respondents in the *Arons*, *Webb* and *Kish* cases, amicus briefs were filed

by the New York State Trial Lawyers Association and the New York City Health and Hospitals Corporation. The Court heard oral argument on October 17, 2007.

At oral argument, the Court explored the ex parte interview issue from the perspective of all of the relevant players: the parties, the physicians, the attorneys and the courts. In addressing the rights of plaintiffs, the Court focused on the existence and scope of the physician-patient privilege. While the parties were willing to concede that the commencement of litigation constituted a waiver of the privilege,[32] there was disagreement regarding the scope of that waiver. Not surprisingly, plaintiffs argued that the waiver applied only to the specific medical condition at issue in the litigation, whereas the defendants advocated for a much broader view. The Court suggested that limits could be placed on interviews to preserve a limited waiver, but the plaintiffs steadfastly maintained that this would not prevent abuses by defense counsel in an unsupervised interview. The Court asked about leveling the playing field. While the defendants posited that fairness required equality of access to this relevant medical evidence, the plaintiffs argued that the field is not level to begin with as the bias of treating physicians against plaintiffs often prevents or limits their access. The Court inquired as to the efficacy of other discovery devices as an alternative to ex parte interviews. The plaintiffs supported this alternative while defense counsel maintained that formal discovery was no substitute for informal interviews.

The Court also focused on the concerns of treating physicians over the time and money spent addressing requests for ex parte interviews. The relative costs of depositions versus informal interviews were discussed. The Court noted that treating physicians remain free to refuse requests for ex parte interviews. It also addressed the alternative federal system of deposing all experts or the possibility of deposing IME physicians as well as treating physicians.

The Court also addressed relevant precedent, HIPAA and the role of the courts in supervising the interviews, if permitted. On the precedent issue, the Court raised two recent cases in which it allowed informal interviews of non-physician fact witnesses.[33] Responding to the Court's inquiries regarding HIPAA, the parties conceded that nothing in HIPAA or the Privacy Standards affected New York State precedent allowing post–Note of Issue interviews. Rather, HIPAA merely presented a practical obstacle to the process. Finally, the Court inquired as to the effect its decision would have on the lower courts. If interviews were allowed, the trial courts would be charged with ordering and policing them. If interviews were not allowed, the lower courts would face a surge in motions for non-party depositions and the burden of policing those proceedings.

D. The Decision

The Court of Appeals reversed in all three cases, finding that the defendants were entitled to HIPAA authorizations permitting them to request ex parte interviews with plaintiffs' treating physicians. The Court specifically rejected the practice of requiring disclosure following ex parte interviews.[34]

The Court started by acknowledging the importance of informal discovery and citing to the recent precedent allowing private interviews of fact witnesses in other contexts.[35] In *Niesig*, *supra*, the Court allowed private interviews of corporate employees with the exception of employees whose acts or omissions were binding on or imputed to the corporation or employees implementing the advice of counsel.[36] In *Siebert*, *supra*, the Court allowed ex parte interviews of a party's former employee.[37] Relying on these precedents and the absence of any " . . . reason why a non-party treating physician should be less available for an off-the-record interview than the corporate employees in *Niesig* or the former corporate executive in *Siebert*," the court extended the common law rule to include ex parte interviews of non-party treating physicians.[38]

The Court noted that by bringing a personal injury action, a plaintiff placed his or her mental or physical condition in issue and thereby waived the physician-patient privilege.[39] Fairness required this waiver as a plaintiff " . . . should not be permitted to affirmatively assert a medical condition in seeking damages or in defending against liability while simultaneously relying on the confidential physician-patient relationship as a sword to thwart the opposition in its efforts to uncover facts critical to disputing the party's claim."[40]

The Court held that the absence of a specific statutory provision authorizing ex parte interviews was not determinative of their permissibility. Interviews have long been part of an attorney's trial preparation and ". . . Article 3101 does not 'close off' these 'avenues of informal discovery' and relegate litigants to the costlier and more cumbersome formal discovery devices."[41] These more informal methods would interfere less with the treating physician's practice of medicine.[42]

The Court also dismissed plaintiff's complaints regarding the "danger of overreaching" in a private interview.[43] An attorney is ethically required to identify his client and interests in a private interview and make it clear to the physician that the interview is voluntary and limited in scope to the medical condition at issue.[44]

Finally, the court rejected the long-standing practice of not seeking an ex parte interview until after the filing of the note of issue.[45] While post–Note of Issue interviews are permissible, they are not recommended as a party is left with no recourse if a treating physician refuses the interview at this late stage in the litigation.[46] If the interview is sought and refused while discovery is still pending, the party seeking the interview can pursue formal discovery against the doctor.[47]

E. The Dissent

In a spirited dissent consistent with his questioning at oral argument, Justice Pigott argued that ex parte interviews are neither necessary nor authorized.[48] He rejected the majority's characterization of ex parte interviews as trial preparation. Citing to the absence of any statutory authority for ex parte interviews, Justice Pigott characterized the interviews as unauthorized discovery. He particularly objected to ex parte interviews conducted after the filing of the Note of Issue based upon the Uniform Rules' limitation of post–Note of Issue discovery to cases of "unusual or unanticipated circumstances."[49]

F. Future Impact of *Arons*

While the Court of Appeals has now confirmed that ex parte interviews are permissible, the practical application of this ruling may require further decisions "fine tuning" the process. It is clear that a defendant is entitled to HIPAA authorizations permitting the interview. It is equally clear that defendants must "reveal the client's identity and interest" and "advise physicians that they need not comply with the request for an interview."[50] Whether the plaintiffs will be permitted to weigh in to this notification process and if so, how, are likely to be sources of debate between plaintiffs and defendants.

Similarly, while it is clear that defendants must make it clear to physicians that the interview is ". . . limited in scope to the particular medical condition at issue in the litigation," the definition and scope of the "medical condition" is likely to be a source of continued disagreement among the parties.[51] Whether plaintiffs will be allowed to weigh in to define the scope of the interviews and the extent of their involvement remains to be seen.

It is not difficult to predict that defendants will begin routinely demanding HIPAA authorizations for all treating physicians, and plaintiffs will seek to limit those authorizations as much as possible. It is equally likely that the parties will turn to the courts to "fine-tune" the mechanics of the ex parte interview process. Thus, while Arons answered the fundamental question regarding the permissibility of ex parte interviews, it is likely that the courts will be called upon to weigh in and refine that answer in the future.

Endnotes

1. *Arons v. Jutkowski*, 2007 NY Slip Op. 09309 (2007).
2. *Cwick v. City of Rochester*, 54 A.D.2d 1078 (4th Dep't 1976); *Anker v. Brodnitz*, 98 Misc. 2d 148, *aff'd*, 73 A.D.2d 589 (2d Dep't 1979), *lv den.*, 51 N.Y.2d 703 (1980).
3. *Id.*
4. *Fraylich v. Maimonides Hosp.*, 251 A.D.2d 251 (1st Dep't 1998); *Levande v. Dines*, 153 A.D.2d 671 (2d Dep't 1989); *Tiborsky v. Martorella*, 188 A.D.2d 795 (3d Dep't 1992); *Luce v. State of New York*, 266 A.D.2d 877 (4th Dep't 1999).
5. HIPAA, passed by Congress in 1996, required Health and Human Services ("HHS") to issue regulations governing the disclosure of protected health information ("PHI"). HHS published the Privacy Standards in 2000, modified them in 2002, and began enforcing them in 2003.
6. *Valli v. Viviani*, 7 Misc. 3d 1002(A) (2005) (HIPAA did not change the law permitting post–Note of Issue interviewing); *Holzle v. Health Care Servs. Group*, 7 Misc. 3d 1027 (2005) (HIPAA authorization not required for ex parte interview); *Browne v. Horbar*, 6 Misc. 3d 780 (2004) (motion for ex parte interview denied); *see Hitchcock v. Suddaby*, 7 Misc. 3d 1026 (2005)(ex parte interview conditioned on service of subpoena and letter with specified disclosures); *Smith v. Rafalin*, 6 Misc. 3d 1091 (2005) (interview allowed with condition that any records received at the interview be disclosed); *Steele v. Clifton Springs Hospital*, 6 Misc. 3d 953 (2005) (ex parte interview limited to medical condition at issue and any recorded statements by the doctor were required to be disclosed); *O'Neil v. Klass* (Supreme Court, Kings County 2004) (interview permitted with prohibition to disclose PHI); *Keshecki v. St. Vincent's Med. Ctr.*, 5 Misc. 3d 593 (2006) (interview would require special authorization and post-interview disclosure); *Beano v. Post* (Supreme Court, Queens County 2006) (interview allowed with special authorization and post-interview disclosure).
7. *Valli v. Viviani*, 7 Misc. 3d 1002(A) (2005)(HIPAA did not change the law permitting post-Note of Issue interviewing); *Holzle v. Health Care Servs. Group*, 7 Misc. 3d 1027 (2005) (HIPAA authorization not required for ex parte interview); *Browne v. Horbar*, 6 Misc.3d 780 (2004) (motion for ex parte interview denied).
8. *See Hitchcock v. Suddaby*, 7 Misc. 3d 1026 (2005)(ex parte interview conditioned on service of subpoena and letter with specified disclosures); *Smith v. Rafalin*, 6 Misc. 3d 1091 (2005) (interview allowed with condition that any records received at the interview be disclosed); *Steele v. Clifton Springs Hospital*, 6 Misc. 3d 953 (2005) (ex parte interview limited to medical condition at issue and any recorded statements by the doctor were required to be disclosed); *O'Neil v. Klass* (Supreme Court, Kings County 2004) (interview permitted with prohibition to disclose PHI); *Keshecki v. St. Vincent's Med. Ctr.*, 5 Misc. 3d 593 (2006) (interview would require special authorization and post-interview disclosure); *Beano v. Post* (Supreme Court, Queens County 2006) (interview allowed with special authorization and post-interview disclosure).
9. *Arons v. Jutkowski*, 37 A.D.3d 94 (2d Dep't 2006).
10. *Id.* at 95 (2d Dep't 2006).
11. *Id.* at 97 (2d Dep't 2006).
12. *Id.*
13. *Id.* at 98-9 (2d Dep't 2006).
14. *Id.* at 100 (2d Dep't 2006).
15. *Id.* at 101 (2d Dep't 2006) *quoting Holzle v. Healthcare Sers. Group*, *supra* at 7 (2005).
16. *Id.*
17. 35 A.D.3d 457 (2d Dep't 2006).

18. *Kish v. Graham*, 40 A.D.3d 118 (4th Dep't 2007).
19. *Id.* at 123 (4th Dep't 2007).
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.*
27. *Id.*
28. *Id.* at 129 (4th Dep't 2007).
29. *Id.*
30. *Id.*
31. *Id.* at 133 (4th Dep't 2007).
32. See *Koump v. Smith*, 25 N.Y.2d 287 (1969).
33. *Niesig v. Team 1*, 76 N.Y.2d 372 (1990); *Siebert v. Ituit*, 8 N.Y.3d 506 (2007).
34. *Arons*, *supra* at 24-25 (2007).
35. *Niesig v Team I*, 76 N.Y. 2d 372(1990); *Siebert v Ituit*, 8 N.Y.3d 506 (2007).
36. *Niesig* at 374 (1990).
37. *Siebert* at 511 (2007).
38. *Arons* at 12 (2007).
39. *Id.*
40. *Id.*
41. *Id.* quoting *Niesig*, *supra* at 372 (1990).
42. *Id.*
43. *Id.*
44. *Id.*
45. *See Anker v. Brodnitz*, *supra*.
46. *Arons*, *supra* at 17 (2007).
47. *Id.*
48. *Id.* at 31 (2007).
49. *Id.* citing 22 N.Y.C.R.R. 202.21(d).
50. *Id.* at 15; fn. 6 (2007).
51. *Id.* at 15 (2007).

