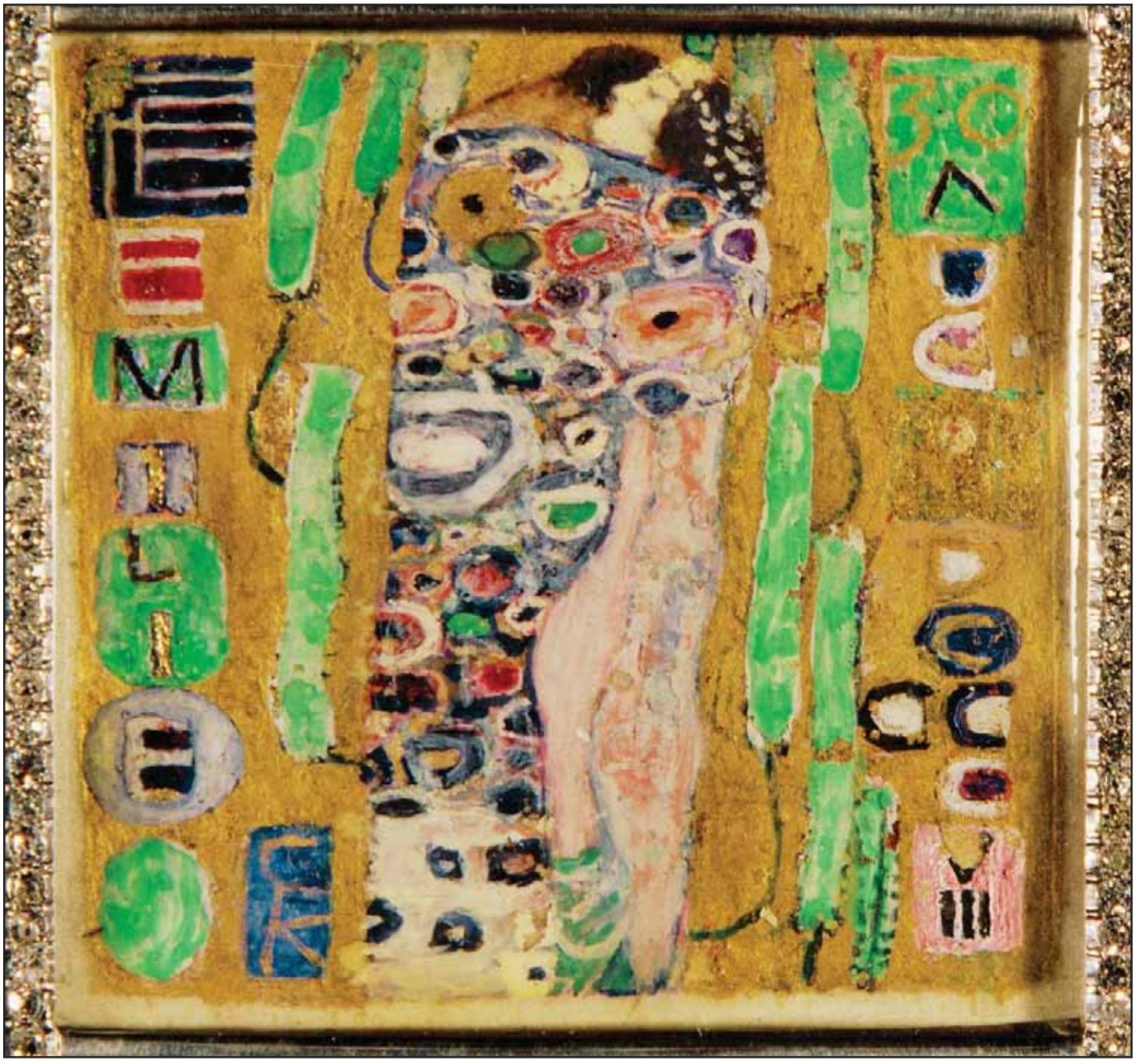
NYSBA WINTER 2009 | VOL.14 | NO.1

Health Law Journal

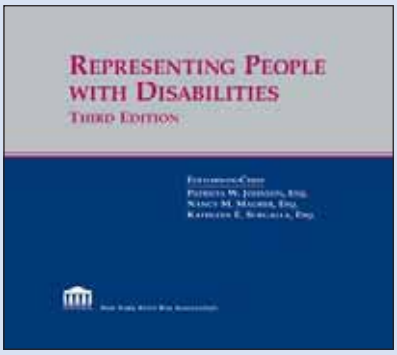
A publication of the Health Law Section
of the New York State Bar Association



NYSBA

Representing People with Disabilities

Third Edition, 2007 Revision



EDITORS

Patricia W. Johnson, Esq.
NYS Commission on Quality of
Care for the Mentally Disabled
Schenectady, NY

Professor Nancy M. Maurer
Albany Law School
Albany, NY

Kathleen E. Surgalla, Esq.
NYS Education Department
Albany, NY

PRODUCT INFO AND PRICES

2007 / 1,588 pp., loose-leaf
PN: 42158

NYSBA Members	**$160**
Non-members	$200

2007 Revision (available to past purchases only) PN: 52155

NYSBA Members	**$130**
Non-members	$155

Key Benefits

- Understand how to litigate federal civil rights on behalf of individuals with disabilities
- Learn to effectively conduct mediation, administrative hearings and appeals, and special education litigation
- Understand the Americans with Disabilities Act, governmental benefits and vocational rehabilitation services for people with disabilities

Representing People with Disabilities, Third Edition, is a comprehensive reference which covers the myriad legal concerns of people with disabilities—including an in-depth examination of the Americans with Disabilities Act.

It is the ideal reference for those who want a "one-stop" source that provides a thorough overview of the legal framework affecting individuals with disabilities.

An alternate format is available for individuals with visual impairments. Please contact the New York State Bar Association.

Prices include a CD-ROM containing entire contents of book with searchable text in PDF format.

Free shipping and handling within the continental U.S. The cost for shipping and handling outside the continental U.S. will be added to your order. Prices do not include applicable sales tax.

Mention Code: PUB0498

Get the Information Edge

NEW YORK STATE BAR ASSOCIATION
1.800.582.2452 www.nysba.org/pubs

NYSBA

HEALTH LAW JOURNAL

Winter 2009

Vol. 14, No. 1

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

Table of Contents

Cover artwork:
Gustav Klimt. *Brooch*, a present from Gustav Klimt to Emilie Floege on her 34th birthday, 1908.

A Message from the Section Chair

What would I do with a billion dollars?

A lot of attention has been focused on the need to rebuild our infrastructure, and the allure of instant jobs through "shovel ready" projects across the country. All are laudable goals certainly championed by well-intended public servants. But, is every out-of-work American ready, willing and able to embrace the proposed "shovel ready" job opportunities? Will those jobs provide long-term employment skills and opportunities for our unemployed neighbors? No doubt many will find long-term jobs through these initiatives. Although I am not an expert in the field—and I don't even play one on TV—it seems hard to imagine that the bulk of the unemployed will find permanent positions through the ballyhooed "shovel ready" jobs just around the corner.

In this time of TARPs' Economic Stimulus packages and bailouts totaling in excess of two and a half trillion dollars, a billion dollars or so seems like pocket change. However, if I had that kind of "change," and the desire to help the unemployed find meaningful, long-term employment, I think the industry to which I would turn would be health care. Okay, admittedly I am a tad biased, since that is the industry I serve through my day job. But, objectively looking at the growing demand for health care services and the plethora of job openings at a wide range of health care entities, spending even just $1 billion on job training for the health care industry would be money well spent all around.

The Healthcare Association of New York recently issued a report citing a few shocking employment statistics. Eighty percent of the hospitals in New York State report difficulty recruiting registered nurses. Fifty-three percent report difficulty recruiting LPNs, and 47% report difficulty finding Patient Care Technicians/Certified Nurse Aides. The statistics are no better for other personnel, with 39% having trouble finding radiologic technicians and technologists, 43% having difficulty recruiting clinical laboratory technicians, and 43% report problems recruiting physical therapists. Maybe they are not "shovel ready," but those statistics reflect a lot of existing job opportunities.

By last count, we have been told nearly 6 million Americans have lost their jobs since the start of the current recession. Same may eventually find jobs in their former fields; many may not. Again: What if we invested even just $1 billion in worker retraining programs focused on health care?

The Brookings Institution advises that the U.S. Department of Labor spends less than $6 billion a year nationwide on all job training and worker retraining programs. The biggest sources of public funds for worker training come from federal grants and subsidized loans for post-secondary education and training through the U.S. Department of Education, and state and local grants to post-secondary institutions, such as state universities and community colleges. Casually glancing through the House and Senate Economic Stimulus proposals, there appears to be some money earmarked for Education. The designated funding seems principally geared toward classroom construction, which sounds like more "shovel ready" jobs to me. But what about channeling some of those funds to pay tuition costs for unemployed workers willing and able to be trained for health care jobs? Assuming it costs a community college $1,000 to train a clinical lab technician, or $1,495 to train a radiological technician, or $7,000 to train an LPN, or even $11,000 for an RN, a paltry $1 billion would provide tuition assistance for an awful lot of people, and net the health care industry some of the workers it desperately needs.

Ross P. Lanzafame

In the New York State Courts

By Leonard M. Rosenberg

Appellate Division Prohibits District Attorney From Prosecuting Nurses for Their Simultaneous Resignations from Nursing Home, and Their Attorney for Advising Nurses That Resignations Were Legal

Vinluan v. Doyle, ___ N.Y.S.2d ___, 2009 WL 93065 (2d Dep't 2009). Petitioners, a group of nurses and their attorney, commenced an Article 78 proceeding to prohibit the District Attorney from prosecuting the nurses for their simultaneous resignations from a nursing home and from prosecuting their attorney for advising them that it was legal to do so. The nurses were recruited to work in the United States by an agency promising that they would be hired directly by individual nursing homes and provided with free travel, housing, medical coverage, and training. They were also allegedly promised training and assistance in obtaining legal residency and nursing licenses. Instead, the nurses signed contracts with an employment agency (a lower paid and less stable form of employment), and were assigned to work at a nursing home where they cared for chronically ill children who needed the assistance of ventilators to breathe. Some nurses were required to work as clerks in the nursing home because the agency failed to obtain nursing licenses for them. Further, they were allegedly housed in a single-family staff house with only one bathroom, inadequate heat, and no telephone service.

The nurses first made informal oral complaints about working conditions and pay. When those complaints went unheeded, they wrote several letters to the agency and nursing home to outline their concerns. Believing their concerns were not properly addressed, they sought the assistance of an attorney, Felix Vinluan, who advised them that they had the

right to resign from their positions once their shifts ended, though it might be better for them to remain at the nursing home while he pursued other remedies on their behalf. The nurses elected to resign from their positions either immediately following their shift or in advance of their next shift, with notice ranging from eight to seventy-two hours.

Within the next year, the Suffolk County Grand Jury handed down a 13-count indictment against petitioners, charging, among other things, conspiracy to endanger the welfare of a child and endangering the welfare of a physically disabled person. The nurses moved to dismiss the criminal indictment in the Supreme Court, Suffolk County, arguing that the prosecution contravened their Thirteenth Amendment rights. Vinluan also moved to dismiss the criminal indictment, alleging violations of his First and Fourteenth Amendment rights. The motion court denied their motions to dismiss, concluding that there was ample evidence before the grand jury to support all of the counts. Petitioners then commenced an Article 78 proceeding seeking a writ of prohibition. The Appellate Division, Second Department, held that these criminal prosecutions constituted an impermissible infringement upon the constitutional rights of the petitioners, and that the issuance of a writ of prohibition to halt these prosecutions was the appropriate remedy in this matter.

When a petitioner seeks relief in the nature of a prohibition, the court must first determine whether the issue presented is the type for which the remedy may be granted. Relying on Court of Appeals precedent stating that prohibition is the proper vehicle to prevent defendants from being prosecuted for crimes for which they could not be constitutionally tried, the court found prohibition to be an available remedy.

The court must then determine whether prohibition is warranted by the merits of the claim. Even if there is merit to petitioners' claims that the prosecution violates their constitutional rights, the court must still decide whether a writ of prohibition should issue as a matter of discretion. This entails weighing several factors, including the gravity of the potential harm caused by the threatened excess of power, whether the potential harm can be adequately corrected on appeal or by other proceedings in law or in equity, and whether prohibition would furnish a more complete and efficacious remedy even though other methods of redress are technically available.

The court found that both the nurses and attorney brought forth meritorious claims. Subjecting the nurses to criminal sanctions for their act of resigning effectively subjects them to involuntary servitude in violation of the Thirteenth Amendment, which "bars compulsory labor enforced by the use or threatened use of physical or legal coercion." The court reiterated Supreme Court precedent in recognizing that though "there is great societal value in the enforcement of contracts and collection of debt, . . . the constitutional prohibition against compulsory service means that no state can make the quitting of work any component of a crime, or make criminal sanctions available for holding unwilling persons to labor." These circumstances did not fall under a narrow class of civic duties that have been traditionally been enforced by means of imprisonment (e.g., military

service), nor did they fall under an exceptional or extreme case justifying a restriction of their Thirteenth Amendment rights. Here, the nurses were engaged in private employment, not public service. Their skills were not so unique or specialized that they could not be performed by any other qualified nurses. Also, the nurses did not abandon their posts in the middle of their shifts, and coverage was obtained. While the Penal Law section underlying the prosecutions proscribes the creation of risk to children and the physically disabled, here, "the greatest risk created by the resignation of these nurses was to the financial health of [the agency]."

The Appellate Division also held that the prosecution violated Vinluan's constitutionally protected rights of expression and association in violation of the First and Fourteenth Amendments, which require a measure of protection for advocating lawful means of vindicating legal rights. Vinluan's legal advice was constitutionally protected because he did not advise the nurses to commit a crime. But more importantly, his good-faith legal advice is protected because it was objectively reasonable. The court commented at length on the "profoundly disturbing" potential impact of a decision to prosecute Vinluan's advice:

> It would eviscerate the right to give and receive legal counsel with respect to potential criminal liability if an attorney could be charged with conspiracy and solicitation whenever a District Attorney disagreed with that advice. . . . A looming threat of criminal sanctions would deter attorneys from acquainting individuals with matters as vital as the breadth of their legal rights and the limits of those rights. Correspondingly, where counsel is restrained, so is the fundamental right of the citizenry, bound as it is by laws complex and unfamiliar, to receive the advice necessary for measured conduct.

The court finally commented that a prosecution which would not only compel the disclosure of privileged attorney-client confidences, but also potentially inflict punishment for the good-faith provision of legal services, goes beyond a First Amendment violation. "It is an assault on the adversarial system of justice upon which our society, governed by the rule of law rather than individuals, depends."

The court concluded that the writ of prohibition should issue as a matter of discretion upon a weighing of the relevant factors. When petitioners are threatened with prosecution for crimes for which they cannot be constitutionally tried, the potential harm to them is so great and the ordinary appellate process so inadequate to address that harm that prohibition should lie.

Second Circuit Court of Appeals Rules That Hospital Is Joint Employer of Nurse Employed by Staffing Agency and Is Therefore Liable for Overtime Pay, Liquidated Damages and Attorneys Fees Under the Fair Labor Standards Act

Barfield v. New York City Health and Hospitals Corporation, 537 F.3d 132 (2d Cir. 2008). Plaintiff Anetha Barfield was a temporary nurse at defendant Bellevue Hospital Center (the "Hospital"). Plaintiff sued on behalf of herself, and a class of similarly situated temporary employees of the Hospital, for violations of the Fair Labor Standard Act (FLSA), 29 U.S.C. §§ 201 *et seq*., for the Hospital's failure to pay overtime wages. Plaintiff was temporarily employed by the Hospital through three separate referral agencies. Through the three referral agencies, plaintiff collectively worked more than 40 hours per week for the Hospital on occasion, although she never worked more than 40 hours per week for the Hospital through any single agency. The parties cross-moved for summary judgment before the District Court on the issue of liability. The District Court granted summary judgment in favor of plaintiff and awarded her unpaid overtime wages and liquidated damages. The District Court, however, reduced plaintiff's claim for attorney's fees based on plaintiff's failure to certify a class.

Plaintiff appealed the reduction of attorney's fees, and the Hospital appealed the court's finding that, as a matter of law, the Hospital was a joint employer with the referral agency under the FLSA, and also appealed the award of liquidated damages. The Court of Appeals affirmed the District Court's ruling in its entirety.

It was undisputed that plaintiff was paid by the referral agencies. The central issue was whether the Hospital was also plaintiff's employer under the FLSA. The court held that "even when the historical facts and the relevant factors are viewed in the light most favorable to [the Hospital], [the Hospital]'s status as [plaintiff]'s joint employer is established as a matter of law." The court concluded that under the traditional four-factor test set forth in *Carter v. Dutchess Community College*, 735 F.2d 8 (2d Cir. 1984), the Hospital exercised sufficient functional control over plaintiff's work to qualify as her joint employer. The Second Circuit also held that the following six factors, outlined in *Zheng v. Liberty Apparel Co.*, 355 F.3d 61, 72 (2d Cir. 2003), indicated that the Hospital was a joint employer of plaintiff: (1) plaintiff worked on the Hospital's premises and used the Hospital's equipment; (2) the referral agencies did not shift as a unit from one putative joint employer to another, but instead each agency employee was assigned to the same hospital; (3) plaintiff performed work integral to the Hospital's operation; (4) plaintiff's work responsibilities at the Hospital stayed the same regardless of which agency referred

her for a particular assignment; (5) the Hospital effectively controlled on-site terms and conditions of plaintiff's employment; and (6) plaintiff worked exclusively for the Hospital.

The court also rejected the Hospital's claim that plaintiff's own actions, specifically using three separate agencies to work more than 40 hours per week when she knew that the Hospital had a policy against temporary employees working more than 40 hours per week, precluded an award for summary judgment in her favor. The court ruled that evidence in the record that the Hospital confirmed and approved all of plaintiff's hours precluded the Hospital from relying on this defense.

The court affirmed the District Court's award of liquidated damages to plaintiff, finding that the Hospital failed to meet its heavy burden of demonstrating it took active steps to ascertain the dictates of the FLSA and then act to comply with them. In so finding, the court noted that liquidated damages are the norm and single damages the exception under FLSA.

The District Court reduced plaintiff's claim for attorney's fees because plaintiff failed to certify the collective class, as the "limited anecdotal hearsay" proffered by plaintiff was inadequate to demonstrate that plaintiff and potential class members together were victims of a common policy or plan that violated the law. Plaintiff argued that her attorney's fees should not have been reduced because she prevailed on her FLSA violation against the Hospital and the certification of the class was not relevant to an award of attorney's fees under the FLSA. The Court of Appeals affirmed, holding that the District Court's assessment of the "degree of success" achieved in a case was not limited to whether a plaintiff prevailed on individual claims. Accordingly, the reduction of plaintiff's attorney's fees was not an abuse of the District Court's discretion since plaintiff's collective class was not certified.

A Medical College's Submission of Negative Evaluation of Anesthesiology Resident to American Board of Anesthesiologists Was Not Defamatory or in Breach of Contract; Alleged Agreement to Provide Neutral Reference in Exchange for Resignation Against Public Policy

Pandian v. New York Health and Hospitals Corp., 54 A.D.3d 590, 863 N.Y.S.2d 668 (1st Dep't 2008).

Plaintiff, an anesthesiology resident in the Medical College, received negative performance evaluations both before and after an incident in which he was reported to have fallen asleep during surgery. Plaintiff alleged that the parties orally agreed that plaintiff would resign in exchange for withdrawal of disciplinary charges against him and a promise of a "neutral" reference in response to any employment or other residency inquiry.

Thereafter, in response to inquiry from the American Board of Anesthesiologists (the "Board"), the Medical College apparently disclosed the incident that led to plaintiff's resignation. Plaintiff then sued the Medical College, alleging that negative evaluations of him and its communications to the Board were defamatory, and in breach of the parties' agreement to provide only a "neutral" response to inquiries. The court affirmed dismissal of plaintiff's breach of contract claim because plaintiff did not allege that defendants agreed to exclude the incident in evaluations sent to the American Board of Anesthesiologists. The court also held that since the Medical College was required to provide evaluations to the Board to ensure the competency of anesthesiologists, plaintiff's alleged agreement would subvert the objective of evaluating residents and thus would be against public policy.

In affirming dismissal of plaintiff's defamation claim, the court determined that plaintiff failed to demonstrate that the Medical College was motivated by actual malice in making the negative statements in plaintiff's evaluations.

Likewise, in affirming dismissal of plaintiff's claim for interference with prospective economic advantage, the court concluded that plaintiff failed to allege a motive of malice or the infliction of injury by unlawful means in defendant's submission of the negative evaluation of plaintiff to the Board. Similarly, the court found that plaintiff's claim for intentional infliction of emotional distress was meritless since plaintiff did not demonstrate that defendant acted in an outrageous and egregious manner in its submission of the evaluation.

Based on the foregoing, the court ruled that plaintiff failed to satisfy any of the necessary criteria to assert a claim against the Medical College, and accordingly, dismissed plaintiff's complaint in its entirety.

Employment Policy Requiring Hospital Employees to Speak English in Certain Situations While on Duty Does Not Violate Federal or State Anti-Discrimination Laws

Pacheco v. N.Y. Presbyterian Hosp., No. 02-CV-9438, 2009 WL 55886 (S.D.N.Y. Jan. 9, 2009). In this suit, plaintiff alleges that the Hospital had discriminated against him and a class of Hispanic employees in violation of Title VI and Title VII, § 1981a, the New York State Human Rights Law and New York City Human Rights Law by prohibiting employees from speaking Spanish at certain times while working in the Hospital's Ambulatory Referral Registration Area (ARRA), and that the Hospital retaliated against him after he complained. The court granted summary judgment dismissal of the complaint.

After receiving complaints that patients believed employees were speaking about and laughing at them in a language other than English, ARRA management required employees to speak English while in the

vicinity of patients. ARRA employees, however, were encouraged to assist Spanish-speaking patients by talking to them in Spanish, and were never prohibited from speaking Spanish while off duty. Further, no Hospital representative had ever made disparaging remarks to plaintiff about his national origin.

Plaintiff alleged that after complaining about the language-restriction policy, an ARRA manager retaliated against him by changing his schedule, telling him he would be assigned to weekend work, and requiring him to complete an assignment shortly before his shift ended. Plaintiff also alleged that the manager criticized his work.

Believing his complaint to the Human Resources Department was ignored, plaintiff sought and obtained a transfer back to his prior position where he received the same salary, benefits, and seniority he had in the ARRA. Plaintiff alleged he was compelled to seek this transfer, and that by doing so his opportunity for positions in other departments, as well as promotions, was hindered.

In asserting his Title VII claim, plaintiff alleged that the Hospital's language-restriction policy involved disparate treatment, disparate impact, hostile work environment, and retaliation.

While Title VII does not expressly identify language as a protected class, an English-only employment policy can, in certain circumstances, give rise to a Title VII racial discrimination claim if the "employer's practices reflect an intent to discriminate on the basis of the classifications protected by Title VII, including race and national origin." In evaluating such claims, courts consider whether there is evidence, aside from the language policy, of the employer exhibiting discriminatory conduct, or whether the employer's policy applied only to work-related communications and was justified by business necessity.

In this case, the court found that, even assuming plaintiff made out a prima facie case of discrimination, he could not establish that the Hospital's language-restriction policy was anything other than a legitimate, non-discriminatory business necessity. The Hospital did not have a "blanket prohibition against any non-English practice," and the requirement to speak English only was limited to situations where employees were on-duty and within hearing range of patients in the ARRA.

The disparate treatment claim also failed because plaintiff could not establish any adverse employment action, either because of his status as a protected class or in retaliation for his complaint about the Hospital's purported discriminatory conduct. There was no evidence that plaintiff's voluntary lateral transfer was a "materially adverse change in the terms and conditions of [his] employment." Similarly, the slight change to plaintiff's work schedule, the alleged criticism, and the request to complete an assignment shortly before his shift ended fell far short of being materially adverse, which requires more than a mere inconvenience or alteration to job responsibilities.

To establish his disparate impact claim, plaintiff had to demonstrate that the Hospital's language-restriction policy, even if facially neutral, imposed a significant adverse or disproportionate impact on a protected class. This requires a burden-shifting analysis where a plaintiff must identify a causal connection between an employment policy or practice and an existing disparity in the workplace. Once a defendant establishes there was a business justification for the policy or practice, a plaintiff must show there was an alternative, non-discriminatory practice that could satisfy the business need without the disparate effect.

In finding for the Hospital, the court stated that plaintiff failed to demonstrate any less discriminatory alternative to the Hospital's policy that employees in the ARRA speak English in certain circumstances, namely, while in the presence of patients.

The court rejected plaintiff's hostile work environment claim because plaintiff could not point to any misconduct so severe or pervasive that it created an objectively hostile or abusive work environment. Plaintiff, who admitted to being fully bilingual in English and Spanish, could not allege difficulty in speaking English in the limited circumstances required by ARRA management. Similarly, plaintiff admitted he suffered no disparaging remarks about his national origin while working in the ARRA.

National Childhood Vaccine Injury Act (NCVIA) Defense Brings Dismissal of Medical Malpractice Action

Crucen ex rel. Vargas v. Leary, 55 A.D.3d 510, 867 N.Y.S.2d 49 (1st Dep't 2008). Plaintiffs brought a medical malpractice action arising from vaccinations the infant plaintiff received at defendant hospitals. The complaint alleged that the defendants administered the vaccines, failed to properly treat the conditions arising subsequent to the vaccinations, and failed to obtain informed consent. Defendants successfully moved to dismiss the complaint on the grounds that the National Childhood Vaccine Injury Act of 1986 (NCVIA) provides a no-fault compensation program for "vaccine related injury or death." The Appellate Division affirmed the dismissal.

In reaching its decision, the court first analyzed whether the NCVIA statute applied. 28 U.S.C. § 300aa provides, in relevant part, that no person may institute a civil action in state or federal court for damages in excess of $1,000 against a "vaccine administrator or manufacturer" arising from a "vaccine-related injury or death associated with the administration of a vaccine," and no court may award damages in excess of $1,000 unless a

petition has been filed for compensation under the National Vaccine Injury Compensation Program. 28 U.S.C. § 300aa-11(a)(2)(A). The statute further states that if such a civil action is filed in state or federal court, the court must dismiss the action. 28 U.S.C. § 300aa-11(a)(2)(B).

Because plaintiffs alleged that each defendant either directly administered covered vaccines or treated plaintiff for injuries that arose shortly thereafter and were attributed to the vaccinations, the defendants were "vaccine administrators" under NCVIA. Additionally, the alleged injuries and the alleged failure to properly diagnose and treat conditions allegedly caused by vaccinations were "vaccine-related," within the meaning of the NCVIA. Accordingly, the court ruled that defendant medical service providers were protected by the NCVIA.

Because plaintiffs admitted that they did not file a petition for compensation under the NCVIA, the court dismissed the complaint in compliance with the clear mandate of the statute.

Finally, the court rejected plaintiffs' contention that defendants should be estopped from raising NCVIA as a defense because they failed to inform plaintiffs of the program, as required by 42 U.S.C. § 300aa-26(d). The court found that estoppel cannot operate to create a right where none exists.

District Court Dismisses Equal Protection Challenge to Kendra's Law, but Declines to Dismiss Americans with Disabilities Act Claim

Mental Disability Law Clinic v. Hogan, No. CV-06-6320, 2008 WL 4104460 (E.D.N.Y. 2008). Plaintiff, the Mental Disability Law Clinic at Touro Law Center (the Law Clinic), filed class actions on behalf of its constituents under the Protection and Advocacy for Mentally Ill Individuals Act (PAMII). Plaintiff alleges that New York Mental Hygiene Law (MHL) § 9.60 (commonly known as Kendra's Law) violates the Equal Protection Clause of the Fourteenth Amendment and the American with Disabilities Act. MHL § 9.60 provides for court ordered "assisted" outpatient mental health treatment (AOT) for persons who have been hospitalized twice within the past three years or who have acted violently toward themselves or others as a result of mental illness. Plaintiff alleges that if Kendra's Law did not contain the eligibility requirements of MHL § 9.60(c)(4), individuals subject to hospitalization could avoid inpatient care by complying with a regimen of AOT.

The District Court denied defendants' motion to dismiss for lack of standing. In reaching that conclusion, the District Court explained that Congress has authorized PAMII organizations, such as the Law Clinic, to sue if they can meet the traditional test of associational standing.

With respect to defendants' motion to dismiss plaintiff's Equal Protection claim requiring that "all persons similarly situated should be treated alike," the District Court applied a rational basis scrutiny rather than the strict scrutiny suggested by plaintiff. The court noted that "Kendra's law does not impinge upon an individual's fundamental right to liberty because it does not speak to whether individuals who fail to meet its criteria will otherwise be committed." Under the rational basis standard, the District Court found that "[a]lthough the law undoubtedly overlooks some who may benefit from intervention through AOT . . . there is no indication of irrationality in the legislature's actions, which appear to be an attempt to balance the state's interest in addressing services to those most at risk for relapse or violence with the civil liberties of other individuals with mental illness."

The District Court reached a different conclusion with respect to plaintiff's ADA claims. In order to make out a claim under Title II of the ADA, a plaintiff must show that (1) she is a qualified individual with a disability; (2) that the defendants are subject to the ADA; and (3) that plaintiff was denied the opportunity to participate in or benefit from defendants' services, programs, or activities, or was otherwise discriminated against by defendants, by reason of plaintiff's disabilities. Here, plaintiff alleged violations of the ADA's so-called "integration mandate," a regulation implementing provisions of Title II, which requires that: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

In interpreting this mandate, the Supreme Court has held that "unnecessary segregation of individuals with mental illness is discriminatory per se and a violation of the ADA; no demonstration of differential treatment between individuals with mental illness and those without is required" (citing *Olmstead v. Zimring*, 527 U.S. 581, 587 (1999)). Based on *Olmstead*, the District Court held that plaintiff stated a claim under the ADA, as individuals who, at the time of an evaluation for inpatient commitment, would and could benefit from AOT but for the requirements of MHL § 9.60(c)(4), are unnecessarily segregated if hospitalized.

Decedents' Niece Lacks Standing to Sue Hospital and Its Board of Trustees for Their Alleged Failure to Use Testamentary Bequests in the Manner Specified by Decedents' Wills

Rettek v. Ellis Hospital, 2009 WL 87592, 08-CV-844 (N.D.N.Y. Jan. 12, 2009). Plaintiff commenced a diversity action, asserting claims for breach of trust, breach of fiduciary duty, imprudent investment under the New York State Not-for-Profit Corporations Law (N-PCL), wrongful modification of the terms of a gift under N-PCL, and seeking the imposition of

a constructive trust, and accounting, and a declaratory judgment against defendant, Ellis Hospital, for the Hospital's alleged failure to use the residuary of her aunt's and uncle's estates in the manner directed in their wills.

Plaintiff's aunt and uncle, the Belangers, directed in their respective wills that 75% of the residuary of each of their estates would pass to Ellis Hospital, "to be used in improving the facilities of the present Nurses Training School" or, if that facility was no longer available to receive the funds, "for an extended care unit or nursing home accommodations. . . ." Plaintiff sat on the Board of Trustees of the Hospital for a period of time in recognition of the gifts she had given the Hospital and in honor of her aunt and uncle's generosity. Upon inquiry, however, she learned that there was no "tangible evidence" that the Hospital had used the Belangers' bequests to benefit the Nursing School. In addition, the Hospital had failed, according to plaintiff, to properly invest the funds. Following negotiations involving the New York Attorney General's Charities Bureau, plaintiff, unsatisfied with the negotiations, filed suit.

The Hospital and the named members of the Board of Directors filed a motion to dismiss, which the Northern District of New York granted. The court held that plaintiff lacked standing to sue under either the New York State Estates Powers and Trusts Law (EPTL) or under the New York State Not-for-Profit Corporations Law.

Under EPTL 81.1, the Attorney General has exclusive jurisdiction to challenge the actions of the trustees of a charitable trust or corporation. While narrow exceptions to this exclusive jurisdiction have been recognized, the law is designed "to prevent vexatious litigation . . . by irresponsible parties who do not have a tangible stake in the matter and have not conducted appropriate investigations." Standing may be conferred upon a private individual if that individual is part of a class of potential beneficiaries that is "sharply defined and limited in number." Donors themselves or their successors in interest may also, in certain circumstances, be able to enforce the terms of a bequest.

Here, the court held that plaintiff does not fall into either narrow exception to the general rule that only the Attorney General has standing to enforce the terms of a charitable bequest. As neither a beneficiary of her aunt and uncle's largesse nor the donor or a successor in interest, she could not, the court reasoned, enforce the terms of her aunt's and uncle's wills.

Similarly, N-PCL § 522, was held not to confer standing upon plaintiff to enforce the restrictions in her relatives' wills. N-PCL § 522 requires a donee that wishes to lift a restriction on a charitable bequest to either get written permission from the donor to do so or to apply to the courts to have the restriction lifted. The court in this matter held, however, that N-PCL does not even confer standing upon a donor to sue to enforce a restriction. It merely provides a donor with a means to uphold the restriction by withholding their consent to the donee. Since the donor has no standing to bring suit pursuant to N-PCL § 522, the plaintiff in this case, the niece of the deceased donors, clearly lacked standing to sue.

Court Holds That Religious Exemption to Immunization Requirement Is Applicable When Failure to Vaccinate Is Genuine, Sincere, and Rooted in Religious Beliefs

Nassau County Department of Social Services v. R.B., 870 N.Y.S.2d 874 (Nassau Cty., Fam. Ct. 2008). The Nassau County Department of Social Services (DSS) filed neglect petitions against the respondent, alleging failure to exercise a minimum degree of care over her three children. After their placement in foster care, the respondent informed DSS that her children were never immunized. The respondent refused to consent to their immunization, asserting that it was a violation of her religious beliefs.

DSS moved for an order directing a hearing to determine whether the respondent qualified for the religious immunity exemption pursuant to New York Public Health Law (NYPHL) § 2164(9), and the hearing was held.

The court noted that while requirements for immunization are valid pursuant to the state's general police power to protect and promote the public welfare, the mandatory vaccination of children prior to entering school is not without exception. Public Health Law § 2164(9) allows for such an exception if the child's "parent, parents or guardian hold genuine and sincere religious beliefs which are contrary to the practices herein required. . . ."

In order for a parent or guardian to qualify for this exception, he or she must prove by a preponderance of the evidence that his or her opposition is a personal and sincerely held religious belief, and that this belief forms the basis for objection to the vaccination.

During her hearing, the respondent submitted a letter from the leader of her congregation, El Shaddai Yisreal. Therein, the leader explained the congregation's beliefs against manmade medications to cure illness and disease. Specifically, he stated that it is against their god's laws for the congregation's members to "go to doctors or take medications or shots of any kind."

The court held that, while it is difficult to define "religious belief," the respondent's basis for her opposition to vaccinations qualified as such. El Shaddai Yisrael espouses beliefs based on interpretations of biblical references which prohibit the administration of man-made medications to cure illnesses, and that the

"Almighty," not man, is the healer of mankind. These beliefs were referenced in the letter from the congregation's leader submitted on behalf of the respondent. The court found that this "deeply rooted view and 'way of life' of the Respondent" constituted "a religious belief."

The court found that the respondent had also satisfied the second requirement for exemption by demonstrating her sincerity in this religious belief, by virtue of her consistent refusal to vaccinate her children, and her testimony that she was willing to place the health of her children at risk rather than have them immunized in violation of her beliefs.

Records Taken by Physician in Examination and Treatment of Patient Are Property of Physician

Chervonskaya v. Bentley, 55 A.D.3d 650, 867 N.Y.S.2d 107 (2d Dep't 2008). In an action to recover damages for medical malpractice, the defendant, an imaging service provider, appeals from an order of the Supreme Court, which denied its motion to compel plaintiffs to return all original mammogram films related to plaintiff.

The Appellate Division reversed the motion court and ruled that the films were property of defendant and had to be returned.

In reaching its decision, the court followed established legal precedent that "records taken by a doctor in the examination and treatment of a patient are property belonging to the doctor." The court further reasoned that the medical release forms signed by plaintiffs indicated that defendant loaned the original mammogram films to plaintiffs and they were required to return those films to defendant as soon as possible. Accordingly, the court ruled that as defendant never relinquished ownership of the original mammogram films, plaintiffs must return the films to defendant.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a Partner/Director 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

Health Care Reform 2009

Although the State's fiscal crisis required Governor David Paterson to advance a wide range of cost containment initiatives in the health and human services arena, the budget also reflects a continuation of prior healthcare reform efforts. The 2009 Executive Budget seeks to redirect the health care system toward more primary and preventative services and proposes a range of new approaches to paying for health care services across all elements of the health care system: in what some view as an overly ambitious agenda, the proposals seek to revamp the way hospitals, nursing homes, home care agencies, ambulatory care and pharmacies are all reimbursed and regulated. While much of the attention in the (as of this writing) ongoing budget debate is focused on the cost containment agenda, the reform proposals merit special attention. Some of the many health care reforms advanced are briefly summarized below.

Hospital Reimbursement Reform: The Governor's proposed budget advances a number of significant changes in Medicaid hospital reimbursement, including the following:

- The Governor proposes that the base year of cost data used for computing hospital inpatient rates be changed from 1981 (augmented by the annual inflation factors and special adjustments since that time) to 2005.
- Medicaid rates will be computed using data that identifies each hospital's costs for serving Medicaid patients in particular, divided by the number of Medicaid patients at that hospital—as opposed to basing payment on a hospital's costs for *all* non-Medicare patients and then dividing by the number of *all*

non-Medicare patients to produce an average cost for all patients at that hospital.

- Instead of grouping hospitals into peer groups of similar hospitals (e.g., rural hospitals or academic medical centers), the proposed new system would eliminate peer groups and instead average the costs of all hospitals in the state (other than graduate medical education) into a single rate applicable to all hospitals.
- The Administration also proposes to adopt a more sophisticated system of Diagnosis Related Groups (DRGs) which reflect the intensity (and cost) of services provided to each patient.

Nursing Home Payment Reform: Effective March 1, 2009, the Executive Budget would replace the current nursing home reimbursement methodology with a new system in which:

- The operating component of the rate would be calculated on a regional basis, utilizing 2005 cost reports.
- The direct component of the operating component would be case mix adjusted and would be calculated utilizing only the number of patients properly assessed and reported in each classification who are eligible for Medicaid.
- A nursing home quality incentive pool would be established that would augment payments to facilities meeting certain quality, staffing and survey criteria.

Home Care Reforms: The Executive Budget would replace the current Certified Home Health Agency (CHHA) reimbursement methodology with an episodic payment system similar to the Medicare prospective payment system.

- A statewide base price would be established for each 60-day episode of care, adjusted by a provider regional wage differential and an individual patient case mix index.
- DOH would be authorized to further adjust such episodic payments for low utilization cases and to reflect a percentage of the cost for high utilization cases that exceed outlier thresholds.
- Initial payments would be based on Medicaid-paid claims in the 2007 base year, which could subsequently be updated by the Commissioner.
- The Executive Budget would establish a home care quality incentive pool that would make additional payments to CHHAs meeting quality measures established by the Commissioner.
- In addition, Medicaid home health services would have to be provided directly by the CHHA, LTHHCP or AIDS home care program, and not via subcontract with a licensed home care services agency—a significant potential structural change for the home care industry. In addition, the Governor proposes to lift the current moratorium on new CHHAs.
- CHHAs receiving bad debt and charity care payments would be required to maintain and provide to the Commissioner a community service plan that, at minimum, outlines the organi-

zation's mission and identifies the populations it serves.

- Regional Long-Term Care Assessment Centers, operated by private entities, would assess individuals' needs for and the authorization of long-term care services. A new uniform assessment tool would be developed to assist in this effort.

Primary and Ambulatory Care Reimbursement Reform: The Executive Budget continues reforms begun last year, including re-appropriating Medicaid investments from inpatient to ambulatory care settings and related enhancements. In particular, the budget proposes to accelerate its implementation schedule for the ambulatory patient group (APG) payment system, which is intended to enhance payment for primary care services. It also extends payments to OMH, OASAS, and OMRDD licensed providers, phased in on a schedule jointly agreed to by the relevant licensing agencies and the Department of Health.

The budget also proposes to establish a new Statewide Medical Home Program, which would provide enhanced Medicaid payments to clinics and clinicians certified by the Commissioner as health care homes, and additional payments to those that meet specific process or outcome thresholds as set by the Commissioner. In addition, the budget establishes a Rural Health Care Access: Adirondack Health Care Home Multipayor Demonstration.

Health Care Coverage Reforms: The Executive Budget proposes a series of eligibility simplification and streamlining measures for the Medicaid and Family Health Plus programs that have been strongly supported by advocates.

- The Budget would eliminate the current resource limitations for children, pregnant women, and low-income families in Medicaid and low-income adults in Family Health Plus.
- The Budget would eliminate the required face-to-face interview for those applying to Medicaid and Family Health Plus and would eliminate the fingerprinting requirement for those applying to Medicaid.
- For children and parents, the Budget would move to a gross income standard in determining Medicaid eligibility as well as modify some eligibility levels.

Pharmacy Reform: The Executive Budget includes a number of provisions related to the sales and marketing practices of pharmaceutical/device manufacturers and wholesalers, including:

- Pharmaceutical/device manufacturers and wholesalers would be prohibited from giving health care providers any payments or benefits (e.g., gifts) of value over $50 in a calendar year. Drug samples, payments in support of specified bona fide research, certain travel reimbursement, and other specified payments are excluded.
- Health care providers and pharmaceutical/device manufacturers and wholesalers would be required to disclose to the State the value and nature of any payments, benefits or discounts of value over $50 transferred during a year as well as the existence of a financial relationship between providers and manufacturers and wholesalers. The proposal would establish civil monetary penalties for violations, and such violations would constitute professional misconduct.
- The Executive Budget would also place certain disclosure requirements on presenters at continuing professional education programs, including a requirement to disclose all financial relationships a presenter has with any pharmaceutical/device manufacturer or wholesaler, among others, and would prohibit presenters from knowingly presenting materials that are false or misleading.
- In addition, Pharmacy Benefit Managers (PBMs) would be subject to a whole host of new mandates, including a requirement to perform their duties with "care, skill, prudence and diligence" and would be required to ensure that every document concerning a disease, condition or treatment that is provided to a participant is not false or misleading, and to disclose any support or involvement of a manufacturer or labeler in the development of such materials.