Nancy May-Skinner is an Appellate Attorney at Fager & Amsler, L.L.P.

The Hospitalist Movement: Strategies for Risk Reduction

By Paul J. Colucci and Jonathan D. Rubin

The last decade or so has witnessed the emergence of a new breed of physician: the hospitalist, a sort of "specialized generalist" whose role is to serve as the attending physician during a patient's hospital stay. The wealth of literature that has been disseminated about the hospitalist movement since its advent discusses many different facets, including the utility of a hospital-based attending on cost management. The purpose of this article is to comment on the ways in which the role of hospitalist impacts risk reduction and avoidance for the institutions that employ these physicians.

"[T]he profession has grown to more than 15,000 nationwide with some estimating that there may soon be more hospitalists than cardiologists."

The term "hospitalist" was first coined by Robert Wachter, M.D. and Lee Goldman, M.D. in an article they published in the *New England Journal of Medicine*.[1] The explosion in the numbers of physicians dedicated to in-hospital care since that time—the profession has grown to more than 15,000 nationwide with some estimating that there may soon be more hospitalists than cardiologists[2]—has produced a wealth of commentary regarding the evolution and current status of the specialty, much of which focuses on its pros and cons with regard to risk management.

The "Pros" of Hospitalist Care

The most obvious allure of the hospitalist to the risk manager is the constant or near-constant availability of an attending physician to the admitted patient in response to a myriad of issues including complaints, communication with the patient and concerned family members, receipt of relevant test results, procuring of consults, communication among caregivers, discussions with social workers and discharge planners, etc. The old model, under which the patient's primary care physician (PCP) would see the patient for a few minutes either early in the morning (when the patient might still be asleep) or after office hours, then scribble a few lines in the chart regarding recent events, was certainly inefficient in many ways. One could not really expect a physician in those circumstances to be as fully involved in the patient's care as another breed of physician whose duty is to oversee every aspect of hospital care. We have defended our share of cases where the genesis of the lawsuit seems to have less to do with the commission of malpractice than with an irate patient/plaintiff whose chief complaint is that his family doctor didn't bother to see him in the hospital. Lawsuits by disgruntled patients against their PCPs often drag the hospital into the case as a defendant to answer for injustices either real or imagined.

Hospitalists and the "High-Volume" Patient

The availability of a dedicated hospital-based physician becomes all the more important in the management of so-called "high-volume" medical diagnoses: congestive heart failure, chronic obstructive pulmonary disease, gastrointestinal bleeds and chest pain.[3] We would add conditions like diabetes and its various complications, and end-stage renal disease, to this list. These patients are not only more debilitated and in need of longer-term care than many other patients, but they generally are admitted to hospitals more frequently, and their medical demands can tax if not overwhelm their community physicians. Given the twin epidemics of obesity and diabetes in America—especially among children—we can envision a continued need for hospitalists for years to come. Indeed, the hospitalist who treats such patients may become as or more familiar with them than the community physician.

Of course, to the extent that such "repeat customers" present with multiple and often serious co-morbidities, and frequently develop complications (pneumonia, ventilator dependency, occlusion of grafts and shunts, delirium, gangrene and amputation, to name a few) or succumb to their illnesses, the involvement of a hospitalist may not prevent the filing of a lawsuit based solely on a bad outcome.

Hospitalists nevertheless have the potential to improve the quality of a patient's care in the hospital setting. The increased presence and familiarity of the hospitalist with hospital administrators, nursing staff, laboratory personnel, departments (physical therapy, respiratory therapy, etc.) and specialists, as well as with the hospital's information systems,[4] creates greater opportunity for important elements of patient care to get accomplished in a timely fashion. Compare this to the community physician who often has to shepherd the patient's care from a remote location and who may not be nearly as familiar with these various elements.

Impact on Emergency Room Care

The emergence of the hospitalist has had a positive impact on the workload of many emergency room physicians between the hours of 4:00 p.m. and 8:00 a.m. Traditionally, nighttime staffing in community hospitals has been limited to emergency department physicians.[5] The availability of hospitalists, however, has greatly unburdened emergency department staff, allowing them uninterrupted care of their own patients.[6] On nights where there is an unexpected influx of patients with varying degrees of acuity of symptoms, the presence of hospitalist staff surely results in better, more dedicated care for both true "emergencies" and other conditions where a hospitalist is better suited to step in.

The Nighttime Dilemma

A related topic has to do with the need for the primary care physician to take overnight and weekend calls in the absence of hospitalist coverage. We have seen any number of cases where the physician (who later finds himself as a defendant in a lawsuit) receives a call in the middle of the night or over the weekend, and refers the patient to the emergency room with plans to see him first thing in the morning—or who takes perhaps more time than he should getting to the hospital. Before the doctor arrives, some calamity has befallen the patient, perhaps as a result of unfamiliar staffing in an emergency room that is ill-equipped to handle the situation. The availability of a hospitalist to admit the patient obviates the need for the community physician to hurry to the hospital, the end result of which may have more to do with an increased level of care for the patient than with a few extra hours of sleep for the community physician.

Shorter Stays: A Paradigm for Risk Reduction

A recurring theme in the literature we have reviewed is the impact of the hospitalist on decreasing the average patient stay. Some studies have cited a reduction in length of stay by a factor of approximately 15%.[7] The mechanism driving this trend seems to involve the ability of the hospitalist to act more quickly in response to various aspects of the patient's care, including laboratory values and test results, and to have better and more established lines of communication with social workers and discharge planners, especially in those cases where the patient needs to go to a subacute care facility instead of home. Consider the following scenario under the old regime: the patient's PCP sees her at 6:00 or 7:00 a.m., heads to the office, has a busy day and is unaware of a relevant test result until the end of the day, or the following morning. The patient may have been ready for discharge that day. A hospitalist, on the other hand, may well have appreciated the test result and approved the patient's discharge the same day. Shortening hospital stays certainly has a financial component, but in view of the rise in incidence and severity of many hospital-acquired infections, it is unquestionably better for most patients to be out of the hospital as quickly as possible.

Potential Pitfalls of the Hospitalist Model from a Risk Management Perspective

Despite the rapid growth of the hospitalist profession and its emergence as a new paradigm in modern medicine, many authors have commented on negative aspects of this trend, several of which could certainly impact the quality of care rendered to patients and the likelihood of errors and bad outcomes which could well lead to litigation. While some of these "negative" aspects of hospitalist care might have been anticipated when the movement started ten years ago, others seem to fall under the category of "unintended consequences."

Patient Reluctance

The first hurdle to overcome for the hospitalist is the introduction to the patient who expects to see his or her PCP at some point during the hospital stay. This process can be dealt with up front by explaining to the patient what a hospitalist is and that the hospitalist will oversee all aspects of the patient's hospital stay. Defining the hospitalist's role up front, with the physician making it clear that he or she can be contacted at any time and for any reason, should go a long way toward alleviating the patient's concerns. Consider the traditional model, where the patient comes in to the hospital through the ER, and is seen by a succession of nurses, physician's assistants, residents, fellows, and attendings of various shapes and sizes—and has little or no idea who is who. The hospitalist takes the guesswork out of this process when his or her role is quickly and clearly defined.

Reduction in Opportunity for House Staff

First and foremost, we have read of concerns that the emergence of the hospitalist has resulted in fewer teaching opportunities for "house staff"—mainly, interns and resident physicians in the nascent phases of their clinical training who, at the completion of their residency programs, are expected to do things such as sit for board certification exams, move on to fellowships, and most importantly, take care of patients without direct supervision in a variety of settings. Prior to the advent of the hospitalist profession, many patients who saw their primary care physician for precious few moments during the course of a typical day undoubtedly grew frustrated by being poked and prodded by young, unfamiliar doctors who they knew or strongly suspected were "learning

on the job." The availability of hospitalists to serve as the patient's primary care physician during the hospital stay, although met with resistance by some patients who prefer their longtime family physician, has likely served to comfort many patients who know they are being tended to by a "real doctor" who is a page or call away from responding to them if necessary.

"[W]e view the increased role of the hospitalist as beneficial to the reduction of hospital-based errors in care and overall exposure to those institutions that employ hospitalists. We should bear in mind, however, that an unintended consequence of this trend is the graduation of less-prepared young doctors from residency programs . . ."

A casualty of this process is the reduction in opportunity for interns and residents to obtain critical clinical experience in obtaining histories, engaging in the process of differential diagnosis, making actual diagnoses, and performing a multitude of procedures ranging from venipuncture to thoracentesis. Many of these opportunities prior to the arrival of the hospitalist came between the hours of 4:00 p.m. and 8:00 a.m., after the attendings and consultants were gone for the day and could not always be expected to return to the hospital for every issue that came up with every patient. With hospitalist staff now dedicated at many hospitals to providing a physical presence and round-the-clock coverage in the hospital, many of the articles we have reviewed discuss the decrease in opportunity for house staff not only with respect to the quantity of patient contacts, but the quality of those contacts—in terms of the nature of the diagnosis, care and treatment that house staff are now engaging in vis-à-vis hospitalists. Although difficult to quantify, there is a concern that new graduates of residency programs in hospitals may be less equipped than their predecessors to begin to independently diagnose and treat their own patients. Indeed, established clinicians have even exhibited reluctance to rely on hospitalists for care of their patients in the hospital, fearing the erosion of their own clinical skills.[8] In those institutions where hospitalists are not typically available at nights and on weekends, this would of course be less of a concern.[9]

Some of the increased need for hospitalist involvement, and concurrent decrease in opportunity for house staff, is undoubtedly tied to legislation limiting the number of hours that can be worked by residents. Whereas residents in some disciplines routinely worked upwards of 100 to 120 hours per week prior to the implementation of these restrictions in 2003, most states (acting in accordance with mandates from the Accreditation Council for Graduate Medical Education) now limit residents to a maximum 80-hour work week.[10] While this limitation has likely resulted in a difficult to quantify reduction in medical errors, a by-product is the reduction in opportunity for house staff.

In sum, we view the increased role of the hospitalist as beneficial to the reduction of hospital-based errors in care and overall exposure to those institutions that employ hospitalists. We should bear in mind, however, that an unintended consequence of this trend is the graduation of less-prepared young doctors from residency programs, some of whom may continue to work in a hospital setting. In terms of the overall impact of this phenomenon on risk management in general, the implications of (relatively) underprepared physicians entering the community are obvious.

Deficiencies in the Discharge Process

Although the hospitalist movement has been touted by its proponents as having the potential to streamline communication with consultants and prevent errors in the transmittal of critical information, it should not be viewed as a panacea. Ideally, the "hospitalist-as-ombudsman" model will prevent the sort of problems that can arise between an attending who may have limited hospital-based contact with his patient and the multitude of other hospital specialists and departments that come into contact with the patient during an admission. However, the potential certainly remains for errors of every imaginable stripe, the lesson being that the potential for increased efficiency and levels of patient care is dependent on a case-by-case basis according to the level of attention given by the hospitalist, both during the admission and at the time of discharge.

The irony here is that hospitalist care has been proposed as preferable to the old system where the patient's primary care physician ran the show during the admission. The downside of that model—the PCP's ability to do so being compromised by his office obligations—has been compared to the ability of the hospitalist to devote more time and be more available to the patient. However, under the old model, the PCP knew what had happened during the admission and could act on these events following the patient's discharge. Replacing the PCP with the hospitalist provides some benefits but adds a layer of necessary communication that did not used to exist.