Whether or not any or all of these proposals are enacted during the budget negotiations remains, as of this writing, to be seen. Some of these reforms have been strongly resisted by provider organizations, who have asserted that the range of reforms cannot be enacted simultaneously, particularly in the context of the State's fiscal crisis and the other dramatic cost containment actions also proposed in the budget. Whether enacted or not, these proposals clearly signal the direction of the current Administration in revamping the health care system and may ultimately be part of a State or national health reform agenda.

Jim Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. **Jim gratefully acknowledges the assistance of James Walsh of Manatt's Albany office in the preparation of this column.**

In the New York State Agencies

By Frank Serbaroli

Health Department

DRGs, SIWs, Trimpoints and the Mean LOS

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.55, 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on HHS audit findings and recommendations. Filing date: September 29, 2008. Effective date: September 29, 2008 until its expiration December 27, 2008. *See* N.Y. Register, October 15, 2008.

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend §§ 86-1.55, 86-1.62, and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on HHS audit findings and recommendations. *See* N.Y. Register, October 15, 2008.

Notice of adoption. The Department of Health amended §§ 86-1.55, 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on HHS audit findings and recommendations. Filing date: December 16, 2008. Effective date: December 31, 2008. *See* N.Y. Register, December 31, 2008.

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.55, 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on HHS audit findings and recommendations to reflect a cost-to-charge ratio which is based on data for the year in which the discharge occurred. Filing date: December 29, 2008. Effective date: December 29, 2008. *See* N.Y. Register, January 14, 2009.

Service Intensity Weights (SIW) and Average Length of Stay

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 86-1.62 of Title 10 N.Y.C.R.R. to change the

SIWs for the diagnosis related group (DRG) classification system for inpatient hospital services to incorporate changes made by Medicare for use in the prospective payment system and to update the SIWs to reflect 2004 costs and statistics reported to the Department by a representative sample of hospitals. *See* N.Y. Register, December 31, 2008.

Notice of emergency rulemaking. The Department of Health amended § 86-1.62 of Title 10 N.Y.C.R.R. to change the SIWs for the diagnosis related group (DRG) classification system for inpatient hospital services to incorporate changes made by Medicare for use in the prospective payment system and to update the SIWs to reflect 2004 costs and statistics reported to the Department by a representative sample of hospitals. Filing date: December 31, 2008. Effective date: December 31, 2008. *See* N.Y. Register, January 21, 2009.

APGs Outpatient Reimbursement Methodology

Notice of adoption. The Department of Health added supbart 86-8 to Title 10 of N.Y.C.R.R to provide a more cost effective payment methodology based on service intensity for certain ambulatory care fee-for-service (FFS) Medicaid services. The new methodology is based on Ambulatory Patient Groups (APGs), which group together procedures and medical visits that share similar characteristics and resource utilization patterns so that services are paid based on relative intensity. The implementation date and methodology for establishing APGs vary for each of the five categories or providers: (1) outpatient and ambulatory surgery services provided by a general hospital; (2) emergency department services provided by a general hospital; (3) diagnostic and treatment centers; (4) free-standing ambulatory surgery centers and (5) federally qualified health centers that voluntarily elect to participate. Filing date: November 17, 2008. Effective date: December 3, 2008. *See* N.Y. Register, December 3, 2008.

Controlled Substances Data Submission

Notice of emergency rulemaking. The Department of Health amended §§ 80.2, 80.23, 80.67, 80.68, 80.69, 80.71, 80.73, 80.74, 80.132 and 80.134 of Title 10 N.Y.C.R.R. to enhance the monitoring capabilities of the Official Prescription Program to detect and prevent drug diversion of prescription controlled substances, to allow practitioners increased flexibility to treat chronic pain from conditions other than diseases, afford hospice patients with more time to partial fill controlled substance prescriptions and to facilitate more humane euthanasia of animals in animal control facilities. Filing date: October 27, 2008. Effective date: October 27, 2008. *See* N.Y. Register, November 12, 2008.

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend §§ 80.2, 80.23, 80.67, 80.68, 80.69, 80.71, 80.73, 80.74, 80.132 and 180.134 of Title 10 N.Y.C.R.R. to require pharmacies to submit prescription information to the Official Prescription Program indicating whether a controlled substance was dispensed as a new prescription or a refill and on the method of payment for the dispensed substance, to require all manufacturers and distributors to submit to the Department information on distribution of controlled substances, to allow practitioners increased flexibility to treat chronic pain from conditions other than diseases, afford hospice patients with more time to partial fill

controlled substance prescriptions and to facilitate more humane euthanasia of animals in animal control facilities. *See* N.Y. Register, December 3, 2008.

Criminal History Record Check

Notice of emergency rulemaking. The Department of Health added a new Part 402 to Title 10 N.Y.C.R.R. to establish standards and procedures for criminal background checks of certain prospective unlicensed employees of nursing homes, certified home health agencies, licensed home care service agencies and long term home health care programs providing direct care or supervision to patients, residents or clients of such providers. Filing date: November 17, 2008. Effective date: November 17, 2008. *See* N.Y. Register, December 3, 2008.

Fingerprinting and Criminal Background Check Requirements (CBCR) for Unescorted Access to Radioactive Materials

Notice of emergency rule making. The Department of Health added § 16.112 of Title 10 N.Y.C.R.R. to implement fingerprinting and CBCR requirements as issued by the U.S. Nuclear Regulatory Commission of individuals allowed unescorted access to large quantities of radioactive materials. Filing date: November 18, 2008. Effective Date: November 18, 2008. *See* N.Y. Register, December 3, 2008.

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add § 16.112 of Title 10 N.Y.C.R.R. to implement U.S. Nuclear Regulatory Commission fingerprinting and CBCR requirements for individuals allowed unescorted access to large quantities of radioactive materials. *See* N.Y. Register, January 28, 2009.

External Appeals of Adverse Determinations

Notice of adoption. The Department of Health amended §§ 98-2.2, 98-2.6 and 98-2.10 of Title 10 N.Y.C.R.R. to provide that external appeals agents shall not be subject to legal proceedings to review their determinations. Filing date: November 17, 2008. Effective date: December 3, 2008. *See* N.Y. Register, December 3, 2008.

Relocation of Extension Clinics

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 710.1(c)(3) and (5) of Title 10 N.Y.C.R.R. to change the relocation of an extension clinic within the same service area from an administrative CON review to only a prior limited review. *See* N.Y. Register, December 3, 2008.

Initial Purchase of Magnetic Resonance Imagers (MRIs)

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 710.1(c)(2) and (3) of Title 10 N.Y.C.R.R. to substitute administrative CON review for full CON review of initial purchases of MRIs. *See* N.Y. Register, November 12, 2008.

Approval of Nonclinical Projects

Notice of adoption. The Department of Health amended § 710.1(c)(6) of Title 10 N.Y.C.R.R to substitute prior limited review for administrative CON review of construction projects with costs between $3 million and $10 million. Filing date: January 13, 2009. Effective date: January 28, 2009. *See* N.Y. Register, January 28, 2009.

Physical Therapist Assistants and Occupational Therapy Assistants

Notice of emergency rulemaking. The Department of Health amended § 505.11 of Title 18 N.Y.C.R.R. to allow physical therapist assistants and occupational therapy assistants to provide services to Medicaid recipients. Filing Date: November 24, 2008. Effective date: November 24, 2008. *See* N.Y. Register, December 10, 2008.

Notice of proposed rulemaking. The Department of Health amended § 505.11 of Title 18 N.Y.C.R.R. to allow physical therapist assistants and occupational therapy assistants to provide services to Medicaid recipients. *See* N.Y. Register, December 10, 2008.

Physician Board Certification Entities

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 1000.1 of Title 10 N.Y.C.R.R. to amend the definition of *board certified* to remove The College Family Physicians of Canada (CFPC). *See* N.Y. Register, October 15, 2008.

Immunization Registry

Notice of adoption. The Department of Health amended § 66-1.2 of Title 10 N.Y.C.R.R. to define requirements for establishment of a statewide immunization registry, including rules for submission of immunization information by health care providers and methods for providers and others to access such information from the registry. Filing date: December 16, 2008. Effective date: December 31, 2008. *See* N.Y. Register, December 31, 2008.

Re-numbers Subpart 86-8 to Subpart 86-9 of Part 86 of Title 10 N.Y.C.R.R.

Notice of adoption. The Department of Health renumbered Subpart 86-8 to Subpart 86-9 of Part 86 of Title 10 N.Y.C.R.R. Filing date: December 16, 2008. Effective date: December 31, 2008. *See* N.Y. Register, December 31, 2008.

Chemical Analysis of Blood, Urine, Breath or Saliva for Alcohol Content

Notice of emergency rulemaking. The Department of Health amended §§ 59.1(c) and 59.4(b) of Title 10 N.Y.C.R.R. to update the conforming list of breath alcohol testing devices currently approved for use by the NHTSA. Filing date: October 6, 2008. Effective date: October 6, 2008. *See* N.Y. Register, October 22, 2008.

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend §§ 59.1(c), 59.1 (d), and 59.4(b) of Title 10

N.Y.C.R.R. to update the conforming list of breath alcohol testing devices currently approved for use by the NHTSA. *See* N.Y. Register, December 3, 2008.

Notice of emergency rulemaking. The Department of Health amended §§ 59.1(c), 59.1(d), and 59.4(b) of 10 N.Y.C.R.R. to update the conforming products list of breath alcohol testing devices currently approved by the NHTSA. Filing date: January 5, 2009. Effective date: January 5, 2009. *See* N.Y. Register, January 21, 2009.

Payment for FQHC Psychotherapy and Offsite Services Payment

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 86-4.9 of Title 10 N.Y.C.R.R. to permit psychotherapy by certified social workers as a billable service under certain circumstances. *See* N.Y. Register, November 5, 2008.

Notice of emergency rulemaking. The Department of Health amended § 86-4.9 of 10 N.Y.C.R.R. to permit psychotherapy by certified social workers as a billable service under certain circumstances. Filing date: December 12, 2008. Effective date: December 12, 2008. *See* N.Y. Register, December 24, 2008.

Enactment of a Serialized Official New York State Prescription Form

Notice of adoption. The Department of Health added Part 910, amended §§ 85.21, 85.22, repealed §§ 85.23 and 85.25 of Title 10 N.Y.C.R.R., amended § 505.3, and repealed §§ 528.1 and 528.2 of Title 18 of N.Y.C.R.R. to mandate a statewide official prescription program, support electronic prescribing, and facilitate the dispensing process. Filing date: November 10, 2008. Effective date: November 26, 2008. *See* N.Y. Register, November 26, 2008.

Childhood Lead Poisoning Screening and Follow-up

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend Subparts 67-1 and 67-3 of Title 10 N.Y.C.R.R. to expand follow-up for children with elevated blood levels; authorize point-of-care laboratory testing; and require reporting. *See* N.Y. Register, November 26, 2008.

Notice of Availability of Federal Funds

Doctors Across New York Physicians Practice Support Request for applications. *See* N.Y. Register, October 15, 2008.

Doctors Across New York Physician Loan Repayment Program Request for applications. *See* N.Y. Register, October 15, 2008.

Applications will be accepted through March 30, 2009 for Special Supplemental Nutrition Programs. *See* N.Y. Register, January 14, 2009.

Applications are being accepted for the New York State Department of Health Refugee Medical Assistance Program. *See* N.Y. Register, January 14, 2009.

Office of Mental Health

Comprehensive Outpatient Programs

Notice of emergency rulemaking. The Office of Mental Health amended Part 592 of Title 14 N.Y.C.R.R. to increase the Medicaid reimbursement associated with certain outpatient treatment programs regulated by the Office of Mental Health. Filing date: September 30, 2008. Effective date: September 30, 2008. *See* N.Y. Register, October 15, 2008.

Medical Assistance Payment for Outpatient Programs

Notice of adoption. The Office of Mental Health amended Part 588 of Title 14 N.Y.C.R.R. to provide increased reimbursement rates and COLAS for certain mental health treatment programs as per the 2008-09 State Budget. Filing date: October 7, 2008. Effective date: October 22, 2008. *See* N.Y. Register, October 22, 2008.

Notice of adoption. The Office of Mental Health amended Part 588 of Title 14 N.Y.C.R.R. to revise and correct inaccurate references to Part 587. Filing date: October 21, 2008. Effective date: November 5, 2008. *See* N.Y. Register, November 5, 2008.

Notice of emergency rulemaking. The Office of Mental Health amended Part 588 of Title 14 N.Y.C.R.R. to effect a modest rate reduction in reimbursement for continuing day treatment programs and modify current methodology. Filing date: December 31, 2008. Effective date: December 31, 2008. *See* N.Y. Register, January 21, 2009.

Medical Assistance Payments for Comprehensive Psychiatric Emergency Programs

Notice of adoption. The Office of Mental Health amended Part 591 of Title 14 N.Y.C.R.R. to increase rates for Comprehensive Psychiatric Emergency Programs as required by the enacted State budget for FY 2008-2009. Filing date: October 9, 2008. Effective date: October 29, 2008. *See* N.Y. Register, October 29, 2008.

Operation of Outpatient Programs

Notice of adoption. The Office of Mental Health amended Part 587 of Title 14 N.Y.C.R.R. to increase the number of children's designated specialty clinics in New York City, in accordance with the enacted 2008-2009 State Budget. Filing date: October 7, 2008. Effective date: October 22, 2008. *See* N.Y. Register, October 22, 2008.

Notice of proposed rulemaking. The Office of Mental Health gave notice of its intent to amend § 587.11(a) of Title 14 N.Y.C.R.R. to increase the age of individuals receiving services in day treatment programs for children. *See* N.Y. Register, November 19, 2008.

Notice of proposed rulemaking. The Office of Mental Health gave notice of its intent to amend §§ 587.5(e)(1) and 587.5(e)(2) of Title 14 N.Y.C.R.R. to correct outdated

references to Medicaid data. *See* N.Y. Register, December 3, 2008.

Waiver Authority

Notice of adoption. The Office of Mental Health amended Part 501 of Title 14 N.Y.C.R.R. to establish waiver authority for the Commissioner of Mental Health under certain circumstances. Filing date: December 8, 2008. Effective date: December 24, 2008. *See* N.Y. Register, December 24, 2008.

Comprehensive Outpatient Programs

Notice of emergency rulemaking. The Office of Mental Health amended §§ 592.8(c), 592.8(d), 592.8 (k), 592.10 (b) and added new subdivisions 592.8(l), and 592.10(c) to Title 14 N.Y.C.R.R. to adjust the Medicaid reimbursement associated with certain outpatient treatment programs. Filing date: December 29, 2008. Effective date: December 29, 2008. *See* N.Y. Register, January 14, 2009.

Office of Medicaid Inspector General

Monetary Penalties

Notice of proposed consensus rulemaking. The Office of the Medicaid Inspector General gave notice of its intent to amend §§ 516.1(c), 516.2, 516.5(a) and add § 516.5(f) and (g) to Title 18 N.Y.C.R.R. to amend the regulations to conform to recently enacted statutory provisions regarding the monetary penalties resulting from the commission of certain proscribed acts in violation of the medical assistance program. *See* N.Y. Register, December 10, 2008.

Compliance Programs for Medical Assistance Providers

Notice of proposed rulemaking. The Office of the Medicaid Inspector General gave notice of its intent to add Part 521, entitled "Provider Compliance Programs," to Title 18 N.Y.C.R.R. to set forth regulations to govern compliance programs of medical assistance providers. As a condition to receive Medicaid payments, the regulation will require providers (those subject to Article 28 or 31 of the public health law or Articles 16 or 31 of the mental hygiene law and any person or entity that submits at least $500,000 in Medicaid claims in a 12-month period) to adopt and implement an effective compliance plan.

The compliance program shall be applicable to: billings; payments; medical necessity and quality of care; governance; mandatory reporting; credentialing and other risk areas that are or should with due diligence be indentified by the provider. Upon enrolling as a Medicaid provider and every December thereafter, the provider must certify to the Department of Health (on a form provided by the Office of the Medicaid Inspector General) that the provider has a compliance program in place that meets the requirements of the regulation.

The Commissioner of Health and the Medicaid Inspector General shall have the authority to determine if a provider's compliance program meets the requirements of the regulation. However, a compliance program that is accepted by the federal department of health and human services office of inspector general and that adequately addresses medical assistance risk areas and compliance issues shall be deemed approved.

If the compliance program is not satisfactory to the Commissioner of Health and the Medicaid Inspector General, then the provider may be subject to sanctions and/or penalties, including revocation of the provider's participation in Medicaid.

A required provider's compliance program shall include: (1) written policies and procedures that describe compliance expectations as embodied in a code of conduct and/or ethics; implement the operation of the compliance program, provide guidance to employees on how to handle and communicate compliance issues to appropriate compliance personnel and describe how compliance issues are investigated and resolved; (2) designate an employee responsible for the day-to-day operation of the compliance plan that reports directly to the chief executive or senior administrator and shall periodically report to the governing body; (3) train and educate all affected employees on compliance issues, expectations and the compliance program; (4) provide for communication lines to the designated compliance personnel that is accessible to all and that includes a method for anonymous and confidential good-faith reporting of potential compliance issues; (5) sets forth disciplinary policies to encourage good-faith reporting of compliance issues; (6) a system to routinely identify compliance risk areas that is specific to the provider type; (7) a system for responding to compliance issues raised; and (8) a policy of non-intimidation and non-retaliation for good-faith participation in the compliance program.

The Office of Medicaid Inspector General will make available on its website compliance program guidelines specific to provider type. *See* N.Y. Register, January 14, 2009.

Provider Self-Disclosure Guidance

The Office of Medicaid Inspector General (OMIG) released January 13, 2009 Provider Self-Disclosure Guidance to replace the existing Department of Health disclosure protocol and establish the process for participating in the Self-Disclosure Program. OMIG has developed this approach to encourage and offer incentives to providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds under the Medicaid program. The guidance sets forth the following: (1) the advantages of self-disclosure, such as forgiveness or reduction of interest payments,

extended repayment terms, waiver or penalties and/or sanctions and decreases the likelihood of imposing an OMIG corporate integrity agreement; (2) when and the factors to consider to disclose inappropriate payment matters; (3) the process for self-disclosure, including but not limited to, informing OMIG of the basis for the disclosure, how the matter was discovered, the time period, an assessment of the financial impact and any corrective action taken by the provider to address the problem; (4) OMIG's expectations regarding its ability to access information materially related to the disclosure and to speak with relevant individuals; and (5) restitution. OMIG will not accept money as full and final payment for self-disclosure prior to the final audit and/or investigatory process.

A description of the Department of Health, Office of Medicaid Inspector General and Department of Insurance regulatory agendas and rules under review can be found in the N.Y. Register, January 7, 2009.

Insurance Department

Standards for the Management of the State Employees Retirement System and the Common Retirement Fund

Notice of adoption. The Insurance Department amended and renumbered Part 136 and added new subpart 136-2 to Title 11 N.Y.C.R.R. to establish high ethical standards, strengthen governance, and enhance transparency of the State Employees' Retirement Systems. Filing date: October 29, 2008. Effective date: November 19, 2008. *See* N.Y. Register, November 19, 2008.

Guidelines for the Processing of COB Claims

Notice of proposed rulemaking. The Insurance Department gave notice of its intent to amend § 52.23(r), retitle and renumber Part 217-1 in sequence, amend new §§ 217-1.1, 217-1.2(d), and add new § 217-2 to Title 11 N.Y.C.R.R. to establish guidelines for the processing of healthcare claims for persons covered by more than one health insurance policy. *See* N.Y. Register, December 24, 2008.

Minimum Standard for the Form, Content, and Sale of Health Insurance, Including Standards for Full and Fair Disclosure

Notice of adoption. The Insurance Department amended Part 52 (Regulation 62) of Title 11 N.Y.C.R.R. to prohibit coverage of certain benefits for persons registered as sex offenders pursuant to Article 6-C of the Corrections Law. Filing date: November 3, 2008. Effective date: November 19, 2008. *See* N.Y. Register, November 19, 2008.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a shareholder in the Health & FDA Business department of Greenberg Traurig's New York office. He is a member of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and serves on the Executive Committee of the New York State Bar Association's Health Law Section. The assistance of Ms. Whitney M. Phelps, an associate at Greenberg Traurig, in compiling this summary is gratefully acknowledged.

In the Journals

American Journal of Law and Medicine, Vol. 24, No. 4 (2008)

- *In Tepid Defense of Population Health: Physician and Antibiotic Resistance*, Richard S. Saver
- *Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation*, Gil Siegal, Michelle Mello, David M. Studdert
- *Drug Preemption and the Need to Reform FDA Consultation Process*, Margaret Gilhooley

Health Lawyer News (American Health Lawyers Ass'n)

- *A Series of Unfortunate Events: Is This the End of the Physician/Hospital Joint Venture*?, C. Mitchell Goldman and Matthew C. Jones (February 2009)
- *The Future of Physician In-Office Diagnostic Testing*, Julie Kass (January 2009)
- *When Disaster Strikes a Residency Program*, Dawn R. Crumel (December 2008)
- *Collision Course: The Intersection of Employment Cases and Peer Review Information*, Maria Greco Danaher (November 2008).

Health Matrix (Case Western Reserve U. Sch. of Law), Vol. 18, No. 1 (2008)

- *High-Deductible Health Plans: Litigation Hazards For Health Insurers*, E. Haavi Morreim
- *Get Sick, Get Out: Medical Causes Of Home Mortgage Foreclosures*, Christopher Tarver Robertson, Richard Egelhof, & Michael Hoke
- *Never Let Your Sense Of Morals Keep You From Doing What's Right: Using Newly Dead Bodies As Educational Resources*, Dale L. Moore
- *Protecting The Unborn As Modern Day Eugenics*, Stephanie Yu Lim
- *International Outsourcing Plus Inexpensive, Quality Healthcare: Binding Arbitration Makes This Telemedical Dream A Reality*, Peter Zawadski
- *Kiss And Make-Up: A Need For Consolidation Of Fda And Cosmetic Industry Regulation Programs*, Deborah E. Mason
- *Ethical And Legal Issues Accompanying Legislation Requiring Hpv Vaccination Of Girls*, Kristin Cook

Indiana Health Law Review, Vol. 5, No. 2 (2008)

- *Proposal for Comprehensive Biobank Research Laws to Promote Transnational Medicine in Indiana*, Jennifer Girod, Katherine Drabiak
- *Strained Applications of the Viability Standard to In Vitro Frozen Embryos—Deconstructing* Jeter v. Mayo Clinic Arizona, Brock J. Heathcotte
- *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, Mark E. Douglas
- *Attorneys, Tell Your Clients to Say They're Sorry: Apologies in the Health Care Industry*, Robin E. Ebert
- *Your Money or Your Lifestyle!: Employers' Efforts to Contain Healthcare Costs—Lifestyle Discrimination Against Dependents of Employees?*, Brendan W. Miller
- *Mandating the Gardasil Vaccine: A Constitutional Analysis*, Kyra R. Wagoner

Journal of Health and Life Sciences Law, Vol. 2, No. 2 (January 2009)

- *Patient-Tailored Medicine, Part Two: Personalized Medicine and the Legal Landscape*, American Health Lawyers Association's Advisory Council on Racial and Ethnic Diversity
- *Patient Access to Unapproved Therapies: The Leading Edge of Medicine and Law*, Leah Voigt Romano and Peter D. Jacobson
- *Enforcement Related to Off-Label Marketing and Use of Drugs and Devices: Where Have We Been and Where Are We Going?*, John N. Joseph, David Deaton, Houman Ehsan, and Mark A. Bonanno
- *Protecting Yourself from Your Assertions: Navigating Multiple Regulatory Schemes and Disclosure*, Alicia Griffin Mills and Ross D'Emanuele
- *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, and Susan Anderson
- *Physician Ownership and Use of In-Office Advanced Diagnostic Imaging Equipment: Are IDTF Standards a Meaningful Response to Overutilization, Quality, and Costs?*, Markus P. Cicka

Journal of Law, Medicine and Ethics, Vol. 36, No. 4 (Winter 2008)

- *Symposium on Organ Donation and Death from Unexpected Circulatory Arrest: Engaging the Recommendations of the Institute of Medicine*
  - *Introduction: Organ Donation and Death from Unexpected Circulatory Arrest: Engaging the Recommendations of the Institute of Medicine,* James M. DuBois and Rebecca L. Volpe
  - *The Washington, D.C. Experience with Uncontrolled Donation After Circulatory Determination of Death: Promises and Pitfalls,* Jimmy A. Light
  - *Legal Authority to Preserve Organs in Cases of Uncontrolled Cardiac Death: Preserving Family Choice,* Richard J. Bonnie, Stephanie Wright, and Kelly K. Dineen
  - *Donation after Uncontrolled Cardiac Death (uDCD): A Review of the Debate from a European Perspective,* Pascal Borry, Walter Van Reusel, Leo Roels, and Paul Schotsmans
  - *Uncontrolled Donation after Cardiac Determination of Death: A Note of Caution,* Christopher James Doig and David A. Zygun
  - *Organ Donation after Circulatory Determination of Death: Lessons and Unresolved Controversies,* James F. Childress
- *On the Cusp: Insight and Perspectives on Health Reform*
  - *America's Uninsured: The Statistics and Back Story,* Diane Rowland and Adele Shartzer
  - *Aiming High for the U.S. Health System: A Context for Health Reform,* Karen Davis, Cathy Schoen, Katherine Shea, and Christine Haran
  - *Private Gain and Public Pain: Financing American Health Care,* Bruce Siegel, Holly Mead, and Robert Burke
  - *Protect the Sick: Health Insurance Reform in One Easy Lesson,* Deborah Stone
  - *Why Public Programs Matter—and Will Continue to Matter—Even After Health Reform,* Elizabeth J. Fowler and Timothy Stoltzfus Jost
  - *War, Its Aftermath, and U.S. Health Policy: Toward a Comprehensive Health Program for America's Military Personnel, Veterans, and Their Families,* Michael J. Jackonis, Lawrence Deyton, and William J. Hess
  - *The States'Role in National Health Reform,* Alan R. Weil and James R. Tallon, Jr.
  - *Reducing Racial, Ethnic, and Socioeconomic Disparities in Health Care: Opportunities in National Health Reform,* Marsha Lillie-Blanton, Saqi Maleque, and Wilhelmine Miller
  - *Aging, Primary Care, and Self-Sufficiency: Health Care Workforce Challenges Ahead,* Fitzhugh Mullan, Seble Frehywot, and Laura J. Jolley
  - *Building an Information Technology Infrastructure,* Melissa M. Goldstein and David Blumenthal
  - *Should a Reformed System Be Prepared for Public Health Emergencies, and What Does That Mean Anyway?,* Rebecca Katz and Jeffrey Levi
  - *Nine Lessons for Health Reform: Or Will We Finally Learn from the Past?,* James A. Morone and David Blumenthal
  - *Health Care Reform: Lessons from the Past, Lessons for the Future,* Gail R. Wilensky
  - *Proving the Skeptics Wrong: Why Major Health Reform Can Happen Despite the Odds,* Chris Jennings
- *Preemption and the Obesity Epidemic: State and Local Menu Labeling Laws and the Nutrition Labeling and Education Act,* Lainie Rutkow, Jon S. Vernick, James G. Hodge, Jr., and Stephen P. Teret
- *The Corporate Transformation of Medical Specialty Care: The Exemplary Case of Neonatology,* Eleanor D. Kinney
- *Neonatal Pain Relief and the Helsinki Declaration,* Robert S. Van Howe and J. Steven Svoboda
- *Brain Death Revisited: The Case for a National Standard,* Eun-Kyoung Choi, Valita Fredland, Carla Zachodni, J. Eugene Lammers, Patricia Bledsoe, and Paul R. Helft

NYS Bar Ass'n Health Law Journal, Vol. 13, No. 3 (Fall 2008)

- *Law and Policy of Health Care Competition for the Twenty-first Century,* Martin Bienstock
- *Constructive Convener or Obstructive Bureaucracy? The Rise, Fall and Potential Return of Local Health Planning in New York State,* Mark R. Ustin
- *The Berger Commission and Catholic/Secular Hospital Alignments,* Peter Millock

- *Serving Your "Berger" Well Done: A Recipe for Closing or Reconfiguring a Not-for-Profit Hospital in New York*, Robert Andrew Wild, Judith A. Eisen, Peter B. Mancino and David A. Langner
- *Successor Liability in New York Post-Berger,* Jeffrey M. Alexander and Sarah Shannon Carlins

Yale Journal of Health, Policy, Law & Ethics, Vol. 9, No. 1 (Winter 2009)

- *"Unnatural Deaths," Criminal Sanctions, and Medical Quality Improvement in Japan,* Robert B. Leflar
- *Opening Stem Cell Research and Development: A Policy Proposal for the Management of Data, Intellectual Property, and Ethics,* David E. Winickoff, Krishanu Saha, and Gregory D. Graff
- *"Till Naught but Ash Is Left to See": Statewide Smoking Bans, Ballot Initiatives, and the Public Sphere,* Patrick Kabat

Other Law Journals

- *Abortion as a Human Right—International and Regional Standards*, Christina Zampas & Jaime M. Gher, 8 Hum. Rts. L. Rev. 249 (2008).
- *Access to Medicines, BRICS Alliances, and Collective Action*, Peter K. Yu, 34 Am. J.L. & Med. 345 (2008).
- *Achieving Medical Device Safety in an Era of Globalization*, Judith K. Meritz & Tyechia L. White, 63 Food & Drug L.J. 647 (2008).
- *Amending TRIPS: A New Hope for Increased Access to Essential Medicines*, Tina S. Batt, 33 Brook. J. Int'l L. 597 (2008).
- *Autonomy and Acute Psychosis: When Choices Collide*, Dora W. Klein, 15 Va. J. Soc. Pol'y & L. 355 (2008).
- *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, Harper J. Tobin, 17 Columbia J. of Gender and L. 111 (2008).
- *Delivering Drugs to the Poor: Will the TRIPS Amendment Help?*, Graham Dutfield, 34 Am. J.L. & Med. 107 (2008).
- *Demand Forecasting for Essential Medical Technologies*, Ruth Levine, Jessica Pickett, Neelam Sekhri and Prashant Yadav, 34 Am. J.L. & Med. 225 (2008).
- *E Pluribus UNOS: The National Organ Transplant Act and Its Postoperative Complications*, Jed A. Gross, 8 Yale J. Health Pol'y, L. & Ethics 145 (2008).
- *The "Ethics" of Organizational/ Institutional Ethics in a Pluralistic Setting: Conflicts of Interests, Values, and Goals*, Roberta S. Loewy, 39 McGeorge L. Rev. 703 (2008).
- *Expanded Access to Phase II Clinical Trials in Oncology: A Step Toward Increasing Scientific Validity and Compassion*, Alice K. Marcee, 63 Food & Drug L.J. 439 (2008).
- *Fees for Physician Testimony: What's Reasonable?*, Timothy J. Harris, 96 Ill. B.J. 460 (2008).
- *The FDA Amendments Act: Reauthorization of the FDA*, Andrew C. von Eschenbach, 63 Food & Drug L. J. 579 (2008).
- *Health Law*, Therese W. Dancks and Matthew J. VanBeveren, 58 Syracuse L. Rev. 1031 (2008).
- *The Influence of Culture, Government and the Law on the Use of Antidepressants for Children in the United States and Pakistan*, Roseann B. Termini & Christine A. Kelly-Miller, 63 Food & Drug L.J. 713 (2008).
- *John Paul II, the Structures of Sin and the Limits of Law*, John M. Breen, 52 St. Louis U. L.J. 317 (2008).
- *Keeping End-of-Life Decisions Away from Courts After Thirty Years of Failure: Bioethical Mediation as an Alternative for Resolving End-of-life Disputes*, David M. Shelton, 31 Hamline L. Rev. 103 (2008).
- *The Large Cost Savings and Other Advantages of an Early Offer "Crimtorts" Approach to Medical Malpractice Claims*, Jeffrey O'Connell, 17 Widener L.J. 835 (2008).
- *Essay: The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, Robin F. Wilson, 34 Am. J.L. & Med. 41 (2008).
- *Mandating a Human Papillomavirus Vaccine: An Investigation into Whether Such Legislation Is Constitutional and Prudent*, Tracy S. Dowling, 34 Am. J.L. & Med. 65 (2008).
- *Mandating a Tobacco-Free Workforce: A Convergence of Business and Public Health Interests*, Micah Berman, J.D. & Rob Crane, J.D., 34 Wm. Mitchell L. Rev. 1651 (2008).
- *Medical Malpractice and State Medical Centers:* Clarke v. Oregon Health Sciences University, Arthur B. LaFrance, 8 Wyo. L. Rev. 433 (2008).
- *Mortality, Equality, and Bioethics*, Eric Cohen, 7 Yale J. Health Pol'y, L. & Ethics 157 (2008).
- *Not for the Faint of Heart: Does a Hospital Owe a Duty to Warn a Squeamish Visitor?,* Marc D. Ginsberg, 41 J. Marshall L. Rev. 473 (2008).

- *On Presidents, Agencies, and the Stem Cells Between Them: A Legal Analysis of President Bush's and the Federal Government's Policy on the Funding of Research Involving Human Embryonic Stem Cells*, Yaniv Heled, 60 Admin. L. Rev. 65 (2008).
- *One Small Step or One Giant Leap Towards Access to Medicines for All?*, G. O'Farrell, 30 Euro. Int'l Property Rev. 211 (2008).
- *Part of the Whole: Tort Law's Compensatory Failures Through a Wider Lens*, Ellen S. Pryor, 27 Rev. Litig. 307 (2008).
- *Pharmacy Compounding of Bioidentical Hormone Replacement Therapy (BHRT): A Proposed New Approach to Justify FDA Regulation of These Prescription Drugs*, Bruce Patsner, 63 Food & Drug L.J. 459 (2008).
- *Pro-life Judges and Judicial Bypass Cases*, Eric P. Babbs, 22 Notre Dame J.L. Ethics & Pub. Pol'y 473 (2008).
- *Protecting Egg Donors and Human Embryos—The Failure of the South Korean Bioethics and Biosafety Act*, Mukta Jhalani, 17 Pac. Rim L. & Pol'y J. 707 (2008).
- *Proxy Consent to Research: The Legal Landscape*, Elyn R. Saks, Laura B. Dunn, Jessica Wimer, Michael Gonzales, Scott Kim, 8 Yale J. Health Pol'y, L. & Ethics 37 (2008).
- *Recognition of the International Human Right to Health and Health Care in the United States*, Eleanor D. Kinney, 60 Rutgers L. Rev. 335 (2008).
- *Resurrecting Gilbert: Facial Parity as Unequal Treatment in the Eighth Circuit's* In re Union Pacific Railroad Employment Practices Litigation, Keri Phillips, 31 Hamline L. Rev. 309 (2008).
- Retail Industry Leaders Ass'n v. Fielder*: ERISA Preemption Trumps the "Play or Pay" Law*, Leslie A. Harrelson, 67 Md. L. Rev. 885 (2008).
- *The Right to Remain Silent: A First Amendment Analysis of Abortion Informed Consent Laws*, Whitney D. Pile, 73 Mo. L. Rev. 243 (2008).
- *The Role of Pharmaceutical Industry in Disseminating Pharmacovigilance Practice in Developing Countries*, Segev Shani & Zohar Yahalom, 63 Food & Drug L.J. 701 (2008).
- *Should Access to Medicines and TRIPS Flexibilities Be Limited to Specific Diseases?*, Kevin Outterson, 34 Am J.L. & Med. 279 (2008).
- *Stemming the Tide of Research and Constitutional Challenges: Embryonic Stem Cell Legislation*, Meredith Mullins, 85 U. Det. Mercy L. Rev. 227 (2008).
- *Think Globally, Prescribe Locally: How Rational Pharmaceutical Policy in the U.S. Can Improve Global Access to Essential Medicines*, Aaron S. Kesselheim, 34 Am. J.L. & Med. 125 (2008).
- *Tobacco Control and SNUS: Time to Take a Stand*, Lindsey C. Dastrup & Jacqueline M. McNamara, 11 J. Health Care L. & Pol'y 12 (2008).
- *Toward Solving the Health Care Crisis: The Paradoxical Case for Universal Access to High Technology*, Ani B. Satz, 8 Yale J. Health Pol'y, L. & Ethics 93 (2008).
- *"Trust Me:" Patent Offices in Developing Countries*, Peter Drahos, 34 Am. J.L. & Med. 151 (2008).
- *The Unmanned Voyage: An Examination of Nanorobotic Liability*, Shalyn Morrison, Alb. L.J. Sci. & Tech. 229 (2008).
- *Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations*, Lucinda Jesson, 15 Va. J. Soc. Pol'y & L. 217 (2008).
- *Whose Cell Line Is It Anyway? Intellectual Property Implications of New Jersey's Policy on Stem Cell Research*, Gary R. Tulp, 38 Seton Hall L. Rev. 1167 (2008).

Sarah Cirba, a student at Albany Law School, assisted in the research for and preparation of this column.

For Your Information

By Claudia O. Torrey

The following highlights reflect informational items of interest in the health care arena:

- The week of January 26, 2009 was the "baptism" of the San Jose, Costa Rica Office of the Food and Drug Administration (FDA; which is within the United States Department of Health and Human Services/HHS); the new HHS-FDA Office in Costa Rica hosted a weeklong conference on *Good Clinical Practices in San Jose*.[1] The workshop included remarks from the Minister of Health for the Republic of Costa Rica, as well as presentations from a number of experts. Also in attendance was Dr. Paul Seligman, HHS-FDA's Regional Director for Latin America, Office of International Programs.

- In December 2008, *The Commonwealth Fund* (CF) launched a new website entitled WhyNotTheBest.org.[2] The goal of this free website resource is to allow health care providers to utilize health care quality data and tools as well as track benchmark comparisons nationwide of approximately 4,500 hospitals.[3] WhyNotTheBest.org was created as a result of the illuminated shortfalls in the United States' health care system prepared in a relatively recent national CF biennial scorecard; this scorecard was alluded to by this columnist in the previous *Health Law Journal* issue (Fall 2008). According to the CF, the United States is not faring well in many health care quality measures. Thus, the hope is that WhyNotTheBest.org will provide a useful resource for the provider industry, and the CF will do its best to add helpful data as it becomes publicly available (example—hospital 30-day re-admission rates).[4] Quoting Dr. Robert Wachter, Associate Chairman of Medicine at the University of California, San Francisco Department of Medicine, "WhyNotTheBest.org represents the marriage of health care transparency and modern Web technologies."

- On November 21, 2008 the HHS published a final rule implementing the *Patient Safety and Quality Improvement Act of 2005* (PSQIA), which is to create opportunities for providers to share patient safety information with independent entities designated as patient safety organizations (PSO);[5] potentially sensitive information will be designated as patient safety work product (PSWP). The framework in which HHS will work with PSQIA allows the Agency for Healthcare Research & Quality to oversee the certification and listing of PSOs, and the HHS Office for Civil Rights will oversee enforcement and investigation. The final rule became effective on January 19, 2009.

  While the term "work product" usually evokes the concepts of privilege and confidentiality, such is not the absolute case with PSWP! Four types of PSWP disclosure situations will not violate a privilege or confidentiality, and six PSWP disclosure situations are permitted with the privilege remaining.[6] In certain situations, the HHS Secretary can receive immunity regarding PSWP.

Endnotes

1. http://www.fda.gov/oia/Workshop_SanJose.htm.
2. http://www.psqh.com/enews/0109f.html.
3. *Id.*
4. *Id.*
5. http://www.mondaq.com/article.asp?articleid=71886&print=1.
6. *Id.*

Claudia O. Torrey, Esq. is a sustaining member of the New York State Bar Association.

News from the Managed Care Battlefield: Out-of-Network Denials and the New York State External Appeal Law

By Kathleen Duffett, R.N., J.D.

I. In the Beginning . . .

In the beginning, providers took care of patients first and talked to the health insurance companies about payment later. But, as Billy Joel sings, "They started to fight when the money got tight and they just didn't count on the tears."

In the 1990s, managed care in New York State started to take off, forever altering the provider/patient/insurer relationship. Generally speaking, a patient with managed care coverage could no longer go to whichever doctor or hospital he or she wanted to or self-refer to a specialist. Providers who wanted to get paid from managed care organizations (MCOs) for performing surgeries, providing specialty consults, etc., now needed to make sure that the MCO authorized this care. And so the fight was on—patients and their providers versus managed care.

"In the beginning, providers took care of patients first and talked to the health insurance companies about payment later. But, as Billy Joel sings, 'They started to fight when the money got tight and they just didn't count on the tears.'"

The mediator of this fight was none other than the State of New York. In 1996, New York State enacted the Managed Care Reform Act (the "Act"),[1] more commonly known as the Managed Care Consumer Bill of Rights.[2] Among other things, the Act established the right of managed care members to contest certain health plan decisions through mandatory grievance and utilization review[3] appeal processes and to obtain emergency care without prior authorization.

But the battle raged on. The state's next attempt at reconstructing the managed care playing field focused on creating an external appeal process, which would allow managed care members to appeal medical necessity denials to an independent third party. The External Appeal Law,[4] which took effect in July 1999, granted managed care members this right. However, the right of a health care provider to initiate an external appeal on the provider's own behalf was limited to those situations where the health plan had issued a retrospective denial.[5]

For members, the new External Appeal Law was a welcome change to the existing landscape. However, health care providers took issue with their limited right to independently initiate an external appeal only when the denial had been issued retrospectively. This issue persists to the present day.[6]

Another persistent issue has been the right of members to access the external appeal process when a request for service is denied because the provider is out-of-network (i.e., not part of the member's health plan network, also referred to as a non-participating provider). This article explores the application of a member's out-of-network appeal rights as of 4/1/08, the effective date of such new rights.

II. Out-of-Network Denials and the New York State External Appeal Process

Chapter 451 of the Laws of 2007 amended Article 49 of the Public Health Law[7] to address out-of-network denials. Effective 4/1/08, a member has the right to pursue an external appeal whenever a health plan denies the out-of-network service that the member has requested but recommends (i.e., approves) an alternate in-network service that the health plan believes is not "materially different" from the requested out-of-network service.[8]

Of note, the right to pursue an out-of-network appeal applies only when the health plan denies a pre-authorization request[9] for such services.