Consider the following scenario: an elderly patient presents to the emergency room complaining of chest

pain. Work-up in the ER includes an EKG, revealing the presence of atrial fibrillation. The patient informs the ER physician that she has never been treated by a cardiologist, has never been told that she has any cardiac abnormalities and that her only medication is an anti-hypertensive. The hospitalist is paged and asked to admit the patient for further work-up. Included in this workup is a consult with a cardiologist, who in view of the apparently new-onset atrial fibrillation and its association with thrombus formation, recommends (but does not order) that the patient be started on a blood-thinning medication, Coumadin. Since the patient's chest pain has resolved and she is eager to go home, the hospitalist agrees to discharge her with specific instructions to follow up with her primary care physician within the next few days. However, because the patient's clotting time must be monitored via serial blood tests whenever Coumadin is started (and the dosage of the drug must often be tweaked to get the patient in the appropriate "range"), the hospitalist does not order the medication in the hospital. Rather, he dictates a discharge summary detailing the patient's hospital course, including the EKG findings and the recommendation regarding the Coumadin. Due to a delay in the hospital's transcription system, the discharge summary does not arrive at the patient's primary care physician's office until four days after the discharge—by which time she has suffered a massive stroke from which she will never recover.

Despite the fact that mechanisms were in place to take good care of this patient—including a hospitalist with access to and familiarity with a cardiologist who saw the patient in the hospital—the ball was obviously dropped in this hypothetical scenario. We agree with the general proposition that hospitalists reduce the dangers of fragmentation of care—but by no means do they eliminate it completely.

The literature we have reviewed contains a number of recommendations aimed at optimizing the lines of communication inside and outside the hospital. Many of these could just have easily applied to the pre-hospitalist model and bear repeating if for no other reason that no one should blithely assume that the new regime automatically improves on the old one.

One author notes that interviews with community physicians reveals that direct communication between hospital physicians and primary care physicians occurs infrequently—in one study, only 3% of primary care physicians reported being involved in discussions about discharge, and only 17% to 20% reported always being notified about discharges.[11] Direct communication—typically by way of a telephone call, the details of which should of course be documented in the hospital chart—increases the likelihood of an immediate response and should be employed in cases like the example cited above, where quick action is required.

"We agree with the general proposition that hospitalists reduce the dangers of fragmentation of care—but by no means do they eliminate it completely."

Of course, even in those instances where a phone call is made, a belt-and-suspenders approach is best. A discharge summary or discharge letter should be sent as soon as possible, reiterating the terms of the direct communication between the physicians or summarizing the details of the patient's admission if no immediate intervention is required and no such direct communication has occurred. There is some consensus in the literature on the information that should be communicated: main diagnosis, pertinent physical findings, results of procedures and laboratory tests, discharge medications with reasons for any changes to the previous medication regimen, details of follow-up arrangements made, information given to the patient and family, test results pending at discharge, and specific follow-up needs.[12] Among these, our experience indicates that changes in medications and pending laboratory results are pieces of information that, if not appropriately followed and communicated to the PCP, represent the most fertile ground for medical error, injury and potential litigation. Consider the patient who is suspected of having pneumonia or a urinary tract infection, is discharged before final culture and sensitivity results are available, and whose specimens grow out bacteria for which appropriate antibiotics are never prescribed because the hospitalist fails to follow for the results or fails to communicate these to the PCP.

We agree that the current JCAHO performance standard, that discharge summaries be completed within 30 days of hospitalization, is insufficient[13] in order to maximize patient safety and minimize the risk to doctors and hospitals that a patient will suffer as a result of information that is not disseminated quickly enough. An across-the-board policy of having the discharge summary available at the time of discharge—at least a provisional summary in advance of a formal, typewritten document—would reduce this risk. It could be argued that the preparation of such a summary, even if information like test results is outstanding, in and of itself serves to prompt the hospitalist to follow for the final results.

As more health care providers inside and outside the hospital setting become proficient in the electronic transfer of data, these summaries can easily be sent via fax or e-mail.[14] A more low-tech approach would add another layer of certainty to the process and invest the patient in his own care: giving the patient a copy of the most pertinent data and asking her to present this to the PCP at the first post-discharge office visit.[15]

"While we agree that in many respects, the hospitalist model presents the opportunity for better care and, perhaps as importantly, enhanced patient perception of the care they receive, the model is only as good as the persons practicing within it."

Summary

Having reviewed the considerable body of literature discussing the advent and development of the hospitalist movement over the course of the past decade, it is evident that some of the heady optimism of the early days has been tempered by the realization that there is no perfect model in medicine, at least with respect to the occurrence of medical error and the close relationship between such error and bad outcomes, many of which lead to litigation. While we agree that in many respects, the hospitalist model presents the opportunity for better care and, perhaps as importantly, enhanced patient perception of the care they receive, the model is only as good as the persons practicing within it. One thing is clear: the old way of doing business with regard to care and treatment is dying. The challenge for hospitalists will be to avoid the pitfalls discussed above and take advantage of their position to enhance patient care. This is admittedly an amorphous goal accomplished in a thousand different ways, but the end result should be a reduction in exposure to hospitalists and hospitals alike.

Endnotes

1. Wachter, R.M., Goldman L., "The Emerging Role of 'Hospitalists' in the American Health Care System," N Engl J Med. 1996; 335:514-517.
2. Wachter, "The Hospitalist Movement 10 Years Later: Life as a Swiss Army Knife," MedGenMed 2006; 8(3):30.
3. Wilson, "Hospitalists Are Here to Stay," Nursing Management, August 2006 at 56.
4. Wachter, "Reflections: The Hospitalist Movement a Decade Later," Society of Hospital Medicine, Vol. 1, No. 4, July-August 2006 at 249.
5. Chen, "Ode to the Hospitalist," Southern Medical Journal, Volume 100, Number 3, March 2007 at 239.
6. *Id.*
7. "Hospitalist," Clinical Privilege White Paper, April 2007, (178) at 1.
8. Hodges, "Hospitalists: Why I Don't Use Them," Medical Economics, January 19, 2007 at 66.
9. Pressel, "Hospitalists in Medical Education: Coming to an Academic Medical Center Near You," Journal of the National Medical Association, September 2006 at 1502.
10. Sehgal et al., "The Expanding Role of Hospitalists in the United States," Swiss Medical Weekly, 2006;136:592.
11. Kripalani et al., "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians," Journal of the American Medical Association, February 28, 2007, Vol. 297, No. 8 at 833.
12. *Id.* at 833.
13. *Id.* at 838.
14. *Id.* at 838.
15. *Id.* at 839.

Paul Colucci is a partner in the Valhalla, New York office of Kaufman Borgeest & Ryan LLP, and focuses his practice on the defense of medical malpractice claims.

Jonathan Rubin is a partner in the same firm's Manhattan office, and also focuses his practice on the defense of medical malpractice claims.

Discovery and Admissibility of Peer Review Materials and Department of Health Investigations in Medical Malpractice Litigation

By Meghann N. Roehl and Patrick B. Curran

In an effort to curb the rise in liability insurance rates in 1985, the New York State Legislature enacted Section 2805-g of the Public Health Law. This statute provided comprehensive reform of the medical and dental malpractice adjudication system, and the continued availability and affordability of quality health services. This malpractice prevention program required every hospital to maintain a coordinated program for the identification and prevention of medical, dental, and podiatric malpractice. Hospitals must establish a committee to address negative health care outcomes, incidents injurious to patients or patient grievances, among other things. These committees have come to be known as Quality Assurance and Peer Review committees.

Neither the proceedings nor the records relating to performance of a medical or quality assurance review function or participation in a medical and dental prevention program shall be subject to disclosure in a malpractice action.[1] Section 2805-m requires that the collection of information and reports from peer review meetings be kept confidential, as they are designed to improve practices which address specific incidents and patient grievances. Limited access to this information is given to the Department of Health to the extent necessary to verify there has been compliance with statutes. This information is not discoverable in a malpractice action. A Freedom of Information Law request may be used to obtain a redacted copy of the Department of Health's investigation and to ascertain whether any findings were made. However, courts will usually preclude or limit a plaintiff from offering these reports as evidence of negligence.

Statements of a defendant physician made before a peer review board or for quality assurance evaluation are not privileged when they relate to the subject matter of the litigation. A physician against whom a medical malpractice action had been brought could be compelled to answer questions during examination before trial which related to statements he had made before a peer review board or for quality assurance evaluation; but the physician could not be compelled to answer questions concerning whether he reviewed a quality assurance evaluation, as any such report is not discoverable.[2]

In *Smith v. Delago*,[3] a complaint was made to the Department of Health as a result of care the plaintiff received from the defendant hospital and the plaintiff's treating physician. The Department of Health conducted an independent investigation, a copy of which the plaintiff obtained from a Freedom of Information Law request. The Department of Health's report included redacted interviews with the hospital staff and the Department of Health's independent review of the medical care provided. Following commencement of a medical malpractice action, defendants moved to prohibit plaintiff's use of the documents obtained from the Department of Health, contending they were confidential under the Education Law and the Public Health Law. Plaintiff cross-moved for production of further documents including peer review documents. The hospital's vice president of risk management submitted an affidavit stating that the requested documents were provided to the Department of Health in furtherance of its internal quality assurance review obligation. The trial court found that the documents generated by the Department of Health were privileged, and plaintiff appealed. The Appellate Division, Third Department held that "the plaintiff was entitled to the production of Department of Health's statements of deficiencies (see Public Health Law § 10 [2]) redacted to remove conclusions of law and the opinions of the Department of Health . . . ," and that "the defendants met their burden of establishing that the other documents were entitled to statutory confidentiality."[4] Hence, reports generated by a peer review investigation were held to be protected. The purpose of this discovery exclusion is to "enhance the objectivity of the review process" and to assure that medical review committees "may frankly and objectively analyze the unity of health services rendered" by hospitals.[5] By assuring confidentiality, these peer review meetings will be thorough and conducted without fear of legal repercussions, thereby improving the quality of medical care.[6]

In cases where the Department's findings related to the very conduct that is the subject of the malpractice lawsuit, New York courts have held that the findings are admissible because of their significant probative value.[7] When administrative findings do not directly relate to allegations in the suit, courts have refused to allow their

introduction into evidence because the potential for prejudice is too great. It is improper to prove that a healthcare provider acted in a certain manner on a particular occasion by showing that it acted in a similar manner on a different occasion.