III. Application of Article 49 to Out-of-Network Denials as of April 2008

A. Definition of Out-Of-Network Denial

New subsection PHL 4900(7-f) defines the term out-of-network denial. In part, it reads:

> "Out-of-network denial" means a denial of a request for pre-authorization to receive a particular health service from an out-of-network provider on the basis that such out-of-network health service is NOT MATERIALLY DIFFERENT (emphasis added) than the health service available in-network. The notice of an out-of-network denial provided to an enrollee shall include information explaining what information the enrollee must submit in order to appeal the out-of-network denial pursuant to [PHL § 4904(1-a)]. An out-of-network denial under [PHL § 4900(7-f)]

> does not constitute an adverse determination as defined in [PHL § 4900(1)]. . . .

The last sentence attempts to make clear that out-of-network denials are *not* medical necessity determinations. However, somewhat confusingly, the appeal process for out-of-network denials now includes the right to external appeal, a process that historically has been limited to medical necessity issues.

Interestingly, the last sentence of the definition reads:

> Notwithstanding any other provision of this subdivision, an out-of-network denial shall not be construed to include a denial for a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by the enrollee.

"Referral" is not defined in Article 49. However, it is defined in the New York State Department of Health (DOH) managed care regulations as "the internal mechanism utilized by the MCO to allow members to access needed services."[10] Typically, this means the process by which the member's provider submits the request for service (whether by phone, facsimile, mail or electronic means) to the member's health plan for utilization review.

The definition of out-of-network denial makes clear that a member does *not* have the right to external appeal if the health plan (or health plan's participating provider) refuses to generate a referral to an out-of-network provider when the basis for the refusal is the availability of an in-network provider. In this case, the member would have grievance rights,[11] which do not result in access to the External Appeal Program.

B. Internal Appeal of Out-of-Network Denials

New subsection PHL 4904(1-a) explains a member's internal appeal rights (i.e., the right to appeal to the health plan) in the event of an out-of-network denial.

> An enrollee or the enrollee's designee may appeal an out-of-network denial by a health care plan by submitting:
>
> (a) a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, that the requested out-of-network health service is MATERIALLY DIFFERENT (emphasis added) from the health service the health care plan approved to treat the insured's health care needs; and
>
> (b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be MORE CLINICALLY BENEFICIAL (emphasis added) to the enrollee than the alternate recommended in-network health service and FOR WHICH THE ADVERSE RISK OF THE REQUESTED HEALTH SERVICE WOULD LIKELY NOT BE SUBSTANTIALLY INCREASED OVER THE IN-NETWORK HEALTH SERVICE (emphasis added).

The terms "materially different" and "clinically beneficial" in this subsection are not defined in the statute. And the standard "for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service" almost defies parsing. However, "medical and scientific evidence" is defined (at length) in PHL 4900(7-e).

The procedural requirements[12] for internal appeals of ordinary medical necessity denials are not nearly as proscriptive as the out-of-network internal appeal process described above. Also, meeting the out-of-network internal appeal procedural requirements is the responsibility of the member and the member's attending physician. Arguably, this can be a daunting prospect for the average member (i.e., a layperson), even with the assistance of his or her attending physician.

C. External Appeal of Out-of-Network Denials

1. Right to External Appeal of Out-of-Network Denial

New subsection PHL 4910(2)(c) speaks to a member's right to an external appeal of an out-of-network denial.

> An enrollee [and] the enrollee's designee . . . shall have the right to request an external appeal when:
>
> . . . the enrollee has had coverage of the health service (other than a clinical trial to which paragraph (b) of this subdivision shall apply), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health service is out-of-network and AN ALTER-

> NATE RECOMMENDED HEALTH SERVICE IS AVAILABLE IN-NETWORK (emphasis added), and the health plan has rendered a final adverse determination with respect to an out-of-network denial or both the health plan and the enrollee have jointly agreed to waive any internal appeal; and
>
> (ii) the enrollee's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, certifies that the out-of-network health service is MATERIALLY DIFFERENT (emphasis added) than the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more CLINICALLY BENEFICIAL (emphasis added), than the alternate recommended in-network treatment and THE ADVERSE RISK OF THE REQUESTED HEALTH SERVICE WOULD LIKELY NOT BE SUBSTANTIALLY INCREASED OVER THE ALTERNATE RECOMMENDED IN-NETWORK HEALTH SERVICE (emphasis added).

Again, the procedural requirements that a member and the member's attending must meet when pursuing an external appeal of an out-of-network denial are much more detailed than the procedural requirements for an external appeal involving an ordinary medical necessity denial.[13]

2. External Review of Out-of-Network Denials: Procedural Requirements

New subsection 4914(2)(d)(C) lays out the procedure the external appeal agent must follow when reviewing an external appeal of an out-of-network denial.

> For external appeals requested pursuant to [PHL § 4910(2)(c)] relating to an out-of-network denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network health service shall be covered by the health plan.
>
> (i) The external appeal agent shall assign one clinical peer reviewer to make a determination as to whether the out-of-network health service is materially different from the health service available in-network.
>
> (ii) If a determination is made [BY THE ONE CLINICAL PEER REVIEWER] that the out-of-network health service IS NOT (emphasis added) materially different from the health service available in-network, the out-of-network health service SHALL NOT (emphasis added) be covered by the health plan.
>
> (iii) If a determination is made [BY THE ONE CLINICAL PEER REVIEWER] that the out-of-network health service IS (emphasis added) materially different from the health service available in-network, the external appeal agent shall assign a panel with an additional two or a greater odd number of clinical peer reviewers which shall make a determination as to whether the out-of-network health service shall be covered by the health plan; provided that such determination shall:
>
> (1) be accompanied by a written statement that:
>
> (I) the out-of-network health service shall be covered by the healthcare plan either: when a majority of the panel of reviewers determines, upon review of the health service requested by the enrollee, the alternate recommended health service proposed by the plan, the clinical standards of the plan, the information provided concerning the enrollee, the attending physician's recommendation, the applicable medical and scientific evidence, the enrollee's medical record, and any other pertinent information that the out-of-network health service is likely to be more clinically beneficial than the proposed in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the in-network health service; or
>
> (II) uphold the health plan's denial of coverage.

(2) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(3) be binding on the plan and the enrollee; and

(4) be admissible in any court proceeding.

Once again, when compared with the procedural requirements that the external appeal agent must follow when reviewing ordinary medical necessity determinations,[14] the out-of-network requirements are considerably more proscriptive.

IV. Application of Out-of-Network Requirements to the Pre-authorization Process

The new requirements affect the handling of pre-authorization requests for out-of-network services as follows.

SITUATION: A member's provider submits a pre-authorization request for an out-of-network service to the member's health plan for utilization review.

Under Article 49's requirements as of 4/1/08, there are four possible outcomes.

1. **Approve the request because the service is medically necessary and is not available in-network.**

   Explanation: Under existing law, if there is a request for an out-of-network service and there is no available in-network service, the health plan *must* make a referral to an appropriate out-of-network provider at no cost to the member other than what the member would have paid in-network.[15]

   As a related matter, the New York State DOH managed care regulations require that managed care organizations "establish a process for the resolution of requests for medically necessary services to be provided by [out-of-network] providers when such services are not available in-network. Such process shall require the approval of the commissioner prior to implementation and shall thereupon be included in the member handbook."[16]

2. **Deny the request because the service is out-of-network and the service is readily available in-network.**

   Explanation: The New York State Insurance Department (SID), which is responsible for the administration of the External Appeal Program, has clarified that denial of a request for out-of-network services when the out-of-network services are readily available in-network is a benefit denial, not a medical necessity denial.[17] In other words, if the requested out-of-network service is available in-network essentially "as is," then the member's right to contest this determination is limited to a grievance.[18] As noted earlier, the grievance process does not provide the member with access to the External Appeal Program in the event the health plan upholds the denial.

3. **Deny the request because the service is out-of-network but approve an alternate health service that is available in-network and is not materially different from the out-of-network service that the member is requesting.**

   Explanation: This is the real change that Chapter 451 of the Laws of 2007 makes to the External Appeal Program. In this circumstance, as of 4/1/08, the member is entitled to internal and external appeal rights that are consistent with new out-of-network appeal requirements described earlier in this article. If the member ultimately decides to pursue an external appeal, the external review agent must review the appeal consistent with the requirements of new PHL § 4914(2)(d)(C) (see Section III(C)(2), above).

4. **Deny the request because the service is not medically necessary regardless of whether the service is provided in-network or out-of-network.**

   Explanation: This is the standard denial for lack of medical necessity that has existed since the inception of the Managed Care Reform Act of 1996. The member has the same internal and external appeal rights that have existed under Article 49 since April 1997 and July 1999, respectively.

V. General Impressions

There was little fanfare involved with publicizing the new out-of-network appeal rights when they took effect on 4/1/08. However, on this date, the SID did post out-of-network appeal information to the "Latest Updates" section of its External Appeal Information home page.

Although members now have an express right to internal and external review of out-of-network denials, the procedural requirements of the out-of-network appeal process are fairly daunting. Also, two of the crucial terms, namely, "materially different" and "clinically beneficial," are not defined in the statute or in the existing external appeal regulations.[19] Likewise, the "for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service" standard is not a model of clarity, leaving it ripe for challenge.

Out-of-network appeal rights are relatively recent. It will be interesting to see if, over time, members exercise their appeal rights in the event of an out-of-network denial. Also of interest is whether any consumer rights attorneys will file lawsuits challenging the terms "materially different" and "clinically beneficial," or challenge the adverse risk standard, particularly as these terms and standards are applied by the external appeal agents.

Endnotes

1. Chapter 705 of the Laws of 1996.
2. Generally speaking, these rights apply to managed care members who receive their health insurance coverage from an HMO with a certificate of authority under Article 44 of the Public Health Law (PHL), a for-profit insurer licensed under Article 42 of the Insurance Law or a not-for-profit insurer licensed under Article 43 of the Insurance Law. Of note, members of Medicare managed care plans or self-insured plans are not covered by the New York State Managed Care Consumer Bill of Rights.
3. Utilization review means the process for determining whether a service is medically necessary. The definition of medical necessity is typically included in the subscriber contract.
4. Chapter 586 of the Laws of 1998. The New York State Insurance Department (SID) administers the External Appeal Program.
5. A retrospective denial (a.k.a. a retrospective adverse determination) is "a determination for which utilization review was initiated after health care services have been provided. Retrospective adverse determination does not mean an initial determination involving continued or extended health care services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider. . . ." (*see* 11 N.Y.C.R.R. 410.2(i)).
6. The seminal case on this issue is *HANew York State v. Serio* (Decision and Order Index No. 3133-01) (Supreme Court, Albany County, February 2002). Bills that were introduced in the 2007–2008 legislative session attempting to expand a health care provider's right to independently initiate an external appeal for denials other than retrospective ones included A.8321 (Gottfried) and S.4481-A (Seward)/A.11737 (Morelle). None of these bills became law. In January 2009, Assemblyman Gottfried introduced A.792 to address this and other review issues.
7. Chapter 451 made corresponding changes to Article 49 of the Insurance Law, even though the references in this article are to Article 49 of the Public Health Law.
8. PHL § 4910(2)(c)(i).
9. A pre-authorization request is a request for utilization review of a service prior to the service being provided (*see* PHL § 4900(8); *see also* PHL § 4903(2)).
10. 10 N.Y.C.R.R. 98-1.2(ii).
11. A grievance is essentially an appeal by a member in response to a health plan's denial of coverage for a reason other than medical necessity (*see generally* PHL § 4408-a and Insurance Law § 4802).
12. See PHL § 4904(2) for the procedural requirements for expedited appeals and PHL § 4904(3) for the procedural requirements for standard appeals.
13. See PHL § 4910(2)(a) for the procedural requirements for external appeals involving medical necessity determinations.
14. *See* PHL § 4914(2)(d)(A).
15. PHL § 4403(6)(a).
16. 10 N.Y.C.R.R. 98-1.13(a).
17. See Question 7 of the "More Frequently Asked Questions" section of the New York State Insurance Department's External Appeal home page, http://www.ins.state.ny.us/extapp/extappqa.htm (accessed July 17, 2008).
18. Section 4408-a of the PHL and Section 4802 of the Insurance Law state the required elements that a health plan must incorporate into its internal grievance process.
19. See the DOH external appeal regulations at 10 N.Y.C.R.R. Part 98-2 and the SID external appeal regulations 11 N.Y.C.R.R. Part 410.

Kathleen Duffett, R.N., J.D., Attorney at Law, is a Registered Nurse and attorney in private practice. She helps health care organizations and providers understand and meet their regulatory obligations. Her practice areas include fraud and abuse, HIPAA, home care operations, hospital operations, managed care and risk management. She is on the Web at www.duffettlaw.com and can be reached at (845) 265 -3965 or kduffett@duffettlaw.com.

The Unified Health Claims Clearinghouse: A Prescription to Simplify and Save on Health Care Services

By Edward S. Kornreich, Herschel Goldfield and Ellen H. Moskowitz

Our health care system is generally perceived as expensive and inefficient, even for those lucky enough to have health insurance coverage. Proposed cures vary and have ranged from government-sponsored single-payor systems to government-facilitated individual choice among competing private health plans. While advocates for single-payor systems tout their efficiency, our political culture has repeatedly rejected such systems as "socialized medicine." Those who favor supporting individuals' personal choice of private health plans confront the argument that individuals will be overwhelmed by the complexity and bureaucracy of their chosen plan.

We suggest an alternative that holds real promise to enhance efficiency, encourage transparency, increase satisfaction and lower costs. The approach would create a unified health claim clearinghouse system, creating a much-needed element of "checks and balances" to the current system by separating ownership of premium cash pools from claims adjudication activities, and leaving in place the private ownership and remaining operations of multiple health care plans. We believe that creating a single independent and largely electronic health care clearinghouse to coordinate the approval of and payment for covered services will result in many of the efficiencies of a single-payor system, while at the same time facilitating individual choice among competing private health care plans. The independent health care clearinghouse will also create a platform for future initiatives that may benefit the broader population that lacks health care insurance.

Private health plans engage in two discrete activities that are in inherent conflict. On the one hand, these plans market health coverage to buyers (typically employers, but also including the government and individuals), collect premiums, and own and invest for their own profit large pools of premium dollars. The size and return on those assets contribute importantly to these companies' bottom line. On the other hand, the plans must, of course, dip into these assets to pay claims, and thus the plans typically "control and manage" the reimbursement of claims submitted by providers and beneficiaries: the health care plan determines whether the claim is complete and timely and whether the item or service is "covered" by the patient's health care plan. This activity is referred to as claims adjudication. The more these companies pay for claims (tellingly, referred to by the insurance industry as the "medical loss") the less money is retained as profit.

This tension is inherent to a system where a single entity both holds premium dollars and adjudicates claims.[1] When health insurance companies had little involvement in health coverage decisions, but generally paid claims as submitted, this tension did not cause obvious harm to patients, but did tend to encourage excessive spending. However, as insurers began in earnest to control claims payment and costs, the claims adjudication process has become fraught with delay, miscommunication and complexity that is vexing to both providers and patients. This complexity, delay and seemingly arbitrary handling of claims is a source of great inefficiency and great dissatisfaction.

"We believe that creating a single independent and largely electronic health care clearinghouse to coordinate the approval of and payment for covered services will result in many of the efficiencies of a single-payor system, while at the same time facilitating individual choice among competing private health care plans."

The process is often further complicated by the need to obtain prior authorization for certain services, and by the necessity for providers to understand and deal with multiple different (but often similar) processes required in order to bill for services, obtain referrals and authorizations, or provide information to health plans. These processes collectively create delay and expense. It has been estimated that physicians spend approximately 14 percent of their gross revenues on billing and insurance related functions (the figure has been estimated at 7–11 percent for hospitals and 8 percent for insurance companies).[2] Combining just the billing costs for both physicians and the insurance companies yields a cost of 22 percent of the amount spent. Such a high level of transaction costs would not be tolerated in most other sectors of the economy. This would be equivalent to paying $6,600 in administrative costs to purchase a $30,000 car, and doing so every year, on top of the aggravation involved in being able to actually obtain the car when you need it, and the possibility that you might have to pay even more if there is a problem with the paperwork.

The high transaction costs are compounded by the informational asymmetry between the buyers of insurance (principally employers or employee health care trust funds) and the insurance plans. There is no readily available source of reliable data on the "quality" of health insurers from the claims adjudication perspective. Buyers of insurance cannot compare frequency of payment delays; error frequency; dissatisfaction of beneficiaries; or the administrative burdens on patients of working with a particular health plan. Even if such data were made available, a principal source of information would be the health plans themselves, hardly a reliable source. While the health care industry, with government intervention, begins to obtain and make available data on the prices and quality of providers, no mechanism is available to readily evaluate the health plans, which play such a crucial role.[3]

This conflicted, complex and expensive system produces delays and denials, probably in excess of what is reasonable. While some value is obtained in the form of cost reduction and better management of care, this is clearly not always, or even the predominant, outcome.

The proposed health care clearinghouse could greatly alleviate these problems. The clearinghouse would be one or more contractors (probably assigned regionally), similar to the existing regional contractors (generally large private insurance companies) that hold contracts from the government to operate the Medicare system. Care may have to be taken to separate ownership of the clearinghouse from any one particular insurer, or to require it to operate as a not-for-profit corporation or under a "utility" type framework. Notably, while no system of claims adjudication is perfect, traditional fee-for-service Medicare which uses these contractors (as distinguished, for example, from private HMO-type Medicare payors) is remarkably effective. For example, Medicare's administrative costs were recently calculated to be 5.2 percent, whereas private sector payor administrative costs fall between 8.9 percent and 16.7 percent.[4] This greater efficiency does not even capture the additional efficiency and reduced stress on providers and patients, who would need to interact with only one claims adjudication entity, instead of many. It is noteworthy that the financial services industry (not a hotbed of support for government control) has on its own largely implemented a single national trading clearinghouse for each type of financial security traded.

Generally speaking, Medicare claims are handled quickly and fairly, there are processes for dispute resolution that appear to work, and providers have indicated that they are very satisfied with the performance of the Medicare fee-for-service contractors. The 2007 Medicare Contractor Provider Satisfaction Survey reported that on a scale of 1 to 6, with 1 representing "Not at all Satisfied" and 6 representing "Completely Satisfied," 85 percent of providers scored their contractors between 4.0 and 6.0.[5] We believe that the root cause of this efficiency is that in traditional Medicare, claims adjudication is by an "intermediary" contractor without a financial interest in the denial of claims. This system of checks and balances can serve as a model. If we utilize the traditional Medicare program claims adjudication system concept—which employs private contractors that have no financial interest in denying or approving claims—as a model for all health care services, we can bring these efficiencies to the health care system as a whole. The result could be enormous cost savings (imagine the benefits of reducing the costs of health care, possibly by a few percentage points—hundreds of billions of dollars), and a reduction of the "hassle factor" for providers and patients.

Under our proposal, a patient or his physician would submit claims for payment to the clearinghouse, not the private health care plan. The clearinghouse would review and coordinate all existing private insurance for the patient, determine if coverage is available, allocate the obligations of payors where more than one is responsible (so-called coordination of benefits) and the amount of any co-pay. (Even for well-insured patients, the disputes between insurance companies over which one is responsible, and for how much, is often a source of delay, non-payment and frustration.) Once the approved service is rendered, payment would be made electronically to the physician or the provider from the payor's account. If a claim is denied, the beneficiary would have the right to an efficient dispute resolution process or appeal. Critically, the process would be, at least to the point of the appeal, entirely electronic, and the clearinghouse would be the mechanism to drive, finally, the creation of integrated computer systems to manage health care services in this country. The contractor would have no financial incentive to delay payment, as the pool of claims dollars would be held by a third party. Incentives would be structured to reward accuracy, efficiency and fairness to all stakeholders: the patient, the provider and the health plan.

The Byzantine, almost deliberately disconnected current system wastes patients' and providers' time and a vast amount of everyone's money. The creation of an independent health care clearinghouse would improve both patient and provider satisfaction with the health care system while reducing costs. While application of a unified clearinghouse to self-funded ERISA plans, Medicare plans, and the Medicaid program would require federal legislation, states would appear already free to require their insurers and HMOs to participate.

Some may object that this approach would strike consumers as too radical a shift or risks higher costs and less choice for consumers. In response, we submit that replacing the existing chaotic, user-unfriendly system operated by large and anonymous bureaucracies with private contractors that might be the very same entities adjudicating claims today, but stripped of their incentive to deny claims, would not be viewed as a radical shift by indi-

vidual patients or providers. Nor does standardizing the payment process through government contractors result in socialized medicine. Payors can still compete on price, quality of network, wellness programs, and even coverage policies. They just will not have control of the claims adjudication process—which will be consistently, simply and fairly administered by a third party contractor.

The new system should also prevent payors from arbitrarily denying care for their own financial benefit. The reduced amount of delay and denial will decrease the payors' ability to profit from the "float" (i.e., the benefit from the use of money retained by delaying payment) that they earn on premium pools. This will not, however, bankrupt the plans. First, they will save on transaction costs. Second, the reliability and greater transparency of payment may result in a moderation of provider price increases. If providers are paid more efficiently, with less delay and arbitrary denials, it may be that rates could (indeed, economic theory suggests would) be lower, even while maintaining the profitability of the payors. In addition, transparency and stability will alone be a significant advantage to all system participants.

It is far better to pay providers for rendering care than bureaucrats for finding ways to deny claims or to fight for their payment. It is better for cost reduction and the application of the free market to have open and honest "rate" negotiations on a level playing field, without the unknown variable of claims denial practices. Whatever you prefer for the future direction of the health care system—single payor or individual choice—the health care clearinghouse is a useful, perhaps necessary, precursor. It will change our system more fundamentally, create more consumer satisfaction and lower costs more than any other step we could reasonably take in the near term.

Endnotes

1. The casualty insurance system often involves the use of claims adjusters, who may play an independent role in mediating the obvious conflicts between claimants and insurers. Many states have introduced a similar concept, by providing for third party appeals of coverage denials. However, this approach is unlikely to be as effective in the health care marketplace as in other insurance markets because of the relative disadvantage of the patient (who is often ill and in serious financial distress), and because of the relatively high frequency of claims in health care compared to casualty claims.
2. J.G. Kahn, R. Kronick et al., The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals, 24 Health Affairs 6 (2005): 1629–1639. Note that the figure for insurance companies does not include a separate amount for administration, estimated to be 9.9 percent of revenue. The total amount, 17.9 percent for billing and administration, is consistent with the separate estimate below of private health plan administrative costs.
3. Merely providing disaggregated, piecemeal information to consumers may not have much of a beneficial effect, as the understanding of price and quality in health care is extremely complex, and individuals may become overwhelmed by data. *See* Paul B. Ginsburg, Shopping for Price in Medical Care, 26 Health Affairs 2 (2007): w208–w216. However, in order to permit the market to play an effective role, information must be made available to decision makers, and making that information available may require government intervention.
4. Merrill Matthews, Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector (Jan. 10, 2006).
5. WESTAT, Medicare Contractor Provider Satisfaction Survey (July 2007).

Edward S. Kornreich is a Partner in the Health Care Department of Proskauer Rose LLP in NYC. He is also Chair-Elect of the NYS Bar Association Health Law Section. Herschel Goldfield and Ellen Moskowitz are Senior Counsels in the Health Care Department of Proskauer Rose LLP in NYC.

The Latest Stark-Go-Round

By Margaret D. Kranz

Introduction

The "Stark Law," a federal law named after California Congressman Fortney "Pete" Stark, prohibits physicians from referring patients for certain "designated health services" to entities with which the physicians (or their family members)[1] have a financial relationship. As is discussed further below, there is a corresponding law in New York, which was first enacted in 1992, and which only applied to clinical laboratory services and x-ray and imaging services when enacted.[2]

The federal law dates back to 1989, when Congress enacted section 1877 of the Social Security Act.[3] Similar to New York State's statute, initially, the federal law focused on prohibiting a physician from referring patients to clinical laboratories in which he or she had a financial relationship. Over the years, the law has evolved, and, currently, unless the arrangement complies with an exception, the Stark Law prohibits physician referrals to the following ten "designated health services" (DHS):

- Clinical laboratory services;
- Physical therapy, occupational therapy and speech-language pathology services;
- Radiology and certain other imaging services
- Radiation therapy services and supplies;
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies;
- Prosthetics, orthotics and prosthetic devices and supplies;
- Home health services
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.[4]

The Stark Law prohibitions apply to both direct and indirect financial relationships. A "financial relationship" is a physician's ownership or investment interest in an entity that furnishes DHS, as well as a physician's compensation arrangement with an entity that furnishes DHS. An ownership or investment interest is a direct or indirect interest in an entity which furnishes DHS. A compensation arrangement is any arrangement involving payment (direct or indirect) between a physician and an entity. Thus, the sweep of the Stark Law prohibitions is wide. The Stark Law is a strict liability statute; intent is irrelevant.

There are a number of exceptions to the Stark Law prohibition. They, too, have evolved over time, and will continue to undergo changes.

Recent Changes

On September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) published the "final phase" of rulemaking under the Stark Law, with an effective date of December 4, 2007.[5]

On July 31, 2008, CMS published the 2009 Inpatient Prospective Payment System final rule (the 2009 IPPS Rule).[6] Included in this missive are a number of revisions to the Stark Law regulations. Many of the revisions became effective on October 1, 2008; however, as discussed below, a number of the changes are not effective until October 1, 2009, in order to provide time to restructure or unwind non-compliant arrangements. This article sets forth the current landscape of the Stark Law and reviews some of the recent significant changes in this area of the law.

Period of Disallowance for Non-compliant Agreements

The "period of disallowance" is the time during which a physician cannot refer a patient to an entity for DHS, and the period during which the entity receiving the referral cannot bill for DHS. The 2009 IPPS Rule clarified that the period of disallowance begins when the financial relationship fails to satisfy the requirements of an exception. If the noncompliance is not related to compensation, the period of disallowance ends on the date that the relationship satisfies the requirements of an applicable exception. If the noncompliance is related to payment of excess compensation, the period of disallowance ends on the date on which all excess compensation is returned to the party which paid it and the relationship satisfies the requirements of an exception. If the noncompliance is related to payment of insufficient compensation, the period of disallowance ends on the date on which the additional compensation is paid and the relationship satisfies the requirements of an exception.

Stand in the Shoes

One of the unique provisions in the Stark Law is the concept of "stand in the shoes." By way of example, in analyzing whether there is compliance with the Stark Law, a financial relationship involving a professional

corporation will be analyzed both with regard to the professional corporation and with regard to the physician who is a shareholder in that professional corporation as if the physician "stands in the shoes" of the professional corporation. Among the changes in the 2009 IPPS Rule is that, if the physician is a "titular owner" (such as a hospital department director who technically "owns" a P.C. for purposes of a faculty practice plan), but derives no financial benefit from that ownership, the "stand in the shoes" analysis may be, but does not have to be, done to measure compliance with Stark.

Definition of "Entity"

Prior to the 2009 IPPS Rule, the Stark Law regulations defined "entity" as the entity which billed for the DHS. In an expansion of the reach of the Stark Law prohibitions, "entity" now encompasses both an entity that bills Medicare for the service and the entity that has performed the service. Thus, if a service like cardiac catheterization (cardiac cath) is provided through a hospital outsourcing arrangement whereby the cardiac cath company provides the equipment, supplies and staff, the cardiac cath company itself would be viewed as a DHS entity. If the owners of the cardiac cath company are referring physicians who provide services, then the expanded definition of "entity" may preclude such a business from continuing. This provision is not effective until October 1, 2009, in order to allow current arrangements to be restructured or unwound.

Litigation challenging the new definition of "entity" with regard to services provided "under arrangement" was initiated in September of 2008.[7] The suit was brought by cardiologists and vascular surgeons who perform cardiac catheterization and related services as an extension of their medical practices as well as by cardiac cath laboratories. Medicare will pay for most cardiac cath lab services only as inpatient or outpatient hospital services, and will not pay free-standing cardiac cath labs for those services. When the revised definition of "entity" set forth in the 2009 IPPS Rule becomes effective, these physicians will be prohibited from referring Medicare patients for cardiac cath services. The challenge to this change in the Stark Law is based, in part, upon the Final Rule being contrary to Congressional intent, specifically noting that there is a statutory "under arrangement" exception in the Stark Law.[8]

"Per Click" Arrangements

There are significant changes to the regulations regarding compensation for leases of equipment or space where physician investors are involved. It is commonplace in the healthcare industry for companies to lease space or equipment to physicians and other health care providers and charge on a per-click basis. A "click fee" is developed and charged whenever the equipment (or space) is used for the care of a patient. The terminology has historically been used for CT scans and MRIs as a reference to the machine that would be "clicked" for each episode of patient care. It also is applicable to a number of other diagnostic and therapeutic modalities.

Although click fees have become customary in both physician-investor and non-physician investor arrangements, in the 2009 IPPS Rules, CMS changed its official position about the propriety of click fees. CMS has explicitly prohibited the use of click fees for space or equipment rentals when referring physician-investors are involved. The commentary on this change is extensive, perhaps indicating CMS' need to explain itself in detail with regard to this change. Among the substantive areas discussed in the commentary are that hospitals are risk-averse (and, therefore, would want to incur a financial obligation for a piece of equipment only to the extent it uses the equipment), that eliminating click fees would restrict access to care, that overutilization would occur, and that there are distinctions between therapeutic and diagnostic modalities. The 2009 IPPS Rule discussion of per-click payments includes the following commentary:

- "Even though the amount of payment per service may not vary, the incentive for overutilization remains because the greater number of referrals, the greater amount of revenue realized by the lessor."
- "The potential for anti-competitive behavior is even more of a concern with respect to physician entity lessors, as such entities typically have more leverage over referral streams than do individual physicians."
- "[I]n practice, per-click leases may be, in some cases, antithetical to fair market value compensation. That is because an entity leasing space or equipment on a per-use basis may pay willingly a significantly higher amount in per-click rental fees to a physician-owned entity, rather than leasing comparable space or equipment from a non-physician entity, because the lessee may still be realizing a profit, or breaking even, on services that are the subject of the lease and may not wish to risk losing referrals for those services and referrals for other services if it contracts with a non-physician lessor."[9]

Additionally, CMS devotes commentary to time-based rental arrangements. The comments submitted included a discussion of "on demand" rental arrangements. CMS noted that "on demand" arrangements are problematic, and views them as a per-use or per-click arrangement. In its discussion, CMS noted the following with regard to "block time" leases:

> We believe that time-based rental payments, such as block time leases, depending on how they are structured, may meet the requirements of the space and equipment lease exceptions, including the requirements that the agreement be at fair market value and be commercially reasonable, even if no referrals were made between the lessee and the lessor, and that they not take into account the volume or value of any referrals or other business generated between the parties. We believe that the same concerns we identified above with respect to certain per-click lease arrangements can exist with certain time-based leasing arrangements, particularly those in which the lessee is leasing the space or equipment in small blocks of time (for example, once a week for 4 hours), or for a very extended time (which may indicate the lessee is leasing space or equipment that it does not need or cannot use in order to compensate the lessor for referrals).[10]

CMS then notes that it will continue to study the block time concept and may propose further rulemaking. CMS cautions that parties utilizing block leases should structure the arrangements "carefully," and should also be mindful of the anti-kickback statute.[11]

Click fee arrangements which involve business entities with no physician investors are still permissible. Given that the industry has developed click fees as an effective measure of value (by not overpaying for a resource that is underutilized or underpaying a business that is being over-utilized), it will be interesting to see how the industry adapts to the changes. Again, this change in the landscape has an October 1, 2009 effective date in order to give time to restructure or unwind existing arrangements.

Academic Medical Centers

In response to concerns expressed by members of the academic medical center (AMC) community when the "final rule" was published in 2007, on November 15, 2007, CMS announced that it was delaying the effective date of the "stand in the shoes rule" as it applied to AMCs.[12] The AMC community had contested the changes on the grounds that they were unworkable. A number of the "final rule" provisions require that fair market value be the payment measure for transactions; in the academic medical center community, there are often "support payments" which foster the mission of a component of an academic medical center. These support payments may be tied to the economic needs of the AMC component being supported, and may have no relationship to fair market value. In response to the concerns, CMS initially extended the enforcement date from December 4, 2007 to December 4, 2008 with regard to academic medical centers and section 501(c)(3) integrated health care systems. CMS provided the extension in order to provide itself with an opportunity to evaluate the impact of the Phase III stand-in-the-shoes provisions on those entities and evaluate any unintended impact.

As a result of its further consideration, in the commentary to the 2009 IPPS Rule, CMS explained that if a compensation arrangement is compliant with the requirements of the detailed AMC exception, that will suffice for Stark Law compliance purposes.

Percentage-Based Compensation for Office and Equipment Leases

The 2009 IPPS Rule contains an outright prohibition on percentage-based compensation for leases of office space or equipment where referring physicians are involved. The standard to be used for establishing office and equipment rent is fair market value. This is yet another aspect of the Stark Law changes that has an effective date of October 1, 2009 in order to give parties to existing arrangements time to unwind or restructure them. The changes prohibit the use of compensation formulae based on a percentage of revenue in determining office space and equipment rental charges. CMS identifies this change as a "targeted approach"; the prohibition on percentage-based compensation does not extend to management or billing services, although CMS will continue to monitor this area.

In addition to revising the office space and equipment rental exceptions themselves, the 2009 IPPS Rule revises the exceptions for fair-market-value compensation arrangements and indirect compensation arrangements to conform to the percentage-based compensation prohibition for office space and equipment rentals. CMS's rationale for the prohibition is based on whether a percentage rental charge is really "set in advance," whether it is really fair market value, and whether the percentage builds in incentives to refer or maintain referral streams between the parties.

The "Temporary Non-compliance" of a Missing Signature

The 2009 IPPS Rule provides a limited grace period for arrangements that comply with a Stark Law exception except that the written agreement is missing a signature. Under this narrow exception, an entity may submit a claim or bill and payment may be made for a DHS if the compensation arrangement fully complied with an ap-

plicable exception but for the fact that a signature was missing. If the missing signature is inadvertent, there is a ninety (90) day cure period; if the missing signature is not inadvertent, there is a thirty (30) day cure period. This provision may be relied upon by an entity only once every three years relating to the same referring physician.

New York's Almost Parallel Statute

As currently drafted, the New York law is not always as permissive as the Stark Law, so a compensation arrangement or an investment or ownership interest that is found to be compliant with the Stark Law may still cause problems in New York State. For example, the 2009 IPPS Rule added the "temporary non-compliance" grace period mentioned above for arrangements that comply with a Stark Law exception but for a missing signature. This grace period cuts across all exceptions that require a written agreement. Thus, an office lease, an employment agreement or a recruitment agreement that, in its substantive terms, complies with a Stark Law exception and is compliant with the New York State statutory scheme is non-compliant under New York law for want of a signature even though it would be considered compliant under the Stark Law if the missing signature is obtained in a timely manner (ninety (90) days for inadvertence; thirty (30) days for non-inadvertence).

The Stark Law regulations contain exceptions for community-wide health information systems, electronic prescribing items and services, and electronic health record items and services.[13] The community-wide health information systems exception allows information technology items and services to be provided by an entity to a physician to allow the physician access to and sharing of electronic health care records and any complementary drug information systems, general health information, medical alerts and related information in order to enhance the community's overall health. The electronic prescribing exception allows an entity to provide hardware, software, information technology and training services, as long as they are used solely to receive and transmit electronic prescription information. The remuneration has to be non-monetary; that is, the actual hardware, software, information technology and training services have to be provided—not funding for the physician to acquire those items or services. The electronic health records exception allows for non-monetary remuneration which is necessary and used predominantly to create, maintain, transmit or receive electronic health records. Each exception contains specific standards which must be met.

Alternatively, the New York State Health regulations contain a limited permission for the provision of computers and related equipment supplies by a clinical laboratory to a health services purveyor (including the provision of computer equipment and supplies by a hospital in order to facilitate the delivery of clinical laboratory services and health services to inpatients and outpatients of the hospital).[14]

Yet another example of a situation where New York State's law does not comport with the Stark Law is establishing a carve-out for charitable donations.[15] The federal exception applies to bona fide charitable donations made by a physician if the following conditions are satisfied: (1) the donee must be exempt from taxation under the Internal Revenue Code, (2) the donation must not be solicited or offered in a way that takes into account the volume or value of referrals or other business generated between the physician and the donee, and (3) the donation arrangement must not violate the federal anti-kickback statute.

The Stark Law also provides a regulatory exception for "fair market value" compensation.[16] This exception allows arrangements between an entity and a physician or groups of physicians for the provision of items or services (other than the rental of office space) by the physician or group of physicians to the entity, or by the entity to the physician or group of physicians if the following conditions are met:

- The arrangement is in writing, signed by the parties and covers only identifiable items or services which are specified in the agreement.
- The writing specifies the time frame for the arrangement, and there can be only one arrangement for the same items or services during the course of a year.
- The compensation must be set in advance, consistent with fair market value, and not be determined in a manner that takes into account the volume or value of referrals or other business generated by the physician who makes the referral, and the writing must specify the compensation.
- The arrangement must not violate the anti-kickback statute or any federal or state law or regulation governing billing or claims submission.
- The services to be performed may not involve the counseling or promotion of a business arrangement or other activity that violates a federal or state law.

There is no similar exception in the New York State law or regulations.

In an effort to address this non-conformity, the "Stark Law" Task Force of the NYSBA Health Law Section has proposed legislation that would bless financial relationships that conform to the Stark Law, both with regard to the definition of financial relationships and their exceptions and with regard to referrals.[17] Conducting a Stark Law analysis of a situation is a daunting task, and counsel may develop a compliant relationship which satisfies the federal standards, only to realize that the arrangement

is non-compliant from a state Stark Law perspective. Because the "evil" (improper self-referral) sought to be addressed by the state and federal policies underlying the legislation is identical, conforming the permissible definitions and exceptions of the state law to the federal law makes eminent sense.

Other Aspects of Stark

In addition to exercising its regulatory authority through the ever-evolving arena of exceptions to the Stark Law, CMS is engaged in enforcing and monitoring the Stark Law from other perspectives as well. On August 15, 2008, CMS published a new "Claim Adjustment Reason Code," providing for denials of Medicare claims based upon non-compliance with the Stark Law. Given the fact-sensitive analysis it takes to establish compliance or non-compliance with the Stark Law (or one of its myriad exceptions), it is unlikely, if not impossible, for CMS or a fiscal intermediary to reject a claim for non-compliance with the Stark Law based solely on the information on the claim form. Accordingly, it is more likely that this Reason Code will be used retrospectively—after a self-disclosure, audit or investigation that identifies arrangements that are non-compliant with Stark, the Reason Code will be used to deny claims that are within the scope of the non-compliance identified in the self-disclosure, audit or investigation.

Disclosure of Financial Relationships Report

Another Stark-related CMS initiative is the impending disclosure of financial relationships report (DFRR). As discussed in the 2009 IPPS Final Rule, CMS is moving forward with its DFRR initiative,[18] the purpose of which is to assess compliance with the Stark Law by requiring surveyed hospitals to provide detailed information about their ownership, investment, and compensation arrangements with physicians. On December 12, 2009, CMS posted the revised DFRR forms and related materials in a revised Paperwork Reduction Act notice. Hospitals, physicians, and other health care providers and suppliers should pay attention to this initiative whether or not they (or their hospitals) are among those facilities being asked to complete the survey. Because CMS will use the results from the DFRR to assess compliance with the Stark law and identify examples and areas of non-compliance, the survey will not be a self-limiting assessment tool.

The DFRR form will be sent to 400 hospitals which are required to respond within 60 days of the date on the cover letter or e-mail transmission. The DFRR grew out of a voluntary survey form sent by CMS in June 2006 to 130 specialty hospitals and 322 general acute care hospitals. The survey was implemented pursuant to Section 5006 of the Deficit Reduction Act of 2005 (DRA), with an initial focus on certain issues relating to physician investment in specialty hospitals. Of the hospitals receiving the voluntary survey, 290 did not respond or provided incomplete responses regarding the financial relationships between the hospitals and physicians.

In developing the DFRR, CMS sought information about the amount of time it would take hospitals to complete the DFRR and the costs associated with completing it, as well as the amount of time that should be given to hospitals to complete and return their responses to CMS. In 2007, CMS had estimated that it would take each hospital about 31 hours to complete the form. This estimate has been increased to 100 hours.[19] The prior version called for completion of the form within 45 days, with $10,000 per day in civil monetary penalties accruing for late submissions. The current rule gives the hospitals 60 days to complete the form, running from the date on the CMS cover letter or e-mail. While CMS notes that it has the authority to impose the $10,000 per day penalties, it has committed that, prior to imposing the penalties, CMS will send a tardy hospital a letter asking why the DFRR was not returned timely. Additionally, CMS is giving hospitals the ability to request an extension for good cause.

CMS has made changes to worksheets 1 and 7 of the DFRR. CMS has also inserted language in attachment 1 to provide that the government will not be estopped from determining that there is a Stark Law violation based upon its review of the financial relationships of entities, whether that review is part of or separate from the DFRR submission. The "Requirement" section of the attachment provides:

> To the extent we do not find a physician self-referral violation based on our review of the DFRR, this should not be taken as an affirmative statement that the financial relationships are in compliance. Further, the government will not be estopped from determining that there is a violation based on further review of information collected either as part of the DFRR or any other source.

CMS has also made global changes to the DFRR referring to the current use of the National Provider Identifier (NPI) rather than to the Unique Physician Identifier Number (UPIN). Despite the passage of time, the DFRR still seeks information for the cost reporting period ending in 2006.

Worksheet 1 asks for basic hospital information. If there are no physicians who had direct or indirect ownership interests, worksheets 7 and 8 must be completed. Otherwise, all worksheets must be completed.

As an example of the breadth of the DFRR, question 4 on worksheet 8 asks whether a physician has made any charitable contributions to the hospital, citing 42 C.F.R. § 511.357(j)—the exception for charitable contributions. If the response is "yes," an explanation must be attached,

including the physicians' names and NPIs. In responding to any question asking about financial relationships, the hospital's response must disclose the financial relationships it has with each immediate family member of the physician as well.[20]

We also note that in the 2007 version of the DFRR, CMS asked for copies of each agreement. CMS has revised worksheet 7 of the DFRR and the related instructions to allow hospitals to submit one copy of a uniform rental or recruitment agreement. CMS notes that this mechanism can be used only if all of the material terms of the agreement are the same. Thus, leases for medical office space with the value of the space and the price per square foot being equal, even if different physicians rent different-size offices, may be considered uniform. However, if the price per square foot varied from tenant to tenant, copies of all agreements should be submitted. CMS notes that if the "uniform" threshold can be met, the hospital would still have to identify each physician who has entered into the uniform agreement. On the issue of what is "uniform," however, the devil may be in the details: what is a "material" term may be subject to interpretation. CMS has provided examples of office lease situations that are obviously "uniform" as well as examples that are obviously not "uniform," leaving it to the providers to guess on close cases.