A healthcare provider's documents are not cloaked by statutory protection merely by being characterized as quality assurance or peer review material. It is the burden of the party invoking the protection to establish that the items being requested "were generated in connection with a quality assurance review function pursuant to Education Law § 6527(3) or a malpractice prevention program pursuant to Article 28 of the Public Health Law."[8] A hospital may waive its privilege by sharing the confidential reports with a disinterested third party.[9] Waiver of this privilege requires the "intentional relinquishment of its known right of confidentiality."[10] Sharing the records, reports and documents with a person interested in the hospital review, such as an employee at the Department of Health, does not waive the privilege.[11]

In *Swanson v. University of Rochester (Strong Memorial Hospital)*, plaintiff requested the disclosure from defendant hospital of four reports made to a patient relations representative of the hospital and the identity of the source of the reports. The hospital maintained that all four reports were privileged, as they were generated following a quality assurance review. The plaintiff argued that the hospital waived its confidentiality because the patient relations representative issued a letter to the plaintiff setting forth certain conclusions regarding the plaintiff's care, which were made after reviewing the reports. The court found that the letter was sent to a patient, in response to his request, who had complained about his care at the hospital. Since a hospital is required to notify the patient by a written response of the findings from the investigation,[12] "the letter sent to the plaintiff by the hospital is clearly part of the program required by the statute for the identification and prevention of medical malpractice" and is protected from disclosure.[13] Moreover, the court determined that the plaintiff was not a disinterested party. The court held that in order "to waive the privilege afforded by the Public Health Law and the Education Law, the hospital must intentionally relinquish its known right of confidentiality."[14]

In determining what is or is not protected by the confidentiality provisions of the statute, the Court is not only weighing the probative value versus the prejudicial effect of the evidence, but also examining whether the hospital invoking the privilege has guidelines and a review procedure for generating these documents.[15] In *Kivlehan v. Waltner,* the injured plaintiff suffered a nearly fatal Group A streptococcal infection after giving birth at the defendant hospital. The plaintiff and her husband commenced a malpractice lawsuit alleging she was infected by her obstetrician. During discovery, plaintiffs moved to compel various records kept by the defendant hospital, which opposed the discovery items on the grounds that they were privileged. The Second Department determined that since the hospital did not make a showing that the information for which the exemption is claimed was obtained or maintained in accordance with the review procedure, the information was subject to disclosure.[16] An *in-camera* review may be conducted in order to ascertain whether the reports and statements were actually generated as a result of a formal peer review meeting, and what review procedure was followed.[17]

An allegation that defendant hospital improperly credentialed a physician is sometimes the basis for a demand to produce the physician's credentialing file. In *Logue v. Velez*, *supra,* plaintiff attempted to obtain a physician's application for privileges to perform a particular procedure. Counsel sought to discover what the hospital considered before granting privileges. The hospital approved the physician's application. The physician performed the procedure upon a patient who later brought a malpractice lawsuit against him claiming that the procedure had been done improperly and that the physician lacked the proper qualifications to perform it. Plaintiff's attorney claimed the application was a statement of the doctor made in the context of a peer review or quality assurance function of the hospital. The Court of Appeals held that plaintiff's attorney was not entitled to a copy of the application because the application preceded the alleged malpractice and, therefore, any peer review or quality assurance meeting which took place could not have discussed the care and treatment rendered to the patient which resulted in the malpractice claim against the physician. While the conclusion reached by the Court of Appeals may seem obvious, lower courts were interpreting the exception for statements very broadly and the Court of Appeals' decision in *Logue* served to curb such an interpretation. It is now clear from the holding in *Logue* that a physician's application for privileges are protected from disclosure by the Education Law and the Public Health Law, and that the exception for statements has no application to these documents.

The basic statutory principle remains intact, that peer review and quality assurance materials as well as Department of Health investigations are to remain confidential. Exceptions are limited to discoverability of a defendant physician's statements, and the Health Department's findings which pertain to the matter in suit.

Endnotes

1. Public Health Law Article 28.
2. *Bryant ex rel. Bryant v. Bui*, 265 A.D.2d 848, 849, 695 N.Y.S.2d 790 (4th Dep't 1999).
3. 2 A.D.2d 1259, 770 N.Y.S.2d 445 (3d Dep't 2003).
4. *Id*. at 1261, 447.
5. *See* Mem. of Assembly Rules Committee Bill Jacket L. 1971, Ch. 990 at 6.
6. *Brazinski v. New York Chiropractic Coll.*, 284 A.D.2d 647, 648, 725 N.Y.S.2d 457 (2001); *Logue v. Velez*, 92 N.Y.2d 13, 677 N.Y.S.2d 6 (1998).
7. *See Cramer v. Benedictine Hosp.*, 190 Misc. 29 191 (Sup. Ct., Ulster Co. 2002) (redacted copy of Department of Health report prepared after investigation of incident underlying plaintiff's medical malpractice lawsuit admitted into evidence); see also *Smith v. Delago*, *supra*.
8. *Swanson v. University of Rochester (Strong Memorial Hospital*), 10 Misc. 3d 1076(a), 814 N.Y.S.2d 893 (Sup. Ct., Monroe Co. 2005).
9. *See Nga Le v. Stea*, 286 A.D.2d 939 (4th Dep't 2001); *Scinta v. VanCoevering*, 284 A.D.2d 1000 (4th Dep't 2001).
10. *See Khan v. New York State Department of Health*, 17 A.D.2d 938, 794 N.Y.S.2d 145 (3d Dep't 2005).
11. *See Smith v. Delago, supra.*
12. 10 N.Y.C.R.R. § 405.7(b)(23).
13. *Swanson, supra*.
14. *Id.*
15. *See Kivlehan v. Waltner*, 36 A.D.3d 597, 827 N.Y.S.2d 290 (2d Dep't 2007).
16. *Id*. at 599.
17. *Kivlehan v. Waltner, supra.; Williams v. Brookhaven Memorial Hospital Center*, 13 Misc. 3d 1204(a) (Sup. Ct., Suffolk Co. 2006).

Ms. Roehl is an Associate at Damon & Morey LLP, practicing in the firm's Litigation Department. She concentrates her practice in the areas of general liability, municipal liability, medical malpractice and nursing home defense.

Mr. Curran is a senior trial attorney at Damon & Morey LLP, practicing in the firm's Litigation Department. He is experienced as trial and appellate counsel in the defense of matters involving medical malpractice, trucking and motor vehicle accidents, product liability, municipal liability, construction accidents, nursing home defense and general negligence litigation.

Ignorance Is Not Bliss: Why Every State Should Adopt the CDC's Revised Recommendations for Routine HIV Screening

By Melissa E. Welch

Introduction

To test or not to test. That is the question that now faces every state or local health agency that has statutory or regulatory hurdles to making human immunodeficiency virus (HIV) testing part of standard medical practice.[1] "Frustrated that more than 25 percent of Americans with HIV infection are unaware of their status and that almost 40 percent of those with newly diagnosed AIDS discover that they are infected less than a year before diagnosis," the Centers for Disease Control and Prevention (CDC) has proposed routine HIV screening in all health care settings.[2] The CDC already recommends regular testing for high-risk groups and in high-prevalence settings.[3] The shift in policy is the extension of screening to the whole population and the elimination of written informed consent and compulsory pretest counseling.[4] Physicians would tell patients that primary care included HIV screening, and patients would have the right to opt out.[5] The CDC believes that general consent for medical treatment should cover consent for HIV testing.[6]

However, "[l]egislation continues to mandate lengthy pretest counseling that varies state to state and by funding stream. A separate written informed consent is still a requirement in more than a dozen states including New York, home to 1 in 6 persons living with HIV."[7] States initially passed these laws when the infection was untreatable and the source of great stigma.[8] The legislation represented a compromise between public health officials who viewed widespread testing as the central feature of their preventative strategy and AIDS activists who worried about the autonomy and privacy of those perceived to be at risk.[9] Yet, the system originally put into place to protect individuals imperils public health efforts to control HIV.[10] "According to advocates of change, the transformation of HIV disease into a complex chronic condition requiring long-term, ongoing clinical management means that the limits imposed when medicine had little to offer have outlived their justification."[11] If the epidemic has evolved over the past twenty-five years, then one should wonder why the testing process has remained static.[12]

I. HIV Becomes Part of the National Landscape

In June of 1981, the CDC published a report about five young homosexual men in Los Angeles, CA, developing *Pneumocystis carinii* pneumonia (PCP) "without a clinically apparent underlying immunodeficiency."[13] This study signaled the start of awareness about Acquired Immune Deficiency Syndrome (AIDS) in the United States.[14] In September of 1982, the CDC gave AIDS its official name.[15] Before this time, the medical community had called the unexplained illness gay-related immunodeficiency syndrome (GRID).[16] Less polite segments of society had used the terms "gay cancer" or "gay plague."[17] Thus, homosexual and bisexual men became the root of AIDS in the public mind.[18] "Of course, AIDS was alive and well in the so-called general population from the beginning."[19] In 1982, reports of AIDS in heterosexual hemophiliacs and other recipients of blood transfusions surfaced.[20]

"'Frustrated that more than 25 percent of Americans with HIV infection are unaware of their status and that almost 40 percent of those with newly diagnosed AIDS discover that they are infected less than a year before diagnosis,' the . . . [CDC] has proposed routine HIV screening in all health care settings."

In April of 1984, U.S. Secretary of Health and Human Services Margaret Heckler announced the discovery of HIV, the virus that causes AIDS.[21] She also pledged that the federal government would produce an antibody test for the virus within six months.[22] Its purpose was to shield the country's blood supply from infected donors.[23] In March of 1985, the Food and Drug Administration (FDA) licensed the first HIV antibody test for commercial distribution.[24] Blood banks and plasma collection centers immediately put it to use.[25] The U.S. Public Health Service followed with a plan to provide state health departments with funding to establish test sites that would enable members of apparent risk groups to learn their HIV status without having to donate blood.[26] Before the year was out, 874 of these alternative test sites were in operation, and 79,100 people had obtained their HIV status.[27] "By the end of 1985, the push for expanded testing was already well under way."[28]

II. All About Testing

"By . . . 1986, AIDS had come to be perceived less as a plague among gay men and more as an infectious, communicable disease that threatened the general public."[29] The "outing" of once married actor Rock Hudson in July of 1985 had stirred anxiety among heterosexuals who had previously felt immune.[30] Public health authorities

responded by depicting testing as the "magic bullet" for combating HIV.[31] In March of 1986, the CDC released recommendations "to facilitate identification of seropositive asymptomatic persons, both for medical evaluation and for counseling to prevent transmission."[32] The guidelines urged confidential and anonymous testing for a wide range of individuals, including IV drug users, immigrants from Haiti or Central Africa, prostitutes, and newborn infants.[33] By June of 1987, 1,100 test sites existed, the newer ones found in STD clinics, women's health centers, hospitals, and drug treatment facilities.[34]

In President Ronald Reagan's first speech on HIV and AIDS in May of 1987, he hailed the benefits of comprehensive testing.[35] He told the American people:

> Just as individuals don't know that they carry the virus, no one knows to what extent the virus has infected our entire society. . . . AIDS is surreptitiously spreading throughout our population and yet we have no accurate measure of its scope. It is time we knew exactly what we were facing. And that is why I support routine testing.[36]

President Reagan's critics contended that he, in fact, supported mandatory testing of select groups.[37] In 1985, the federal government had instituted mandatory testing of military personnel and recruits, immigrants, and workers in the departments of Defense and Labor.[38] By 1988, many states had passed legislation regarding the compulsory screening of marriage applicants, pregnant women, newborns, hospital patients, the mentally ill and retarded, prisoners, intravenous drug users, and sex offenders.[39] Some states repealed these measures, but "no legal protections against the discrimination of people with HIV or AIDS were in place."[40]

In contrast, the public health community argued that testing necessitated informed consent, confidentiality, and counseling.[41] Then U.S. Surgeon General C. Everett Koop warned that threatening policies and practices would drive the epidemic underground.[42] "For most of the epidemic, HIV-antibody testing . . . required two visits. The first visit consisted of a pretest counseling session and a blood draw, but test results and posttest counseling were not provided until the second visit," usually two weeks later.[43] Depending on the setting and population, 10% to more than 50% of testees did not return for their results.[44]

Counseling focused on typical messages about the test, the significance of positive and negative results, and risk reduction.[45] Preliminary studies of the testing process showed a significant decline in dangerous behavior among those who tested positive.[46] The same studies demonstrated little change among those who were negative.[47] To counter this effect, the CDC issued another set of recommendations in January of 1993.[48] They emphasized the importance of "client-centered" counseling and personalized risk-reduction plans.[49] Subsequent studies documented increased condom use among seronegative patients at STD clinics that followed these tactics.[50]

Innovations in medical therapies offered another reason to bolster testing.[51] The FDA approved azidothymidine (AZT) in March of 1987. Clinical trials had displayed the drug's ability to slow down the progression of AIDS.[52] "The promise of living with HIV or AIDS as a chronic disease provided more incentive for infected people to undergo testing and begin treatment before their immune systems were ravaged beyond repair."[53] In 1989, studies confirmed that AZT also delayed the onset of AIDS in some asymptomatic persons.[54] That same year, researchers found that aerosolized pentamidine could prevent PCP, AIDS' most common and deadly opportunistic infection.[55]

"Perhaps the most dramatic use of biomedical advances as exigency for expanded testing and case identification was sparked in late 1995 and 1996, when the first protease inhibitors were approved and combination or 'cocktail' therapies were found to be effective in reducing viral loads of some people to undetectable levels."[56] In accordance with the chronic disease paradigm, public health officials and health care providers advocated routine testing for those at elevated risk for HIV.[57] Experts stated that this highly active antiretroviral therapy (HAART) would work at its maximum potential if administered right after infection.[58] In the aftermath of HAART's development, legislators called for routine testing without explicit consent.[59] Conversely, many feared that without a requirement for written consent, testing would, in effect, become mandatory.[60]

III. HIV Exceptionalism

The outcry over a proposal that even bordered on compulsory testing was not surprising in the 1990s. In the early 1980s, the gay community's response to detection through blood screening had been overwhelmingly negative.[61] Gay and AIDS activists, especially at Gay Men's Health Crisis in New York City, had campaigned against the test with the slogan, "No Test Is Best."[62] They had reasoned that in the absence of proven treatment, a positive diagnosis would have caused gay men psychological distress and made them targets of additional discrimination.[63] They had not been wrong. Throughout the 1980s, gay men with HIV or AIDS suffered the denial of insurance, the loss of employment and housing, and difficulty in securing health care from apprehensive providers.[64] States enacted laws making it a criminal offense to transmit HIV intentionally.[65] In 1988, fewer than half the states had statutes to guard the confidentiality of HIV-related information.[66] Propositions for quarantine, universal mandatory screening, and tattooing of the infected were not uncommon.[67] Injection drug users and immigrants from developing countries faced equally severe stigmatization.[68]

On the other hand, public health authorities and medical professionals had the responsibility to monitor, prevent, and treat HIV infection.[69] They "struggled with the task of reconciling patients' rights to privacy and nondiscrimination with collective rights to public health protection."[70] "Out of the ensuing bitter conflict emerged some exacting standards for specific written consent and requirements for pretest counseling. This approach was markedly different from what typically happened in clinical settings, where physicians ordered blood work for patients who were generally unaware of what was being tested for and consent was assumed."[71] Instead of applying standard methods for disease control,[72] public health officials "cater[ed] to the uniqueness of the disease" by allowing civil liberties to be paramount.[73]

IV. Exceptional Rates of Infection

"[K]nowledge of HIV status is critical in a generalized epidemic for prevention and access to care."[74] Despite substantial progress in HIV treatment, the United States and the rest of the world have fallen short in identifying "the reservoir of those infected and unaware of their serostatus."[75] AIDS experts have theorized that continuous reliance on a single HIV counseling and testing model is largely to blame for this phenomenon.[76] For example, New York State has required pretest counseling and written informed consent since 1988.[77] The New York City Department of Health and Mental Hygiene estimates that each year, more than 1,000 New York City residents, three per day, receive a concurrent diagnosis of HIV and AIDS.[78] Many of these late testers unknowingly carried the virus for ten years or more[79] in spite of having had multiple contacts with the health care system.[80] Nationally, 40% of new diagnoses are concurrent.[81]

These trends are alarming because the CDC has calculated that people unaware of their positive status spread 50% to 70% of new infections.[82] However, studies have indicated that individuals reduce precarious behaviors by about 50% once they receive positive test results.[83] Moreover, today's medications can reduce viral loads and further lower the likelihood of transmission.[84] Early detection is particularly critical because "HIV enters the body and replicates with a tremendous burst of viral activity, making those with new infections more likely to transmit HIV than individuals with chronic infections."[85] The CDC has reported that around one million Americans are living with HIV, and 250,000 do not know it.[86] Approximately 40,000 people learn annually that they are seropositive.[87] That number has remained stable for more than fifteen years.[88] It is not hard to speculate that increased testing could reverse this cycle.

What have changed are the demographics of the epidemic, mostly because of inaccurate assessments of risk.[89] "From 1989 to 1999, the percentage of AIDS cases that were attributable to heterosexual transmission increased 265%."[90] Between 1999 and 2002, heterosexuals accounted for 35% of new diagnoses.[91] Still, heterosexuals frequently underestimate their vulnerability.[92] Half of all new HIV infections in the United States occur among thirteen to twenty-four-year-olds, mainly due to unsafe sex practices.[93] Yet, adolescents, even high-risk adolescents, rarely seek testing on their own.[94]

Racial and ethnic disparities have also widened because of faulty perception.[95] In a recent survey of men who have sex with men (MSM) who tested positive for HIV, nine out of ten of the African American participants were unaware of their serostatus.[96] Only six out of ten of the white respondents were not aware.[97] One explanation for the results was the proportion of men who are on the "down low" in the African American community.[98] Men on the down low have sex with men but continue to have sex with women and identify themselves as heterosexual.[99] As a consequence, they tend to ignore prevention messages directed towards openly gay men.[100] Caucasian men are more likely to live in gay-identified neighborhoods than either African American or Hispanic men.[101] Unique cultural factors discourage openness about homosexuality among Hispanic men, too.[102] In Hispanic families, the high value placed on masculinity (machismo) deters males from confronting their risk of contracting HIV.[103]

Minority women fare no better. By 1988, the percentage of AIDS cases per 100,000 was fourteen times higher among African American women and seven times higher among Hispanic women than compared to white women.[104] In 2003, African American women compromised 69% of new female infections,[105] but African Americans only constituted 13% of the total population.[106] A six-year study of African American women in three cities in North Carolina illustrated that "despite the high prevalence of risk behaviors . . . the majority of women perceived themselves to be at low risk for acquiring HIV infection."[107] Many of the women who were seropositive found out through prenatal care.[108] These rising rates of diagnosis among women, minorities, young people, and heterosexuals underscore the need for early intervention to stem the tide of HIV.[109]

V. The CDC's Response

"Considerable success in the prevention of HIV infection in the United States has been achieved."[110] In the mid-1980s, more than 150,000 people a year tested positive.[111] Nevertheless, serious obstacles remain.[112] "Changes in beliefs regarding the severity of HIV infection, prevention fatigue, and increases in methamphetamine abuse and STDs also present new challenges to HIV prevention. These challenges are compounded by deep-rooted social problems and inequities. Poverty, homelessness, racism, homophobia, and gender inequality all affect HIV risk and can limit the effective delivery of prevention programs and medical services."[113] No one understands these concepts better than the officials at the CDC. Since

1946, the CDC has been at the forefront of public health efforts to prevent and control infectious and chronic diseases.[114] HIV and AIDS has been no exception.

Over the years, the CDC has released guidelines to make HIV testing more accessible, promote advancements in testing technology, overcome resource and provider constraints, and serve the varied needs of those undergoing screening.[115] Recently in 2001, the CDC issued the "HIV Prevention Strategic Plan through 2005."[116] Its goals were to decrease the number of HIV diagnoses from 40,000 a year to 20,000 and enlarge the percentage of infected individuals who were aware of their status.[117] The CDC suggested that health care providers in high-prevalence settings (local prevalence of infection is $\geq 1\%$) should regularly offer testing to their patients.[118] In low-prevalence settings, the CDC encouraged providers to perform targeted testing based on risk.[119]

By 2003, "it had become clear that the number of new HIV infections was not decreasing and that the proportion of infected persons who were aware of their HIV serostatus had not changed appreciably."[120] The CDC responded with another initiative, "Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic."[121] In this plan, the CDC proposed making HIV screening a routine part of care on the same voluntary basis as other diagnostic and screening tests.[122] The CDC recognized that pretest counseling is desirable but may not be practical in all circumstances.[123] "Because time constraints or discomfort with discussing their patients' risk behaviors caused some providers to perceive requirements for prevention counseling and written informed consent as a barrier, the initiative advocated streamlined approaches."[124] Nonetheless, the CDC still called for this regular testing when the local prevalence of infection was $\geq 1\%$.[125]

In March of 2004, the CDC assembled practitioners, representatives from professional organizations, and local health officials to refine its suggestions even further.[126] The parties agreed that the testing process could be simpler.[127] To have complied with the AHP initiative, providers would have needed population-based estimates of the local prevalence of infection, but such estimates were not easily accessible.[128] The CDC worked over the next two-and-a-half years to formulate universal screening guidelines.[129] The CDC released its revised recommendations on September 22, 2006 in the wake of the XVI International AIDS Conference held in Toronto, Canada in August.[130]

The CDC's basic premise is that "HIV screening is recommended for patients [aged thirteen to sixty-four] in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening)."[131] The CDC urges persons at high risk to have annual testing.[132] They include intravenous drug users, individuals who exchange sex for drugs or money, sex partners of HIV-infected persons, MSM, and heterosexuals who have had more than one sex partner since their last HIV test.[133] The CDC leaves practitioners to use their clinical judgment when deciding to rescreen patients not deemed to be at elevated risk.[134]

The CDC asserts that "[s]pecific written consent for HIV testing should not be required" because "general consent for medical care should be considered sufficient to encompass consent for HIV testing."[135] The CDC also believes that pretest risk counseling does not have to accompany diagnostic screening.[136] Instead, the CDC supports giving patients oral or written information about HIV infection and the meaning of positive and negative results.[137] However, the CDC encourages prevention counseling unlinked to testing in settings that normally assess unsafe practices, such as STD clinics.[138] Additionally, "those who want assistance with changing behaviors should be provided with or referred to HIV risk-reduction services. . . ."[139]

The CDC has updated its recommendations for pregnant women as well.[140] In 2001, the CDC released "Revised Recommendations for HIV Screening of Pregnant Women."[141] The guidelines endorsed universal screening of pregnant women[142] but did not advocate for an opt-out approach.[143] In contrast, the latest recommendations state that "[a]ll women should receive HIV screening consistent with the recommendations for adults and adolescents."[144] A second test during the third trimester is suggested for women who receive prenatal care in facilities that identify one infected woman per 1000 screened, who are at heightened behavioral risk, or who have symptoms consistent with acute infection.[145] If a woman has an undocumented status at the time of labor, the CDC presses her physician to offer her a rapid HIV test.[146]

VI. Why Universal Routine Testing Holds Great Promise

Eighty-one percent of adults in the United States see health care providers at least once a year.[147] Although "the process of testing . . . is not a conversion experience that magically produces behavior change,"[148] the absence of routine screening in the United States has resulted in missed occasions to diagnose, treat, and stop the spread of HIV.[149] In a survey conducted in 2006, 65% of adult respondents agreed that HIV testing should resemble the screening for any other disease, without special procedures such as written consent.[150] The American Medical Association (AMA) has already announced that it will work with the CDC and other organizations to enable physicians to carry out the voluntary guidelines as quickly as possible.[151] The sooner the better since researchers have reported increasing resistance to medications used in simplified drug regimens to treat HIV and prevent its transmission.[152]