Given that CMS is moving forward with the DFRR initiative, this is a good time for hospitals to review the ownership, investment and compensation relationships they have with physicians (and their family members). The review should include not only a substantive review of the relationships for compliance with the Stark Law but, because many hospitals maintain this documentation in a de-centralized fashion, developing a centralized inventory of where the information is located is also a wise move.

Penalties

The basic remedies in the Stark Law are clear and unambiguous—an improperly submitted claim is denied; an improperly made payment must be refunded. In addition, there are civil monetary penalties and potential exclusion from federal health care programs. In the event the Department of Justice seeks enforcement of the Stark Law, there could also be exposure under the Civil False Claims Act and the Criminal False Claims Act, among others. Thus, the Stark Law is not to be taken lightly.

Conclusion

While the concept behind the Stark Laws, both federal and state, is laudable—physicians should not engage in over-utilization and unnecessary patient care in order to make money on their investments and referrals—the evolution of the Stark Law exceptions remains an evolving crazy quilt for health care providers and their counsel to decipher.

Endnotes

1. For ease of reading, the term "physician" will refer to "physician (or immediate family member)" except where the context clearly requires otherwise. The regulations expansively define "immediate family member or member of a physician's immediate family" as husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild." 42 C.F.R. § 411.351.
2. New York Public Health Law §§ 238, *et seq*.
3. Codified at 42 U.S.C. § 1395nn.
4. 42 U.S.C. § 1395nn(h)(6); 42 C.F.R. § 411.351.
5. 72 Fed. Reg. 51012.
6. The rule was published in the August 19, 2008 Federal Register at 73 Fed. Reg. 48434.
7. A challenge to the change in the definition of "entity" has been initiated in the Federal District Court for the District of Columbia, *Colorado Heart Institute, LLC et al. v. Levitt*, Civil Action No. 1:08-cv-01626-RMC. The plaintiffs filed a motion for summary judgment on December 18, 2008 arguing that CMS exceeded its authority under the Stark Law and violated the Administrative Procedure Act when expanding the definition of "entity." In the interest of full disclosure, Mintz Levin is counsel to the plaintiffs in the case.
8. 42 U.S.C. § 1395nn(e)(7).
9. See 73 Fed. Reg. 48718.
10. 73 Fed Reg. 48719.
11. The anti-kickback statute prohibits improper payments in return for referring individuals for items for services payable in whole or in part by any Federal health care program. The anti-kickback statute is codified at 42 U.S.C. 1320a-7b.
12. 72 Fed. Reg. 64161.
13. 42 C.F.R. § 411.357(u), (v) and (w).
14. 10 N.Y.C.R.R. 34-2.9.
15. *See* 42 C.F.R. § 411.357(j).
16. 42 C.F.R. § 411.357(l).
17. NYS Stark Law Task Force, Proposed Amendments to the Health Practitioner Referrals Law (the "State Stark Law"), 13 NYSBA Health Law J. 59 (Fall 2008).
18. See 73 Fed. Reg. 48740-48745.
19. 73 Fed. Reg. 48743.
20. See the definition of "immediate family member" at endnote 1.

Margaret D. Kranz, Esq., is Of Counsel at Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C. Ms. Kranz's practice spans the full gamut of regulatory and transactional matters for providers in not-for-profit and proprietary sectors. She served as General Counsel at Cabrini Medical Center from 1994 to 2007, and is a Member-at-Large of the Executive Committee of the Health Law Section of the State Bar Association.

The Perennial Problem Discharge—How It Hurts the Patient, the Provider, the Payer and the Health Care System

By James G. Fouassier

Everyone acknowledges that the ever increasing cost of health care in this country, the aging out of the "baby boomers," the apparent inability of current health care funding mechanisms to support adequate medical and hospital care, and the need to provide a minimally acceptable level of health care for the large portion of the uninsured and underinsured are posing virtually insurmountable problems. One focus of the discussion has been "unnecessary" care and treatment, and whether the root causes may be attributed to inefficiency, greed or both. Payers no longer want to pay for high-intensity medical care and treatment when lower levels are equally if not more medically appropriate given the specific condition and circumstances of a particular patient. From this paradigm has developed a costly and administratively cumbersome system of utilization reviews, clinical guidelines, peer review organizations, internal and external appeal mechanisms and litigation, as different constituents vie for the ever shrinking health care dollar. Health care providers are also faced with the advent of denials of claims based upon the concept of "adverse events," sometimes called "hospital acquired conditions." Providers do not want to render unnecessary care and incur the legal and financial risks that may arise from such behavior in today's closely regulated and monitored environment.

Acute care general hospitals are intended to serve acutely ill patients. People who are not acutely ill should not and, more importantly, *cannot* be maintained in facilities designed to provide acute levels of care. State licensure for such facilities expressly contemplates the medical care and treatment of the acutely ill. Furthermore, hospitals have a legal and moral obligation to keep themselves accessible to the most acutely and severely ill patients, and they cannot do so if they are required to manage patients with chronic long term conditions. This is precisely why the law imposes separate licensure and operational requirements on subacute, rehabilitation, and long term care facilities different from those for acute care hospitals.[1] Chronically ill patients no longer requiring inpatient care should be transferred to facilities which are specifically designed and licensed for long term care and are best able to provide for their extended medical needs. Most acute care hospitals simply are not able to extend optimal long term chronic care.

The parameters of our undertaking are best summed up by the accreditation requirements of the Joint Commission:[2]

> The hospital's processes for transfer or discharge are based on the patient's assessed needs. To facilitate discharge or transfer, the hospital assesses the patient's needs, plans for discharge or transfer, facilitates the discharge or transfer process, and helps to ensure that continuity of care, treatment and services is maintained.

Joint Commission Comprehensive Accreditation Manual for Hospitals, January 2007, at Standard PC.15.

Standard PC.15.20 recites that discharge "is based on the patient's assessed needs and the hospital's capabilities." The discharge process must be driven exclusively by the medical needs of the patient as determined by the health professionals who have assumed his or her care, and not by a variety of social or financial factors which at best are only peripherally relevant.

"[H]ospitals have a legal and moral obligation to keep themselves accessible to the most acutely and severely ill patients, and they cannot do so if they are required to manage patients with chronic long term conditions."

Consequently a hospital cannot effect a discharge that is not safe and medically appropriate given the condition of the patient. Such a discharge would be unethical and possibly negligent, giving rise to liability under common law tort and contract theories. For Medicare providers, improper discharges are expressly prohibited by regulation. Medicare regulation[3] allows a Medicare patient to be transferred only to an "appropriate facility" where the patient can receive post-hospital care; such a facility is expressly defined as one which can meet the patient's medical needs.[4]

Barriers to Proper and Timely Discharges

This article will not delve into issues related to lost revenue. While it is tempting to critics to attribute all discharge planning to a hospital's financial motives, as if the need to remain solvent were some kind of evil, for our present purposes I limit our discussion to discharge

decisions that are dictated solely by the needs of the patient. I note the obvious, however, in stating that when we consider the needs of the patient, his or her finances almost always will be a factor. When medical care is unreimbursed by an insurer or other third party payer, the cost of the care becomes the patient's personal financial responsibility. Unreimbursed acute hospital care costs may well exceed hundreds or thousands of dollars a day. Such an expense rapidly builds up, and will have to be satisfied from the assets of the patient if there is no insurance coverage or if benefit programs such as Medicare or Medicaid do not pay all of the costs of the admission or service. Absent denials issued concurrently by a payer engaged in utilization management, it is not possible to determine with any degree of accuracy how much of an inpatient bill will be paid by third parties, since hospital bills are not generated and submitted until discharge, but in the situation I have described it is likely that the patient's responsibility will be substantial. When the patient is unable or unwilling to pay such costs, the financial loss is borne by the provider.[5]

Institutional or Systemic Barriers

One significant barrier to timely discharge is the unavailability of medically appropriate subacute, rehabilitative or long term chronic/custodial facilities or services. This usually is because no appropriate bed (or even facility) is available. A ventilator dependent dialysis patient in need of chronic long term care may be difficult to place because of the limited number of facilities offering dialysis for vent patients. Add to the mix a mobility issue such as paralysis or morbid obesity and placement becomes even more problematic. As the economy continues to deteriorate and health care costs (especially for such high intensity care) continue to escalate, this institutional barrier will present more and more often. Short of engaging in projects to expand facilities to accommodate subacute specialty beds, new acquisitions or strategic alliances with subacute, rehabilitation or long term care facilities may be the only viable options if the uncompensated costs of continued acute hospital care become excessive.

Another routine obstacle, much more common and becoming a greater problem as the economy worsens, is the lack of a means of payment, or inadequate insurance or health plan coverage, for the required care. An acute care hospital is compelled by EMTALA[6] to accept an acutely ill patient presenting through the emergency department. There is no similar obligation imposed by law on a subacute, rehabilitation or chronic long term care facility such as a skilled nursing facility. If the patient (or his family) cannot pay or cannot guarantee personal financial responsibility for services not covered or paid "short"[7] by a health plan, the patient is not accepted. This issue is relevant not only in the context of institutional placement. Many patients, when stable, optimally might be accommodated at home with adequate support tailored to the patient's needs, but vendors will not commit to providing necessary home health aides and nurses, durable medical equipment or pharmaceuticals without payment. A hospital will not discharge a patient to his or her home without such support in place because the discharge would be medically inappropriate and possibly unsafe, and the deficiencies well may result in a rapid readmission. Hence home placement also is frustrated for lack of funds.

Sometimes discharge planning is complicated by the absence of a legal representative for an incompetent or incapacitated patient unable to facilitate his or her own discharge by approving admissions and by filing applications for insurance and health plan benefits, Medicare or Medicaid, and who might access and collate the documentation necessary to support such applications. Most subacute, rehabilitation and long term care facilities insist that the person purporting to sign admission papers and obligate payment be someone with appropriate legal authority to act.[8] Rare is the patient (especially a younger one now suddenly suffering the effects of a catastrophic illness or severe trauma) who had the foresight to execute a durable power of attorney, a health care proxy or another advance directive allowing an agent to act as decision maker on his or her behalf. In these cases the only viable option is for a family member or the hospital to commence proceedings for the appointment of a guardian.[9] This work must be done by an attorney and is expensive. Where family members are unwilling or just as often unable to pay for the legal services, the hospital may be the only party that has sufficient interest and the wherewithal to incur the expense. Guardianship proceedings are also time consuming. Staff members must assist counsel in the preparation of necessary affidavits and documents and appear in court as witnesses. Court calendars are congested and, barring a true emergency, hearing dates will be scheduled next in the order of filing. If there is resistance by the family or even by the patient, the proceedings may be more protracted. In this writer's experience, it is not unusual for a routine proceeding, from the filing of initial papers to the issuance of an order appointing a guardian, to the guardian accepting and qualifying, to average three months or more.

One of the more difficult institutional issues is presented by the regulations governing approval of Medicaid eligibility for follow-up care. Medicare or some unusually generous commercial insurance or health plan will cover some subacute and chronic care only for relatively short courses of treatment. Most chronic care providers, knowing this, will decline to accept a patient without either a commitment to pay privately or approved Medicaid eligibility, for fear of being "stuck" with the patient after any short term coverage is exhausted. Unlike Medicare, which is a government entitlement program, Medicaid eligibility is a function of financial need. Since younger patients and/or those with financial means generally

are not eligible, the issue of obtaining Medicaid to cover long term chronic care usually does not even arise until the illness or injury occurs, the patient already is in the hospital bed, and the need for a funding source for an appropriate plan of long term care presents itself. Consequently, all of the work and all of the time consumed in the complex environment of Medicaid application and eligibility (including the appeal of initial denials of eligibility via "fair hearings" and even possible lawsuits) is borne at the expense and exposure of the hospital.

Social Barriers

Occasionally a reluctant physician or other medical professional frustrates a discharge; usually the impetus is a personal or long-standing professional relationship with the patient or family member which influences decision making. There may be an honest but unfounded difference of opinion with other members of the medical team (as, for example, a medical clearance inhibited by a last minute "psychiatric consult" gratuitously rendered to be sure a patient is "competent" to approve his own discharge). When these issues do present themselves they generally can be addressed peer to peer and may be relegated to the realm of "discipline." This problem is not insurmountable as long as the hospital's administration demands appropriate consultation and consensus among all members of the patient's medical care team.

A greater social barrier to a timely discharge is a lack of cooperation by the patient or family in the discharge process or the outright refusal of the patient to consent to the discharge. There are many reasons. Subjective dissatisfaction with the recommended facility or nursing home is one. The refusal, unwillingness or inability to marshal assets and commit financial resources is another. Notwithstanding acceptance by an appropriate rehabilitation or chronic care facility, sometimes the patient or family refuses to consent to discharge or to sign admission papers. This last tactic frustrates the subacute or chronic care facility's ability to bill for its services and be paid for the care it renders and, quite understandably, is often fatal to any acceptance. (Objecting family members sometimes make known their complaints to the facility considering accepting the patient, a strategy that often results in a declination.) Patient and family concerns also may be expressed in terms of distance, cleanliness, reputation, or a myriad of other factors not directly relevant to the medical propriety of the facility; sometimes the issues are advanced precisely to impede discharge from the hospital. Often the patient or family is unwilling to accept the medical diagnoses, prognoses and recommendations of the hospital staff for necessary subacute, rehabilitative, custodial and other long term care and discharge planning because the patient or family believes that their loved one will receive the "best" care by remaining in the hospital. This is especially so when the issue is palliative care for terminally ill patients. Transfer to hospice is an acknowledgment of pending death, a bitter reality understandably difficult for some to accept.

Sometimes a patient can return home with varying degrees of support. Here again, family cooperation is essential. Only the most expensive health plan or insurance policy will pay for as much home care as would be optimal; usually the family has to assist in some manner during certain periods of the day or night. Consequently, a lack of participation or the unwillingness or inability to supplement the cost of the home care services can preclude this alternative even if otherwise medically appropriate. (Ironically, a hospital sometimes finds itself opposing a family's request for a home discharge because the family refuses to acknowledge that it is unable to provide an appropriate level of care and unrealistic in considering the extent of resources that must be devoted to the patient. Families frequently advance the offer to take the patient home in an effort to preserve the patient's assets notwithstanding that the suggestion clearly is not in the patient's best interests.)

The cooperation of the patient and family also is essential to marshalling patient assets and securing coverage from third parties, especially Medicaid, so there are funds from which to pay for additional rehabilitative or chronic care. The refusal of a patient or family members to disclose and expose assets which must be made available to satisfy Medicaid eligibility requirements denies the availability of the most common source of funding for any subacute or chronic care. Once again, since facilities rendering such care are not mandated by law to accept an indigent patient or bear the burden of extensive uncompensated care, placement is unlikely and the patient remains in the hospital's acute care bed. Presumably, if a guardian is appointed he or she will be empowered to take control of a patient's assets to effect Medicaid planning, to make all applications for Medicaid and other government benefits and to approve both the hospital discharge and the follow-up admissions, committing the private financial resources of the patient, if any, including any private insurance, with Medicaid later assuming liability once the asset thresholds are met.

Unfortunately these processes are complex and time consuming, more so when the patient or family opposes the activities of the hospital and even goes so far as to secure legal counsel to assert that opposition.

Exposure for the Patient

Patients who unnecessarily remain at acute care hospitals are at risk to develop decubitii (commonly known as "bed sores"), assorted antibiotic resistant conditions such as MRSA and VRE[10] and other "hospital acquired conditions."[11] A patient's strength deteriorates as physical and occupational therapy needs cannot fully be addressed over the long term. Hospital care and services made necessary as a result of "hospital acquired conditions"

may not be compensated even when there is a third party source of payment (e.g., Medicare's comprehensive new plan to deny payments for certain "adverse events," an idea now being picked up by Medicaid and commercial health plans).

Furthermore, a not insignificant concern today is that when a patient is uninsured or underinsured, the patient and/or family may be required to address significant acute care hospital costs that are substantially greater than charges incurred at facilities providing care at lower acuity levels. Insurers are quick to deny continued stay and inpatient courses of treatment as "not medically necessary," thus cutting off hospital payment even when a source of reimbursement otherwise exists. Hospitals take seriously their responsibility to advocate for patients requiring continued acute care in the face of aggressive denial strategies by insurers, but when continued inpatient care is not required, a hospital will not assert the contrary in bad faith. Consequently, when uncompensated days are incurred because of a lack of cooperation in the discharge process it is neither unfair nor unlawful (given proper notice and appeal rights) that the patient be held financially accountable.

Exposure for the Payer

It is beyond cavil that insurers and other institutional payers do not want to pay for acute care services when non-acute services are more medically appropriate. Payers also will not pay for services which, although medically necessary, may not have been required had earlier placement of a patient into a more appropriate level of care avoided the condition for which services now are required, regardless of whether they were "avoidable," i.e., caused by some culpable provider conduct. In light of the impending financial crisis caused by increasing healthcare costs and overstretched dollars and resources, one would imagine that this impetus alone would have generated more interest among the payer community in facilitating problem discharges. Unfortunately, other than simply denying continued care as unnecessary, most plans and payers do little to work with hospitals to address this growing problem.[12]

Exposure for the Hospital

A hospital incurs significant costs for unreimbursed care. Legal remedies against patients for large balances generally are illusory given the patients' financial limitations and inability to pay. The patients themselves, as well as family members purporting to act for the patients, often are particularly aware that their financial circumstances have rendered them "judgment proof" and that threats of financial liability asserted to secure cooperation in discharge planning are meaningless.

Equally important is the impact of a problem discharge on other patients; those who are acutely ill and present either through the hospital's emergency department or by transfer from other facilities unable to perform the necessary acute care services required for the immediate health, safety and well-being of the patient. Simply put, the treatment of acutely ill patients is compromised, and relevant federal and state regulations adversely implicated, when acute care beds are occupied by non-acute patients. The problem discharge patient still has to be fed, cleaned and administered whatever regimen of medication and therapies may be required, with some additional time devoted to rendering necessary chronic care services like physical therapy. In the meanwhile nursing staff are distracted from the care of acutely ill patients, some of whom are "doubled up" or even left in the hallways in the vicinity of the emergency department.

"Hospital acquired conditions"[13] may result in legal liability against a hospital. The nature and extent of the regulatory, licensing, quality of care, and other medical and legal criteria implicated by such an unfortunate series of events are beyond the scope of this article, but the reader will discern that the issues are of real consequence. In the meantime, data reflecting "hospital acquired conditions" and excessive lengths of stay are being collated by a variety of insurers and payers such as Medicare, as well as by federal and state health authorities, and may adversely impact overall reimbursement, quality of care obligations, eligibility for grants and participation in other government funding programs, and in the public perception of a hospital as inefficient and even dangerous.

More hospitals are striving to meet developing goals for greater transparency of patient satisfaction data. Use of survey methodologies and data development such as the Press-Ganey HCAHPS initiative, and the use of such patient satisfaction data by CMS in determining levels of Medicare reimbursement, add yet another element to the paradigm.[14] One cannot contemplate patient satisfaction being more adversely affected than by a 14-hour delay in admission from the emergency department or an admission to a hospital hallway or alcove with only screens for privacy.

The billing of services in this context also raises the specter of fraud and abuse. The reader's attention is directed to the recent case of *U.S. ex rel Raymer v. University of Chicago Hospitals*,[15] in which overcrowding and overcensus issues, *inter alia,* were raised as the bases of claims of fraudulent and abusive billing practices. There may be false claims consequences not only for billing for acute care services and treatment rendered to non-acutely ill patients but, more importantly, for billing for acute care services rendered to acutely ill patients in substandard, quality-inhibited circumstances (i.e., knowingly and intentionally billing for services rendered in contravention of licensing requirements). The gravamen of the issue from the perspective of the regulators is that the provider is billing and the government is paying for what purport-

edly are acute care services but the beneficiaries are not receiving an acceptable level of services.

Would our federal and state regulators excuse a hospital's ability to render optimal treatment to the greatest number of acutely ill patients who would present in the event of an influenza pandemic or another terrorist attack because the hospital has been unable to discharge patients who just did not want to leave?

Remedies

I previously addressed proceedings in the nature of guardianship. Here in New York State, guardianship proceedings for "incapacitated" adults are maintained pursuant to the provisions of Mental Hygiene Law Article 81. Jurisdiction over similar proceedings for minors is in the New York Family Court under Family Court Act § 661 and in the New York Surrogate's Court under Surrogate Court Procedure Act article 17.

Hospitals, both individually and through their trade associations, might consider advocating for the adoption of laws such as the New York Family Health Care Decision Act,[16] which has been introduced in the state legislature every year since 1992 but has yet to pass. The Act would apply when a once competent adult has failed to designate a health care proxy or give other "clear and convincing" evidence of intentions (such as a "living will"). The procedure is much faster and more economical than the existing guardianship system. As proposed, it is the hospital which would be able to designate a "surrogate" decision maker from a list of persons established by the law, with the surrogate then making medical decisions. No court intervention would be required either to invoke the act or to empower the surrogate decision maker. While the proposal requires the surrogate to take into account the wishes of both the patient and the family, the surrogate will be expected to act independently in the best medical interests of the patient, regardless of patient or family opposition.

Another idea gaining some support is to improve the efficiency of the guardianship process by establishing "transfer authorization panels." The idea, developed by Robert Swidler, General Counsel to Northeast Health in Albany and the Editor-in-Chief of this publication, is to effect a medically appropriate transfer or discharge decision prior to the institution of the guardianship proceeding. A three-person panel at every hospital (consisting of a health care professional, a local DSS representative and a layperson from the community) would serve as a standing committee empowered to approve a transfer or discharge after reviewing the medical records, consulting with treating physicians and meeting with the patient to discuss discharge or transfer proposals. Some determination of a lack of capacity would be a condition precedent to approval of the plan. To induce subacute, rehabilitation and skilled nursing facilities also to accept the plan, the hospital could agree to institute a guardianship proceeding after the transfer or discharge.[17]

Every hospital administration should adopt a uniform patient discharge and placement policy making clear that while the hospital always will act in patient's best medical interests in recommending necessary medical care and appropriate discharge, the hospital must manage the process and not allow a patient or family member to frustrate necessary subacute, rehabilitation or custodial care by subjective or improper behavior that is not in the patient's best interests, and which exposes the patient to adverse medical consequences and the hospital to legal liability and economic loss. This requires a commitment that oppositional conduct by patients and their families, no matter how sincere or well motivated, will not be allowed to divert attention from the appropriate medical needs of the patient as determined by the hospital's medical staff. In New York State this is not inconsistent with existing law and regulation. New York Department of Health regulations make clear that discharge planning should be a collaborative effort between the hospital, the patient and the family. Family participation is excused, however:

> (ii) when the hospital has made a reasonable effort to contact a patient's family / representative in order to provide an opportunity to participate in the discharge planning process or to explain the reason for transfer or discharge, and the hospital is unable to locate a responsible family member/representative, or, if located, such individual refuses to participate. The reasons a patient's family/representative did not participate in the discharge planning process or did not receive an explanation of the reason for a patient's transfer or discharge shall be noted in the patient's medical record. A reasonable effort shall include, but not be limited to, attempts to contact a patient's family/ representative by telephone, telegram and/or mail.

10 N.Y.C.R.R. 405.9(f)(6)(ii).

The mandate to discharge patients no longer acutely ill is clear and unequivocal:

> **Patients discharged from the hospital by their attending practitioner shall not be permitted to remain in the hospital** without the consent of the chief executive officer of the hospital except in accordance with provisions of subdivision (g) of this section [governing appropriate appeal rights for Medicare and non-Medicare patients]

10 N.Y.C.R.R. 405.9(f)(7)(ii) (emphasis added).

The hospital's policy also should include provisions for legal action to compel a patient's discharge when all else has failed.

In a typical situation the patient and family have been advised that the patient no longer is acutely ill and requires an alternate level of care. The patient (or family) either refuses to acknowledge the validity of the determination or else agrees with the staff but proceeds to frustrate the discharge by any means possible. If the hospital determines that the patient has financial assets the threat of a self-pay bill (if legally permissible) often will elicit some level of cooperation. On the other hand if the patient is "judgment proof" a suit for money damages is a waste of time. If there is some valid basis to maintain a guardianship then the good faith assertion that the hospital will so act may encourage a family to cooperate with the discharge plan. Keep in mind, however, that in most jurisdictions some objective indicia of "incapacity" are required. A patient in full command of his mental faculties is not "incapacitated" as that term is defined in the statute. In New York such case law as exists on point is clear on this.[18]

Two additional avenues of legal redress present themselves. The first is a summary proceeding for eviction which, in New York, is governed by section 713(7) of the New York Real Property Actions and Proceedings Law. This is the standard "landlord-tenant" proceeding. The second is a plenary action for trespass, with an application for preliminary injunctive relief, enjoining the patient from further refusal to accept an appropriate placement.

Under the common law as applicable in most states the patient is at best a licensee of the hospital, with no possessory interest.[19] When the license terminates or is revoked and her or she refuses to remove from the premises, such person is deemed to be a trespasser and is subject to eviction by self-help, without any recourse to the courts.[20] A hospital obviously should not employ such a heavy-handed procedure: besides being poor policy, most states and many participating facility agreements establish some degree of "due process" for patient discharges generally, and Medicare patients also are entitled to separate notice and appeal procedures commonly known as HINN;[21] all of this effectively precludes self-help. Eviction should contemplate the technical revocation of the patient's "license" on adequate notice to the patient and the family, along with appropriate appeal information. The hospital then may institute a summary proceeding for possession in the local equivalent of a "landlord-tenant" court.[22] The hospital may seek the appointment of a guardian *ad litem* to represent the patient during the pendency of the proceeding if there is any indication that the adult patient is "incapable of adequately prosecuting or defending his rights" (New York Civil Practice Law and Rules 1201). If the patient retains his or her own counsel, it is questionable whether the court will discern the need for a GAL, but strategically it may be preferable to deal with someone other than the patient directly.

The summary proceeding will result in a quick hearing.[23] Unfortunately, in most states the jurisdiction of a local landlord-tenant court to fashion an appropriate remedy is limited. [24] Landlord-tenant courts are not designed to accommodate the unique needs of persons with significant medical issues. All those courts usually can do is grant possession of premises and ancillary relief in the form of money damages; they cannot compel the patient to accept any kind of placement. Thereupon the patient may continue to refuse to cooperate. The hospital's only remedy then would be to secure an order of eviction and seek the assistance of the Sheriff, who literally will put the patient out at the curb. Only in the clearest case where there is no foreseeable need for assisted care is this acceptable. Alternatively, the hospital may have made arrangements for an ambulette to take the patient home or to a subacute facility or SNF which previously extended acceptance, or anywhere else the patient wanted to go. What if the patient flatly refuses to leave? Does the hospital staff strap him onto a gurney and roll him out the door? In addition, the admitting facility almost certainly will require an affirmative acknowledgment of consent to an admission, if for no other reason than to secure a guarantee of payment or authorize the facility to bill a third party payer. What if the patient refuses to sign the admission papers and the facility declines to accept him? Since the hospital cannot facilitate an unsafe discharge it has secured a pyrrhic victory at best.

The other alternative is a plenary action for trespass, with a request for a preliminary injunction prohibiting the patient from refusing the next viable placement, and the possible assistance of a guardian *ad litem*. This sounds complicated but, upon contemplation, may be the preferable way to proceed. In New York the failure of the patient to vacate upon revocation of the "license" is a *de facto* trespass,[25] and is actionable as such. The public policy implications of a refusal to vacate a much-needed acute care bed, together with the "continuing nature" of the trespass and the insufficiency of any remedy based on money damages should satisfy the equitable requirements for injunctive relief notwithstanding that the trespass remedy is legal in nature. This procedure, in the specific context of hospital discharges, initially was adopted in New Jersey[26] and in the federal courts in Washington, D.C.[27] More recently a New York court also adopted the "trespass and injunction" procedure (*Wyckoff Heights Medical Center v. Rodriguez*, 191 Misc. 2d 207, 741 N.Y.S.2d 400 (Sup. Ct., Kings Co. 2002)). The *Syracuse Law Review* cited the *Wyckoff Heights* case in its nationally recognized "Survey of New York Law" as follows:

> Finally, of particular importance to acute care hospitals, a New York court autho-

> rized hospitals to discharge patients who refused to leave. This decision is significant for acute care hospitals because it marks the first time that a New York court has recognized the authority, and even the duty, of a hospital to compel patients who no longer need its services to leave, so that it can keep its services available to the acutely ill.
>
> 53 Syracuse L Rev 629 (2003).

The *Wyckoff Heights* procedure has since been followed in Connecticut.[28] One important *caveat*: The New York court made much of the fact that the proper discharge and appeal notice requirements set out in regulations[29] were "meticulously followed." Strict compliance with every notice and due process requirement is essential. All acute care general hospitals should be familiar with the Medicare HINN procedures and the NODMAR[30] or equivalent notice and appeals processes applicable in their jurisdictions or which may apply pursuant to their contracts with particular plans and payers. (Remember that just because the plan cuts off payment does not mean that other contract provisions respecting member notices and appeals no longer apply.)

In the context of eviction or injunction a guardian *ad litem* may be of particular assistance in reaping the practical benefits of any court order. It is not beyond possibility that the patient will refuse the mandate of the court to accept the next available placement, even if threatened with a contempt citation. The court will not compel a medically unsafe discharge. In the exercise of its equitable and general jurisdiction, however, a court could invest the GAL with the authority to consent to any discharge planning and admission as otherwise would be appropriate, upon the court's direction. Most courts of general jurisdiction are empowered to appoint a referee or receiver to act on behalf of a party who is unable or unwilling to comply with its orders.[31]

An Interesting Footnote and a Dose of Reality

On Sunday, August 3, 2008, in a front-page story entitled "Deported, by US Hospitals," the *New York Times* reported on several noteworthy cases in which hospitals faced with the crushing costs of unreimbursed hospital care effected the discharge of seriously disabled patients to their home countries. The subjects of the lead, Luis Alberto Jiminez and Martin Memorial Medical Center, are parties to litigation which, when finally resolved, may bear upon the issues raised in this article. The intermediate appellate decision of the Court of Appeal of Florida, Fourth District, is entitled, *Montejo Gaspar Montejo, as Guardian of the Person of Luis Alberto Jiminez v. Martin Memorial Medical Center, Inc.*, 935 So.2d 1266, 2006 Fla. App LEXIS 14039 (8-23-08). The underlying facts are as follows.

In February 2000, Luis Alberto Jimenez, an undocumented native of Guatemala who was living and working in Florida, sustained brain damage and severe physical injuries as a consequence of a car crash. Jimenez was transported to Martin Memorial Medical Center and remained there until June 2000, when he was transferred to a skilled nursing facility. The injuries suffered by Jimenez rendered him incompetent and a circuit court judge appointed a guardian of Jimenez's person and property. On January 26, 2001, Jimenez was readmitted to Martin Memorial on an emergency basis and, as of November 2001, was still incapacitated and still receiving medical care at Martin Memorial. The guardian then filed a plan indicating Jimenez would require 24-hour care at a hospital or skilled care facility for the next 12 months. The costs of Jimenez's medical care were mounting; he was indigent and Medicaid refused to pay because he was an undocumented alien.

The hospital convened a discharge planning committee for Jimenez, and it determined that the next level of care he needed was traumatic brain injury rehabilitation. Qualified facilities in Florida would not accept Jimenez because he was indigent and did not qualify for Medicaid. The treating physicians had determined that Jimenez had reached a "therapeutic plateau," that remaining at the hospital would not improve his condition, and that the hospital, as an acute care facility, could not provide for his long-term therapy needs. Consequently the hospital intervened in the guardianship proceedings, claiming that its acute care facility was not appropriate for long-term rehabilitative care, and sought permission from the guardianship court to discharge the patient and have him transported to Guatemala for further care.

The hearing court found that federal law required the hospital to demonstrate that the discharge plan was medically appropriate.[32] In attempting to meet this burden, and over the hearsay objections of the guardian, the hospital offered a letter from the Vice Minister of Public Health in Guatemala which stated: "[T]he system of the Rehabilitation and Orthopedic Hospital 'Dr. Edwin Harold von Ahn,' is ready to give the necessary care to Mister Luis Alberto Jimenez, 28 years of age and originally from the City of Antigua Guatemala, Sacatepequez [sic] and will do so as soon as he arrives to this country. We will evaluate and transfer him to the most appropriate facility for the treatment of his condition. The medical treatment to be available will be without any cost to Mister Jimenez."

Following a hearing the guardianship court granted the hospital's request to effect the discharge over the guardian's objections and authorized the hospital to provide transportation and an attendant at the hospital's cost. Subsequently, and on the same day that his motion for a rehearing was denied, the guardian filed a notice of appeal as well as an application to stay the guardianship

court's order. The hospital's response was due by 10:00 a.m. the following day but sometime before 7:00 a.m. the hospital took the patient to the airport via ambulance and transported him by private plane to Guatemala.

In an opinion issued on May 5, 2004, the appellate court reversed the order of the guardianship court that had authorized the hospital to transport Jimenez to Guatemala. In the opinion's final paragraph, the panel wrote that it was reversing not only because there was insufficient evidence that Jimenez could receive adequate care in Guatemala, but also that because of the collateral involvement of federal immigration authorities, the guardianship court lacked subject matter jurisdiction to authorize the transportation of the patient.[33]

Arguing that the effect of such a ruling was to render the transfer order void *ab initio*, the legal guardian then instituted suit for false imprisonment and unlawful detention. The trial court dismissed the action, finding that the guardian had no standing, the hospital had absolute immunity by virtue of the prior court order allowing it to act, and that because of that prior order, the plaintiff as a matter of law could not establish at trial that the detention was unlawful. The appellate court again reversed, finding that the underlying order was void as a matter of law.[34] Such a void order (as opposed to one merely voidable) could not confer immunity, especially when the subject of the order was a private right or benefit rather than a public one. At trial, it held, the plaintiff could show that the detention and subsequent actions by the hospital were unwarranted and unreasonable under the circumstances. In particular, and most relevant for our purposes, the appeals court made much of the fact that it earlier had vacated the initial order allowing the hospital to act because the proposed discharge might have been unsafe, citing its earlier decision in the same case.

The hospital also had argued that the appeal was moot because the patient was gone and federal immigration law precluded his readmission. The court turned that argument back against the hospital, however, by using it to bolster its finding that the guardianship court had no subject matter jurisdiction to authorize the hospital to transport the patient to Guatemala in the first place because federal immigration law preempts deportation.[35] In addition, the mootness argument obviously is only possible because the hospital itself effected the departure before the court could rule on the pending motion for stay.

As to the merits, the guardian had argued that there was no substantial competent evidence to support the discharge from the hospital. At the evidentiary hearing the hospital attempted to satisfy the federal discharge requirements, as well as the hospital's own discharge requirements, by offering into evidence the letter from the consulate. The guardian objected to this letter as hearsay, but the trial court admitted it. The letter constituted the only basis upon which the guardianship court issued its decision. The letter was not admissible in evidence under any exception to the hearsay rule, the court found, and the hospital in its brief had not responded to the argument that it was precluded. Even if the letter had been admissible, the court held that it lacked the relevant degree of specificity necessary to satisfy either the federal regulations or the hospital's own discharge procedures. In fact, the court found that the only admissible evidence as to whether appropriate care would be available in Guatemala was the testimony of the guardian's expert, to the effect that that there were no public healthcare facilities providing traumatic brain injury rehabilitation in Guatemala.

"At the end of the day the hard decision as to whether to 'evict' a patient (yes; evict *is the way it will read in the newspaper and* evict *is the word that will be used on the 10:00 p.m. news) will require a careful analysis of all of the financial, legal and ethical questions presented by the particular patient in a specific clinical context."*

Not reported in the decisions but buried in the news article is the fact that the hospital had arranged for Jimenez's transfer not just to his home town but specifically to a local hospital that would have been able to care for his needs. It was that local hospital, not Martin Memorial, that later effected the arguably improper discharge to his home.

The action continues as of the date of this writing. The guardian is seeking millions of dollars in damages.

Conclusion

At the end of the day the hard decision as to whether to "evict" a patient (yes; *evict* is the way it will read in the newspaper and *evict* is the word that will be used on the 10:00 p.m. news) will require a careful analysis of all of the financial, legal and ethical questions presented by the particular patient in a specific clinical context.[36] It should not even be considered unless the provider has in place a comprehensive, properly adopted policy addressing the several most likely circumstances under which such a decision might become necessary, and unless the provider is certain that all of the patient's due process has been meticulously observed, especially whatever prior notice and appeal rights are established by law, regulation and the provider's own procedures.

Endnotes

1. *See, e.g.*, NY Pub. Health L Articles 28 (hospitals); 28-D (nursing homes); 35 (radiological diagnostic centers); 46-B (assisted living facilities); *also, generally*, Article 2 Title 2 (Public Health Council).
2. The Joint Commission, formerly the Joint Commission for the Accreditation of Healthcare Organizations, is an independent, not-for-profit organization. The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting certain performance standards. Its stated mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. www.jointcommission.org.
3. 42 C.F.R. § 482.43(d).
4. 42 C.F.R. § 482.21(b)(2).
5. In the wake of federal class actions challenging the tax-exempt status of not-for-profit hospitals, a number of states adopted legislation mandating financial assistance or charity care for "indigent" patients. In New York, eligibility is based on a percentage of the federal income poverty level. NY Pub Health Law § 2807-k(9-a); *see also* Letter of Richard F. Daines, MD, Commissioner, to hospital chief executive officers dated June 22, 2007.
6. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd; *see also* 42 C.F.R. § 489.24.
7. A "short" payment implies a payment less than what a provider will accept. The concept is relevant when a provider is not being paid a fixed negotiated rate as a part of a provider network but instead is "out of network" for the patient's insurer or, alternatively, when the patient is uninsured.
8. Contrary to popular opinion, absent a valid power of attorney or health care proxy a "spouse" or adult child is not legally empowered to make financial or health care decisions for an incapacitated or incompetent adult. In New York, for powers of attorney established by statute see General Obligations Law §§ 5-1501 through 5-1506; for health care proxies and agents see Pub Health Law §§ 2980 through 2994.
9. New York Mental Hygiene Law Article 81. The burden of proof which must be met by a party seeking the appointment of a guardian is high. In New York, under Article 81 an appointment requires proof by the standard of "clear and convincing evidence" that the patient is likely to suffer harm because he or she is unable to provide for his or her own personal needs or manage his or her property *and* that the patient cannot adequately understand and appreciate the nature and consequences of his functional limitations and inabilities. Where a patient is *unable* to cooperate with discharge planning due to some physical or mental limitation, a showing of need usually is straightforward (regardless of what the family says or does); a patient *able but unwilling* presents an entirely different situation. See the discussion in the main article, *infra*. A stubborn or recalcitrant patient with a "difficult personality" still may be capable of understanding the risks inherent in remaining in an acute care hospital bed, or the financial or social problems he perpetuates, but if he also is capable of making his own personal and financial decisions, a court will not appoint a guardian for him. *See, e.g.*, *Matter of Louis Koch* (Sup. Ct., Queens Co. 11-16-99, 16743/99): "The Court recognizes and appreciates [the hospital's] dilemma. It is beyond question that Mr. Koch is a difficult and uncooperative individual. He continues to be a patient at [the hospital] despite the fact that he has not been in need of acute care [for five months]. Nevertheless, [the guardianship provision of] the Mental Hygiene Law is not the appropriate vehicle to redress the predicament in which [the hospital] finds itself."
10. *Methicillin-resistant Staphylococcus aureus*, or MRSA, must be treated with other strong antibiotics. Some strains of *Enterococci* are resistant to Vancomycin are called *Vancomycin-resistant Enterococci*, or VRE, and also are very difficult to treat.
11. On July 31, 2008, the Centers for Medicare & Medicaid Services (CMS) announced new Medicare and Medicaid payment and coverage policies to improve safety for hospitalized patients. The Inpatient Prospective Payment System (IPPS) FY 2009 final rule expands the list of selected hospital-acquired conditions (HACs) that will have Medicare payment implications that began on October 1, 2008. In addition, CMS has announced the initiation of three Medicare National Coverage Determinations (NCD) proceedings for "wrong surgery," a category of "never events" included in the National Quality Forum's (NQF's) list of Serious Reportable Adverse Events. Further, the Agency has issued a State Medicaid Director (SMD) letter outlining the authority of State Medicaid Agencies to deny payment for selected hospital-acquired conditions. *See* http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3224&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.
12. Securing the cooperation of participating plans in the discharge process is an issue rarely considered, let alone the subject of discussion. Most plans and payers have little interest in utilization review and case management if a hospital's reimbursement methodology is case based as opposed to charge based. Overlooked is the obvious: case based rates such as "DRGs" are intended to pay providers for acute services, not custodial care. At the same time, the participating provider agreement prohibits balance billing the member if the payer pays the required rate. Hospitals are advised to consider contract provisions that engage their plans and payers in the discharge process, such as by requiring the plan to advise the member that any reimbursement to the hospital is not intended to pay for any days not medically necessary. An additional remedy, if allowed by law, would be an express reservation of right to balance bill the member for unnecessary days as "non-covered,"notwithstanding that the days would have been encompassed by the case based rate if otherwise medically necessary if, upon written notification by the facility to the member, he or she still remains inpatient. (This would be akin to the situation allowed by Medicare when a HINN notice is sustained.) The remedy would not apply, of course, when a discharge or transfer may not be effected in a safe and medically appropriate manner through no fault of the patient.
13. *See* note 11, *supra*.
14. As to Press-Ganey, *see* http://www.pressganey.com/cs/our_services/hcahps_integrated. As to Medicare reimbursement and patient satisfaction, *see* http://www.cms.hhs.gov/hospitalqualityinits/30_hospitalhcahps.asp.
15. 2006 U.S. Dist. LEXIS 7943 (2-28-06).
16. For the text of the most recent proposal see Assembly Bill No. 5406-A (2005).
17. Readers may learn more about Mr. Swidler's particular proposal by contacting him at swidlerr@nehealth.com.
18. *See*, *e.g.*, *Matter of Louis Koch (Mt Sinai), supra* at note 9.
19. New York Real Property Actions and Proceedings Law § 713:

> Grounds where no landlord-tenant relationship exists. A special proceeding may be maintained under this article after a ten-day notice to quit has been served upon the respondent in the manner prescribed in section 735, upon the following grounds: * * * * * 7. He is a licensee of the person entitled to possession of the property at the time of the license, and (a) his license has expired, or (b) his license has been revoked by the licensor, or (c) the licensor is

> no longer entitled to possession of the property; provided, however, that a mortgagee or vendee in possession shall not be deemed to be a licensee within the meaning of this subdivision.