"Inevitably, the effects of such challenges to the status quo will be felt throughout the country, in health departments, hospitals, and other clinical settings."[153] Yet,

universal routine testing is not a novel concept in HIV detection and prevention. In 1985, the U.S. Public Health Service called for regular screening of high-risk pregnant women.[154] At the time, mothers were delivering 1,500 infected babies a year.[155] By the late 1980s, it was obvious that targeted testing was missing 50% to 70% of high-risk women.[156] The U.S. Public Health Service, American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics began advising all pregnant women to undergo testing.[157] In 1996, Congress passed the "Baby AIDS" amendment to the annual Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.[158] The amendment stipulated that states had to mandate newborn testing by the year 2000 if they could not demonstrate either a 50% reduction in pediatric AIDS cases or that 95% of women received an HIV test during prenatal care.[159]

This undertaking has enjoyed great success. The number of infants infected with HIV through perinatal transmission decreased from 1,650 during the early to mid-1990s to as few as 144 in 2002.[160] "Medical record data suggest that the 'opt-in' voluntary testing approach is associated with lower testing rates than . . . the 'opt-out' voluntary testing approach. . . ."[161] By 2004, the Texas, Michigan, Tennessee, and Arkansas legislatures all opted for routine testing with the informed right of refusal over routine testing requiring explicit consent.[162] Surveys have confirmed that women prefer routine to risk-based testing because it lessens the stigma associated with taking an HIV test.[163]

Universal routine testing also makes good economic sense.[164] Even in low-prevalence settings, screening for HIV once every three to five years compares favorably with screening for chronic conditions like breast cancer, colorectal cancer, diabetes, and hypertension.[165] "[S]tudies have found that traditional, client-centered counseling and testing is much less cost-effective ($110,000 per infection prevented) because of high labor costs and low HIV prevalence among those seeking testing."[166] In New York City, researchers anticipate that over five times more tests could be funded relying on routine screening rather than on the current model.[167] The CDC predicts that near-universal screening could prevent half to two-thirds of the 40,000 new infections a year and save the nation $4 to $5.4 billion in health care expenditures.[168] The lifetime cost of care for a patient with HIV averages $200,000.[169]

In addition, "[t]he availability of oral fluid, urine, and fingerprick testing, along with rapid tests, has made it easier to provide HIV testing in a wide range of clinical and nontraditional settings. . . ."[170] Rapid tests produce results in as little as twenty minutes.[171] Patients do not have to return unless they need confirmatory testing after an initial positive finding.[172] In 2002, a state-funded pilot program in Massachusetts used the OraSure HIV-1 antibody detection system in four urgent care centers.[173] The use of oral swabs facilitated the identification of HIV-infected patients that were medically underserved and turned to emergency departments for their primary care.[174]

VII. The Difficulties of Implementing the CDC's Recommendations

The CDC itself recognizes that "states, local jurisdictions, or agencies might have statutory or other regulatory impediments to opt-out screening, or they might impose other specific requirements for counseling, written consent, confirmatory testing, or communicating HIV test results that conflict with these recommendations."[175] Still, the CDC urges all states and their respective agencies to adhere to them within the parameters of their current policies and to consider measures that will resolve differences.[176] The CDC was in a similar position when it issued guidelines on the universal screening of pregnant women in 2001, but "many states began to respond to the recommendations by revising some of their state legislation. . . ."[177] The CDC is optimistic that states will choose to do the same now.[178] The CDC intends to release technical guidance to ease observance sometime this year.[179]

Of course, there will be problems. New York is a case in point. A state law dating from the 1980s makes it impossible to carry out the voluntary federal guidelines.[180] That legislation mandates written informed consent and counseling before and after an HIV test.[181] New York not only had the country's highest rates of infection in the 1980s but skilled advocacy groups who fought for people with HIV and AIDS.[182] Despite the protections, countless individuals have never been tested, although "awareness of the disease is high and testing is widely available, as is treatment, even for those who cannot pay."[183]

In December of 2005, New York City Health Commissioner Dr. Thomas Frieden launched a battle in the state capital to amend the law.[184] Unfortunately, he made no headway in convincing the recently departed Pataki Administration in Albany.[185] It remains to be seen what side the Spitzer Administration will choose.[186] Those who oppose changing the legislation contest that written informed consent is not a barrier, especially since the New York State Department of Health simplified the form in 2005.[187] They blame doctors who are uncomfortable raising the subject with their patients.[188]

Conclusion

An HIV diagnosis is devastating, but the alternative—not getting care, spreading the infection to others, and dying prematurely of AIDS—is worse.[189] "A generation ago, cancer was stigmatized; it is now markedly less so owing to increased identification of cases, improved treatment, and public education."[190] Although HIV is a communicable disease, there is hope that by normalizing the testing process, HIV can move in the direction that cancer once did.

"When HIV testing became available 20 years ago in the absence of treatment and in the context of discrimination, the use of prescriptive regulations mandating counseling and separate written consent . . . was reasonable."[191] However, half a million lost American lives later, it is hard to justify their continued existence.[192] Controlling epidemics is the responsibility of the government, working in unison with physicians, patients, and communities.[193] The CDC has stepped up to the plate by loosening the strictures of HIV exceptionalism.[194] It is up to the states to decide if they will follow. In the past, "as often as not, ideology and politics, not support for what works, have driven" HIV testing policy.[195] Hopefully though after more than twenty-five years, lawmakers will realize that the test is actually best.

Endnotes

1. *See* Ctrs. for Disease Control and Prevention, *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, 55 (RR-14) MORBIDITY & MORTALITY WEEKLY REPORT 1, 13 (2006) [hereinafter *Recommendations*] (urging health care providers in the public and private sectors to test their patients on a regular basis for HIV).
2. Ronald Bayer & Amy L. Fairchild, *Changing the Paradigm for HIV Testing—The End of Exceptionalism*, 355 NEW ENG. J. MED. 647 (2006) (recounting efforts over the past decade to relax the constraints of HIV exceptionalism).
3. *Id.*
4. *See id.*
5. *See id.*
6. *Id.* at 648.
7. Douglas J. Koo et al., *HIV Counseling and Testing: Less Targeting, More Testing*, 96 AM. J. PUB. HEALTH 962 (2006) (arguing that the United States is ready for a streamlined approach to HIV screening).
8. *See id.*
9. *See* Bayer & Fairchild, *supra* note 2, at 648.
10. *See* Koo et al., *supra* note 7, at 962.
11. Bayer & Fairchild, *supra* note 2, at 649.
12. *See* Koo et al., *supra* note 7, at 962.
13. Ctrs. for Disease Control and Prevention, *Pneumocystic Pneumonia—Los Angeles*, 30 (21) MORBIDITY & MORTALITY WEEKLY REPORT 1, 2 (1981) (highlighting the unusual occurrence of previously healthy individuals coming down with PCP).
14. Annabel Kanabus & Jenni Fredriksson, *The History of AIDS: 1981-1986*, AVERT, Sept. 7, 2006, http://www.avert.org/his81_86.htm.
15. J. BLAKE SCOTT, RISKY RHETORIC: AIDS AND THE CULTURAL PRACTICES OF HIV TESTING 38 (2003).
16. *Id.*
17. *See id.*
18. *See id.* at 39.
19. *Id.* at 41.
20. *Id.* at 38.
21. *Id.* at 37-38.
22. *See id.* at 38.
23. *Id.*
24. *See* Richard Wolitski et al., *Evolution of HIV/AIDS Prevention Programs—United States, 1981-2006*, 296 J. AM. MED. ASS'N 760, 761 (2006) (calling for HIV prevention programs for underserved populations at high risk).
25. *See id.*
26. *See id.*
27. *Id.*
28. SCOTT, *supra* note 15, at 56.
29. *Id.* at 57.
30. *See id.* at 58.
31. *See id.* at 3, 10.
32. Ctrs. for Disease Control and Prevention, *Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus*, 35 (10) MORBIDITY & MORTALITY WEEKLY REPORT 152 (1986) (suggesting ways to interrupt the spread of HIV), http://www.cdc.gov/ mmwr/preview/mmwrhtml/00032640.htm.
33. *Id.*
34. SCOTT, *supra* note 15, at 56, 59.
35. *See id.* at 60.
36. *Id.*
37. *See id.*
38. *Id.* at 42, 57.
39. *Id.* at 60.
40. *Id.* at 43, 60.
41. *See id.* at 57.
42. Bayer & Fairchild, *supra* note 2, at 648.
43. Wolitski et al., *supra* note 24, at 761.
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *See* Ctrs. for Disease Control and Prevention, *Technical Guidance on HIV Counseling*, 42 (RR-2) MORBIDITY & MORTALITY WEEKLY REPORT 1, 11 (1993) (asserting that counseling has to be tailored to the behaviors, circumstances, and special needs of the person being served).
49. *Id.* at 11-12.
50. Wolitski et al., *supra* note 24, at 761.
51. *See* SCOTT, *supra* note 15, at 58.
52. *Id.*
53. *Id.* at 47.
54. *Id.* at 71.
55. *Id.* at 71-72.
56. *Id.* at 74.
57. *Id.* at 75.
58. *See id.*
59. *See id.*
60. *See* Bayer & Fairchild, *supra* note 2, at 649.
61. SCOTT, *supra* note 15, at 41.
62. *Id.*
63. *See id.* at 41-42.
64. *See id.* at 53.
65. *Id.* at 54-55.

66. *Id.* at 60.
67. *See* Thomas R. Frieden et al., *Applying Public Health Principles to the HIV Epidemic*, 353 NEW ENG. J. MED. 2397 (2005) (declaring that HIV should be treated like other communicable diseases).
68. *See id.*
69. *See* Lawrence O. Gostin & David W. Webber, *HIV Infection and AIDS in the Public Health and Health Care Systems*, 279 J. AM. MED. ASS'N 1108 (1998) (evaluating whether prerequisites for HIV screening have blocked it from entering mainstream medicine).
70. *See id.*
71. Bayer & Fairchild, *supra* note 2, at 648.
72. *See* Frieden et al., *supra* note 67, at 2397.
73. *See* Zita Lazzarini, *What Lessons Can We Learn from the Exceptionalism Debate (Finally)?*, 29 J.L. MED. & ETHICS 149 (2001) (pressing for a transformation in how society views disease, the scope and limits of public health power, and individual control over health information).
74. Elizabeth Marum, *Scale-up of Voluntary HIV Counseling and Testing in Kenya*, 296 J. AM. MED. ASS'N 859 (2006) (documenting government efforts in Kenya to enhance access to HIV testing).
75. *See* Koo et al., *supra* note 7, at 962.
76. *See id.*
77. Bayer & Fairchild, *supra* note 2, at 648; *see also* N.Y. PUB. HEALTH LAW § 2781 (2006).
78. Koo et al., *supra* note 7, at 962.
79. *Id.*
80. *See* Frieden et al., *supra* note 67, at 2399.
81. Koo et al., *supra* note 7, at 962.
82. *See* Donald G. McNeil, Jr., *U.S. Urges H.I.V. Tests for Adults and Teenagers*, N.Y. Times, Sept. 22, 2006, at A1.
83. Frieden et al., *supra* note 67, at 2399.
84. *Id.*
85. Rebecca Voelker, *Detecting Acute HIV Infections Feasible, North Carolina Program Demonstrates*, 289 J. AM. MED. ASS'N 2633, 2634 (2003) (describing a surveillance system in North Carolina that uses technology capable of confirming HIV infection within days or weeks of exposure).
86. David Brown, *U.S. Recommends Routine Testing for the AIDS Virus*, WASH. POST, Sept. 22, 2006, at A1.
87. Wolitski et al., *supra* note 24, at 762.
88. Brown, *supra* note 86, at A1.
89. *See* Curt G. Beckwith et al., *It Is Time to Implement Routine, Not Risk-Based, HIV Testing*, 40 CLINICAL INFECTIOUS DISEASES 1037 (2005) (holding that risk-based testing limits the ability of the health care community to diagnose HIV).
90. *Id.*
91. *Id.*
92. *Id.* at 1038.
93. MARGO BELL, CARE OF THE HIV-POSITIVE ADOLESCENT: DEVELOPMENTAL STAGES AND PROVIDER SENSITIVITY PLAY A SPECIAL ROLE 36 (2006) (identifying ways to facilitate HIV treatment for infected adolescents).
94. *See* Beckwith et al., *supra* note 89, at 1038.
95. *See* Wolitski et al., *supra* note 24, at 762.
96. CTRS. FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS AMONG MEN WHO HAVE SEX WITH MEN 3 (2006) (pointing to the need for culturally sensitive educational services for bisexual and homosexual men).
97. *Id.*
98. *See id.* at 4.
99. *Id.*
100. *See id.*
101. *Id.*
102. *Id.*
103. *See id.*
104. SCOTT, *supra* note 15, at 73.
105. Richard M. Selik et al., *Diagnoses of HIV/AIDS—32 States, 2000–2003*, 293 J. AM. MED. ASS'N 791 (2005) (criticizing the lack of prevention programs for minority populations).
106. *Id.*
107. Peter Leone et al., *HIV Transmission Among Black Women—North Carolina, 2004*, 293 J. AM. MED. ASS'N 1317, 1318 (2005) (highlighting that disadvantaged black women need to prioritize health issues such as HIV).
108. *Id.*
109. *See* SCOTT, *supra* note 15, at 3.
110. Wolitski et al., *supra* note 24, at 762.
111. *Id.*
112. *Id.*
113. *Id.*
114. About the CDC, http://www.cdc.gov/about/default.htm (last visited May 30, 2007).
115. Wolitski et al., *supra* note 24, at 761.
116. Beckwith et al., *supra* note 89, at 1038.
117. *Id.*
118. *Recommendations*, *supra* note 1, at 3.
119. *Id.*
120. Beckwith et al., *supra* note 89, at 1038.
121. *Recommendations*, *supra* note 1, at 3.
122. *Id.*
123. *Id.*
124. *Id.*
125. *See* Beckwith et al., *supra* note 89, at 1038.
126. *See Recommendations*, *supra* note 1, at 3.
127. *See id.*
128. *See* Beckwith et al., *supra* note 89, at 1038.
129. *See Recommendations*, *supra* note 1, at 3.
130. *See* Robert Steinbrook, *Message from Toronto—Deliver AIDS Treatment and Prevention*, 355 NEW ENG. J. MED. 1081 (2006) (recapping the major themes from the latest world AIDS conference).
131. *Recommendations*, *supra* note 1, at 1, 7.
132. *Id.* at 1.
133. *Id.* at 7.
134. *Id.*
135. *Id.* at 1.
136. *Id.*
137. *Id.* at 7-8.
138. *Id.* at 8.
139. *Id.* at 12.
140. *Id.* at 8.
141. Beckwith et al., *supra* note 89, at 1038.

142. *Id.*

143. Bayer & Fairchild, *supra* note 2, at 648.

144. *Recommendations*, *supra* note 1, at 8.

145. *Id.* at 9.

146. *Id.*

147. Samuel A. Bozzette, *Routine Screening for HIV Infection—Timely and Cost-Effective*, 352 NEW ENG. J. MED. 620, 621 (2005) (declaring that the failure to institute widespread HIV screening represents a critical disservice to patients and the future health of the nation).

148. SCOTT, *supra* note 15, at 120.

149. *See* Koo et al., *supra* note 7, at 962.

150. *Recommendations*, *supra* note 1, at 5.

151. Press Release, Nancy Nielsen, AMA Bd. Member, Am. Med. Ass'n, AMA Welcomes New Centers for Disease Control and Prevention (CDC) Recommendations for Routine HIV Testing (Sept. 21, 2006).

152. *See* Joan Stephenson, *Researchers Report Findings on HIV Drug Resistance, New Infections*, 291 J. AM. MED. ASS'N 1431 (2004) (warning that HIV is circumventing once-effective medicines).

153. Bayer & Fairchild, *supra* note 2, at 648.

154. SCOTT, *supra* note 15, at 161.

155. *See id.* at 162.

156. *See id.* at 163.

157. *See id.*

158. *Id.* at 160.

159. *Id.*

160. Ctrs. for Disease Control and Prevention, *Twenty-Five Years of HIV/AIDS—United States, 1981–2006*, 55 (21) MORBIDITY & MORTALITY WEEKLY REPORT 585 (2006) (stressing that prevention of HIV requires a renewed commitment from persons at risk, persons infected, and society as a whole).

161. Aaron Roome et al., *HIV Testing Among Pregnant Women—United States and Canada, 1998–2001*, 288 J. AM. MED. ASS'N 2679 (2002) (assessing prenatal testing strategies in the United States and Canada).

162. *See* Bayer & Fairchild, *supra* note 2, at 648.

163. *See* Beckwith et al., *supra* note 89, at 1039.

164. *See* Koo et al., *supra* note 7, at 963.

165. *Id.*

166. *Id.*

167. *See id.*

168. *See* Frieden at al., *supra* note 67, at 2400.

169. *Id.*

170. Wolitski et al., *supra* note 24, at 761.

171. *See id.*

172. *See* Allyn K. Nakashima et al., *Late Versus Early Testing of HIV—16 Sites, United States, 2000–2003*, 290 J. AM. MED. ASS'N 455, 456 (2003) (cautioning that late testing results in missed opportunities to prevent HIV).

173. Rochelle P. Walensky et al., *Voluntary HIV Testing as Part of Routine Medical Care—Massachusetts, 2002*, 292 J. AM. MED. ASS'N 678 (2004) (summarizing the success of a program in Massachusetts to implement routine HIV testing in emergency rooms).

174. *See id.* at 678-79.

175. *Recommendations*, *supra* note 1, at 13.

176. *See id.*

177. *See* Telebriefing, Kevin Fenton, Dir., Nat'l Ctr. for HIV, STD, & TB Prevention, Ctrs. for Disease Control & Prevention, CDC Announces Final Recommendations for Routine HIV Screening in Health Care Settings (Sept. 21, 2006).

178. *See id.*

179. *See* Dear Colleague Letter from Julie Louise Gerberding, Dir., Ctrs. for Disease Control & Prevention, & Kevin Fenton, Dir., Nat'l Ctr. for HIV, STD, & TB Prevention, Ctrs. for Disease Control & Prevention (Sept. 21, 2006).

180. Richard Perez-Pena, *New Federal Policy on H.I.V. Testing Poses Unique Local Challenge*, N.Y. Times, Oct. 2, 2006, at B1.

181. *See id.*

182. *See id.*

183. *See id.*

184. *See id.*

185. *See id.*

186. *See* Sewell Chan, *Rifts Emerge on Push to End Written Consent for H.I.V. Tests*, N.Y. Times, Dec. 25, 2006, at B1.

187. *See* Perez-Pena, *supra* note 180, at B1.

188. *Id.*

189. *See* Thomas R. Frieden et al., *The Authors Reply: Public Health Principles for the HIV Epidemic*, 354 NEW ENG. J. MED. 877, 878 (2006) (responding to criticism of an article written in a prior volume of the New England Journal of Medicine).

190. *Id.*

191. Frieden et al., *supra* note 67, at 2397.

192. *See id.*

193. *Id.* at 2400.

194. *See* Bayer & Fairchild, *supra* note 2, at 648.

195. *See* Deborah A. Cohen et al., *Cost-Effective Allocation of Government Funds to Prevent HIV Infection*, 24 HEALTH AFFAIRS 915 (2005) (pushing policymakers to adopt cost-effective prevention measures rather than politically expedient ones).

Melissa E. Welch received a BS from Georgetown University's School of Foreign Service magna cum laude in May 2001. She received her JD from Fordham Law School in May 2007. While at Fordham, she spent a semester in the Urban Policy Clinic, where she wrote a position paper for the New York City Bar AIDS Committee. She also interned in the General Counsel's Office at NYU Medical Center. Ms. Welch currently works in the Corporate Secretary's Office at NewYork-Presbyterian Hospital and recently passed the New York and Massachusetts bar exams.

This article won the 2007 Barry Gold Memorial Health Law Student Writing Competition.

Editor's Selected Court Decision

***Elba Ortiz, et al., Appellants, v. Ahmad M. Jaber, et al., Defendants*, 843 N.Y.S.2d 384, 2007 NY Slip Op. 07414 (2d Dep't, Oct. 02, 2007)**

In an action, inter alia, to recover damages for personal injuries, etc., the plaintiffs' appeal from a judgment of the Supreme Court, Kings County (Kramer, J.), entered March 21, 2006, which, upon an order of the same court dated March 29, 2005, granting those branches of the motion of the defendant Lutheran Medical Center pursuant to CPLR 4404(a) which were to set aside a jury verdict in favor of the plaintiffs and against it on the issue of liability, and for judgment as a matter of law, is in favor of the defendant Lutheran Medical Center dismissing the complaint insofar as asserted against it.

ORDERED that the judgment is affirmed, with costs.

Block & O'Toole (Pollack, Pollack, Isaac & DeCicco, New York, N.Y. [Kenneth J. Gorman and Brian J. Isaac] of counsel), for appellants.

Garson Gerspach DeCorato & Cohen, LLP, New York, N.Y. (Joshua R. Cohen, Andrew S. Garson, and Robert M. Applebaum of counsel), for respondent.

STEPHEN G. CRANE, J.P., ROBERT A. LIFSON, EDWARD D. CARNI, RUTH C. BALKIN, JJ. DECISION & ORDER

On September 16, 1997, the plaintiff Elba Ortiz (hereinafter the plaintiff) underwent laparoscopic surgery, which was performed by the defendant Ahmad M. Jaber at the defendant Lutheran Medical Center (hereinafter Lutheran). The plaintiff, along with her husband, commenced this action, inter alia, to recover damages for personal injuries. Jaber settled with the plaintiffs. The case proceeded to trial against Lutheran on the theory that, because Jaber had been a defendant in 21 previous medical malpractice actions over the course of his career, Lutheran violated its own by-laws and the Public Health Law in re-credentialing him upon his most recent application for hospital privileges.

The plaintiffs' expert testified at trial that Lutheran should have considered Jaber's entire history of malpractice cases prior to re-credentialing him, and, in light of the number of such cases, should have conducted additional investigation or denied or restricted his privileges. The defense experts testified that Lutheran did, in fact, adhere to its by-laws by conducting a review of Jaber's entire file, including all medical malpractice cases against him, and was only required by statute to consider "pending" cases on his most recent application for privileges (*see* Public Health Law § 2805-k).

The jury found in favor of the plaintiffs on the issue of Lutheran's liability for negligent re-credentialing. In a posttrial motion to set aside the verdict, inter alia, Lutheran argued that the plaintiffs' expert's testimony failed to establish that, in the re-credentialing process, Lutheran had violated its own by-laws or the Public Health Law, or that it should have denied Jaber's application for hospital privileges based upon the fact that he had been named as a defendant in previous medical malpractice cases.