20. *See*, *e.g.*, *Wales v. Giuliani*, 916 F. Supp. 214, 1996 U.S. Dist. LEXIS 1433 (E.D.N.Y.), citing *Livingston v. Tanner*, 14 N.Y. 64 (1856):

> Nor could the owner, before entry, maintain an action of trespass against [a tenant at sufferance] (4 Kent, 117; 2 Black. Com., 150; Cruise's Dig., tit. 9, ch. 2.). But the owner could enter upon the tenant at sufferance and dispossess him by force, and reap the crops, and thus determine the tenancy, and the tenant could have no remedy by action. (Wilde v. Cantillon, 1 Johns. Ca., 128; Hyatt v. Wood, 4 Johns. R., 150; 2 Black. Com., 150.) This was upon the general principle that where one had no interest or property in the soil, and no exclusive possession, trespass quare clausum fregit could not be maintained. There can be no doubt whatever that, before our statutes on the subject of notice to tenants at will and by sufferance, the plaintiff might have either entered upon the defendant and dispossessed him, or brought ejectment and recovered possession without any demand or notice whatever.

21. "Hospital issued notice of noncoverage"; *see* Social Security Act §§ 1154(a), 1154(e), 1879; *see also* 42 C.F.R. §§ 411.404, 412.42(c), 489.34.

22. After the 10-day notice to quit has been served; *see* New York RPAPL § 713, *supra*.

23. In New York the hearing or trial may not be adjourned more than ten days from the initial return date without the consent of both sides. N.Y. RPAPL § 745(1).

24. In New York these courts of limited jurisdiction may award possession and an incidental judgment for money damages to abide the possessory interest awarded (RPAPL § 747) but not injunctions generally (see NY Civil Court Act § 209(b) and parallel provisions in the New York Uniform District, City Town and Village Court Acts).

25. *Wyckoff Heights Medical Center v. Rodriguez,* 191 Misc. 2d 207, 741 N.Y.S.2d 400 (Sup. Ct., Kings Co. 2002)).

26. *Jersey City Medical Center v. Halstead*, 169 NJ Super. 2, 404 A.2d 44 (Superior Ct., Chancery 1979).

27. *Lucy Webb Hayes National Training School v. Geoghegan*, 281 F. Supp 116 (D.C. Dist. Columbia 1967)).

28. *Midstate Medical Center v. Doe*, 49 Conn. Supp. 581, 898 A. 2d 282 (2006).

29. 10 N.Y.C.R.R. 405.1.

30. "Notice of discharge and Medicare appeal rights," required to be given to the Medicare beneficiary when the hospital determines that acute care no longer is required or that the hospital no longer can deliver the appropriate level of care to the beneficiary; 42 C.F.R. § 422.620.

31. In New York *see, e.g.*, Civil Practice Law and Rules (CPLR) 5106; CPLR Article 64.

32. As a Medicare provider, the hospital was required to comply with federal discharge requirements contained in 42 U.S.C. § 1395X(ee) and 42 C.F.R. § 482.43. Under 42 C.F.R. § 482.43(d), the patient can be transferred by a hospital only to an "appropriate facility" where the patient would receive post-hospital care. Such a facility is defined as one which can meet the patient's medical needs. 42 C.F.R. § 482.21(b)(2). 59 Fed. Reg. 64149. An argument can be made that the appellate court took these sections out of context, in that they apply only to Medicare beneficiaries and are not intended to affect the discharges of all acute care hospital patients.

33. *Montejo v. Martin Mem'l Med. Ctr., Inc,* 874 So. 2d 654 (Fla. 4th DCA 2004).

34. *Montejo v. Martin Mem'l Med. Ctr., Inc*, 935 So. 2d 1266 (Fla. 4th DCA 2008).

35. Federal immigration law apparently preempts deportation while certain activities are pending. The court cited to *Florida Auto. Dealers Industrial Benefit Trust v. Small*, 592 So. 2d 1179 (Fla. 1st DCA 1992), an ERISA preemption case, in support of its holding that federal immigration law, like ERISA, completely preempts state courts of subject matter jurisdiction to grant orders which may result in "deportation." This is a curious line of reasoning based on a convoluted interpretation of federal preemption and its application to the facts, effectively denying the guardianship court subject matter jurisdiction over issues falling squarely within its statutory jurisdiction under state law because of the supposed existence of a "federal question."

36. An excellent analysis of the interaction of the law, medical ethics and clinical needs in effecting problem patient discharges is presented by Robert Swidler, Terese Seastrum and Wayne Shelton in "Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues," *The American Journal of Bioethics,* Vol. 7(3):23–28 (2007).

James Fouassier, Esq. is the Associate Administrator of the Department of Managed Care at Stony Brook University Hospital, Stony Brook, New York. His opinions are his own and may not reflect those of Stony Brook University Medical Center or the State University of New York. He may be reached at: jfouassier@notes.cc.sunysb.edu.

Creating a Cost-Efficient Statewide Public Guardianship System in New York State

By Daniel Leinung

New York State's guardianship system is falling short in providing necessary services for all individuals who require guardianship services. The current system lacks effective advocates for those who are the most vulnerable in our society. A statewide public guardianship system is needed to ensure that those individuals who need guardianship services but cannot afford a private guardian and do not have family to take care of them have advocates to look out for their interests. Cases such as Mrs. C's (explained below) are all too common in New York and show what can happen to people like her who do not have effective advocates to look out for their interests.

Mrs. C is a 78-year-old woman who has lived in her apartment in Brooklyn since she was 10 years old. Three years ago, Mrs. C was the victim of a robbery and was left for dead by the burglar. It wasn't until several days later that the NYPD found her on her floor in serious need of medical attention. She was taken to the hospital and after observation for several days, was deemed to be all right. Mrs. C requested to go home, but the hospital staff, because of her age and Parkinson's disease, diagnosed her with dementia and sent her to a nursing home, which turned out to be only 1.5 blocks away from her apartment. Over the next several months, Mrs. C requested to go home on numerous occasions, and attempted to "escape" her "prison." The nursing home, seeking to find someone to make decisions for her, petitioned the Brooklyn Supreme Court to have a guardian appointed. During the hearing, Mrs. C again stated that she wished to go home, but the court relied solely on the nursing home's evaluation that she should not be able to return home without a family member or friend involved. Mrs. C was trapped. The nursing home became her guardian and she was to spend the rest of her life in the nursing home, even though she had a house less than two blocks away.[1]

Mrs. C is one of the many examples of how the current guardianship system in New York is falling short. As evidenced by Mrs. C's situation, New York State lacks a system for people like her to have advocates to look out for their interests. However, there are several reforms that can be instituted to make sure that people like Mrs. C don't fall through the cracks. This article will look at one of the major shortcomings of New York's guardianship system: the lack of a statewide public guardianship system that can act as a safety net for those people like Mrs. C who do not have the assets or family to serve as guardians. I will use the State of Florida's public guardianship system as well as the Vera Institute's Guardianship Project, a not-for-profit demonstration project located in Brooklyn, as examples of how a public guardianship system could work in New York State.

"A statewide public guardianship system is needed to ensure that those individuals who need guardianship services but cannot afford a private guardian and do not have family to take care of them have advocates to look out for their interests."

Statewide Public Guardianship System

One of the major shortcomings of New York's guardianship system is the lack of an effective public guardian system. Currently, there is no effective system in place to enable those who are in desperate need of a public guardian to obtain one. This leaves thousands of needy New Yorkers who require assistance with no one to look after them. When incapacitated New Yorkers have no one to care for them because they lack sufficient resources and have no family, a guardian may be appointed by the court. In New York, a judge often appoints a lawyer as guardian to a needy individual. When this is the case, the lawyer, who oftentimes has dozens of guardianship "clients," shuttles the incapacitated person off to a nursing home and leaves him or her there to die, while collecting the court-imposed fee as guardian. Clearly, this is a major problem. There must be some type of safety net to ensure that guardians assume an advocacy role for those who do not have the resources to obtain reliable and responsible guardianship services.

Some states, including Illinois, California, and Florida, have public guardianship systems that serve as safety nets for their neediest citizens.[2] Florida, the state with the largest percentage of people age 65 and over per capita, revamped its guardianship system in the late 1990s.[3] Although Florida had tried to provide guardianship services for those in need through a patchwork of programs including lawyers' pro bono work and not-for-profit organizations, there remained a large population of indigent wards in the state who had no one advocating for them.[4] To deal with this problem, the state legislature passed the Public Guardianship Act, which created the Statewide Public Guardianship Office (SPGO) within the Department of Elderly Affairs.[5] The purpose of this office was to set up a system to "provide a public guardian to those persons whose needs cannot be met through less

drastic means of intervention."[6] The SPGO is intended to serve only those who do not have the resources to retain a guardian for themselves or family members to provide these services.[7]

The SPGO works as a centralized organizational office for all public guardians in the state. There are 17 local offices, which serve as the public guardian for their local areas.[8] The SPGO appoints and oversees all public guardians in the state, which includes registering, monitoring, educating, and screening all employees in each public guardian office.[9] Further, the SPGO is required to conduct regular investigations into the practices of each local office, thus ensuring that every person under public guardianship is getting effective care.[10]

In determining who should serve as a public guardian, the executive director of the SPGO,[11] after consultation with local officials knowledgeable in guardianship matters, establishes a list of persons in each locality who are best qualified to serve as public guardians.[12] These public guardians have to have knowledge in the area of guardianships and have a professional staff to help carry out the duties of the guardianship, with the ratio of professional staff to wards being no greater then 1:40.[13] The public guardian, or one of the professional staff, is required to visit each ward at least once every three months to assess his or her condition and living situation.[14] Just like regular guardians, the public guardian is required to maintain "proper financial, case control, and statistical records"[15] and must file an annual report, as well as undergo an independent audit every two years.[16]

The public guardians serve as guardians of only incapacitated people of limited financial means and must do a search for any relatives, friends, bank, or corporation who are qualified and willing to serve as guardian of the incapacitated person.[17] If such person or entity is found, the guardian will petition the court to have that person/entity named guardian. This essentially makes the public guardianship a temporary guardianship, until and if another qualified individual can be found. This reinforces the view of public guardianship as a last resort—only for those who truly have no one else willing to provide the services needed.

This Statewide Office provides a safety net for those incapacitated persons who do not have the resources and ability to care for themselves. The local offices become guardians of these people as a last resort, and when they do, the SPGO maintains a high level of oversight over those placed under their guardianship. This reduces the number of abuses that may occur in the system and ensures that those placed under their care receive the best care possible.

The Vera Institute's Guardianship Project is a perfect model of how a not-for-profit or county guardianship office could run. Because it works with all five judges of the Kings County Supreme Court and has well over 150 clients (and is seeking to expand to 300), the Guardianship Project is an excellent model of how a county-level office of public guardianship could work in a larger statewide system such as that of Florida.[18] This approximates the caseload a county public guardian office would handle. The organizational structure of the Guardianship Project could serve as an excellent model for how a county-level guardianship office could operate.

The Guardianship Project is appointed guardian of a person deemed incapacitated under Article 81 of the Mental Hygiene Law. The project is appointed guardian of the person and the property of the incapacitated person (IP), and its staff carries out all of the responsibilities of a guardian. The Guardianship Project consists of several professionals, including social workers, attorneys, accountants, and other support staff who deal with the legal, financial, and day-to-day issues of the person placed under their guardianship. The attorneys address the legal issues, the social workers offer intensive care management, and the financial group offers assistance with managing money and paying bills. This includes scheduling regular medical appointments, paying medical costs, other bills, and any other financial obligations of the incapacitated person.[19] Oftentimes negotiations with nursing homes, hospitals, and electric companies have to be undertaken to satisfy outstanding bills for medical treatment or other everyday expenditures. The project also deals with everyday issues such as installing smoke alarms, making sure there is enough food in the refrigerator, changing light bulbs and "flushing" furnaces in the client's home. The staff is charged with making sure that not only the legal and financial needs of the adjudged incompetent person are taken care of, but also that the person's everyday needs and safety concerns are addressed as well.

The Guardianship Project's staff receives and manages all of the money from the Project's clients including bank accounts, Medicare/Medicaid payments and Social Security payments. Similar to a pooled special needs trust, the Guardianship Project keeps all of the client money in an FDIC insured centralized bank account, with sub-accounts for each client. The staff uses a system called Computrust to efficiently manage and keep track of each client's finances.[20] By using the Computrust system, the staff can inventory income as it is received for each individual account and the expenses of each client. When a client dies, the remainder of the client's assets is distributed as provided in his will. However, if there is no will, then after all funeral and other administrative expenses are paid, the remainder of the client's assets escheats to the state. The Guardianship Project does not keep the client's money.

Some counties might not have the resources to staff a public guardian office. If this is the case, then not-for-profits such as the Vera Institute, which is funded by grants and can be supplemented with state aid, could

assist these counties in providing public guardianship services. Large counties such as Kings (Brooklyn) might be overwhelmed with the number of public guardians needed. In cases such as this, a not-for-profit such as the Vera Institute could step in to help as well. Florida also allows not-for-profit corporations to serve as public guardians when the counties are unable to provide the needed services.[21] Allowing not-for-profits to provide assistance would work exceptionally well in New York State, given the widely differing financial resources of the various counties throughout the state.

New York should institute a public guardianship system that is similar to the one in Florida. Having a statewide guardianship system, with individual local offices and oversight by a central office, would provide a safety net for those New Yorkers who are most in need of such services. This system would be accountable to a central commissioner or director, who would be in charge of making sure that the public guardians throughout the state were giving the utmost care and diligence to those under their guardianship. Further, not-for-profits such as the Vera Institute could provide assistance to local guardianship offices. This form of public guardianship service would be much more effective than the current system. With the oversight of a centralized regulatory office and the involvement of not-for-profits, New York's Public Guardianship Office would serve as a safety net for those who are in dire need of guardianship services and do not have the resources to obtain them.

Funding the Public Guardianship Office

Although creating public guardianship offices throughout the state, as well as a centralized oversight office, will no doubt increase the responsibilities placed on the local governments, much of the required infrastructure is already in place. The Supreme Courts throughout the state each have some form of guardianship office already set up and knowledgeable staff who deal with guardianships everyday. However, offsetting the extra expenses, this new system would require other methods of funding. Again, both Florida's and the Vera Institute's systems provide examples of effective funding schemes.

Florida has funded its program by creating a pooled special needs trust to supplement state investment in public guardianships. Florida's Public Guardianship Act created the "Foundation for Indigent Guardianship, Inc." a not-for-profit organization that serves as a "direct-support organization" to the SPGO.[22] The Foundation was organized to conduct programs, raise funds, and make expenditures for the benefit of the SPGO.[23] The first action taken by the Foundation was to create a State Public Guardianship Pooled Special Needs Trust.

The State Public Guardianship Pooled Special Needs Trust was developed to help incapacitated people who voluntarily opt into the public guardianship system. The system allows them to maintain a high quality of life in return for allowing the system to retain any funds remaining when the incapacitated person dies.[24] A special needs trust allows disabled people to retain the benefit of their savings, but only to supplement government benefits which fall short of meeting their actual needs.[25] For instance, a person's assets in a special needs trust do not count toward his or her eligibility for Medicaid. A "pooled" trust is one in which each person in the trust has his or her own sub-account, but all of the sub-accounts are "pooled" together to create a larger account. This allows the trust to get larger returns on investments, while maintaining each individual's separate sub-account. Pooled Special Needs Trusts protect those individuals who have more assets, while allowing everyone to benefit from the program.

As required by federal law, Pooled Special Needs Trusts must be established and managed by a not-for-profit agency.[26] In Florida, the trust is run by The Foundation for Indigent Guardianship, Inc., a not-for-profit that was created by the Florida Legislature to provide financial support to the Statewide Public Guardianship Office.[27] To eliminate any conflicts of interest, the trust has two co-trustees. This allows one trustee to act as the beneficiary (FIG) of the trust for the benefit of the incapacitated person and another co-trustee to be the "administrative" trustee, charged with saying "yes" or "no" to distribution requests.[28] Through the mechanism of a pooled special needs trust, upon the death of the beneficiary, all of the retained funds (after legal debts and obligations) pass directly to the trust and then, pursuant to its bylaws, the trust transfers these funds over to the SPGO.[29] The SPGO then uses these funds to benefit the cause of public guardianship in the state, thus making the money continually available to serve the interests of the most vulnerable and needy residents of the state.[30]

The Guardianship Project also has several interesting ways of securing funding that could serve as a model for county-level guardianship offices. Although originally funded by grants, the Guardianship Project has mostly transitioned to state money as well as court-imposed fees for serving as guardians paid by those clients who have enough assets.[31] Although the fees cover only a small portion of the Project's budget, they do help offset some of the costs.[32]

The Vera Institute also minimizes its costs by making the guardianship process more efficient. The wards under their care are given the greatest degree of independence possible. In New York City for example, the average monthly cost of a nursing home stay is $9,375 per month, while the cost for home health care is less than half as much.[33] With the Project's projected caseload of 300 clients, if the project can help clients stay home and avoid unnecessary nursing home care, that would relate to a savings of $4.3 million a year.[34] Often, elderly people are in nursing homes not because they need intense

constant medical care, but because they have nowhere else to go. The Guardianship Project often takes these people, who do not belong in a nursing home, and assists them in returning to their houses where they are more comfortable. Often, the Project's staff has to create a safe discharge plan before the nursing home will release the person, thus ensuring that he or she has a safe place to live and adequate care.[35] By removing these people who want to return their homes and do not need the constant and expensive care of a nursing home, the Guardianship Project is saving money for both the client and the state since a substantial amount of the nursing home stay would be paid for by the state through Medicaid. Therefore, the project not only saves money, but also works to give the client the greatest amount of independence and self-determination possible. Mrs. C's case is a perfect example of this.

Normally, in a case like Mrs. C's, the nursing home would petition the court to get a permanent guardian appointed for Mrs. C, usually an attorney. This attorney would most likely keep Mrs. C in the nursing home, checking up on her once or twice a year as required by law, while managing her assets for her. Mrs. C would stay in the nursing home for the rest of her life, paying for it through Medicaid or other government benefits after her assets had run out. Mrs. C would stay "trapped" in the system, without anyone to look out for her or be her advocate. However, this is not what happened. Instead, the Vera Institute's newly created "Guardianship Project" was appointed her guardian. After the Guardianship Project's staff had several meetings with Mrs. C, it became clear that she knew where she was and where she wanted to go. The Guardianship Project's staff got to work immediately to return her to her community. The Project's staff pushed through the legal paperwork to get her out of the nursing home and back into her apartment. She was given a home health aide for 8 hours a day and, after several months, it became apparent that she did not require this assistance at all. Mrs. C, with a little help from the Guardianship project and her friends, could now live independently.[36]

New York State can take pieces from both the Florida and Guardianship Project models to use in funding its public guardianship system. A statewide pooled special needs trust would not only provide for greater oversight of the funds of an incapacitated person placed under guardianship, but would also offset some of the costs associated with implementing a statewide public guardianship office. Similar to Florida and federal law, New York State law has provisions for the creation of supplemental needs trusts for persons with persistent disabilities.[37] In fact, one of the guardian's powers in managing the assets of the incapacitated person is to create trusts for his or her ward's property.[38] Further, New York case law has upheld several decisions by the guardian to place an incapacitated person's property into a pooled special needs trust.[39] Creating a statewide special needs trust would be extra-beneficial in both funding the state system and to the individuals participating in the program since the principal or income of the trust is not deemed to be an "available resource" to the beneficiary, and therefore does not count toward the beneficiary's eligibility for Social Security Disability Insurance and Medicaid. Thus, the beneficiary can become eligible for such benefits while the income from their money in the trust supplements their support.[40]

"[A] statewide guardianship system . . . would save millions of state dollars a year by decreasing Medicaid spending, decreasing abuses in the system, and making the system more efficient."

The Guardianship Project is an excellent model for how a local New York guardianship office could be run. These offices could be supplemented by the statewide trust fund and run by a system such as Computrust. The local offices would help reduce unnecessary expenses by giving their wards the most independence and self-autonomy as is safe while still meeting their needs. Further, when incapacitated persons under public guardianship die without a will, the remainder of their estate would be able to go directly to the Statewide Trust Fund.[41] This way all of the money stays within the system to continually help those in need of public guardians.

New York is in desperate need of a public guardianship system. The current process of appointing disinterested lawyers who have very little concern for their client's best interest and few of the practical skills necessary to effectively advocate for their clients is unfair to these vulnerable individuals. There needs to be a system of professional guardians, who have an expertise in health care and guardianship services, to provide these services for all people who need them, regardless of their financial resources. Instituting a statewide guardianship office would ensure that every person in New York State would be able to obtain the necessary guardianship services he or she requires while increasing oversight of those placed under the state's guardianship. Similarly, on the local level, the Vera Institute's model would be both cost-effective and more responsive to the needs of the incapacitated person.

Although the initial organization of a statewide guardianship system may be expensive, such a system would save millions of state dollars a year by decreasing Medicaid spending, decreasing abuses in the system, and making the system more efficient. Even though creating such an office would increase the responsibilities of the local governments, the beneficial dual effects of ensuring that every person in the state who requires guardianship services can obtain them and making the system more efficient more than outweigh the cost of setting up such a system.

Endnotes

1. This anecdote is excerpted from: Local Initiative Funding Partners, 2007 Graduate Studies: The Guardianship Project, Jason Hyde, Guardianship Project Team Supervisor, December 2007 *available at* http://www.lifp.org/html/project/2007GraduateStories/VeraInst.html and from Jean Callahan & Andrea Snelson, "Team Approach to Guardianship Preserves the Independence of Ward, Generates Savings for State," 29 BIFOCAL 35, 35-39 (Feb. 2008) *available at* http://www.abanet.org/aging/docs/Feb_08_ABA_Bifocal_J.pdf.
2. See Cal. Gov't Code 27430 (Deering 2003); 20 Ill. Comp. Stat. Ann. 3955/30 (West 2002).
3. The U.S. Census Bureau estimates that there are 3,037,704 persons over 65 years old in Florida, approximately 17% of the entire Florida population. U.S. Census Bureau, *Estimates of the Population by Selected Age Groups of the United States and States and Puerto Rico: July 1, 2006, available at* http://www.census.gov/popest/states/asrh/SC-EST2006-01.html.
4. Steven E. Quinnell, Florida Guardianship Practice, 5th ed. Chapter 20. (Fla. Bar CLE 5th ed. 2005).
5. FLA. STAT. § 744.7021 (2005).
6. *See id.* § 744.702.
7. *See id.*
8. Florida Dept. of Elderly Affairs, Statewide Public Guardianship Office, http://elderaffairs.state.fl.us/english/PUBGUARD/public_guardians.html.
9. Fla. Bar CLE 5th ed. 2005; FLA. STAT. § 744.1083.
10. FLA. STAT. § 744.708.
11. The executive director of the SPGO, who is appointed by the Secretary of Elderly Affairs, has the responsibility of running the Office. FLA. STAT. § 744.7021.
12. *Id.* § 744.703.
13. *Id.* This staff includes an attorney, a social worker, a psychologist, or a nurse practitioner; FLA. STAT. § 744.708.
14. *See id.* at § 744.708(6).
15. *See id*. at § 744.708(1).
16. *See id.* at § 744.708(5(a)).
17. *See id*. at § 744.704.
18. The Vera Institute, "The Guardianship Project," http://www.vera.org/otherwork/guardianship.htm.
19. *Id.*
20. Computrust is a software program that assists staff in managing the assets of its clients as well as other data on each client. An overview of the system can be found at: http://www.computrustcorp.com/.
21. FLA. STAT. § 744.703(1).
22. Rebecca Berg, Scott Solkoff, Lauchlin Waldoch, *Q & A: Introduction to the State of Florida Public Guardianship Pooled Special Needs Trust*, Florida Bar Journal 64, May 2007.
23. FLA. STAT. § 744.7082; this includes obtaining grants and other forms of funding for the Office. *Id.*
24. Berg at 64.
25. *Id.* at 64; Special Needs Trusts are codified at 42 U.S.C. § 1396p(d)(4)(C).
26. 42 U.S.C. § 1396p(d)(4)(C)(i).
27. Berg at 64.
28. *Id*. at 65.
29. *Id.*
30. *Id.*
31. A list of the organizations that have provided grants for the Guardianship Project can be found at: http://www.vera.org/otherwork/guardianship-supporters.html.
32. Roohi Choudhry and Jim Parsons. *The Guardianship Project: Implementing a New Model of Guardianship Services in New York City*. New York: Vera Institute of Justice, 2008, *available at* www.vera.org.
33. Callahan, *supra* note 1, at 37.
34. Local Initiative Funding Partners, 2007 Graduate Studies: The Guardianship Project, December 2007, *available at* http://www.lifp.org/html/project/2007GraduateReports/VeraInst.pdf.
35. *Id.*
36. Local Initiative Funding Partners, 2007 Graduate Studies: The Guardianship Project, Jason Hyde, Guardianship Project Team Supervisor, December 2007 *available at* http://www.lifp.org/html/project/2007GraduateStories/VeraInst.html.
37. *See* N.Y. ESTATES, POWERS AND TRUSTS LAW 7-1.12.
38. *See* N.Y. MENTAL HYG. LAW § 81.21(a)(6).
39. *See In re Perry* (Surr. Ct., Westchester Co.) N.Y.L.J., June 14, 2000 (approving guardian's transfer of an incapacitated person's assets to a pooled supplemental needs trust).
40. *Id.* § 7-1.12(b)(3).
41. Many who are placed under public guardianship do not have wills that leave much to individuals, since if these individuals can be ascertained, they would most likely serve as the guardian. However, for those placed under guardianships, their wishes expressed in a will, will of course be carried out.

This is an excerpt from an article entitled "Reforming New York State's Guardianship System: It's Time for a Change (Again)" which is appearing in the 2009 spring publication of the *Albany Government Law Review*.

Changes for Powers of Attorney in New York: Health Care Payment and Billing Matters[1]

By Rose Mary Bailly and Barbara S. Hancock

On January 27, 2009, Governor David Paterson signed Chapter 644 of the Laws of 2008, effective March 1, 2009, amending the General Obligations Law to provide significant reforms to the use of powers of attorney in New York.[2] Chapter 644 was the result of eight years of study by the New York State Law Revision Commission. Throughout the process, the Commission recognized that the power of attorney is an effective tool for attorneys and the public at large for estate and financial planning and for avoiding the expense of guardianship. The power of attorney is also a simple document to create. It can be obtained from any number of websites on the Internet or in a stationery store and its execution merely requires the Principal's signature and its acknowledgment before a notary public. But this simplicity belies the extraordinary power that the instrument can convey, and its popularity has also led to its use for transactions far more complex than were originally contemplated by the law, particularly in the areas of gift giving and property transfers.

The instrument's power is also demonstrated by the fact that the potential authority of the Agent can include power to transfer assets that pass by the Will as well as those that usually pass outside a Will, such as joint bank accounts, life insurance proceeds, or retirement benefits.

The Principal can delegate these sweeping powers to the Agent without fully recognizing their scope, (particularly if the Principal executes the document without the benefit of legal counsel). Unless the instrument is a springing power of attorney, i.e., one that becomes effective upon the occurrence of a specified event such as the Principal's incapacity, the Agent can act immediately and, in all cases, without notifying the Principal. Under a durable power of attorney or springing durable power of attorney, which continues in effect after the Principal's incapacity, the Agent acts without oversight when an incapacitated Principal is no longer able to control or review the Agent's actions, a situation which under common law would have terminated the power of attorney.

Despite the broad authority associated with this important, popular and powerful tool for financial management, the General Obligations Law, which governs powers of attorney, has been silent as to a number of matters. These omissions include descriptions of the Agent's fiduciary obligations and accountability, the manner in which the Agent should sign documents where a handwritten signature is required, the parameters of the Agent's authority to make gifts to third parties and to himself or herself, the manner in which the Principal can revoke the document, the circumstances under which a third party may reasonably refuse to accept a power of attorney, and the effect on powers of attorney of the 2003 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule regarding medical records. The statute's provisions have been ambiguous in other areas such as gift-giving authority and authority to make other property transfers.

Based on its study, the Commission concluded that while a power of attorney should remain an instrument flexible enough to allow an Agent to carry out the Principal's reasonable intentions, the combined effect of its potency and easy creation, the general obligations law's silence about several significant matters, and ambiguities about the authority to transfer assets can frustrate the proper use of the power of attorney, particularly when a Principal is incapacitated and can no longer take steps to ensure its proper use. Chapter 644 addresses these statutory gaps and clarifies the ambiguities to assist parties creating powers of attorney and third parties asked to accept them.

A. General Provisions: Chapter 644 creates a new statutory short form power of attorney. On or after the chapter's effective date, to qualify as a statutory short form power of attorney, an instrument must meet the requirements of section 5-1513.[3] The statutory short form is not valid until it is signed by both the Principal and Agent, whose signatures are duly acknowledged in the manner prescribed for the acknowledgment of a conveyance of real property.[4] The date on which an Agent's signature is acknowledged is the effective date of the power of attorney as to that Agent; if two or more Agents are designated to act together, the power of attorney takes effect when all the Agents so designated have signed the power of attorney with their signatures acknowledged.[5]

A power of attorney executed prior to the effective date of Chapter 644 will be continue to be valid, provided that the power of attorney was valid in accordance with the laws in effect at the time of its execution.[6]

* * *

C. HIPAA Privacy Rule: Chapter 644 adds the term "health care billing and payment matters" to the term "records, reports and statements" as those terms are explained in construction section 5-1502K,[7] so that an Agent can examine, question, and pay medical bills in the event the Principal intends to grant the Agent power with respect to records, reports and statements without fear that the HIPAA Privacy Rule would prevent his or her access to the records. This provision is applicable to all powers of attorney executed before, on or after the effective date of

Chapter 644.[8] It does not change the law forbidding the Agent from making health care decisions.[9]

The General Obligations Law has been silent as to the relationship between the power of attorney, an Agent's authority to access medical records under New York law, and the Privacy Rule, a federal regulation regarding individual medical information promulgated in April 2003 pursuant to HIPAA. The ambiguity about an Agent's authority to access medical records under New York law arose out of several factors. Neither subdivision K on the statutory short form, power to access records, nor section 5-1502K, which construed the term "records," contained an express reference to medical records. Moreover, section 18 of the Public Health Law, which identifies qualified persons who are entitled to access to a patient's health records, does not include all Agents acting pursuant to a power of attorney.[10] As a result, health care providers have refused to make records available to an Agent seeking clarification of a medical bill, without express language added to the power of attorney document authorizing such release.

The ambiguity created by the lack of express reference to medical records in section 5-1502K is exacerbated by the HIPAA Privacy Rule, which creates national standards limiting access to an individual's medical and billing records to the individual and the individual's "personal representative." Under the Privacy Rule, health information relating to billings and payments may be available to an Agent if the Agent can be characterized as the Principal's "personal representative" as defined in the Privacy Rule. Under the regulations, the "personal representative" for an adult or emancipated minor is defined as "a person [who] has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care. . . ."[11]

The general obligations law has limited the authority of the Agent to financial matters, and expressly prohibits the Agent from making health care decisions for the principal. The public health law defines a health care decision as "any decision to consent or refuse to consent to health care."[12] "Health care," in turn, is defined as "any treatment, service or procedure to diagnose or treat an individual's physical or mental condition."[13]

The Principal may grant health care decision-making authority to a third party only by executing a health care proxy pursuant to section 2981 of the Public Health Law. The health care proxy law makes clear that financial liability for health care decisions remains the obligation of the Principal.[14] As a practical matter, payment issues are left to the Principal or the Principal's Agent. The Privacy Rule regarding access to records does not take into account a statutory structure such as New York's, which permits the division of the responsibilities for health care decisions and bill paying between two representatives, the health care agent and the Agent.

Conclusion

With these changes, New York's law has been updated and refined to reflect the complexities that surround the use of powers of attorney in financial and estate planning matters.[15]

Endnotes

1. This is an excerpt from a more comprehensive article in the New York State Bar Association *Journal*, March/April 2009 on the changes to the power of attorney law. This excerpt focuses on a change of particular interest to health care attorneys. The article is based on the New York State Law Revision Commission's *2008 Recommendation on Proposed Revisions to the General Obligations Law—Powers of Attorney*. The Commission's 2008 Recommendation, Chapter 644 and other material related to Chapter 644 can be found at the Commission's website: http://www. lawrevision.state.ny.us.
2. At the time of the writing of this article, a bill had been introduced in the Legislature to extend the effective date to September 1, 2009. A. 4392/S. 1728.
3. C. 644, § 2, 5-1501B; § 19, 5-1513. All statutory references for amendments to the general obligations law are to the sections in Chapter 644.
4. C. 644, § 2, 5-1501B(1).
5. C. 644, § 2, 5-1501B(3).
6. C. 644, § 21.
7. C. 644, § 12.
8. C. 644, § 21.
9. C. 644, § 12, 5-1502K(1).
10. *See* N.Y. Pub. Health Law § 18(1)(g) (refers only to attorneys who hold a power of attorney from an otherwise qualified person or the patient's estate specifically "authorizing the holder to execute a written request for patient information." An otherwise qualified person is the patient, Article 81 guardian, parent of an infant, guardian of an infant, or distributee of the deceased patient's estate if no executor or administrator has been appointed.).
11. 45 C.F.R. § 164.502(g)(2).
12. *See* N.Y. Pub. Health Law § 18.
13. N.Y. Pub. Health Law §§ 2980(4) and (6).
14. *See* N.Y. Pub. Health Law § 2987.
15. In so doing, New York's law has come in line with the laws of many other jurisdictions and the recent amendments to the Uniform Power of Attorney Act, *available at* http://www.law.upenn.edu/bll/archives/ulc/dpoaa/2008_final.htm.

Rose Mary Bailly, Esq. is the Executive Director of the New York State Law Revision Commission. Barbara S. Hancock, Esq. is the Counsel to the Commission.

Note: The revised Power of Attorney Law has an original effective date of March 1, 2009. However, the effective date was delayed until September 1, 2009, after the extension was passed by the Senate (S.1728) on February 24 and by the Assembly (A.4392) on February 10. The bill was signed into law by the Governor as Chapter 4 of the Laws of 2009.

The New York State Bar Association supported this extension in order to provide practitioners with sufficient time to prepare for these significant changes.

For more information please visit our Web site, www.nysba.org.

This article is based on the New York State Law Revision Commission's 2008 Recommendation on Proposed Revisions to the General Obligations Law – Powers of Attorney. The Commission's 2008 Recommendation, Chapter 644 and other material related to Chapter 644 can be found at the Commission's Web site: http://www.lawrevision.state.ny.us.

Power of Attorney
New York Statutory Short Form

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney by executing this Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

I, _____, hereby appoint:
[name and address of principal]

_____ as my agent(s)
[name(s) and address(es) of agent(s)]

If you designate more than one agent above, they must act together unless you initial the statement below.

(___) My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)

If every agent designated above is unable or unwilling to serve, I appoint as my successor agent(s): _____

_____
[name(s) and address(es) of successor agent(s)]

Successor agents designated above must act together unless you initial the statement below.

(___) My successor agents may act SEPARATELY.

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications".

(e) This POWER OF ATTORNEY REVOKES any and all prior Powers of Attorney executed by me unless I have stated otherwise below, under "Modifications".

If you are NOT revoking your prior Powers of Attorney, and if you are granting the same authority in two or more Powers of Attorney, you must also indicate under "Modifications" whether the agents given these powers are to act together or separately.

(f) GRANT OF AUTHORITY:

To grant your agent some or all of the authority below, either (1) Initial the bracket at each authority you grant, or (2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

(___) (A) real estate transactions;
(___) (B) chattel and goods transactions;
(___) (C) bond, share, and commodity transactions;
(___) (D) banking transactions;
(___) (E) business operating transactions;
(___) (F) insurance transactions;
(___) (G) estate transactions;
(___) (H) claims and litigation;
(___) (I) personal and family maintenance;
(___) (J) benefits from governmental programs or civil or military service;
(___) (K) health care billing and payment matters; records, reports, and statements;
(___) (L) retirement benefit transactions;
(___) (M) tax matters;
(___) (N) all other matters;
(___) (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;
(___) (P) EACH of the matters identified by the following letters: _____

_____

You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent. However, you cannot use this Modifications section to grant your agent authority to make major gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Major Gifts Rider.

_____

_____

(h) MAJOR GIFTS AND OTHER TRANSFERS: STATUTORY MAJOR GIFTS RIDER (OPTIONAL)

In order to authorize your agent to make major gifts and other transfers of your property, you must initial the statement below and execute a Statutory Major Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make major gifts and other transfers. The preparation of the Statutory Major Gifts Rider should be supervised by a lawyer.

(___) (SMGR) I grant my agent authority to make major gifts and other transfers of my property, in accordance with the terms and conditions of the Statutory Major Gifts Rider that supplements this Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

I wish to designate _____, whose address(es) is (are) _____ as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation", you may do so above, under "Modifications".

(___) My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION: This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT: In Witness Whereof I have hereunto signed my name on _____ _____,20_____.

PRINCIPAL signs here: ==>_____

(Acknowledgment)

[STATE OF)

) ss.:

COUNTY OF)

On the _____ day of _____, in the year _____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____ _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

_____

Notary Public]

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;

(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manner: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or give major gifts to yourself or anyone else unless the principal has specifically granted you that authority in this Power of Attorney or in a Statutory Major Gifts Rider attached to this Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest. You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent:

The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT: It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we _____, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here:==>_____

(acknowledgement(s))

[STATE OF NEW YORK)

) ss.:

COUNTY OF)

On the _____day of _____, in the year _____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____ _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

_____

Notary Public

STATE OF NEW YORK)

) ss.:

COUNTY OF)

On the _____day of _____, in the year _____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____ _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

_____

Notary Public]

2008 N.Y. Laws ch. 644, § 19, 5-1513; 2009 N.Y. Laws ch. 4 (amending effective date from March 1, 2009 to September 1, 2009).

Editor's Note: This form is a draft POA which is being distributed for comment/suggestions. If you have any comments/ suggestions, please e-mail them to Dan McMahon, NYSBA Publications Director at dmcmahon@nysba.org. A final version of the new POA form will be distributed once any necessary changes (if any) have been made. Final spacing has not been determined by the official publishers. Italics have been added to the portions of the new Statutory Short Form Power of Attorney and Major Gifts Rider that are instructional. Lines representing spaces and acknowledgments in brackets are illustrative only and have been added for clarity and convenience.

Power of Attorney New York Statutory Major Gifts Rider Authorization to Make Major Gifts or Other Transfers

CAUTION TO THE PRINCIPAL: This OPTIONAL rider allows you to authorize your agent to make major gifts or other transfers of your money or other property during your lifetime. Granting any of the following authority to your agent gives your agent the authority to take actions which could significantly reduce your property or change how your property is distributed at your death. "Major gifts or other transfers" are described in section 5-1514 of the General Obligations Law. This Major Gifts Rider does not require your agent to exercise granted authority, but when he or she exercises this authority, he or she must act according to any instructions you provide, or otherwise in your best interest.

This Major Gifts Rider and the Power of Attorney it supplements must be read together as a single instrument.

Before signing this document authorizing your agent to make major gifts and other transfers, you should seek legal advice to ensure that your intentions are clearly and properly expressed.

(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS

Granting gifting authority to your agent gives your agent the authority to take actions which could significantly reduce your property. If you wish to allow your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

To grant your agent the gifting authority provided below, initial the bracket to the left of the authority.

(____) I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code. This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(b) MODIFICATIONS:

Use this section if you wish to authorize gifts in excess of the above amount, gifts to other beneficiaries or other types of transfers. Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. If you wish to authorize your agent to make gifts or transfers to himself or herself, you must separately grant that authority in subdivision (c) below.

(____) I grant the following authority to my agent to make gifts or transfers pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:

_____

_____

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE MAJOR GIFTS OR OTHER TRANSFERS TO HIMSELF OR HERSELF: (OPTIONAL)

If you wish to authorize your agent to make gifts or transfers to himself or herself, you must grant that authority in this section, indicating to which agent(s) the authorization is granted, and any limitations and guidelines.

(____) I grant specific authority for the following agent(s) to make the following major gifts or other transfers to himself or herself:

_____

_____

_____

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(d) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Major Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on _____, 20____.

PRINCIPAL signs here:

_____

(acknowledgment)

[STATE OF NEW YORK)

) ss.:

COUNTY OF)

On the _____ day of _____, in the year _____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____ _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

_____

Notary Public]

(f) SIGNATURES OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Major Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Major Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of major gifts.

_____	_____
Signature of witness 1	Signature of witness 2
_____	_____
Date	Date
_____	_____
Print name	Print name
_____	_____
Address	Address
_____	_____
City, State, Zip code	City, State, Zip code

(g) This document prepared by: _____

2008 N.Y. Laws ch. 644, § 19, 5-1514; 2009 N.Y. Laws ch. 4 (amending effective date from March 1, 2009 to September 1, 2009).

Editor's Note: This form is a draft POA which is being distributed for comment/suggestions. If you have any comments/suggestions, please e-mail them to Dan McMahon, NYSBA Publications Director at dmcmahon@nysba.org. A final version of the new POA form will be distributed once any necessary changes (if any) have been made. Final spacing has not been determined by the official publishers. Italics have been added to the portions of the new Statutory Short Form Power of Attorney and Major Gifts Rider that are instructional. Lines representing spaces and acknowledgments in brackets are illustrative only and have been added for clarity and convenience.

Does Practicing Evidence Based Medicine Decrease a Physician's Risk of Being Sued by a Patient?

By Andrew Feldman and James Eagan

Health Care providers are required to follow the standard of care and provide patients with the best care possible. However, what exactly constitutes the "standard of care" is often hotly debated in courtrooms throughout the country in medical malpractice trials. In theory, "evidence based medicine" should clarify the standard of care, improve the quality of care, and reduce the number of medical malpractice cases. This article examines whether practicing evidence based medicine will actually decrease the likelihood of a health care provider being sued.

Throughout the ages, those who took on the mantle of responsibility for the health of others in their community learned from their experiences and then passed down the wisdom they learned. Of course, like today, some were better than others. Some were able to process the good and bad experiences and determine what would be best for that next patient. But what constituted the "standard of care" differed greatly depending on the when the care was rendered, where the care was rendered and who was rendering the care.

Today, it has become obvious that society as a whole is better off if medical professionals join together in broad-reaching studies that determine the best way to treat patients with existing and emerging medical technology. In the 1990s, the term that became the vogue for this practice was "evidence based medicine." With the rise of evidence based medicine, the "standard of care" has become much more easily defined, as the care and treatment of various diseases has become standardized throughout the country.

In New York State, courts instruct juries that medical malpractice is "the failure to use reasonable care under the circumstances, doing something that a reasonably prudent doctor would not do under the circumstances, or failing to do something that a reasonably prudent doctor would do under the circumstances. It is a deviation or departure from accepted practice."[1]

However, courts play a very limited role in rejecting evidence that is clearly without scientific basis.[2] As long as the "expert" physician has documented qualifications within his or her area of specialty and the evidence offered is not obviously lacking scientific basis, courts will leave most decisions about strength of evidence and standards of practice up to a jury.[3] The jury (almost always made up of laypersons) ends up having to judge whether the expert witnesses at trial are credible and/or reliable when testifying about the usual and customary standard of care. Of course, these critical issues are being decided by lay jurors, with little or no medical background, who are undoubtedly influenced by sympathy for the injuries, which may or may not have been caused by the alleged malpractice.

Evidence based medicine, if available for every medical decision, would take away the need for trials in medical malpractice litigation. If we were able to establish rules for the care and treatment of all diseases, when a practitioner was challenged regarding the care provided, the court would only have to turn to a specific page of the evidence based medicine textbook to determine if the care provided was acceptable. The problem we encounter is that in the everyday world, evidence based medicine has not evolved to a point where it has answers for every problem, nor will that ever be possible. There are only certain areas of medicine where evidence based medicine has established rules that have effectively determined how certain conditions should be treated. As we know, even those findings which now appear clear may be refuted in the future as further evidence is gathered and analyzed.

The following is an example of how evidence based medicine practice could play out at a trial. Current evidence based medicine is that annual chest X-rays in smokers do not affect mortality rates for lung cancer. However, while annual chest X-rays are not the current standard of care, even though an annual chest X-ray does not decrease mortality rates, it does increase the odds of earlier diagnosis. Imagine the cross-examination of the defendant-doctor whose long-time smoking patient has died at age 50, leaving behind a wife and two kids.

Plaintiff's Attorney:	Doctor, am I correct that in general, the earlier you detect cancer, the more likely the patient is to survive?
Defendant-Physician:	Yes.
Plaintiff's Attorney:	Am I also correct that if you order annual chest X-rays for a heavy smoker, such as Mr. Smith, you are more likely to detect lung cancer at an earlier point in time?
Defendant-Physician:	Yes, but according to national studies, even though we may be able to detect lung cancer earlier, we have learned that detecting it earlier does not

	increase the odds that the patient will have a better outcome.
Plaintiff's Attorney:	But didn't you just tell this jury that if you detect cancer early, the patient has a better chance to beat it?
Defendant-Physician:	Yes, but . . .
Plaintiff's Attorney:	And now you want this jury to believe that if you had ordered annual chest X-rays on Mr. Smith and diagnosed this disease before it spread throughout his body, it would have had absolutely no bearing on his outcome?
Defense Attorney:	Objection your Honor. Counsel has misstated the Doctor's testimony.

As you can see from this exchange, while an impartial physician who is well versed in the applicable evidence based medicine would not be influenced by this exchange and would understand that studies have proven that earlier detection of lung cancer does not lead to a better outcome, it is difficult to convince a lay jury to accept this type of evidence. It is easier for a layperson to accept the general rule that if you diagnose a problem earlier, you increase the odds of a favorable outcome. It is much more difficult, although certainly not impossible, to explain to a jury that an earlier diagnosis may not help at all, even though you have the best evidence in the world to support your position.

The other problem that is encountered in court is the hearsay objection to evidence based medicine. A court will not allow a witness to testify about hearsay unless there is an applicable exception. While hearsay usually refers to words spoken by a person, it also covers a medical article or study. Generally speaking, courts will not allow a physician to cite a medical article or study in court to support his or her position because the author of that article or study is not subject to cross-examination by the opposing party. In the above example, for instance, the court would probably sustain an objection to the doctor's reference to "national studies." So, even if a physician closely follows all of the evidence based medicine guidelines, the guidelines themselves may not be allowed into evidence at trial. As a defendant, the doctor would need to rely on the testimony of his own expert to present the evidence based medicine guideline as the standard of care, but the expert will probably not be allowed to specifically cite that national standard.

While the Court of Appeals has not directly ruled on the use of evidence based medicine, in *Hinlicky v. Dreyfuss*,[4] the Court did examine the issue and allow a defendant-physician to refer to a set of clinical guidelines published by the American Heart Association and the American College of Cardiology that were used during the treatment of the patient as "demonstrative" evidence to illustrate the defendant-physician's decision-making process, even though it was hearsay. The Court declined to comment on whether the evidence would have been admissible under the professional reliability exception to the hearsay rule.[5]

The more common way in which evidence based medicine guidelines are used at trial is on cross-examination when a physician/expert concedes that the guidelines are the type of evidence commonly relied upon in that field and the evidence is deemed authoritative by the expert.[6]

One of the key factors in evidence based medicine is how to best use limited medical and financial resources. Studies examine whether the benefit of using a screening test makes financial sense. The problem is that at trial, a defendant in a medical malpractice case can never argue that a test was not ordered because it was too expensive. Regardless of finances, medical practitioners must follow the standard of care when ordering tests or meticulously document why a test cannot be performed. In the event that an insurer refuses to pay for a test the physician believes is necessary, the physician should become an advocate for the patient and document those efforts in the patient's chart.

With that background information in place, we still need to address the question: Does practicing evidence based medicine expose the health care provider to an increased risk of a medical malpractice claim? The answer to that question, of course, is no. If a physician is practicing evidence based medicine, he or she is staying closely aware of the current standard of care and following all of the guidelines for patient care which are established. However, it must be noted that just because a health care provider is practicing evidence based medicine does not mean that he or she is insulated from exposure to a malpractice claim. Malpractice trials almost always come down to a "battle of the experts" and there are physicians who will create their own standard of care and will testify that specific evidence based medicine standards are either wrong or not relevant to the situation under review.

Academic organizations have, upon occasion, created guidelines for standards of care involving specific treatment regimes. This is found particularly for specific surgical procedures. However, these guidelines are generally prepared with as much generalization as possible, since medicine is not an exact science, and potentially these guidelines could be used against a doctor involved in a malpractice lawsuit; even if doctors perform a procedure properly, in a medically accepted fashion, an argument could be made that the doctor deviated from the accepted norm if the procedure did not conform to the published

guidelines, even if the surgeon did everything appropriately under the circumstances presented. At times, deviations are necessary, in the sound judgment of the practitioner, and if evidenced based medicine was the only standard, it could result in a negative decision in a malpractice case.

Conclusion

In theory, evidence based medicine should decrease the number of medical malpractice cases. Clear standards on the care and treatment of conditions the doctor faces in practice will not only improve care, but document that the service met the standard of care. However, whenever possible, plaintiffs' attorneys and their experts will use evidence based medicine to their advantage, as they attempt to define the standard of care and establish that an error was made. This makes it more critical than ever that health care practitioners keep themselves up to date with new developments and implement those developments into their daily practice in a timely fashion.

Of course, while evidence based medicine gives health care providers good general rules to follow in practice, evidence based medicine does not, and cannot, replace common sense. Each patient presents a unique set of circumstances and the doctor must not allow evidence based medicine to fully dictate how one practices. Each patient must be dealt with as an individual and each patient's specific issues must be closely evaluated to determine the best course of action.

Practicing evidence based medicine will not prevent a doctor from getting sued, but evidence based medicine should improve the quality of care offered to patients and increase the confidence physicians have in the treatment provided, thereby decreasing the risk of litigation.

Endnotes

1. New York Pattern Jury Instructions, 2:150, 3d Edition, 2007.
2. *See Daubert v. Merrell Dow Pharmaceutical*, 509 U.S. 579, 113 S. Ct. 2786 (1993) and *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 119 S. Ct. 1167 (1999).
3. *Texter v. Middletown Dialysis Center, Inc.*, 22 A.D.3d 831 (2d Dep't 2005).
4. 6 N.Y.3d 636, 815 N.Y.S.2d 908 (2006).
5. *Id*. at 648.
6. *Lenzini v. Kessler*, 43 A.D.3d 220, 851 N.Y.S.2d 163 (1st Dep't 2008).

Mr. Feldman and Mr. Eagan are members of the law firm Feldman, Kieffer & Herman, LLP, which has offices throughout New York State. Mr. Feldman is a graduate of the University of Buffalo School of Law and has counseled health care professionals for over 35 years. Mr. Eagan is a graduate of the Tulane University School of Law and has an active trial practice focusing on medical malpractice litigation.

David Axelrod, M.D.: His Impact on the Law and Public Policy

By Peter J. Millock

David Axelrod, M.D., served as New York State Commissioner of Health from January 1979 to May 1991. His tenure extended over four gubernatorial terms and 13 legislative sessions. During that time, the State Legislature added 25 articles to the Public Health Law[1] and substantially changed 20 other articles;[2] the State Department of Health promulgated more than 750 regulations;[3] and the State Court of Appeals decided 143 cases to which the Department of Health or Dr. Axelrod was a party.[4] As the nation's foremost public health official of the 1980s,[5] Dr. Axelrod helped to shape these developments in the law and the public policies these laws reflected.

This article marks the 30th anniversary of Dr. Axelrod's appointment as Governor Hugh Carey's Commissioner of Health. It will outline the sources of Axelrod's perception of the law and public policy and examine the areas of the law and policy where his impact was greatest.

Axelrod's view of the law affected the following issues:

- Toxic substances and hazardous wastes
- Smoking
- Medical ethics
- AIDS
- Medical Malpractice
- Quality of Care
- Access to Health Care

1. Toxic Substances and Hazardous Wastes

David Axelrod first made his mark in the area of toxic substances and hazardous wastes. As head of the New York State Health Department's laboratories and later as Commissioner, he directed the state's public health assessment efforts at the Love Canal in Niagara Falls, New York from 1977 to 1979.

Dr. Axelrod influenced the law concerning disclosure and confidentiality in the consolidated personal injury actions by hundreds of Love Canal residents. As part of the Department's efforts to gather epidemiological information about Love Canal residents in 1978, the Department prepared questionnaires for the residents and conducted interviews. The residents consented to the use of the questionnaire for research purposes only. Then, in the litigation brought by the residents, the corporate defendants sought access to the questionnaires. Axelrod resisted disclosure, asserting that Public Health Law specifically allowed the Department to secure and keep confidential information for research, that this was a critical state public health policy,[6] and that release of the questionnaires would undermine the Department's ability to secure such records to assess future threats to public health.[7]

The Appellate Division, Fourth Department agreed with Dr. Axelrod.[8] The Court read Public Health Law to bar disclosure and found that the "right" to confidentiality attached to the Commissioner of Health and not to the residents and so could not be waived by the residents.

Years later, Axelrod spearheaded an effort to reach toxic spill records sealed by a court. In that matter, the Xerox Corporation had entered into a settlement with two families who alleged that a toxic discharge from a Xerox plant had damaged their health. The judge sealed the records of the case. Later, the Department, gathering information about the spill, sought access to the sealed records. At Axelrod's direction, the Department of Health appeared as an *amicus curiae* to urge the court to grant Xerox's motion to modify the sealing order. The court denied Xerox's motion but, on its own motion, partially unsealed the record to allow access to epidemiological and environmental data.[9]

This case sparked concern about sealing records of court settlements. After the decision, Chief Judge Wachtler of the New York Court of Appeals asked the court system's Advisory Committee on Civil Practice to study the issue. In 1991, the Uniform Rules for Trial Courts were amended to require a court to determine good cause for sealing and, in reaching that determination, to consider the "interests of the public as well as of the parties."[10]

Axelrod's fear that there were other "Love Canals" elsewhere in the state led him to push for broad legislative mandates to address old hazardous waste sites. In 1979, the State Legislature passed a landmark law giving the state specific authority to address hazardous waste sites.[11] The law reflected the bifurcation of responsibility for the problem between the State Departments of Environmental Conservation and Health by giving each agency its own extraordinary powers. The Department of Health's powers were triggered by a finding that the site posed a "condition dangerous to life or health."[12]

Axelrod's influence on the government's response to chemical exposure cannot be measured soley by particular laws and decisions. His impact was felt in the whole mode of government decision making and its legal manifestations. Axelrod was a vigorous proponent of risk assessment as a basis for government action. By risk assessment, he meant a detailed scientific quantification of likely

morbidity or mortality resulting from a particular regulatory standard or action.

He wrote in 1978:

> As I have repeatedly emphasized, safety, after all, is a political judgement, not a toxicologic one, nor one of absolute certainty. It is composed of two components: An estimate of hazard, and a policy constraint expressed or implied for accepting a degree of hazard in exchange for benefit. With respect to the first component, we look to scientists, technologists, epidemiologists and others for an objective evaluation of hazard. With respect to the second, we look to administrative process.[13]

Explaining this to the court in the Love Canal trial 12 years later, he said:

> Ultimately the determination of the acceptability of a level of risk is a governmental determination based upon—or a societal determination based upon the potential benefits as well as the risk associated with a particular exposure. In a case where there is effectively no benefit one might conclude that there should be zero risk. . . .[14]

2. Smoking

Dr. Axelrod was directly responsible for the establishment of the most extensive statewide restrictions on smoking in indoor areas open to the public in the nation and, concurrently, for one of the most restrictive readings of state agency rulemaking discretion by the New York Court of Appeals.

Axelrod was a longtime advocate of personal behavior modification and public health education. He often decried the emphasis on high-cost cures in lieu of low-cost prevention. As Commissioner of Health, he fostered programs for prenatal testing, prenatal care, immunization, child nutrition, and primary care programs. He also shared the growing sentiment among medical professionals that smoking was a pernicious addiction that was costing society and the health care system billions of dollars a year.

While the State Public Health Law had restricted smoking in some public places (e.g., libraries and museums) since 1975,[15] the State Legislature had rejected perennial efforts by anti-smoking advocates to extend these restrictions. The Legislature's failure to act despite the mounting scientific evidence about the harm caused by secondary smoking persuaded Axelrod that the State Legislature would never withstand the strenuous opposition of the tobacco industry to meaningful restrictions on smoking.

In 1986, Axelrod asked the State Public Health Council to examine the possibility of imposing restrictions on smoking through regulation. The Public Health Council was created in 1913[16] to set public health policies through the State Sanitary Code.[17] The Sanitary Code addresses issues as diverse as drinking water quality, summer camp safety and AIDS reporting. The Council is made up of the Commissioner of Health and 14 other members appointed by the Governor with the consent of the State Senate.

The Public Health Council responded to Axelrod's request with enthusiasm. It held public hearings across the state. It solicited medical and legal advice and negotiated with numerous affected persons from bowling alley proprietors to bingo game sponsors. In February 1987, the Council approved broad restrictions on smoking in indoor areas open to the public.

The regulation was to go into effect in May 1987, but just before its effective date, a restaurant owner in rural Schoharie County, New York challenged the Public Health Council's authority to promulgate the smoking restrictions. The plaintiffs asserted that only the Legislature, and not the Council, could impose smoking restrictions.

The Court of Appeals agreed with the plaintiffs. In its 1987 decision, *Boreali v. Axelrod*,[18] the Court found several "coalescing circumstances" supporting its conclusion that the Public Health Council had usurped a legislative function. The "coalescing circumstances" identified by the Court were that the regulation was based upon economic and social, and not public health concerns; the restrictions were comprehensive; the State Legislature had repeatedly failed to extend smoking restrictions; and the Council did not need special expertise and technical competence to develop the regulation.

Two years after the *Boreali* decision, the State Legislature passed smoking restrictions[19] almost identical to the aborted Public Health Council regulations. The minor differences were largely in the enforcement mechanism. The connection between the Council regulations and the Legislature's statute was clear. The Council's efforts focused public attention on the issue and galvanized public support for legislative action when the Council's efforts failed. If the Public Health Council had not acted, smoking legislation would have been delayed or failed entirely.

One unintended consequence of Axelrod's smoking initiative was the legacy of *Boreali*. *Boreali* is now commonly cited in complaints and briefs filed by regulated industries against any agency regulation. The Court has tended to limit *Boreali* to its particular "coalescing circumstances,"[20] but, without doubt, it encouraged regulated industries to challenge regulations and made government agencies leery of using regulations in lieu of legislation.

3. Medical Ethics

In the second half of Dr. Axelrod's tenure, New York State broke new ground on several key medical ethics issues and developed new confidence in its ability to deal with other issues of this kind. The vehicle for policy formulation was Governor Mario Cuomo's Task Force on Life and the Law.

Governor Cuomo created the Task Force by executive order in March 1985[21] in the wake of his well-publicized speeches on abortion. He had a long-standing interest in medical ethical issues and was concerned that the Legislature and the state agencies were unable or unwilling to reach agreements on the appropriate public approach to these complex and divisive issues.

The Task Force includes physicians, theologians, and lawyers. The religious and ethnic diversity of its membership reflected the diversity of New York State. Axelrod chaired the Task Force and actively directed its work. The Task Force supplanted less formal advisory groups that Dr. Axelrod had assembled to advise him on medical ethics questions.

Axelrod urged the Task Force to devise practical solutions to ethical questions. This meant that the Task Force, going beyond its closest model, President Carter's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, developed and promoted proposed laws for legislative consideration.

However, on the first issue it addressed—determination of death—the Task Force shied away from legislation and, at the Commissioner's urging, proposed a Department of Health regulation recognizing brain death as a basis for determining death. Axelrod believed that the State Legislature would not overcome objections of the Orthodox Jewish community to incorporating brain death standards into law.

The Task Force issued a report on determination of death in 1986.[22] As authority for a regulation, the Task Force relied on the Court of Appeals decision in *People v. Eulo*,[23] a criminal case, in which the Court held that irreversible cessation of all brain activity satisfied the legal definition of death. The Department promulgated the recommended regulation in 1987.[24] The regulation recognized cessation of brain function as a possible basis along with cessation of heart and lung function for a hospital to determine that death had occurred.

While the regulation was pending, the State Assembly was considering a bill which would force hospitals to accommodate the religious beliefs of patients concerning determinations of death.[25] In Axelrod's view, this bill would undermine one goal of the pending regulation—a definite and universal basis for determining death.

However, in order to respond to the concerns of the Orthodox Jewish community, Axelrod agreed to add language to the regulation drafted by the Task Force. The added language required hospitals to establish a written policy which includes a procedure "for the reasonable accommodation of the individual's religious or moral objection to the determination as expressed by the individual, or by the next of kin or other person closest to the individual."[26]

The Task Force on Life and the Law next tackled do-not-resuscitate (DNR) orders. The stage was set for Task Force deliberations on this issue by newspaper reports about issuance of DNR orders without the consent of patients and a December 1986 Grand Jury report of similar abuses at a hospital in Queens, New York.[27]

The Task Force ultimately recommended detailed legislation to protect patients from being subjected to DNR orders without consent and the opposite problem—undesired resuscitation. The law passed by the Legislature in July 1987[28] addressed a multitude of issues including the determination of the patient's capacity to make decisions about DNR orders, surrogate decision making for patients who lacked capacity and dispute mediation.

In addition to shepherding the proposal through the Task Force, Axelrod strongly supported two key provisions of the DNR proposal which facilitated its passage by a reluctant Legislature. The first provision was the presumption that every person admitted to a hospital consents to a cardiopulmonary resuscitation (CPR).[29] The second provision was the requirement that a surrogate decision maker consider the patient's religious and moral beliefs to determine the patient's wishes about CPR.[30]

The next major work of the Task Force was in the area of surrogate decision making and, in particular, the use of the health care proxy. The immediate impetus for Task Force deliberations in this instance was an opinion from the New York Attorney General that durable powers of attorney for financial matters could not be used to delegate powers to decide about medical care.[31] Therefore, persons lacked a vehicle for controlling health decisions required after they became incapacitated.

The Task Force deliberations on health care proxies focused on the scope of the agent's authority, the commencement of the agent's authority, the nature of the proxy form, the physician's obligation to respect the agent's decision, and the liability of the agent and physician.

At Axelrod's behest, the Task Force approached the proxy as a procedural mechanism to effectuate a person's wishes and not a limitation on the substantive validity of such wishes. The Task Force did address two substantive health care decisions: the basic right recognized by the Task Force that a patient may choose to forgo health care

and the limitations placed on the agent's ability to reject nutrition and hydration for the patient.

The second limitation was crucial to addressing concerns of the Roman Catholic Church and assured its practical support for the landmark health care proxy bill passed by the Legislature in 1990.[32] Dr. Axelrod's personal credibility with the leaders of the Roman Catholic Church in New York and key advisors to the Church was crucial to their acceptance of the proxy bill with this limitation on the agent's authority. As in the case of the determination of death regulation, Axelrod's recognition of and acceptance of religious diversity and basic understanding of and sympathy toward many religious concerns allowed him to craft compromise language.

4. AIDS

The AIDS epidemic dominated the public health forum during most of Dr. Axelrod's tenure as Commissioner of Health, though it was unknown to policy makers when he took office in 1979. His course in setting the state's AIDS policies, more than in any other public policy area, revealed his effort to harmonize government police power and individual rights. He favored public health education, protections against discrimination, and universal precautions against transmission of infection. These programmatic choices affected his position on the following legal issues:

- closure of gay bathhouses
- HIV testing and confidentiality legislation
- listing of AIDS as a communicable and sexually transmissible disease
- use of HIV status in insurance determinations

As public awareness of the AIDS epidemic grew in the 1980s, public outrage at promiscuous gay sexual activity increased. The San Francisco health commissioner unsuccessfully attempted to close gay bathhouses in that city. Public attention switched to New York City in 1985, pressuring Mayor Koch and, to a lesser degree, Governor Cuomo, to do something about the gay bathhouses in Manhattan.

Initially, Axelrod encouraged the State Public Health Council to prohibit facilities from allowing "unsafe sexual activities" on their premises. After much debate about whether "unsafe" activities should include vaginal sex, the Council, at Axelrod's urging, opted for a narrower definition because of limited evidence of heterosexual transmission and a judgment that a broader definition would undermine the efficacy of any restriction. The Public Health Council adopted the regulation in October 1985 over the strong objection of AIDS advocates.[33]

The City of New York then used the regulation to inspect several gay bathhouses in Manhattan. Axelrod directed State Health Department investigators to assist the city and to inspect similar facilities elsewhere in the state.

Based on the investigation, the City of New York brought a legal action to close one of the more popular gay bathhouses. The bathhouse operator resisted the City's suit and challenged the Public Health Council regulation for lacking scientific merit and as an invasion of its patrons' rights of privacy and association. The court deferred to the scientific judgment of the Council, rejected the constitutional claims of the defendants because of the particular dangers of AIDS, and granted the City a preliminary injunction closing the bathhouse.[34]

While this activity may have presaged a regulatory approach to AIDS, it was a symbolic act demonstrating the state's insistence that gays modify their lifestyles to curb the disease and the only effort of the kind fostered by Axelrod. His next contribution was to the landmark legislation passed in 1988 to restrict disclosure of AIDS information.[35] This law, strongly supported and influenced by Dr. Axelrod, required patient consent for AIDS testing, mandated counseling for all HIV test subjects, limited access to that information by persons providing medical care and social services to the patient, and authorized contact notification only when there were known needle and sex partners whom the physician reasonably believed the seropositive individuals refused to inform.

Axelrod also fought discrimination against persons with AIDS in less dramatic ways. When a major hospital in Westchester County refused to hire an HIV-positive person as a pharmacist, Axelrod fined the facility and insisted upon numerous commitments from the facility for staff training and heightened records confidentiality.[36] When a major nursing home on Long Island refused to admit persons with AIDS, Axelrod fined the facility and secured commitments for non-discriminatory admissions and staff training.[37]

Axelrod also opposed listing AIDS as a communicable and sexually transmissible disease as those terms were defined in the Public Health Law and regulations. Listing as a communicable disease would allow local boards of health, among other things, to isolate infected persons,[38] to quarantine premises,[39] to seek judicial commitments of infected persons to hospitals,[40] and to verify sources of the disease.[41] Designating AIDS a sexually transmissible disease would require local boards of health to provide free diagnosis and treatment of the disease[42] and require clinics providing obstetrical and gynecological care to offer tests for the disease.[43] Dr. Axelrod believed these implications of listing would discourage voluntary testing for HIV and erode the confidentiality of seropositive persons, thereby jeopardizing their employment and housing.

Axelrod's refusal to list AIDS as a sexually transmissible and communicable disease was challenged by the

State Medical Society and several specialty societies which sought a court order mandating listing. Axelrod's discretion not to list was supported by the Court of Appeals in *NYS Society of Surgeons v. Axelrod*.[44] The court, in its unanimous decision, narrowed the question to the value of mandatory testing and contact notification and accepted Dr. Axelrod's position that those activities would be impractical and would deter cooperation of HIV-positive persons with public health officials. The court also said that listing would be inconsistent with the AIDS anti-disclosure law.

Axelrod also promoted access to insurance for HIV-positive persons. As the asymptomatic period for AIDS lengthened, he feared that more and more persons either HIV-positive or with identified risk factors for AIDS would be denied years of health coverage and, thereby, be without adequate health care for both AIDS and unrelated illnesses.

Axelrod urged the State Superintendent of Insurance to adopt regulations prohibiting underwriting practices which might increase the number of uninsurable New Yorkers. He officially certified to the Superintendent that such practices were contrary to the health care needs of the public. The Insurance Department adopted a regulation[45] which banned insurers from (i) considering HIV test results in determining an applicant's insurability, (ii) requesting an applicant to submit to HIV testing, or (iii) inquiring whether an applicant had previously submitted to an HIV test or about the results of an HIV test.

The insurance industry challenged the regulations and the Court of Appeals, in *Health Insurance Association of America v. Corcoran*,[46] affirmed the Appellate Division, Third Department's invalidation of the regulations for the reasons stated by that court. The Third Department[47] had reasoned that using HIV test results as a basis for determining insurability was a sound underwriting practice and, citing *Boreali*, found that the Superintendent had severely stretched his authority over the form, content and sale of insurance policies to further the Commissioner of Health's public health policy objectives.

5. Medical Malpractice

The medical malpractice debate has raged across the land for decades and nowhere have the battles been as fierce as in New York State. Since the mid-1970s, the State Legislature has been the forum for debate about changes in the tort system and has enacted many reforms.[48] The State Department of Health was not very involved in these debates until 1986 when Dr. Axelrod convinced the State Legislature to authorize and fund a study of medical practice in New York State. Axelrod believed that the debate between physicians and trial lawyers had been characterized by rhetoric and not fact. He wanted the facts.

At Axelrod's request, Harvard University commenced a massive evaluation of hospital care, medical malpractice cases, costs incurred by victims of poor care, and physician practice responses to the prospect of malpractice litigation in New York. The State Medical Society and the State Hospital Association joined in the work. The results of the study[49] were released by Axelrod and Harvard in February 1990. Trial lawyers immediately condemned the study's conclusion that the tort system fails to compensate many victims of poor care. Organized medicine embraced that finding but downplayed the study's conclusion about the actual extent of poor care.

Influenced by the Harvard Study findings, Axelrod described the medical malpractice system as follows:

> Our experience with the existing malpractice system has demonstrated major inequities not readily tolerated in a democratic system. Only a relatively small number of individuals ever receive compensation for injuries resulting from medical care. The amount of time from injury to final settlement is inordinate, and places additional burdens on the injured party. A relatively small percentage of the total expenditure directly related to the malpractice system ever finally reaches the injured party. The transaction costs for the present system are disproportionately high in terms of the benefits provided to injured parties.[50]

The failure to provide benefits to victims of poor care was illustrated later in 1990 during a series of public hearings on the Harvard Study held by the Departments of Health and Insurance. At each hearing, victims poignantly described the physical, emotional and monetary burdens of the poor care they had received, but only one of these victims had secured any compensation from the medical malpractice system.

Axelrod urged the adoption of a new way to compensate victims of poor care. He envisioned a system that did not depend on a laborious and sometimes fruitless effort to prove fault, a system that worked quickly and cheaply and, most importantly, a system which provided compensation to many more victims than the current one. We are still waiting for this vision to become a reality.

6. Quality of Care

Among his many governmental responsibilities, Dr. Axelrod gave highest priority to assuring that physicians and health facilities provided adequate quality of care to their patients. No other activity occupied as much of his time or emotional energy as this effort. No other aspect of his work brought him more credit and enmity.

Axelrod ceaselessly spoke out against negligent and impaired physicians. He was a proponent of a strong physician discipline system. Every disciplinary case passed across his desk, and he diligently examined cases and not infrequently recommended stricter sanctions than the committee which heard the evidence and the State Board of Regents, which issued the final disciplinary decision.

The most significant structural reform in the disciplinary process was effected after Axelrod's resignation when the State Board of Regents was eliminated from the process.[51] Two years earlier, in 1989, Dr. Axelrod made the crucial decision which facilitated passage of the reform bill when he suggested that the Commissioner of Health also be eliminated from case reviews. This balance—the elimination of both the Regents and the Health Commissioner—made the reform bill more palatable and strengthened the argument that it would simplify the disciplinary process.

While he devoted much time and energy to physician discipline and was personally offended by poor care, Axelrod came to recognize the inherent insufficiencies of this and any case-by-case enforcement scheme. He was acutely aware of the inadequate investigatory and prosecutorial resources available to the State and the fiscal impossibility of hiring enough staff to do the job. He was also discouraged by the time administrative adjudication and litigation took and he was frustrated by the constraints that rules of evidence and procedure placed on access to the facts in a case. As a result, Axelrod favored broader, more structural assurances of good medical care.

One such assurance was periodic physician recredentialing. In May 1986, at Axelrod's urging, Governor Cuomo announced his support for physician recredentialing and directed Axelrod to establish a committee on the subject.[52] The committee's January 1988 report strongly supported recredentialing of all physicians and examined ways recredentialing could be done.[53]

Another assurance of better medical care strongly advocated by Axelrod was meaningful consumer information about health providers. He championed consumer information because of his basic scientific inclination toward informed decision making; he believed that informed consumers would raise standards of provider performance and force providers of poor care out of the market. The Department's reports on Caesarean sections[54] and hysterectomies[55] were examples of this effort. The most sophisticated initiative was the Department study of cardiac arterial bypass grafts released in December 1990.[56] This study developed detailed information on relative performance by cardiac surgeons in New York and the hospitals where they worked.

Axelrod released the names of the hospitals and the quality of their relative performance on bypass grafts, but he refused to release the same information for individual physicians. While this contradicted one of his goals for developing this type of information, Axelrod felt constrained by the prohibitions in the state's Personal Privacy Protection Act against government release of personal information[57] and did not want to dissuade providers from cooperating with the Department's information gathering efforts.

Newsday commenced a lawsuit to challenge this stance. In 1991, the Supreme Court, Albany County, decided that the Department must release the information about individual physicians.[58] The court reasoned that the surgeon has no legitimate expectation that the results of his surgery will not be released to the public and that any such expectation is outweighed by the public interest in obtaining it.

Axelrod was also a strong advocate of hospital quality assurance and frequently spoke publicly about this subject. This emphasis on quality assurance was reflected in Axelrod's insistence that hospital boards be knowledgeable of and accountable for deficiencies in care; that deficiencies be measured as objectively as possible based on outcomes, not procedural compliance; and that hospitals themselves perform most quality assurance activities.

Axelrod wanted all hospitals to be judged not by paper compliance with procedural standards, but through an objective evaluation of health outcomes. For this reason, in 1988, he disassociated the state's hospital survey process from the Joint Commission on Accreditation of Hospitals. He also directed that the Hospital Code be reformed to focus on outcomes rather than process and structure standards. The new code reflected an emphasis on outcomes and prescriptive rules in areas where Axelrod believed that currently accepted practices and procedures were not sufficient (e.g., anesthesia and maternity services).[59] He also backed changes in both the hospital and nursing home survey process which focused on identifying outcomes which diverge to a significant degree from acceptable norms as the basis for citing a facility for a violation of quality of care regulations.[60]

Finally, Axelrod believed that he had to rely on hospitals to regulate themselves because hospitals were more familiar with their strengths and weaknesses and the state would never have enough resources to police them. The quality assurance amendments passed in 1985 at his behest required that hospitals develop coordinated malpractice prevention programs,[61] conduct investigations prior to granting or renewing physician privileges,[62] and report to the state on certain incidents occurring in the hospital.[63] Even the stipulations negotiated between the Department and errant hospitals required the hospitals, and not the Department, to do most of the quality assurance work.

Axelrod recognized that many hospitals would be reluctant to assume these burdens of quality assurance. At times, he took a more directive approach as illustrated

by his effort to limit the long hours of work demanded of hospital interns and residents.

In 1986, the Libby Zion case dramatized the medical implications of long hours of work for interns and residents and the inadequate supervision of house staff. Libby Zion was a young woman who died in a Manhattan hospital when exhausted residents allegedly ignored her rapidly deteriorating condition. While the Department brought actions against the facility and physicians involved,[64] Dr. Axelrod thought a more structural change was required. He established a commission to review the issue.[65] The commission issued a report in October 1987[66] strongly advocating restrictions on working hours for interns and residents. Those recommendations were promulgated as part of the hospital code effective January 1, 1989.[67] A subsequent legal challenge to the regulations by the Hospital Association of the State of New York failed.[68]

7. Access to Health Care

A key factor defining Dr. Axelrod's term as Commissioner of Health was his firm support for broader access to health care. Axelrod fought to save inner city hospitals in financial distress,[69] to pay hospitals more for their bad debt and charity care,[70] to create the state health service corps,[71] to break down artificial constraints on practice by nurses[72] and midwives,[73] to establish less expensive alternatives to acute care facilities and nursing homes, and to require that health insurance coverage be community-rated and made available on an open enrollment basis. On a more philosophical level, he opposed two-tiered health care systems and health care rationing schemes despite their growing appeal at a time of scarcer resources and an aging population.

Axelrod believed that facilities should have a legal obligation to provide care to the poor. He was particularly distressed that facilities enjoying tax exemptions did not provide extensive free care to the poor, but he could not excite interest in reviewing the tax exempt status of those facilities.[74]

Axelrod was more successful in implementing requirements that nursing homes admit Medicaid patients. Again, he chose as his forum the Public Health Council. At Axelrod's request, the Council studied the question of whether nursing homes were admitting Medicaid eligible persons in their catchment areas. The Council concluded that many nursing homes were not doing enough and promulgated a regulation to correct the problem.[75] The regulation required that applicants for certificate of need approval for new nursing homes admit Medicaid eligible persons at a rate equal to a certain percentage of the Medicaid admissions rate of facilities in the same planning area in which the beds were to be located.

The proprietary nursing home industry challenged the regulation under *Boreali* as beyond the Public Health Council's authority and as an unauthorized quota, but, in 1991, the Court of Appeals upheld the regulations.[76] The Court found that the Legislature had articulated a policy in favor of access by the poor to nursing homes and empowered the Public Health Council to consider the needs of Medicaid patients in evaluating applications to build new nursing home beds. The Court also relied on the legislative policy decisions in favor of Medicaid patients when it rejected the petitioner's quota argument.

On a broader scale, Axelrod had long championed the need for universal coverage as an essential pre-requisite for a democratic society. He found it morally repugnant that the United States was the only remaining industrial democracy without this basic reform.

Axelrod came to see *universal coverage* as a term that symbolized much wider reform in the system, including especially a method for controlling equitably the growth of medical spending across all providers and not just hospitals. His experience with hospital and nursing home reimbursement legislation had persuaded him of the need for more stable and comprehensive financing reform of the system, including such mechanisms as a state budget and reimbursement tied to the state's ability to pay.

While Axelrod believed this was a national issue, he was ready for his state to begin the process of moving toward this critical reform.

He asked that the Department begin efforts to prepare a proposal in late 1987. A first draft was finished in early 1989. It was called Universal New York Health Care or UNY*Care. The draft was circulated among selected national experts and among state agencies.

A distinctive feature of the plan was its use of a "single payer authority" and an electronic claims clearinghouse. The single payer organization could help the state achieve many of the efficiencies of "single payer systems" financed entirely by taxes. The innovation could help the state continue to move toward reform, even in days when the fiscal climate forbade major new proposals expanding access.[77] Eighteen years after Dr. Axelrod's resignation, we are still debating these issues.

Conclusion

David Axelrod's approach to public policy and health law reflected his profound intelligence and practicality.

First, as demonstrated by Axelrod on almost all issues, he believed in an aggressive executive. He fashioned a non-traditional role for the Health Department to effect his policies. The reaction of the Court of Appeals to his aggressive exercise of government authority does not fit a clear pattern or consistent philosophy. The Court rebuffed Axelrod on smoking regulations and restrictions on a health insurer's use of AIDS information, but it upheld him with regard to listing of AIDS as a communicable

and sexually transmissible disease and requirements that new nursing homes admit Medicaid eligible persons. While the Court of Appeals did not draw a clear legal line between permissible and impermissible executive action, Axelrod pressed to and beyond that line wherever it was and whenever he judged the prospect for eventual success to be reasonably good.

The Legislature's reaction to Axelrod's aggressive style of public health leadership was clearer and more negative. The Legislature continued to pass major health legislation proposed by Axelrod, but it tried to constrain his agency's prerogatives by restricting its rule-making discretion.

Second, on all issues other than medical ethics, Axelrod chose the vehicle which he thought would best effect his health policy preferences. He was frequently skeptical of the Legislature's willingness to resolve contentious issues and chose the regulatory path over which he had more control to implement his policies. He was not confident in the ability of the lower courts to understand complicated health policy issues, so he did not pursue an affirmative litigation strategy.

Third, as seen in the debate over DNR and the health care proxy, Axelrod believed decisions about medical ethical issues were best resolved by the Legislature once a consensus was forged that would provide a basis for legislative action. This position was shared by the Court of Appeals which consistently deferred to the Legislature on ethical issues.[78]

Fourth, as seen in the discussion of AIDS, medical malpractice, and toxics, Axelrod believed that public health laws and regulations should be based, as far as possible, on facts and proof. Whether "scientific truth" will prevail in the disposition of any future health law issue cannot be predicted, but strong precedents for such reliance were set by Axelrod over a long period and the courts, in general, have appeared to be willing to defer to the kind of agency expertise and objective analytical capability that Axelrod tried to build in the State Health Department.

Endnotes

1. *See, e.g.*, Act approved July 5, 1989, ch. 244, § 5, 1989 N.Y. Laws 632, 632-39 (codified at N.Y. Pub. Health Law Art. 13-E (Regulation of Smoking in Certain Public Places) (McKinney P.P. 2009)). Act approved Sept. 1, 1988, ch. 584, § 2, 1988 N.Y. Laws 1132, 1133-42 (codified as amended at N.Y. Pub. Health Law Art. 27-F (HIV and AIDS Related Information) (McKinney P.P. 2007)) (further amended by Act approved March 26, 1991, ch. 193, 1991 N.Y. Laws 462).
2. *See, e.g.*, N.Y. Pub. Health Law Art. 25 (Maternal and Child Health) (McKinney 2007) (amended 1980, 1984, 1986, 1987, 1989, 1990, 1991); N.Y. Pub. Health Law Art. 28 (Hospitals) (McKinney P.P. 2009) (amended 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991).
3. *See e.g.*, N.Y. Comp. Codes R. & Regs. tit. 10, §§ 405.1-405.28 (1990) (eff. Jan. 1, 1989); N.Y. Comp. Codes R. & Regs. tit. 10, §§ 63.1 - 63.10 (1991) (final regulation eff. August 21, 1989).
4. *See e.g.*, *In re New York State Society of Surgeons v. Axelrod*, 77 N.Y.2d 677 (1991); *Boreali v. Axelrod*, 71 N.Y.2d 1 (1987).
5. Sack, *Health Chief's Illness Leaves Albany Policies in Doubt*, N.Y. Times, April 1, 1991, at 81, col. 1 (See comment of Dr. Howard H. Hiatt at 87, col. 2); Wehrwein, *Axelrod's Powerful Mix of Brilliance, Brashness*, Times Union, April 18, 1991, at 8-8, col. 1.
6. Affidavit of David Axelrod, M.D. at 8, para. 16 (December 30, 1981), *In re Love Canal*, 112 Misc. 2d 861 (Sup. Ct., Niagara Co. 1982) (No. 41203), *aff'd*, 92 A.D.2d 416 (4th Dep't 1983).
7. *Id*. at 10-11, para. 20.
8. *In re Love Canal*, 92 A.D.2d 416 (4th Dep't 1983).
9. *Del Monte v. Xerox Corp*., Index No. 14121/86 (Sup. Ct., Monroe Co. August 15, 1989).
10. Uniform Rules State and Federal, Part 216 (McKinney Pamph. 1991).
11. Act of July 20, 1978, ch. 487, 1978 N.Y. Laws 883 (codified as amended at N.Y. Pub. Health Law §§ 1389-a to 1389-d) (McKinney P.P. 2009).
12. N.Y. Pub. Health Law § 1389-b(2) (McKinney P.P. 2009).
13. Memorandum by David Axelrod, M.D., *Health Implications of Materials Found in or Associated with the Love Canal* (May 12, 1978).
14. Record at 3593-3594, *United States v. Hooker Chemical & Plastics Corp*., No. 79 Civ 990 (W.D.N.Y. Dec. 20, 1990).
15. Act effective July 1, 1975, ch. 80, § 1, 1975 N.Y. Laws 103 (repealed 1990).
16. Act of May 16, 1913, ch. 559, § 2, 1913 N.Y. Laws 1515, 1515-16 (current version at N.Y. Pub. Helath Law § 220 (McKinney 1990)).
17. Act of May 16, 1913, ch. 559, § 2-b, 1913 N.Y. Laws 1515, 1516-1517 (N.Y. Pub. Health Law § 225 (4) and (5) (McKinney 1990 & P.P. 1991)).
18. *Boreali v. Axelrod*, 71 N.Y.2d 1 (1987).
19. Act approved July 5, 1989, ch. 244, 1989 N.Y. Laws 632 (codified at N.Y. Pub. Health Law §§ 206(1)(p), 340(1)(b), 347(3) and Art. 13-E (McKinney P.P. 2009)).
20. *See, e.g.*, *Versailles Realty Co. v. DHCR*, 76 N.Y.2d 325 (1990); *New York State Health Facilities Ass'n. v. Axelrod*, 77 N.Y.2d 340 (1990).
21. N.Y. Comp. Codes R. and Regs tit. 9. § 4.56 (1984) (Executive Order No. 56).
22. New York State Task Force on Life and the Law, *The Determination of Death* (July 1986).
23. *People v. Eulo*, 63 N.Y.2d 341 (1984).
24. N.Y. Comp. Codes R. and Regs. tit. 10, § 400.16 (2007).
25. 1987-88 Assembly Bill 4882, 211th Leg., Regular Sess.
26. N.Y. Comp. Codes R. and Regs., tit. 10, § 400.16(e)(3) (2007).
27. *Report of the Special January Third Additional 1983 Grand Jury Concerning "Do Not Resuscitate" Procedures at a Certain Hospital in Queens County* (Sup. Ct., Queens Co. Crim. Term February 8, 1984).
28. Act effective April 1, 1988, ch. 818, 1987 N.Y. Laws 1526 (codified at N.Y. Pub. Health Law Art. 29-B (McKinney 2007)) (amended by Act approved March 26, 1991, ch. 370, 1991 N.Y. Laws 730).
29. N.Y. Pub. Health Law § 2962(1) (McKinney 2007).
30. N.Y. Pub. Health Law § 2965(5)(a) (McKinney P.P. 1991) (renumbered 2965(3)(a) by Act approved March 26, 1991, ch. 370, § 5, 1991 N.Y. Laws 730, 731-32).
31. 1984 Op. Att'y Gen. 58 (No. 84-F16).
32. Act effective January 18, 1991, Ch 752, 1990 N.Y. Laws 1533 (codified at N.Y. Pub. Health Law Art. 29-c (McKinney 2007)).
33. N.Y. Comp. Codes R. & Regs. tit. 10, §§ 24-2.1 through 24-2.3 (1988), repealed in 2000.