A hospital is required to review an independent physician's qualifications before granting or renewing privileges (Public Health Law §§ 2805-j; 2805-k; *see Condolff v State of New York*, 18 AD3d 797; *Raschel v Rish*, 110 AD2d 1067, 1068; *Napolitano v Huss*, 272 AD2d 308; *Sledziewski v Cioffi*, 137 AD2d 186, 189). In the absence of evidence that Lutheran acted in violation of its by-laws or the Public Health Law in re-credentialing Jaber, there was no valid line of reasoning and permissible inferences which could possibly lead rational persons to the conclusion reached by the jury (*see Cohen v Hallmark Cards*, 45 NY2d 493, 499; *Tsatsakis v Booth Mem. Med. Ctr.*, 37 AD3d 591, 593; *Nyon Sook Lee v Shields*, 188 AD2d 637, 639-640).

Accordingly, the Supreme Court properly set aside the jury verdict and awarded Lutheran judgment as a matter of law.

CRANE, J.P., LIFSON, CARNI and BALKIN, JJ., concur.

Recent Events

- **Primer on Human Subject Research**. This timely program was held at the Cornell Club on October 19, 2007, and was both well attended and well received. The program was organized by Sal Russo, of N.Y.C. Health and Hospitals Corporation.
- **Fall Retreat in Cooperstown**. This retreat, which included a conference on Medicaid Fraud, set an attendance record for the Section. The roster of speakers was extraordinary, and included James Sheehan, the Medical Inspector General; Deborah Bachrach, the State Medicaid Director; and Heidi Wendel, Director of the Attorney General's Medicaid Fraud Control Unit. The luncheon speaker was Hank Greenberg, Counsel to the Attorney General. In addition to attending the conference, attendees enjoyed a beautiful weekend at the Otesaga Hotel, on Otsego Lake in Cooperstown.
- **Long Term Care CLE Luncheons**. The Special Committee on Long Term Care recently held CLE luncheons on three different topics:
  - October 29, 2007—Managed Care and HMO contracting in the LTC world.
  - November 27, 2007—IPRO and Expedited Determinations.
  - December 5, 2007—Assisted Living—Summary of New Regulations.

  A fourth CLE Luncheon is scheduled for February 2008 on the topic: Olmstead Revisited—Concepts on Least Restrictive LTC.

  The Special Committee is chaired by Raul Tabora of Ruffo Tabora Mainello & McKay P.C. in Albany. Please contact Raul A. Tabora, Jr., at rtabora@ruffotabora.com or (518) 218-2088 if you would like to attend the luncheon. Registration must be accomplished through NYSBA for appropriate credit.

Upcoming Programs—Save these Dates

- January 30, 2007—Annual Meeting. The Section's program at the Annual Meeting will be on "Medical Malpractice, Quality Assurance and Fraud." The luncheon speaker will be Tom Conway, General Counsel to the NYS Department of Health. The program is being organized by Harold Iselin of Greenberg Traurig in Albany; Hermes Fernandez of Bond Schoeneck and King in Albany; and Frank Serbaroli of Cadwalader, Wickersham & Taft in NYC. Register on-line through the NYSBA website, www.nysba.org.
- May 2008—Conference on Long Term Care (Date TBA). This conference will cover a range of issues relating to long term care. The Local Program Chairs are: NYC—Jerome Levy of Duane Morris, LLP; Albany—Anna Colello of NYS Department of Health; and Rochester—Mary Ross of Harter Secrest.

In the Section's Blog

Supraspinatus, the Section's Health Law Blog which was introduced last May, continues to provide immensely valuable information to New York health lawyers on a timely basis. Recent blog topics include:

- A Contrary View on EMRs
- Insurance Department Asks for Delay in United-Healthcare Policy Rollout

Further information about upcoming programs is always available at www.nysba.org/health. Just click on "Events."

- Increase in DOH Annual Fee for Bond Financed Facilities
- DOH Reports Progress on Berger Commission Implementation
- NYSTEM: Ethics Committee of ESSCB
- AG and Legislative Leaders Announce "Doctor Ranking Model Code" Initiative
- Clinical Trial Patient Has Hospital-Patient Relationship
- AG, Aetna Agree Over Physician Rankings
- DOH to Analyze "Near Misses" at NY Hospitals
- Medical Centers Catching Retail Clinic Wave
- NY Senate Health Chair Summarizes 2007 Health Laws
- Insurance Department Proposes "Principles-Based" Regulation
- Personal E-mails Sent by Hospital Executive to Private Counsel Using Hospital E-mail System Not Privileged

Past blog topics are archived and can be accessed. *Supraspinatus* can be found at http://nysbar.com/blogs/healthlaw/.

Blog Hits Century Mark: 100 Entries

On December 20, NYSBA President Kathryn Grant Madison contributed the 100th entry to *Supraspinatus*, the Section's Blog. She wrote,

> I want to thank the Health Law Section for allowing me to provide the 100th entry to this blogsite. We are actively promoting the use of information technology and blogs are an ideal tool for keeping lawyers informed and attracting new members. The Health Law Section blog has become the prototype for our Association, and we are delighted with your success. We hope our other Sections follow your lead.

She also noted that this year she established the first-ever President's Blog. "While we haven't gotten to 100 posts yet, the feedback has been outstanding."

Next *Journal* Edition

The next edition of the *Journal* will focus on Home Health Care Law. The Special Editor will be Jerome Levy, a member of Duane Morris, LLP. Persons interested in submitting an article should contact Mr. Levy at JTLevy@duanemorris.com.

Supraspinatus

The Official Unofficial Blog of the Health Law Section

http://nysbar.com/blogs/healthlaw

Visit Supraspinatus (SOO-pra-spy-NATE-us) to:

- Catch the latest news and developments affecting New York health law practitioners.
- Find links to primary and secondary sources (as available).
- Search through back posts on topics of interest.
- Read comments from other visitors and submit your own!

Please join in the discussions, voice your considered opinion and impact trends in the making . . . and more! Or just visit and browse quietly.

http://nysbar.com/blogs/healthlaw

(updated on a regular basis!)

The supraspinatus muscle attaches the top of the humerus (upper arm bone) to the medial scapula (shoulder blade) and initiates the first 15 degrees of motion of the upper arm—such as when one raises a hand to ask a question or to volunteer.

Section Committees and Chairs

The Health Law Section encourages members to participate in its programs and to volunteer to serve on the Committees listed below. Please contact the Section Officers (listed on the back page) or Committee Chairs for further information about these Committees.

Committee on Consumer/Patient Rights
Mark Scherzer
Law Offices of Mark Scherzer
7 Dey Street, Suite 600
New York, NY 10007-3105
mark.scherzer@verizon.net

Randye S. Retkin
New York Legal Assistance Group
450 West 33rd Street, 11th Floor
New York, NY 10001
rretkin@nylag.org

Committee on Ethical Issues in the Provision of Health Care
Kathleen M. Burke
New York Presbyterian Hospital
525 East 68th St.
Room W-109
New York, NY 10021-4873
kburke@nyp.org

Committee on Fraud, Abuse and Compliance
Steven Chananie
Garfunkel, Wild & Travis
111 Great Neck Road
Great Neck, NY 11021
schananie@gwtlaw.com

Marcia B. Smith
Iseman Cunningham Riester & Hyde, LLP
9 Thurlow Terrace
Albany, NY 12203
msmith@icrh.com

Committee on Health Care Providers
Francis J. Serbaroli
Cadwalader Wickersham & Taft LLP
1 World Financial Center, 31-138
New York, NY 10281
francis.serbaroli@cwt.com

Committee on Long Term Care
Raul A. Tabora, Jr.
Ruffo, Tabora, Mainello & McKay, P.C.
300 Great Oaks Boulevard, Suite 311
Albany, NY 12203
rtabora@ruffotabora.com

Committee on Managed Care
Robert P. Borsody
Phillips Nizer LLP
666 Fifth Avenue, 29th Floor
New York, NY 10103
rborsody@phillipsnizer.com

Harold N. Iselin
Greenberg Traurig LLP
54 State Street
Albany, NY 12207
iselinh@gtlaw.com

Committee on Membership
Hon. James F. Horan, ALJ
New York State Health Department
433 River Street
5th Floor, Suite 330
Troy, NY 12180-2299
jfh01@health.state.ny.us

Committee on Mental Health Issues
Carolyn Reinach Wolf
Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP
1111 Marcus Avenue, Suite 107
Lake Success, NY 11042
cwolf@abramslaw.com

Mental Retardation/Developmental Disabilities Providers
Hermes Fernandez
Bond Schoeneck & King, PLLC
111 Washington Ave
Albany, NY 12210-2211
hfernandez@bsk.com

Nominating Committee
James D. Horwitz
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
jhorwitz@glensfallshosp.org

Committee on Professional Discipline
Carolyn Shearer
Bond, Schoeneck & King, PLLC
111 Washington Avenue
Albany, NY 12210-2211
cshearer@bsk.com

Kenneth R. Larywon
Martin Clearwater & Bell, LLP
220 East 42nd Street
New York, NY 10017
larywk@mcblaw.com

Committee on Public Health
Margaret J. Davino
Kaufman Borgeest & Ryan
99 Park Avenue, 19th Floor
New York, NY 10016
mdavino@kbrlaw.com

Committee on Publications
Robert N. Swidler
General Counsel and Vice President for Legal Affairs
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
swidlerr@nehealth.com

Executive Committee
Peter J. Millock
Nixon Peabody, LLP
30 S. Pearl Street, 9th Floor
Albany, NY 12207
pmillock@nixonpeabody.com

Special Committee on Bylaws
Patrick Formato
Abrams Fensterman Fensterman et al.
1111 Marcus Avenue, Suite 107
Lake Success, NY 11042-1109
pformato@abramslaw.com

Special Committee on Insurance and Liability Issues
Esther Widowski
Widowski and Steinhart, LLP
425 Madison Avenue, Suite 700
New York, NY 10017-1126
ewidowski@aol.com

Special Committee on Legislative Issues
James W. Lytle
Manatt, Phelps & Phillips LLP
30 South Pearl Street, 12th Floor
Albany, NY 12207
jlytle@manatt.com

Website Coordinator
Ross P. Lanzafame
Harter Secrest & Emery LLP
1600 Bausch and Lomb Pl.
Rochester, NY 14604
rlanzafame@hselaw.com

Publication and Editorial Policy

Persons interested in writing for this *Journal* are welcomed and encouraged to submit their articles for consideration. Your ideas and comments about the *Journal* are appreciated as are letters to the editors.

Publication Policy: All articles should be submitted to:

Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
(518) 271-5027
e-mail: swidlerr@nehealth.com

Submitted articles must include a cover letter giving permission for publication in this *Journal.* We will assume your submission is for the exclusive use of this *Journal* unless you advise to the contrary in your letter. Authors will be notified only if articles are rejected. Authors are encouraged to include a brief biography with their submissions.

Editorial Policy: The articles in this *Journal* represent the authors' viewpoints and research and not that of the *Journal* Editorial Staff or Section Officers. The accuracy of the sources used and the cases cited in submissions is the responsibility of the author.

Subscriptions

This *Journal* is a benefit of membership in the Health Law Section of the New York State Bar Association.

The *Journal* is available by subscription to non-attorneys, libraries and organizations. The subscription rate for 2008 is $105.00. Send your request and check to Newsletter Dept., New York State Bar Association, One Elk Street, Albany, NY 12207.

HEALTH LAW JOURNAL

ISSN 1530-3926 ISSN 1933-8406 (online)

NEW YORK STATE BAR ASSOCIATION
HEALTH LAW SECTION
One Elk Street, Albany, New York 12207-1002

ADDRESS SERVICE REQUESTED

NON PROFIT ORG.
U.S. POSTAGE
PAID
ALBANY, N.Y.
PERMIT NO. 155