34. *City of New York v. New Saint Mark's Baths*, 130 Misc. 2d 911 (Sup. Ct., Spec. Term N.Y. Co. 1986), *aff'd*., 122 A.D.2d 747 (1st Dep't 1986).
35. Act approved September 1, 1988, ch. 584, 1988 N.Y. Laws 1132 (codified as amended at N.Y. Pub. Health Law Art. 27-F (McKinney 2007)) (further amended by Act approved March 26, 1991, ch. 190, 1991 N.Y. Laws 462).
36. *In re Westchester, as operator of Westchester County Medical Center* (B.H.S. 88-31) (State of New York, Dep't of Health, December 1988) (Stipulation and Order).
37. *In re Nassau County Department of Social Services, as operator of A. Holly Patterson Geriatric Center* (NH 90-31) (State of New York, Dept. of Health, June 1990) (Stipulation and Order).
38. N.Y. Pub. Health Law § 2100(2)(a) (McKinney 2002); N.Y. Comp. Codes R. & Regs. tit. 10, § 2.29 (2000).
39. N.Y. Pub. Health Law § 2100(2)(b) (McKinney 2002).
40. N.Y. Pub. Health Law §§ 2120 and 2123 (McKinney 2002).
41. N.Y. Comp. Codes R. & Regs. Tit. 10, § 2.6 (2007).
42. N.Y. Pub. Health Law § 2304(1) (McKinney 2002).
43. N.Y. Pub. Health Law § 2308-a (McKinney 2002).
44. *In re New York State Society of Surgeons v. Axelrod*, 77 N.Y.2d 677 (1991).
45. N.Y. Comp. Codes R. & Regs. tit. 11, § 52.27 (2002).
46. *Health Insurance Ass'n. of America, v. Corcoran*, 76 N.Y.2d 995 (1990).
47. *Health Insurance Ass'n. of America v. Corcoran*, 154 A.D.2d 61 (3d Dep't 1990), *aff'd*, 76 N.Y.2d 995 (1990).
48. *See, e.g.*, Act approved July 2, 1985, ch. 294, 1985 N.Y. Laws 685 (amended by Act approved July 8, 1986, ch. 266, 1986 N.Y. Laws 470).
49. *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, The Report of the Harvard Medical Practice Study to the State of New York* (1990).
50. Letter from David Axelrod, M.D. to Assemblyman James Tallon (May 23, 1990).
51. Act approved May 14, 1991, ch. 606, 1991 N.Y. Laws 1143.
52. *Report of the New York State Advisory Committee on Physician Recredentialing* 2 (January 1988).
53. *Report of the New York State Advisory Committee on Physician Recredentialing* (January 1988).
54. Bureau of Biostatistics, New York State Department of Health, *Cesarean Childbirth in New York State, A Statistical Profile* (November 1987).
55. New York State Department of Health, *Hysterectomies in New York State, A Statistical Profile* (June 1988).
56. Hannon, Kilburn, O'Donnell, Lukacik, Shields, *Adult Open Heart Surgery in New York State: An Analysis of Risk Factors and Hospital Mortality Rates*, 264 JAMA 2768-74 (1990).
57. N.Y. Pub. Officers Law Art. 6-A (McKinney 2008).
58. *Newsday v. New York State Dept. of Health*, No. 3408-91 (Sup. Ct., Albany Co. October 15, 1991).
59. N.Y. Comp. Codes R. & Regs. tit. 10, §§ 405.1-405.28 (2007).
60. Hospital Comprehensive Survey Process instituted in July 1988. New York Quality Assurance System (NYQAS)—surveillance system in effect October 1988 through June 30, 1991.
61. Act approved July 2, 1985, ch. 294, § 3, 1985 N.Y. Laws 685, 686-87 (codified as amended at N.Y. Pub. Health Law § 2805-j (McKinney 2007)).
62. Act approved July 2, 1985, ch. 294, § 3, 1985 N.Y. Laws 685, 687-88 (codified as amended at N.Y. Pub. Health Law § 2805-k (McKinney P.P. 2009)).
63. Act approved July 8, 1986, ch. 266, § 31, 1986 N.Y. Laws 470, 498-99 (codified as amended at N.Y. Pub. Health Law § 2805-1 (McKinney P.P. 2007)).
64. *In re The Society of New York Hospital, as Operator of the New York Hospital* (0C-87-17) (State of New York, Dept. of Health) (March 1987) (Stipulation and Order). After the administrative hearing, Dr. Axelrod recommended that the charges against Gregg W. Stone, M.D. and Luise L. Weinstein, M.D., be dismissed. *In re Gregg W. Stone, M.D. and Luise L. Weinstein, M.D.* (State of New York, Dept. of Health, State Board for Professional Medical Conduct) (November 14, 1989) (Commissioner's recommendation). The Board of Regents rejected Dr. Axelrod's recommendation. *In re Gregg W. Stone* No. 10462 (June 1990) (Vote and Order); *In re Luise L. Weinstein*, No. 10461 (June 1, 1990) (Vote and Order). The Appellate Division annulled the Board of Regents' determination. *In re Gregg W. Stone v. Thomas Sobol*, Nos. 61351/61352 (3d Dep't decided and entered October 31, 1991) (LEXIS, NY Library, APPDIV file). After the administrative hearing, Dr. Axelrod recommended that the charges against Raymond Lionel Sherman, M.D. be dismissed. *In re Raymond Lionel Sherman, M.D.* (State of New York, Dept. of Health, State Board for Professional Medical Conduct) (December 3, 1990) (Commissioner's Recommendation). The Board of Regents accepted Dr. Axelrod's recommendation *In re Raymond Lionel Sherman*, No. 11609 (April 30, 1991) (Vote and Order).
65. Final Report of the New York State Ad Hoc Advisory Committee on Emergency Services 1 (October 1987).
66. Final Report of the New York State Ad Hoc Advisory Committee on Emergency Services (October 1987).
67. N.Y. Comp. Codes R. & Regs. tit. 10, § 405.4(b)(6) (2002).
68. *In re Hospital Ass'n. of New York State v. Axelrod*, 145 Misc. 2d 345 (Sup. Ct., Albany Co. 1989), *aff'd*, 164 A.D.2d 518 (3d Dep't 1990).
69. N.Y. Pub. Health Law § 2807-a(9), now N.Y. Pub. Health Law § 2808-6) (McKinney 2007).
70. N.Y. Pub. Health Law §§ 2807-a(9) and 2807-c (McKinney P.P. 2008) (§ 2807-c amended L. 1991, chs. 165, 266, 519, 563, 677).
71. N.Y. Pub. Health Law §§ 231-233 (McKinney 2002).
72. N.Y. Ed. Law §§ 6902 and 6910 (McKinney P.P. 2001).
73. 1991-92 Assembly Bill 8784, 214th Leg., Regular Sess. 1991-92 Senate Bill 6321, 214th Leg., Regular Sess.
74. *See generally*, Fox, Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 Journal of Health Politics, Policy and Law 251 (Summer 1991).
75. N.Y. Comp. Codes R. & Regs. tit. 10, § 670.3 (1995).
76. *New York State Health Facilities Ass'n. v. Axelrod*, 77 N.Y.2d 340 (1991).
77. New York State Department of Health, *Universal New York Health Care (UNY*CARE), A Proposal* (Sept. 1, 1989).
78. *In re Westchester County Medical Center (O'Connor)*, 72 N.Y.2d 517 (1988).

Peter J. Millock is a member of Nixon Peabody LLP and its Health Services Practice Group. Mr. Millock's work is focused on affiliations and mergers of physicians and hospitals, regulatory and enforcement matters before state agencies, and legislative lobbying for health care entities. Mr. Millock served as General Counsel, NYS Dept. of Health, between 1980 and 1995. He is an Associate Professor at SUNY Albany, School of Public Health, and immediate past Chair of the Health Law Section of the State Bar Association.

I'm Interested in Health Law—Now Where Can I Get a Job?

By Jennifer S. Bard, J.D., M.P.H.

Introduction

Health care is a trillion-dollar industry[1] that has grown exponentially over the past 10 years with very little sign of slowing. The demand for legal services has tracked the growth of the industry,[2] and, as a result, attorneys calling themselves "health lawyers" have grown from a small core of specialists to a large and diverse group of individuals who are as likely to specialize in bond issuance and tax planning as in torts or food and drug law. Moreover, the increasing regulation of health care has created substantial need for lawyers specializing in compliance with a vast array of federal, state and local regulations. Where 15 years ago most health law was done by small, specialized law firms, today many of the nation's biggest law firms have thriving health law practices. Health lawyers have several different professional organizations[3] as their numbers continue to increase. The American Health Lawyers' Association boasts that their "membership is diverse not only in background but in their practice areas and settings. More than 10,000 members strong, the membership of Health Lawyers includes in-house counsel, solo practitioners, health professionals, government attorneys, academicians, and students."[4] Whether you are attracted to health law because of its robust growth or because you have a pre-existing interest in the health care industry, this article will help you explore the vast opportunities available to lawyers with an interest in health law. It will also provide you with the information you need whether you are currently in law school or are thinking of applying to law school.

The demand for lawyers familiar with the special needs of the health care industry is reflected in the rapid expansion of health law programs in the nation's law schools.[5] Where 10 years ago there might have been a lone course in law and medicine, there is now a variety of courses in health law ranging from malpractice to financial transactions, from ethics to biotechnology. While perhaps a dubious honor, health care law programs have attracted the attention of *U.S. News & World Report* and are now ranked every year.[6] Increasingly, law schools are offering certificates in health law for J.D. level students and graduate studies in health law for those who already have law degrees. These degrees, called LLMs, can be excellent springboards for lawyers looking to change their specialty. The appendix of this article contains a listing of health law graduate programs.

This article came about while I was teaching on the faculty of the University of Texas Medical Branch in Galveston, Texas and was co-teaching with Dr. William J. Winslade.in the University of Houston Law Center's Health Law LLM program. It has expanded over time and now has a more general focus on getting a job in the health law field at any stage of your career. There are specific sections on individual situations such as looking for work right out of law school and for students getting an advanced degree in health law. My premise is that knowledge about the field of health law, whether it is biotechnology, patients' rights, hospital acquisitions, or regulatory work opens the door to a wide array of interesting career opportunities. In addition to the traditional law firm positions, I will discuss working for the government, a non-profit, a corporation, and in academe.

About This Guide

Writing this guide for students interested in health law presents the challenge of speaking to all of you in your diverse interests and stages in your life. Many people studying health law are already health care professionals. Others are looking for their first job of any kind. Among graduate students the range of experience is even more diverse. Backgrounds vary from individuals who have just graduated from law school to experienced malpractice attorneys and even hospital counsel. What you all share is a desire to work in the health care field. I hope this article will be helpful to you. Its goal is to gather in one place a range of jobs which may interest you.

As indicated in the over one hundred Web citations in this article, the Internet is an invaluable source for career advice. There are sites which list health care law jobs, academic jobs, non-profit jobs and government jobs. Many of these sites also allow you to post your resume so it will be available to potential employers. In looking for Web sites I used two search engines, Ask.com and Google.com. Any search engine with which you are familiar will probably work just as well.

First things first: a lot about finding a job is common sense, and you already have a lot of options available to you. Whether you are in law school or if you have already graduated, your school's career services office is your best overall job counselor. If you want to work outside your school's geographic area, the career services office can probably get you reciprocity at another school. In addition, there are dozens of books providing guidance on everything from identifying your interests to networking.[7] I recommend that you go to your career services office, a well-stocked bookstore or a public library and read as many of these as catch your eye. Each book has at least a useful nugget of information that will help you in your job search. My guiding theory for all career advice is that you spend too much of your life at work to do something

you do not like. Although your focus as a job seeker is often to get hired anywhere, in fact there will always be options. Time you spend finding out what you want to do is well spent. That is why my primary advice to job seekers in law school is to take advantage of externships and clerkship opportunities that will get you inside places where you think you would like to work. I will talk about this more later, but the best strategy for getting hired is to become known to the person doing the hiring.

The classic way to start out thinking about what kind of work you would like to do is to read Richard Bolles' *What Color Is Your Parachute*,[8] which takes you through a series of exercises to identify what kind of job would fulfill your work needs. That's important. In the throes of job hunting it often seems that any job with a paycheck and health insurance is a job you want. However, to let you in on a secret, the more the job is compatible with what you like to do, the more likely you will get it and, having gotten it, will enjoy it and grow professionally in it.

Another good book concerns the practicalities of legal job hunting: *Guerilla Tactics for Getting the Legal Job of Your Dreams*, by Kimm Alayne Walton, J.D.[9] Walton promises your money back if you use her "tactics" yet do not have a "job you'll enjoy" "doing interesting work with people you like" within "one year of the day you graduate."[10] Another book which I found very helpful is Barbara Sher's *WishCraft*.[11] She has written several books including a must read for second-career folks called *It's Only Too Late If You Don't Start Now*.[12]

As I hope this article will show you, there are many sources to find current listings for jobs that may interest you. Despite this plethora of information, the concept of the "hidden job market" is still a very real one. These are jobs that have not been advertised yet or may never be advertised. They may also be jobs that do not yet exist. This market is your opportunity to be proactive. Identify firms, agencies, or companies for whom you want to work. Using the Internet or a paper directory find the name of the person at the entity doing the work you want to do. In the case of a legal job outside of a law firm, this will often be someone in the office of the general counsel at a hospital or insurance company. For purposes of career exploration, it is always better to contact someone doing the job you want to do rather than the human resources or personnel office. It may well be necessary to file an application with this office when there is an official job opening, but with the increasing availability of information about institutions and their employees through the Internet, you do not need to go through the personnel office first.

Contacting people in the places where you want to work is an effective general strategy because even if they do not have a job opening, they are in the position of knowing about them. Please understand, however, that you are contacting these people for information and do not expect that they will have job openings. On the other hand, some organizations like a state's Attorney General's Office keep a pool of interesting candidates and consult it regularly when there is an opening so it is worthwhile to come to their notice even if there is no current job being listed.

The process I describe above is often called "informational interviewing" and is gone into in much greater detail in many excellent books. Richard Bolles in *What Color Is Your Parachute* is the authority on "informational interviewing" and his book says almost everything there is to say.[13] I want to endorse the process, however, because I have often seen it lead to employment. For example, when I was looking for a job working in-house at a hospital, some of the best advice I got was to apply to State Attorney General's Offices since they are almost all involved extensively in health care law. I had no idea and it turned out to be the best advice anyone has ever given me.

For emphasis, though, I want to repeat Bolles' mandate that you should never ask these people for a job if you told them you are only there for information.[14] Rest assured that if they like you and do know of a job opportunity, they will tell you. Otherwise, just get their advice and write them a prompt thank you letter.

This handbook is divided into eight sections; they are:

1. How to Find a Job
2. Fellowship Opportunities
3. Career Advice on the Web for Lawyers
4. Help Finding Health Law Jobs
5. Tapping into the Non-profits
6. Finding Jobs in Academe
7. In-House Counsel
8. Finding Work in the Government

Part 1: How to Find a Job

Let's get started right away. Question number one: What do you want to do? Is this a trick question? Isn't the obvious answer that you "want to get a job?" Well, no. The most effective way to get a job is to know what kind of work you want to do. A wise person once advised me that it was impossible to get what "your heart desires" unless you know what that is. Too many people approach job searches from the perspective of seeing what jobs are available. You are most likely to find a position where you are satisfied if you devote some time to thinking about your interests. If I can't persuade you to read further and you still want to jump in, the appendix to this article has links to Web sites with jobs, lots of jobs. Dive in. But I encourage you to keep reading through the article as you do so. Even if you've already found a job you want, I have other advice that will increase your chances of getting it.

Are you back? Did you enjoy looking? Did you see a lot of jobs? Even if none of them interests you at the moment, these job sites are a good way to get a feel for the wide range of possibilities available to you. The jobs include everything from assistant legal director of a nonprofit in Washington, D.C., to an administrative position at a major university.

Here's something else you should remember while doing your search: Usually, the best way to get a job is to get your foot in the door first. If you are in law school, the way to do this is with externships or with summer clerkships. But even if you have graduated, many job seekers find that temporary or contract jobs are a good way to gain experience and make contacts while you show off your skills to a potential future boss. This is just as true if you are already working as it is for students. If you are practicing law in an area other than health law and want to make the switch, get on the Web and find the contact information for the health lawyers association in your city or state. I guarantee they will be delighted to have your help in planning meetings or other committee work even though you are interested in but not yet practicing health law.

Part 2: Fellowships Opportunities

There are a number of fellowship programs of interest to lawyers looking for jobs having to do with health. Most of the health law in the country is done by government attorneys in government agencies. Unfortunately, government jobs are highly sought after, and it can be very difficult to break in. That's why the Presidential Management Intern Program (PMI), which I will discuss in more detail later, is so valuable to students graduating from law school. The PMI is designed to attract outstanding graduate students to public service. While being paid a government salary, participants in the program have first crack at the most interesting policy jobs in government. These are jobs that would probably never be advertised. When the program is over, participants will have worked for four federal agencies and will have an inside track at being hired by the agency of their choice.

Another interesting fellowship program is the highly prestigious White House Fellows Program.[15] Since this is for individuals who are at the early to mid-stages of their careers, but not at the absolute beginning, it could be a very attractive opportunity for students who already have some experience in public service.

I have also included information on fellowships that provide for further training in health law policy or bioethics. Additional training in health law will make you even more attractive to the admissions committees of these programs.

Part 3: Career Advice on the Web for Lawyers

Everyone on the Web wants to give you career advice. I have identified those sites geared particularly to lawyers.[16] These sites are an interesting way to get a general feel for the market and, again, get further ideas of where to look for opportunities. The best sources of career advice are your professors, your career services office, and people you know (and will get to know) who do the kind of work you are looking for.

Part 4: Help Finding Health Law Jobs

It is important to understand that the way to find and get a job in health law depends on what type of job you are looking for. The primary distinction is between a job in a law firm or the legal department of a corporation and a legal job in an institution like a hospital for which law is not the primary activity. Another major distinction is the academic world—both teaching and administration—which has its own hiring process. It is with this distinction in mind that I raise the issue of recruiting agencies also called head hunters. First, these agencies probably cannot help you find a first job in a law firm. However, when you are making a lateral move or when you are trying to get a job in a health care institution, they may be able to help since these jobs are often filled through recruiters. The primary thing to know, however, is the difference between recruiters who are paid by your future employers and those who ask you to pay them. Be very wary of the latter. It should not cost you anything to be brought to the attention of an employer. If someone asks you for money to do this, investigate long and hard as to whether they really have information or contacts that you cannot get otherwise. Also, ask yourself whether the price they are charging is worth the service they are offering. Some companies, such as one I recommend, provide a useful service by charging you a small monthly fee for access to a searchable data base of job listings.[17] Another piece of conventional wisdom is that you shouldn't contact recruiters, but rather wait for them to contact you. That is not necessarily true when you are trying to switch areas or careers and they may not have heard of you. My advice would be to identify recruiters who seem to have interesting jobs in areas where you want to work. Write a personal letter to the recruiter telling him or her about your background and your interests. You will go into that recruiter's pool, most probably a computer database that will highlight you when a job arrives that matches your experience.[18]

Remember, too, that there are recruiters who are specific to specific industries and that you will want to investigate recruiters who fill health care administrative jobs as well as those whose focus is on placing lawyers. Thus, jobs in risk management, ethics, [19] compliance, or research may be in the hands of a health care recruiter, not a legal recruiter.

The etiquette of working with a recruiter is that whoever tells you about a job first is the one who gets the fee. That said, there is nothing to prevent you from contacting a number of different recruiters even if this ends up with two different recruiting firms alerting you to the same job.

You should know that like real estate agents, recruiters expect to get a commission from the employer if they bring the job to your attention. However, that does not mean that you cannot deal with several recruiters at once. Your responsibility is merely to identify who told you first. Any dispute about who that was will take place between the recruiters and will not affect your job chances.

A final word on recruiters: You will often see advertisements in legal publications for "career counselors" who specialize in placing lawyers in attractive, non–law firm jobs. These agencies will charge both you and your employer a fee. If you are offered these services for free in connection with being fired or laid off you should definitely make full use of their time, advice and contacts. I do not, however, think it's worth paying out of your own pocket for anything more than a few hours of consultation on, for example, your resume. Given the explosion of job information created by the Internet, it is just no longer true that these companies will know of jobs you could not find otherwise. Moreover, the "advice" they offer is freely available from your career counseling center, you favorite professors, many Web sites, and dozens of very helpful books.

Part 5: Tapping Into the Non-profits

The world of non-profit organizations offers a rich array of jobs for lawyers with health care experience. Since these entities don't have the money to advertise, as private firms do, it is somewhat harder to find out about openings. Luckily, there are a number of excellent Web sites that do a good job of listing open positions.[20]

The key to looking in the nonprofit sector is to think broadly. While certainly there are positions for lawyers per se, in fact there is a range of opportunities that may be of interest to you as a person with an interest in or knowledge of health care even though they are not characterized as "law jobs." These include jobs in policy, lobbying, and administration. In your local or career services library you will find a book called the *Yellow Guide* to non-profits. This lists every non-profit agency in the country. It is a rich source for identifying organizations in which you are interested.

Part 6: Finding Jobs in Academe

A. Positions in Academic Administration

The most common view of finding a job as a health lawyer in academe is to be hired by a law school to teach health law. This is, however, just a small slice of the pie. In addition to law schools, hundreds of institutions teach health law courses to people interested in being administrators and paralegals. As a lawyer with training in health law, you are also a very attractive candidate for an administrative job in a law school or other academic institution. The opportunities are even richer if you have an LLM. For example most law schools with an LLM program have an LLM as an administrator. Also, as law schools become complex conglomerations of "Institutes" and "Centers," the possibilities for jobs within the organization structure have increased exponentially. More traditionally, there are administrative jobs in student life, admissions, financial aid, and of course, career services. Further, as more schools realize the importance of internships, lawyers are being hired to run placement programs and supervise the participants. Much of this advice, and the advice below, is of general use to anyone interested in using their legal training to work in academe.

B. Legal Research and Writing

Many law schools have a legal research and writing program staffed by people seeking to begin academic careers. These jobs usually pay a reasonable, if not lavish, stipend and serve to put you on the faculty of a law school. They also provide excellent opportunities to gain teaching experience, find mentors, and even do some publishable writing of your own. Because many applicants are interested in only a two- or three-year stay, keeping these positions filled is an ongoing need for law schools. Of course, some people like teaching these courses so much that they eventually seek a permanent role as the head of a law school's legal research and writing program. It is important to investigate the specifics of the program of schools in which you are interested.

C. The Clinic

Almost every law school has a clinic which combines practical, hands-on experience with instruction from experienced attorneys. For a job seeker, these clinics combine the opportunity to share your knowledge with the next generation of attorneys while keeping your own skills sharp. Increasingly, law schools are developing special health law clinics or are adding health law cases to their clinic load. These developments have increased opportunities for lawyers with an interest in health care.

D. Teaching Law in a Law School: The Meat Market

The traditional way to get a law teaching job is the system sponsored by the Association of American Law Schools (AALS). This system is a highly organized combination of job fairs and dating service in which each candidate fills out one form outlining his or her credentials and these forms are sent out in 1,000-page books to every law school interested in hiring. Once a school's faculty appointment committee reviews all the forms, it selects candidates to invite for interviews at the central event in Washington, D.C. This is the "dating" part. After tremulously filing the form in August, you wait for the phone to ring. Then, if it does ring, you start making half-hour appointments for interviews with schools from across the country all in a single day. About two weeks to a month afterward, you may hear from a school inviting you to a second interview on campus.

That's the official story. In fact, the ins and outs of the law school hiring market are as complex as the tax code. Sometimes professors and judges will make specific personnel recommendations to schools where they have contacts. Schools looking for someone to fill very specific positions may directly contact known experts in that area.

Much good material has been written about navigating the law school teaching market. You can, and should, consult your professors to see if they can offer you strategic tips or even recommend you for a position. On average, fewer than 70 applicants are hired to teach law every year out of the thousands who apply. The prospects are even worse than statistics indicate since many individuals with platinum credentials receive multiple offers.

So that's the bad news. Here's the good news: Each of you is distinguishable from the general applicant pool to the extent that you are already a health care professional or have pursued further study in health law. A growing trend in law school hiring is to look for students with advanced degrees. While this includes the traditional LLMs, it has also expanded to include people with master's degrees and Ph.D.'s in health-related subjects like medicine and nursing, of course, but also public health, political science and history or economics.[21] The degree also guarantees that you have done some serious writing, which will make it easier for a law school to make the decision to hire you.

Since writing is so important, the most helpful thing you can do before entering the law teaching job market is to review all the papers you have written at a post-graduate level and choose the best candidates to turn into a law review article. Just as valuable are short pieces you write on legal topics for a professional organization with a publication such as the Hart Leadership Program Institute's Web site.[22] Those of you working already in health care institutions will discover that there are numerous self-published periodicals in desperate need of content. The secret to getting published is that the more publications you have in any respectable venue, the better your chances of getting your work into more selective media.

The core of being a law professor is to publish articles. When evaluating a candidate who has written nothing but a law review note, the schools must rely on traditional indications of success like clerkships and class rank. By presenting yourself as an individual who likes to write and does so often, you will lift yourself to the top of the pile.

Another way to get a teaching position in a law school is to develop a new health law course and pitch it to the Dean. You should also include information about your credentials and express your availability as an adjunct or lecturer. This works best for graduates who have actual experience in health care law that the existing faculty may lack.

E. Teaching Law Outside of a Law School

For many of us the only law teaching we know about occurs in law schools. This is not true. My job is to teach law to students in a medical school. There are similar positions in nursing schools, schools of public health,[23] allied health schools, and business schools that offer coursework in health law and policy. There is also a national network of local and community colleges that train paralegals and health care workers. To search for jobs with schools in your area, start by getting all the catalogs of every local learning institution. The suggestion about developing a new course that only you can teach applies here, too. Not only will you be paid for this work, but also if it goes well, you will be sought out in your community to teach and lecture.

F. Academic Administration Outside of Law Schools

Academe is also a rich source for interesting administrative jobs. Many colleges and graduate schools, for example, look for a lawyer to administer their internal honor codes and systems of internal discipline. Universities are wonderful places filled with centers and programs eager to have a lawyer as an administrator or director's assistant. Finally, in something of a contradiction to the usual view of lawyers in society, lawyers in academe are still presumed to "know" things about business, affirmative action, and complex problem solving that the usually quite sheltered faculty does not. Therefore, lawyers are sought after in Student Services positions.

Part 7: In-House Counsel

As outside legal services become more expensive, health care organizations and insurance companies have shifted their emphasis toward bringing the day-to-day legal operations under one roof. Serving as in-house counsel can be one of the most exciting health law jobs. You are on the front line as unique problems arise. The bad news, however, is that new law school graduates are almost never hired for in-house jobs because the hospitals and companies don't have the resources to give a new lawyer the training he or she will need to be effective. Luckily, recent federal legislation including HIPAA[24] and Sarbanes-Oxley[25] has made legal regulation compliance a hot issue and one that many companies, health care entities included, are addressing by creating compliance offices staffed by lawyers. After the dramatic shutdown of hospitals like Johns Hopkins[26] and the University of Pennsylvania,[27] any medical institution doing research is clamoring for lawyers to oversee their IRBs and to head off problems before they are front-page news. The American Health Lawyers Association has an active in-house counsel practice group which is an excellent source for information about issues, and jobs, in this area.[28]

In addition to compliance and research concerns, every hospital faces legal issues ranging from contracting for services, supplies, and equipment, to credentialing doctors and dealing with malpractice suits. A number of institutions have separated these functions into "legal counsel" which handles the contracting, employment disputes, patents, and "risk management," which is responsible for avoiding and managing medical incidents before they become lawsuits. A nurse/attorney is a top contender for a risk management job, as they are believed to understand both medical decision-making and liability control.

The caveat about these jobs is that people who have them love them and seldom leave. That's why you may have to be flexible regarding geography. Also, since these are often small departments, these in-house counsel offices often don't hire new graduates, but rather are looking for an individual with experience in a particular area such as contracting, patents, or Medicare reimbursement. Your first step in finding an in-house job at a hospital is to talk with people who already have these jobs. Learn what specialty areas they need and study them. If you have the opportunity, ask to work as an intern. Whether this is a formal program arranged through your school for academic credit or something you arrange yourself, it will give you experience to list on your resume and contacts in the field. Regarding specific openings, the best Web site is the American Health Lawyers Association's active job listing service.[29]

Part 8: Finding Work in the Government

The federal government of the United States employs millions of individuals. Many thousands more are hired by state, county and municipal governments. Lawyers in the federal government serve as FBI agents, prosecutors, and drafters of highly specialized legislation. There is so much available for a health care lawyer in government that the problem becomes sifting through opportunities to find what suits you best.

The federal government is huge and there is a wide range of entities and departments with positions for health law attorneys. The Department of Health and Human Services,[30] which encompasses stem cell research, drug approvals, and the Medicaid and Medicare division, may well be the largest employer of health care lawyers in the country.[31] The Food and Drug Administration (FDA) has its own legal staff to support is consumer protection mission.[32]

In addition to the many federal opportunities, each state presents a rich array of agencies and the lawyers who represent them. Much of this work is done through the Attorney General's Office. In all states the attorney general is an elected official charged with representing the legal interests of the entire state. In almost every case this includes a conglomeration of state hospitals, licensing boards, and regulatory agencies. While the character of every AG's office is different, the most effective approach is to contact the Attorney General directly. He will refer your letter to the lawyers who oversee hiring but, if you impress him, he can follow up with the staff. As always, another excellent route is to submit your resume through someone you know at the AG's office. This may help bring your application to the top of the pile.

Every Health Department, Department of Children and Families, Department of Mental Health, and Department of Social Services, which oversees the Medicaid Program, need lawyers. Here again, your most high-yield approach is to write the Commissioner. He or she will forward your letter to departments that are hiring. The best way to search for all federal jobs is through the website USA Jobs, http://jobsearch.usajobs.opm.gov. The general occupation code for legal jobs is 09, but you have a joint degree or other job skills you should search more widely for jobs, such as policy jobs, which do not require a law degree. The federal government has a very little known, very impressive program, called the Presidential Management Fellows program (PMF), which is designed to attract to the federal service outstanding graduate students from a wide variety of academic disciplines who have an interest in, and a commitment to, a career in the analysis and management of public policies and programs. PMF members have access to rotations in every federal agency where they can test their interests and skills. A high proportion of PMF graduates are hired by the agency of their choice in a process that is completely outside the world of advertised positions and letters of inquiry.

Another very prestigious program is the White House Fellows. This highly selective program brings promising, early career professionals into the Executive Branch, where they work closely with top officials. The White House Fellows program may be particularly appropriate for LLMs who have a background and a proven track record in human service professions.

Advice for Those in Law School Now

If you are in law school now you have the opportunity to select elective courses that will prepare you for a career in health law. What are these courses? Obviously the health law–specific courses you can take depend on the offerings of your law school. You should consult with your own faculty to get their ideas and advice. In addition to those classes whose main focus is health law, there are some important basics that will increase your marketability. These include employment and labor law; nonprofit taxation; intellectual property; commercial transactions and insurance law.

Also, while you are in law school, you should take every opportunity available to work in health law settings. Whether these are externships for credit or paid clerkships or even volunteer opportunities, your best chance of getting a job is to have worked in a place. This is only

common sense. If you were hiring someone, would you rather have a stranger with an impressive resume or an individual that you know to be smart, hard-working and easy to get along with? Also, use your time in law school to write. If you are on law review, do your note on a health law related topic. If you are not, meet with your professors to discuss opportunities to submit articles to scholarly publications outside of your school or to local or national professional organizations. Consider writing opinion pieces for local papers. These are terrific ways to build a reputation. Most newspapers are looking for pieces of no more than 750 words about a topic of current (and by current they mean that week) interest. Newspapers will almost always accept submissions electronically so you should be able to quickly respond when there is an item of interest in the news.

Advice for Those Contemplating Law School

For the convenience of those who have not yet applied to law school, here in one place is all the information you need to get started. Let me add some advice of my own. First, never, never take the LSAT cold. It is simply not true that you cannot study for the LSAT. You can and should. Unfortunately, your LSAT score and your GPA will be the primary factors in your law school admission. There are many commercial companies with proven track records in preparing people for the LSAT. I have no opinion on whether any one is better than another. I do know, however, that all are expensive. I would start the process by buying a book or on-line program that lets you take a sample LSAT so you have an idea of your strengths and weaknesses. You can then make a better decision about what kind of preparation material suits you best. Can you study on your own with commercial material? Would you do better with a short, group class? Do you need individual instruction? It's up to you, but please do yourself a favor and go in prepared. Other people will. Also, whatever their stated policy, every school engages in some sort of rolling admissions. So be prepared to get your application in at the first posted date that applications are accepted. Even if you are short a recommendation or a document, your application may be judged by date of filing, so get it in. It is easier to get in when the upcoming class is empty than when there are only a few slots left to fill. Finally, although law schools do not require interviews, almost every school will be receptive to your meeting with a member of the admissions department. Do this if you can—it can make the difference between your being a number and your being a known quantitative.

Here is a summary of some of the categories of pre-law information and resources.

Law School Admissions Council (LSAC)

The LSAC puts out a booklet, "Think About Law School," that outlines the process of taking the LSAT (Law School Admissions Test), what the LSDAS (Law School Data Assembly Service) does and the CRS (candidate referral service) does. This booklet also covers general overview information related to what to expect from law school, curriculum, statistics related to applicants, and a list of recommended resources for more information and LSAC publications.

Law School Data Assembly Service (LSDAS)

The LSAC website gives general information on the LSDAS process.[33] Essentially, the LSDAS prepares a report with an undergraduate academic summary, LSAT scores, letters of recommendation and transcripts. This report is disseminated to designated ABA-approved schools. The LSDAS report is available for five years after registration. Other information offered on the website includes: getting started, LSAT, ABA-approved law schools, fee information, financial aid information, minority perspectives, information for LGBT applicants, law school rankings and resources, and LSAC data.

There is also an LSAT/LSDAS checklist for how to get started. The LSAT & LSDAS information booklet explains pertinent information about creating an online account, registering for the LSAT, alternative testing, accommodations for persons with disabilities, fee waivers, refund policy, ethical conduct, test center arrangements, regulations, what to bring the day of the test, LSAT scoring, how to cancel the score, data and chart on success of repeating the LSAT, score reporting, information about LSDAS Law School Forums, letters of recommendation information, transcript information, information about predictors of law school performance and LSAT scores, confidentiality and fairness procedures.

Other Pre-law Internet Resources

- www.ilr.cornell.edu/studentservices/ac/lawschool.html—Cornell's student services site gives advice on applying to law school.
- http://stu.findlaw.com/prelaw/considering.html—Findlaw for students has a list of pre-law resources.

LSAT Prep Courses

- Get Prepped (http://www.getprepped.com/multiweekclass.html) offers a multi-week prep course for the LSAT. Option A offers 24 classes for $899 and Option B offers 15 classes for $579.
- Kaplan (http://www.kaptest.com) offers test prep services for the LSAT for around $1,100.
- Princeton Review (http://www.lawpreview.com/LP_2002/Edited/free_forum.php?) also offers LSAT prep courses.
- ScorePerfect (http://www.scoreperfect.net/sp/lsat/) offers an LSAT prep course for Texans in Austin, College Station, Dallas, Houston and San Antonio. The company is owned by Robin Singh, who also uses the TestMasters mark outside of Texas.

Other prep services: PowerScore (http://www.powerscore.com), PrepMaster's LSAT intensive review (http://www.prepmaster.com/toc.html), Oxford Seminars LSAT test prep master course (http://oxfordseminars.com/Pages/LSAT/lsat_about.htm), Campus Access (http://www.campusaccess.com/campus_web/educ/e5grad_lalstpre.htm).

Law School Prep Courses

- Barbri (http://www.lawschoolprep.com/program/program.shtm) offers a preparatory course for law school candidates. There is a 5-day program overview of the first year courses and mock classes and 1-day workshops on law school skills and legal research and writing.
- Princeton Review/ Law Preview Law School Forums offer free law school workshops on LSAT strategy, mock law school classes, and law admissions & career panel discussions. (http://www.lawpreview.com/LP_2002/Edited/free_forum.php?).

Law School Application Personal Statements

Admissions Essays offers assistance with writing law school personal statements.[34] This service essentially surveys personal information and helps write the personal statement. Cost for this service is $285. Another service is an essay critique service which reviews and critiques personal statements that were written by the applicant. The cost for the critique is $165.

Accepted is a website that offers tips and helpful instructions on how to write a personal statement.[35] This website also gives tips for writers of letters of recommendation, sample law school personal statements, and a list of "do's and don'ts" for writing the personal statement. This website also addressed addendums, optional essays, and wait-list follow-up letters. This website also offers law school application and personal statement consulting services.

Essay Edge also offers editing services for law school personal statements.[36] They also offer a comprehensive service package which includes a "seven-stage law school admissions consulting and writing process that will help you with topic selection, outline creation, and the editing of the final draft" for a cost of $299.95. Law360.com offers tips for writing law school admissions essays.[37] Virtual Red Ink offers editing services for personal statements from $30 to $170.[38] Admissions Consultants offers consulting services for J.D. and LLM admissions candidates.[39]

Financial Aid

LSAC offers a financial aid brochure, *Financial Aid for Law School: A Preliminary Guide*, that discusses financial aid options for attending law school and payment programs and options for after law school. Other financial aid resources are recommended on The Princeton Law Review website,[40] as well as various school and financial aid websites available by a Google search.

Early Decision Admissions Process

Many schools have an Early Decision process for applicants who have decided on a clear, first-choice school. The Law School commits to give an Early Decision to the applicant in exchange for the applicant's commitment to withdraw and not initiate further applications at other law schools after being accepted by the Early Decision school. The applicant essentially commits to attend a specific school in exchange for the certainty of an early admissions decision.

Conclusion

I hope this work in progress is helpful to you in beginning your job search. No matter how many times this piece is revised, however, it will not keep up with the explosive growth of information available on the Internet. Please let each other, and me, know of other useful sites you find in your own surfing. Final advice, though: you can't get a job sitting at home surfing the Web. It is absolutely true that the best way to find a job is through other people and the best way to get a job is by being there. All the efforts you make to be known to potential employers through informational interviewing, unpaid internships and committee work will bring you closer to what you want. Think about everyone you know and who they know. Remember that your school's health law faculty can be your most valuable link to health law jobs. Let them know what interests you so they can give your name to potential employers who call asking for a lawyer with health care expertise.

Good luck!

Endnotes

1. *See* U.S. Dept. of Health & Human Services, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (last visited Dec. 1, 2007). The United States Department of Health and Human Services' Centers for Medicare and Medicaid Services estimate that in 2005 the U.S. spent $2.0 trillion on health care. This equals $6,697 per person.
2. aareahttp://law.case.edu/student_life/journals/health_matrix/141/rothstein.pdf. (last visited Dec. 1, 2007). (In reflecting on the growth of health law over the past 50 years, Professor Mark Rothstein writes that

   > in the last fifty years, law has become an integral (if not universally welcomed) part of medicine. Physician practices are now concerned with privacy notices, informed consent documents, and advanced directives. At most hospitals, expanded in-house legal departments have been joined by related departments of risk management, regulatory compliance, and health information privacy and security. 213.

3. These organizations include the American Bar Association's Health Law Section, http://www.abanet.org/health/, which includes 12 separate interest groups, http://www.abanet.org/health/01_interest_groups/index.html; The American Health Lawyers' association, http://www.healthlawyers.org; The American College

of Legal Medicine, https://www.aclm.org/Default.aspx. In addition, almost every state bar has its own health care law section.

4. American Health Lawyers' Association, http://www.healthlawyers.org/Template.cfm?Section=Who_We_Are& Template=/ContentManagement/HTMLDisplay.cfm&ContentID=51783 (last visited Dec. 1, 2007).
5. *See* Henry Greely, *Some Thoughts on Academic Health Law*, 41 WAKE FOREST L. REV. 391 (2006); Mark Rothstein, *The Growth of Health Law and Bioethics*, 14 HEALTH MATRIX: JOURNAL OF LAW-MEDICINE 213 (2004).
6. U.S. News & World Report, *America's Best Graduate Schools 2008,* U.S. NEWS & WORLD REPORT, *available at* http://grad-schools.usnews.rankingsandreviews.com/usnews/edu/grad/rankings/rankindex_brief.php (last visited Dec. 16, 2007).
7. *See* American Bar Association, http://www.abanet.org/carreercounsel (last visited Dec. 20, 2007).
8. RICHARD BOLLES, *What Color Is Your Parachute*, Ten Speed Press, Published 2003.
9. KIMM ALAYNE WALTON, *Guerrilla Tactics for Getting the Legal Job of Your Dreams* (Harcourt Legal & Professional Publications, Inc. 1999) (1995).
10. *Id.*
11. BARBARA SHER, *Wishcraft: How to Get What You Really Want* (Ballantine Books, 2nd ed., 2003).
12. *Id.*
13. Bolles, *supra* note 8.
14. *Id.*
15. *See* White House Fellows Program, http://www.whitehouse.gov/fellows (last visited Dec. 20, 2007).
16. One of the most reliable websites is the American Bar Association, http://www.abanet.org/careercounsel.com (last visited Dec. 16, 2007).
17. Attorney Jobs, http://www.attorneyjobs.com (last visited Dec. 17, 2007).
18. *See, e.g.*, Recruiters Online, http://www.recruitersonline.com (last visited Dec. 16, 2007).
19. Ethics Jobs, http://www.ethicsjobs.com (last visited Dec. 17, 2007).
20. *See* Appendix.
21. *See, e.g.*, Grad Schools.Com, *Biomedical and Health Sciences Graduate Programs*, http://www.gradschools.com /biomed _health.html?WT.srch=1&gclid= CPrZrbXcjI8CFR2NgQodZTT9Hw; All Allied Health Schools, http://www.allalliedhealthschools.com/featured/health-administration-all-degree programs/?src=goo_ahs_hca_20355b; Guide to Health Care Schools.Com, http://www.guidetohealthcareschools.com (last visited Dec. 16, 2007).
22. *See* Hart Leadership Program Institute, http://www.pubpol.duke.edu/centers/hlp/index.html (last visited Dec. 17, 2007).
23. Public Health Law Association, http://www.phla.info/jobbank.htm (last visited Dec. 1, 2007). The Public Health Law Association has begun keeping a listing of jobs in public health law.
24. Health Insurance Portability & Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996).
25. Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745 (2002).
26. Meredith Wadman, Johns Hopkins Researchers Fume over Government Crackdown, Nature 412, 363 (July 26, 2001).
27. News story about shutdown by office of human subject research protection office.
28. American Health Lawyers Association In-House Council, http://www.healthlawyers.org/Template. cfm?Section=Group_Descriptions&CONTENTID= 42273&TEMPLATE=/ContentManagement/ContentDisplay. cfm (last visited Dec. 1, 2007).
29. American Health Lawyers Association, http://www.healthlawyers.org/Template.cfm?Section=Career_Center (last visited Dec. 16, 2007).
30. Dept. of Health & Human Services, http://www.hhs.gov (last visited Dec. 16, 2007).
31. For specific information about finding a job with the Dept. of Health & Human Services both regionally and in Washington, D.C. please consult the following two websites: http://www.hhs.gov/careers/findjob.html & http://www.hhs.gov/ogc/career. html.
32. Food & Drug Admin., http://www.fda.gov/jobs/attorney.html (last visited Dec. 1, 2007).
33. Law School Admissions Council, http://www.lsac.org/LSAC.asp?url=/lsac/lsdas-general-information.asp (last visited Dec. 17, 2007).
34. Admissions Essays, http://www.admissionsessays.com (last visited Dec. 17, 2007).
35. Accepted, http://www.accepted.com/law (last visited Dec. 17, 2007).
36. Essay Edge, http://www.essayedge.com/law/editing (last visited Dec. 17, 2007).
37. Law360, http://www.law360.com/law-school-admission-essays.html (last visited Dec. 17, 2007).
38. Virtual Red Ink, http://www.virtualredink.com/wst_page12.html (last visited Dec. 17, 2007).
39. Admissions Consultants, http://www.admissionsconsultants.com//lawschool/index.asp (last visited Dec. 17, 2007).
40. *See* The Princeton Review, http://www.princetonreview.com/home.asp (last visited Dec. 17, 2007).

Jennifer S. Bard, J.D., M.P.H. is a 1987 graduate of the Yale Law School and has worked in law firms, state and federal governments, and non-profits. Her experiences has ranged from her first job clerking for a Federal District Court Judge to her current job as a professor of law and director of the health law program at Texas Tech University School of Law. In between, she spent five years litigating mergers and acquisitions at a big New York Law firm, did a stint as a health care policy analyst at an AIDS Advocacy Group and taught on the faculty of a medical school.

Thank you to William J. Winslade, Ph.D., J.D., James Wade Rockwell Professor of Philosophy of Medicine at the Institute for Medical Humanities, University of Texas Medical Branch at Galveston, and Distinguished Visiting Professor of Law and Associate Director for Graduate Programs, Health Law & Policy Institute at the University of Houston Law Center, for encouraging me write the first draft of this for the LLM program at the University of Houston Law Center's Health Law Institute. Thank you to Texas Tech University School of Law students Kristi Ward '05, Pamela Ferguson '05, Gina Spike '06 and Brendan Murray '07 for their excellent work as research assistants. As with any work involving the Internet, the links were live when last checked but may well not be when referenced later.

APPENDIX

Law Employment Listings

- ABA Human Resources, http://www.abanet.org/hr/home.html
- ABA Internship Opportunities, http://www.abanet.org/hr/interns/home.html
- ABANET Internship & Career Opportunities, http://www.abanet.org/lsd/jobopp.html
- Advanced Legal Services, http://www.hrpages.com/law/
- Affiliates, http://www.affiliates.com/
- American Corporate Counsel Association Jobline, http://www.acca.com/jobline/
- American Health Lawyers Association, http://www.healthlawyers.org/home.htm
- American Internet Classifieds: Legal Employment Classifieds, http://www.bestads.com/aic/employment/legal/
- America's Job Bank, http://www.ajb.dni.us/
- AmeriClerk, http://www.americlerk.com/
- Arizona State University College of Law, http://www.law.asu.edu/placement/
- Assigned Counsel, http://www.assignedcounsel.com/
- Attorney Find, http://www.attorneyfind.com/
- Barrister Referrals, Ltd., http://www.barristerreferrals.com/
- Baylor University School of Law, http://law.baylor.edu/CareerSvcs/
- Bench & Bar of Minnesota, http://www.mobar.org/law/index.htm
- Boston University School of Law, http://www.bu.edu/law/careers/index.html.
- Brooklyn Law School, http://www.brooklaw.edu/career/
- Byron Employment Australia, http://employment.byron.com.au/
- California Western School of Law, http://www.cwsl.edu/main/default.asp?nav=career_services.asp&body=career_services/home.asp
- Cambridge Staff, http://www.cambridgestaff.com/
- Canadian Lawyer Index, http://www.canlaw.com/
- Career Builder, http://www.careerbuilder.com/
- Career Magazine, http://www.careermag.com/
- CareerPath.com (search help wanted ads from newspapers around the country)
- Careers & Jobs, http://www.starthere.com/jobs/
- CareerSite.com, http://www.careersite.com/
- Case Western Reserve University Law School, http://lawwww.cwru.edu/careers/
- Chronicle of Higher Education Job Listings, http://chronicle.com/jobs
- CityJobs—UK Legal Site, http://www.cityjobs.co.uk/cgi-bin/campaign.cgi?tid=903
- Coleman Legal, http://www.colemanlegal.com/
- Contract Counsel, http://www.contractcounsel.com/
- Counsel Network, http://www.headhunt.com/
- Counsel Source, http://www.counselsource.com/
- eAttorney, http://www.eattorney.com/
- Emory University School of Law, http://www.law.emory.edu/cms/site/index.php?id=363
- Emplawyernet, http://www.emplawyernet.com/
- Filcro Legal Staffing, http://www.filcro.com/page3.html
- Findlaw.com, http://www.findlaw.com/
- Findlawjob.com, http://www.findlawjob.com/
- Firm Finder, http://www.firm-finder.com/
- Franklin Pierce Law Center, http://www.piercelaw.edu/career/aboutus.htm
- Gibbons Arnold & Associates, Inc., http://www.gibsonarnold.com/
- Harvard Law School, http://www.law.harvard.edu/Admissions/career.html
- HeadHunter.NET, http://www.headhunter.net/
- Hieros Gamos, http://www.hg.org/employment.html
- Hornsby Partner, Inc., http://hornsbypartners.com/

- HOTRESUME.COM, http://www.hotresume.com/
- Howard C. Bloom Co., http://www.bloomlegal-search.com/
- If Come.com, http://ifcome.com/
- iHireLegal.com, http://www.ihirelegal.com/
- Indiana University School of Law—Bloomington, http://www.law.indiana.edu/careers/
- Indiana University School of Law—Indianapolis, http://indylaw.indiana.edu/career/internetjobs.htm
- infirmation.com, http://www.infirmation.com/
- Interactive Lawyer, http://www.interactive-lawyer.com/TLrecr.html
- Internet Job Locator, http://www.joblocator.com/
- Interview Experts, http://www.interviewexperts.com/
- JobBank USA, http://www.jobbankusa.com/
- JobHunt, http://www.job-hunt.org/
- JOBlynx, http://www.joblynx.com/
- Jobsite (United Kingdom / Also hosts "Jobs by E-Mail," a service that mails you jobs tailored to your specifications), http://www.jobsite.co.uk/
- Jobsite, http://www.jobsite.co.uk/
- JOBTRAK, http://www.jobtrak.com/
- John Marshall Law School, http://www.jmls.edu/careersvcs/index.shtml
- Law Bulletin, http://www.lawbulletin.com/
- Law Forum, http://www.lawforum.net/employ.htm
- Law Forum, http://www.lawforum.net/resume.htm
- Law Journal Extra! Law Employment Center, http://www.lawjobs.com/
- Law Resources, Inc., http://www.lawresources.com/
- Law Student Resources: Jobs and Internships, http://members.aol.com/dcingle/jobs.htm
- LawGuru.com Legal Jobs, http://www.lawguru.com/classifieds/viewads.html
- LawInfo Employment Center, http://jobs.lawinfo.com/
- LawInfo Employment Center, http://jobs.lawinfo.com/
- LawInfo.com, http://jobs.lawinfo.com
- LawLinks.com, http://lawlinks.com/ar-emply.html
- Lawlinks.com, http://www.lawlinks.com/
- Lawmatch.com, http://www.lawmatch.com/
- Lawyers Weekly Jobs, http://www.lawyersweekly-jobs.com/
- Legal Hire, http://www.legalhire.com/
- Legal Internships Home Page, http://www.usd.edu/~legalint/
- Legal Report, http://www.legalreport.com/
- Legal Search, http://legalsearchonline.com/
- Legal Search Network, http://www.legalsearchnetwork.com/
- Legal Services Corporation Funded Programs with Web Sites, Legal Services Corporation Office of the Inspector General Employment Opportunities, http://oig.lsc.gov/jobs/jobs.htm
- Legal Week, http://lwk.co.uk/
- Legalrecruiter.com, http://www.legalrecruiter.com/
- Legalstaff, http://www.legalstaff.com/
- LEXIS-NEXIS Employment Center, http://www.lexis-nexis.com/lncc/employment/
- Life After Law, http://www.lifeafterlaw.com/
- Longbridge International, http://www.longbridge.com/
- LPA Legal Recruitment, http://www.the-lpa.co.uk/
- Mailing Lists, http://www.legalemploy.com/maillist.htm
- Major Legal Services, Inc., http://www.lawplacement.com/
- Major, Hagen & Africa Attorney Search Consultants, http://www.mhasearch.com/
- Margot Haber Legal Search, Inc., http://www.haberlegal.com/
- Martindale Hubbell, http://www.martindale.com/
- Minority Corporate Counsel Association, http://www.mcca.com/

- Missouri Bar Placement Bulletin, http://www.mobar.org/law/index.htm
- Monster.com, http://www.monster.com/
- Moyer Paralegal Services, http://www.moyer-paralegal.com/
- Myjob.com, http://www.myjob.com/
- http://www.paralegals.org/Center/home.html
- National Lawyers Association Resume Forum, http://www.nla.org/resume/main.html
- National Legal Aid & Defender Association Job Opportunities, http://www.nlada.org/jobop.htm
- NationJob Network, http://www.nationjob.com/legal/
- NetTemps, http://www.net-temps.com/
- Net-Temps, http://www.net-temps.com/
- Oklahoma City University School of Law, http://www.okcu.edu/law/careerservices/
- Oxford Legal, http://www.oxfordlegal.com/
- Oxford Search Group, http://www.oxfordsearch.com/
- Paralegal Classifieds, http://www.paralegalclassifieds.com/
- Paul Feldman & Associates, Attorney Recruitment Specialists, PeopleQuick.com (Canadian temporary legal help), http://www.peoplequick.com/
- Philadelphia Lawyer Employment Links, http://www.phillylawyer.com/Employment/employment.htm
- Pine Tree Legal Assistance Employment Opportunities, http://www.ptla.org/ptlajobs.htm
- Princeton Legal Staffing Group, http://www.princetonlegal.com/
- PSD International Group Recruitment—Law Page, Public Service JobNet, www.law.umich.edu/currentstudents/ PublicService/jobnet.htm
- Recruiters OnLine Network, http://www.recruitersonline.com/
- Romac Legal, http://www.romaclegal.com/index.html
- San Diego Source Legal Classifieds, http://www.sddt.com/classified/ads/
- Social Law Library Employment Resources, http://www.socialaw.com/irg/er.html
- Special Counsel, http://www.specialcounsel.com/
- Sterling Careers Legal Search and Consulting Firm, http://www.sci-law.com/
- SummerClerk.com, http://www.summerclerk.com/index.asp
- Syracuse University College of Law, http://www.law.syr.edu/careerservices/
- Tax Law, http://www.law.com/
- Texas Office of the Attorney General, http://www.oag.state.tx.us/agency/jobs_ag.shtml
- TexLaw, http://www.texlaw.com/
- The Associates, http://www.associates.org/
- The Counsel Network, http://headhunt.com/
- The Internet Job Locator, http://www.joblocator.com/
- The Jameson Group, http://www.thejamesongroup.com/
- The Job Beat, http://www.searchbeat.com/jobs.htm
- The Lawyers Guide to JobSurfing on the Internet, http://www.legalemploy.com/lwyrsgd.htm
- The Legal Employment Bookstore, http://www.legalemploy.com/bookstore.htm
- Todays Legal Staffing, http://www.todayslegal.com/
- Top Jobs on the Net, http://www.topjobs.net/
- University of Kansas, http://www.law.ku.edu/career_alumni/career_services.shtml
- University of Pittsburgh, http://www.law.pitt.edu/career/index.php
- University of Texas, http://www.utexas.edu/law/depts/career/index.html
- Update Legal Staffing, http://www.updatelegal.com/
- USC Law School, http://lawweb.usc.edu/carserv/
- Usenet Newsgroups, http://www.legalemploy.com/news.htm
- VirtualResume, http://www.virtualresume.com/
- Wake Forest University School of Law, http://www.law.wfu.edu/careerservices.xml
- Wall Street Journal Career Center, http://www.careers.wsj.com/
- Washburn University, http://washburnlaw.edu/career/

- Washington University, http://ls.wustl.edu/CSO
- WISBAR (Wisconsin Bar), http://www.wisbar.org/bar/emp-menu.htm
- Worktree.com, http://www.worktree.com/
- Yahoo General Employment Index, http://hotjobs.yahoo.com/
- Zarak Group, http://www.zarakgroup.com/

Specific Sites for Health Law Jobs

- Science & Law Recruiting, Inc., www.imeg.com/scilaw/

Nonprofit Organization Listings on the Web

- ACCESS, http://www.accessjobs.org/
- American Medical Association, http://www.ama-assn.org/
- American Marketing Association, http://www.ama.org (job listings at the AMA)
- Community Career Center, http://www.nonprofit-jobs.org/ (databank of non-profit jobs)
- Association Center, http://www.associationcentral.com/ (databank of non-profit jobs)
- ASPH Employment Council, http://cfusion.sph.emory.edu/PHEC/phec.cfm (public health employment connection)
- National Association for Public Interest Law Job Listings, http://www.napil.org/napjob.html
- The Chronicle of Philanthropy, http://philanthropy.com/
- The Foundation Center, http://fdncenter.org/
- National Council of Non-profit Associations, http://www.ncna.org/
- Idealist.org, http://www.idealist.org/
- Non Profit Employment, http://www.nonprofitemployment.com/
- Exec Searches.com, http://www.execsearches.com/exec/default.asp (recruiters for non-profit entities)
- Feminist Majority Foundation, http://www.feminist.org
- The Heritage Foundation, http://www.heritage.org/About/JobBank/index.cfm
- Finding Work in the Government Vacancies in the Federal Inspector General Community, www.pmf.opm.gov
- www.ustreas.gov/inspector-general/vacancies/
- U.S. Department of Justice Attorney/Law Student Hiring and Career Information, http://www.usdoj.gov/oarm/
- U.S. Department of Justice Career Opportunities, http://jobsearch.usajobs.opm.gov/a9dj.asp
- Federal Jobs Central, http://www.fedjobs.com/
- Federal Jobs Digest, http://www.jobsfed.com/
- FedWorld, http://www.fedworld.gov/
- United States Office of Personnel Management, http://www.opm.gov/

Resources for Nurses

- The American Association of Nurse Attorneys (TAANA), http://www.taana.org/

Note: This article was the winning entry in the Barry Gold Memorial Health Law Writing Competition 2008

The Validity of "Voluntary" Medical Malpractice Exculpatory Agreements in New York

By Matthew J.B. Lawrence

Introduction

The medical malpractice system has been the focus of a variety of "reform" proposals seeking to stem the tide of rising healthcare costs.[1] One intuitively plausible and easily implemented proposal is to leave the decision of whether the malpractice system is "worth it" to each patient. If the costs of having the option to bring a malpractice suit truly outweigh the benefits as seen by a given patient, that patient should simply sign a medical malpractice exculpatory agreement prior to treatment, contracting out of the malpractice system, or some component thereof, in exchange for a lower fee.[2] Law and Economics scholars have been discussing versions of this proposal for more than three decades,[3] although they are by no means uniform in their endorsement of the idea.[4]

The actual enforceability of medical malpractice exculpatory agreements is an unsettled question. Courts treat everyday exculpatory agreements—such as those we sign when we go horse-back riding—as they do any other contract, enforcing them as long as they are entered into voluntarily.[5] But exculpatory agreements pertaining to medical malpractice have repeatedly been invalidated, often under the mysterious "void-for-public-policy" test.[6]

Courts seem loath to enforce medical malpractice exculpatory agreements. This fact is highly relevant for the active academic debate about contracting out of the malpractice system. If medical malpractice exculpatory agreements are not enforceable, private reform could not take place without legislative intervention, which would undercut much of these proposals' appeal.[7]

This problem has not gone unnoticed by proponents. In one symposium, Medical Malpractice: Can the Private Sector Find Relief?[8] (Private Malpractice Symposium), a few of the participating scholars attempted to come up with recommendations for an enforceable medical malpractice exculpatory agreement. They argued that courts would enforce medical malpractice exculpatory agreements if they featured a few tweaks. These scholars noted that the few exculpatory agreements challenged in courts featured certain objectionable traits. These traits, such as being too broad or leaving patients without meaningful choice,[9] made it easy for courts to invalidate them. According to these authors, agreements could be easier "for courts to swallow"[10] if they were non-adhesive (meaning patients would not be required to sign to obtain service), and both specific (clearly worded so as to actually inform the consumer) and narrow (only waive negligence and not gross negligence, or only waive punitive damages).[11]

This article makes two contributions. Part I provides a thorough analysis of the enforceability of exculpatory agreements for malpractice in a particular jurisdiction—New York—that follows the majority rule.[12] It concludes that while exculpatory agreements in the healthcare context are generally unenforceable, the enforceability of "voluntary" exculpatory agreements—such as those suggested by some scholars in the Private Malpractice Symposium, remains an open question. In light of this, Part II argues that the ambiguity in the doctrine should be interpreted in favor of a *per se* rule against even ostensibly voluntary exculpatory agreements between doctor and patient. Such a rule is justified by a novel argument in freedom-of-contract terms against enforcement: there is a hidden cost to patients of "choosing" when it comes to malpractice liability. A patient who refuses to sign an exculpatory agreement signals to her healthcare provider both that she is willing to litigate and that she feels there is a chance her doctor could perform negligently. Patients who are fairness-regarding (concerned about appearing to be fair patients) are afraid to do this. As I explain, these patients may sign simply as a result of the pressure associated with this signaling effect.

I. The Uncertain Enforceability of Voluntary Exculpatory Agreements

Contracts are usually enforced if voluntarily entered, but sometimes some "overriding interest of society" justifies invalidating a contract "on grounds of public policy."[13] Exculpatory agreements—agreements in which one party relieves the other party for potential liability—are no exception. While exculpatory agreements are "disfavored" and courts look with scrutiny on their terms to be sure they are in fact voluntarily entered,[14] they are enforceable if found to be voluntary.[15] But when it comes to medical malpractice exculpatory agreements, the "void-for-public-policy" test has often been a barrier to enforcement. As an oft-cited[16] and possibly the most thorough treatment on the subject explains:

> The application of [the void-for-public-policy test] to exculpatory contracts between hospitals or physicians, on the one hand, and patients, on the other, has been considered in relatively few instances. It can, however, be said that what

> rulings there are indicate generally, but not uniformly, that contracts of the kind mentioned are invalid.[17]

The claim that exculpatory agreements between patient and healthcare provider are "generally" invalid is quite accurate. Cases using the void-for-public-policy test to invalidate medical malpractice exculpatory agreements abound,[18] while cases upholding the clauses are difficult to find.[19]

But it is actually very unclear whether the resistance medical malpractice exculpatory agreements have faced is a result of something about the agreements which makes them categorically void or a result of the types of agreements with which courts have been presented. In the Private Malpractice Symposium, scholars noted that those agreements that have been challenged in courts have all been either vaguely worded or adhesive, which made it easy for courts to conclude that the contracts were in fact not entered into voluntarily.[20] Thus these agreements would have been unenforceable whether they had to do with medical treatment or not; they were simply poor test cases.[21] These scholars argued that better agreements would be non-adhesive and clearly worded.[22]

There are no reported cases of a court confronting a medical malpractice exculpatory agreement of the sort suggested by scholars in the Private Malpractice Symposium. Thus it is unclear whether a patient and provider taking these scholars' suggestions to heart would see their agreement enforced. This Part uses a case study of the law in the state of New York to show that the recommendations of the Private Malpractice Symposium scholars are certainly a necessary requirement of an enforceable medical malpractice exculpatory agreement. But they are by no means sufficient. The case law is ambiguous about whether even a non-adhesive, clearly worded contract would be invalid simply because it implicated the doctor-patient relationship.

A. Medical Malpractice Exculpatory Agreements in New York

A case study is a valuable way to approach the enforceability of voluntary medical malpractice exculpatory agreements. Because these agreements are governed by common law, each individual state jurisdiction applies its own rule. Attempts to "sum up" the holdings in these cases lead to a glossing over of the doctrine, and have failed to result in clarification.[23] As other scholars have recognized,[24] New York provides an excellent body of law for such a study.[25] This is especially true because, although there are no recently reported cases in which New York courts have upheld an exculpatory agreement in healthcare, some healthcare providers in New York continue to attempt to use these agreements in healthcare contracts.[26]

In New York, the void-for-public-policy test was first applied to medical malpractice exculpatory agreements in *Ash v. New York University Dental Center*.[27] An exculpatory agreement used by the New York University (NYU) Dental Center was invalidated in an earlier case because it did not specifically mention negligence.[28] The NYU Dental Center simply added "negligence" to its agreement,[29] and the court was forced to confront a question that prior courts had been able to avoid through strict interpretation:[30] Could this properly worded agreement be enforced? While a prior New York Supreme Court case had held a release valid and been affirmed without opinion, the *Ash* court expressly declined to follow that holding.[31] It read the issue as one of first impression and joined a growing majority of state courts in finding the exculpatory agreement void for public policy.[32] Specifically, the court employed a two-pronged test, finding that the "special relationship" between the doctor and the patient in the case along with the state's interest in the level of care received by its citizens meant the agreement could not be upheld.[33]

B. The Void-for-Public-Policy Test, Categorical Rule or Case-by-Case Analysis?

New York courts now cite *Ash* as the controlling case on medical malpractice exculpatory agreements,[34] but the courts applying the *Ash* court's void-for-public-policy holding have shown confusion about whether the case created a categorical rule against the enforcement of all medical malpractice exculpatory agreements or rather just found a particular agreement void.[35] Supporting a reading of Ash as creating a categorical rule is the treatment of these agreements in two post-*Ash* appellate cases in New York, *Rosenthal v. Bologna* and *Creed v. United Hos*pital.[36] In *Rosenthal*, the First Department, without a great deal of discussion, cited *Ash* in holding an exculpatory agreement void because of "the State's interest in the health and welfare of its citizens, and also because of the highly dependent (and thus unequal) relationship between patient and health care provider."[37] In *Creed*, the Second Department didn't discuss the waiver it held invalid at all, simply stating that "we agree with our colleagues in the First Department that an agreement such as the one upon which these affirmative defenses are based, violates public policy."[38] The *Creed* court's one-sentence dismissal by citation to *Ash* strongly supports reading *Ash* as establishing a categorical rule.

But there is also good reason to read *Ash* for the narrower finding that a *particular* exculpatory agreement in healthcare, which featured an absence of bargaining power, among other things, was invalid as contrary to public policy. First, such a reading is supported by *Ash* itself. The court did not mention that it was departing from previous cases, which might have been expected if it was indeed breaking from the established case law.

More importantly, the court entered into an analysis of the particular bargaining dynamics and implications of the agreement at issue, suggesting that the mere fact that the agreement dealt with malpractice and was between provider and patient was not enough to render it unenforceable.[39] Additionally, the *Ash* court limited its holding to "the instant case"[40] and exculpatory clauses "of the type here in issue."[41]

Furthermore, while there is some hint in the application of *Ash* in subsequent cases that the case established a categorical rule, there is also evidence that it did not. Other than *Creed*, subsequent cases applying *Ash* have required more than a simple finding that the exculpatory agreement deals with medical treatment and is between provider and patient. The court in *Rosenthal*, while citing *Ash*, recognized as important to its position that the plaintiff had "entered the agreement . . . from a disadvantaged position" and that the release did not specifically mention negligence.[42] In the recent case of *Poag v. Atkins*, the court cited *Ash* for the proposition that the "judicial imprimatur of agreements that purport to release individuals or entities from liability for the rendition of medical treatment is *typically* withheld."[43] The court went on to invalidate the agreement, but not without also considering the same interpretive issues raised in the line of cases discussed above.[44] Other post-*Ash* decisions have engaged in a similar analysis.[45]

C. Possible Sources of the Categorical Approach

The distinction between categorical versus case-by-case approaches to the void-for-public-policy test under *Ash* is important because the former approach would seem to invalidate even a voluntarily entered and fairly bargained agreement. This would create tension in the doctrine, because it would be a significant departure from the earlier line of cases which had suggested that a voluntary exculpatory agreement in healthcare was theoretically enforceable[46] and had engaged in painstaking analysis of the language and circumstances of each contract.[47] Perhaps more troubling, such a rule would apparently leave little room for those hoping to craft an enforceable exculpatory agreement.

This section explores the reason *why* some courts might have interpreted *Ash* as creating a categorical rule. It argues, by process of elimination, that the most likely source of such an interpretation is the ambiguous greater-responsibility justification for the special-relationship prong of the void-for-public-policy test. In other words, there is ambiguous language in *Ash* having to do with the fact that the "greater responsibility" owed by doctor to patient undermines the contract, and there is a good argument that it is this ambiguous language that has led some courts to apply *Ash* as a categorical rule. This article will later suggest that the "greater responsibility" justification be interpreted in favor of a *per se* rule against the enforcement of even a "voluntary" exculpatory agreement and the abandonment of the case-by-case approach to the enforceability of most medical malpractice exculpatory agreements.

The Ash court's two-prong rule focused on (1) the public interest in the quality of healthcare administered and (2) the "special relationship" between doctor and patient.[48] In search of the most likely source of a categorical reading of the case, this section takes these up in turn.

The public-interest-in-healthcare prong does not justify a categorical rule. This prong was the product of the court's concern that agreements allowing cheaper, reduced-quality care would lead to "a de facto system in which the medical services received by the less affluent are permitted to be governed by lesser minimal standards of care and skill than that received by other segments of society."[49] But exculpatory agreements need not affect quality to be value-adding in healthcare, and they certainly need not affect the quality of care for the less affluent.[50]

The second prong of the Ash test was the "abuse of a special relationship" between patient and provider in invalidating the exculpatory agreement.[51] The Ash court actually gave two very different justifications for the special-relationship prong. At the time Ash was written, a prominent contracts treatise explained, speaking of the use of "special relationships" to invalidate exculpatory agreements generally, that there were multiple "bases for deciding that an otherwise valid agreement to exempt one from future liability to another is invalid because the parties are in a certain relationship to each other."[52] One was that "a relationship often represents a situation in which the parties lack equal bargaining power; and one of them must either accept what is offered or be deprived of the advantages of the transaction."[53] But a second and independent basis was that "some relationships, such as, for example, that of physician and patient, are such that once entered upon they involve a status requiring of one party greater responsibility than that required of the ordinary person, and, therefore, a provision avoiding liability is peculiarly obnoxious."[54] The court in *Ash* leaves an ambiguity about which of these justifications for the special relationship prong it employed.[55]

The "bargaining power" justification is relatively straightforward and does not suggest a categorical rule. In spite of its broad language, treatment of the justification by the court makes clear that it is actually an argument that the contract was one of adhesion[56]—the patient either had to sign or seek treatment from a different provider—which is a traditional ground for invalidating contracts on a case-by-case basis.[57]

The "greater responsibility" justification is the more likely source of a categorical rule against the enforcement of medical malpractice exculpatory agreements. Read literally, the justification does not require any facts be established beyond the simple fact that the exculpatory agreement was between a provider and a patient to whom that provider owed a "greater responsibility" than that of the

ordinary citizen. Ostensibly, this greater responsibility is a necessary element of every patient-provider relationship. Furthermore, there is no reasoning provided in *Ash* or elsewhere for why the fact that one party owes the other a greater responsibility might undermine a contract. Thus there is no underlying purpose that could be used to guide application of the greater-responsibility justification.

If courts applying *Ash* as a categorical rule are basing this finding on the greater-responsibility justification, the result is an ambiguous doctrine. Courts have not articulated what about medical malpractice exculpatory agreements or the "greater responsibility" owed by doctor to patient justifies invalidation. And without a more specific understanding, there is no way to predict how a court might rule on an ostensibly "voluntary" exculpatory agreement.

II. New York Courts Should Adopt a *Per Se* Rule Against Enforcement of Voluntary Exculpatory Agreements Between Patient and Doctor

It seems that the enforceability of a voluntary exculpatory agreement under New York law remains an open question. This Part points out that there is a cost to patients of refusing to sign even an ostensibly voluntary exculpatory agreement beyond just a higher fee that undermines the notion of voluntary assent: In choosing the protection of liability over a price reduction patients inevitably signal their perception of their provider's competence, and patients try to avoid so signaling for fear of both retaliation and the fairness cost of appearing untrusting, litigious or unfair. Because of this cost, exculpatory agreements between doctor and patient may never be truly voluntary; I therefore argue that the ambiguity surrounding *Ash* should be interpreted to create a *per se* rule against exculpatory agreements between doctor and patient except in limited cases.

A. Exculpatory Agreements Between Doctor and Patient May Never Be Truly Voluntary

1. Fairness Costs in Theory

Recent developments in behavioral law and economics set the stage for a previously unidentified cost to patients of contracting over malpractice liability. In behavioral law and economics, "fairness" describes the experimentally observed behavior of actors who seem to consider the needs of others in making a decision[58] or retaliate against those who apparently fail to do so.[59] In other words, experimental studies have observed people going out of their way both to treat others fairly and retaliate against those they perceive to be unfair. This behavior is not merely experimental; fairness considerations have been seen to constrain market prices and discourage wage reductions.[60]

Important about the fairness costs and benefits which attach to an action is that they depend not on the action itself, but on the decision from which that action results.[61] This means that fairness-regarding actors are not concerned with actions themselves, but the decisions that underlie those actions and what those underlying decisions reveal about the person or entity acting.[62] An important implication is that the decisions people make are often constrained by fairness costs, but if the action can be made mandatory—if choice can be removed—these costs are no longer a consideration.

2. Fairness Costs in Malpractice

The "fairness" behavior observed in behavioral law and economics can also be identified in the doctor-patient relationship. There are numerous examples of patients making decisions they would rather not make, all else being equal, to avoid appearing untrusting or unfair to their doctor. One scholar reports an interview with a woman who claimed to avoid the subject of costs with her doctor for fear of being insulting or provoking retaliation.[63] In another paper,[64] I point out that patients face a fairness cost to the decision to seek a second opinion—expressed distrust of their doctor—that policymakers do not, which explains the otherwise mysterious success of mandatory second opinion programs: An order-of-magnitude more patients obtain second opinions under a mandatory regime than a voluntary regime,[65] implying many patients are made to obtain second opinions who do not want them, but surveyed patients don't mind mandatory second opinion programs.[66] The reasons proffered by patients who do not obtain voluntary second opinions suggest that (1) fairness costs indeed inhibit the decision to obtain a second opinion[67] and (2) the fact that fairness costs are vitiated by removing the element of choice explains why patients who do not choose to obtain second opinions do not mind being forced to get them.[68]

A patient deciding whether to sign an exculpatory agreement that waives malpractice liability—or the availability of punitive damages—faces these same fairness costs. A patient who decides she would rather maintain the option of a suit for negligence signals unambiguously both her willingness to sue and that she believes there is a substantial likelihood her doctor will perform negligently. Similarly, a patient who decides she would rather not waive the right to seek punitive damages thereby reveals that she thinks there is a good chance her doctor will behave in a reprehensible manner. It is easy to see why patients would wish to avoid doing either of these things, and indeed exactly this sort of cost was once described as inhibiting the decision to sign an arbitration agreement—a related but complicated question not addressed in this article.[69] An Association of the Bar of the City of New York committee found that

> [I]f the physician or the hospital is to receive a copy of the agreement and the

> patient knows this, the execution of the agreement by the patient may not be voluntary because he or she will feel some compulsion to comply with the express or implied desire of the hospital or physician that the agreement be executed.[70]

Thus, for anyone concerned with appearing to be a trusting or fair patient, the presence of fairness costs means an exculpatory agreement between doctor and patient may not be truly voluntary.

B. The Impossibility of Case-by-Case Review Justifies a *Per Se* Rule

While many patients faced with voluntary exculpatory agreements will sign for fear of offending their doctor, others might be unaffected by fairness costs and choose to sign (or not to sign) based only on their genuine preferences. Thus, on first glance, the recognition of fairness costs in the decision to waive malpractice should not counsel in favor of changing New York courts' cautious case-by-case approach to voluntariness:[71] if a court is confronted with a voluntary exculpatory agreement, it need only continue the practice of approaching the agreement with caution, and simply be on the lookout for fairness costs affecting the patient's decision.

The cautious case-by-case approach is no longer possible because, unlike analyzing the language of an agreement or the availability of alternatives, it is simply too difficult to determine whether a given patient was worried about showing distrust or unfairness to her doctor when she signed an agreement.[72] Given this fact, New York courts should not simply be cautious in deciding whether an exculpatory agreement is truly voluntary. They should adopt a *per se* rule. New York courts should complete the transition from case-by-case analysis of exculpatory agreements in the healthcare context to a bright line rule of nonenforceability. Courts need not abandon—or do disservice to—their allegiance to freedom of contract principles in doing so. That is because the basis of such a rule would not be a finding that all such agreements violate some vague "public policy"—a finding courts have continually hesitated to make—but rather an evidentiary determination similar to the familiar *per se* rule in antitrust: although a truly voluntary exculpatory agreement could be theoretically enforceable, exculpatory agreements between doctor and patient are so unlikely to be voluntary, and identifying voluntary agreements is so difficult for courts, that all exculpatory agreements between doctor and patient are *per se* invalid.[73]

Such a rule would not be perfect, nor would it lay the issue of voluntary exculpatory agreements completely to rest. First, it would apply only to agreements between a patient and his or her doctor. Because patients wish to avoid appearing fair to their doctors, the *per se* rule need not apply to agreements waiving liability for a patient's managed care organization, or an agreement waiving liability for the doctor but somehow guaranteeing the patient anonymity (although such an agreement would still need to pass the usual hurdles).[74] But an added advantage of such a rule—beyond ensuring that "voluntary exculpatory agreements" designed to pass the doctrinal tests but nonetheless coercive are not enforced—would be bringing greater clarity to the doctrine, saving courts from litigation over meaning and voluntariness, and saving doctors from the uncertainty currently surrounding exculpatory agreements.

C. *Per Se* Rule Would Not Apply to Anonymous Agreements

The signaling pressure discussed in this Part affects only a patient who has some reason to believe her doctor will find out whether she decided to sign the offered exculpatory agreement or not. If a contract somehow avoided the possibility of signaling pressure, the per se rule would not be justified and courts should engage in case-by-case analysis of the other "voluntariness" factors.

While the possibility of an anonymous contract may seem far-fetched, there are two ways this may be done—either (1) contract for something that does not implicate a signaling effect or (2) find a way to denude the contracting process of that effect. The first option is relatively straightforward, and doctors and patients arguably already have found ways to do so. Arbitration agreements, which are widely enforced,[75] may be viewed as one way to contract out of the malpractice system without signaling anything about the patient's perception of the doctor's competence or the patient's willingness to litigate. Agreements waiving non-negligent experimental treatment may be another example.[76]

But if the decision to sign does create a signaling effect—as an agreement exculpating negligence inevitably will—the agreement can still be cured if the patient has credible reason to believe that the doctor will never know whether she signed the agreement or not. This confidentiality would cure the signaling effect associated with the decision to sign, and thereby avoid the greater-responsibility justification for the special-relationship prong and the accompanying categorical approach.

Confidential contracting would not be as difficult as it sounds, especially given current institutional arrangements in the provision of medical services. There are two ways such a contract could be completed. First, an arrangement might utilize indirect contracting between patients and managed care providers in a way that would not signal to doctors which patients had signed agreements.[77]

Second, a doctor and patient could enter into a traditional contract confidentially, without going through a managed care provider or other third party. Contract law leaves plenty of room for such an arrangement.

The doctor would have to present and explain both fee arrangements—one including an exculpatory agreement, one not—as two separate offers. She would then simply invite the patient's acceptance of either offer through a confidential medium. This way the doctor would remain in the dark whatever the patient's decision. Such an arrangement would be perfectly legal; the Restatement of Contracts makes clear that the offeror may invite acceptance by whatever reasonable means she designates in making the offer, be it performance or, in this case, acceptance delivered to a third party.[78] Neither is the doctor's awareness that the contract offer has been accepted a requirement of contract formation under the Restatement.[79] Of course, even if the contract could be formed confidentially, the patient might want a credible guarantee that her decision to sign or not would remain confidential. Confidentiality and privacy clauses are common elements of contracts. In this case, both offered contracts need only include clauses guaranteeing confidentiality, and perhaps providing some warranty in the event that confidentiality was breached. For example, they might designate an independent third party—such as someone in the doctor's front office or even the doctor's malpractice insurance company—to maintain the confidentiality of the agreement.

III. Conclusion

New York courts have not yet encountered the sort of voluntary exculpatory agreements between doctor and patient suggested by some scholars, which relieve the doctor of potential liability (for negligence, punitive damages, or non-economic damages) while, by design, ensuring that patients understand the agreement and giving patients the option of obtaining the same treatment without signing the agreement (albeit for a higher price). In spite of the general unenforceability of medical malpractice exculpatory agreements, courts continue to engage in case-by-case analysis and such a contract would present a matter of first impression. But courts can never be sure that an exculpatory agreement between doctor and patient, however carefully crafted, is truly voluntary, because many patients might sign only for fear of making a choice that could make them look untrusting, litigious or unfair. Thus, New York courts should abandon case-by-case review and adopt a *per se* rule against enforcement of exculpatory agreements between doctor and patient anytime this signaling effect may be at play.

Endnotes

1. Whether malpractice reform is actually needed is a subject of great debate. Some reports suggest that malpractice payouts are actually fairly small and that ballyhooed high insurance premiums are the result not just of payouts but also of the difficulty in pooling and pricing malpractice risk. *See* Sylvia Law & Steve Polan, Pain and Profit: The Politics of Malpractice 170 (1978) ("[T]he timing and abruptness of the malpractice crisis were generated more out of the economic insecurity of the industry as a whole rather than by factors strictly related to malpractice."); Thomas Cohen & Kristen Hughes, *Medical Malpractice Insurance Claims in Seven States, 2000-2004*, U.S. Dep't Justice, NCJ 216339 (March 2007), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mmicss04.pdf (most claims closed without compensation and few payouts over $1 million). *But see* Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, *in* Medical Malpractice and the U.S. Healthcare System (William M. Sage & Robert Kersh eds., 2006) (only forty cents of every dollar paid to malpractice system goes to patients); Frank M. Studdert et al., *Medical Malpractice*, 350 New England J. Med. 283 (2004) (threat of malpractice leads to unnecessary procedures and avoidance of high risk patients).
2. This argument has received a great deal of attention, especially among economists, over the past three decades. For an overview of the literature in the context of an argument against the desirability of exculpatory agreements as a policy matter, see Jennifer Arlen, *Contracting Over Malpractice Liability* 2–3 nn.3–5 (N.Y. Univ. Ctr. for L. & Econ., Working Paper No. 08-12, 2008), *available at* http://ssrn.com/abstract=1105368 (citing references). *See also* Maxwell J. Mehlman, *Fiduciary Contracting Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. Pitt. L. Rev. 365 (1991).
3. An early example is the influential article by Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1 Am. Bar. Ass'n Res. J. 87 (1976).
4. *See, e.g.*, Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability*, *in* Medical Malpractice and the U.S. Health Care System: New Century, Different Issues (Rogan Kersh & William Sage, eds.) (Cambridge 2006) (economic analysis arguing against exculpatory agreements).
5. *See, e.g.*, *Cefali v. Buffalo Brass Co. Inc.*, 748 F. Supp. 1011 (W.D.N.Y. 1990) (attorneys' fees awarded as a result of breach of covenant not to sue).
6. Thomas A. Moore & Matthew Gaier, *Courts Disfavor Exculpatory Releases*, New York L. J., Oct. 6, 1998, at 1 (describing validity of waivers in New York). *See also* A.M. Swarthout, *Validity and Construction of Contract Exempting Hospital or Doctor from Liability for Negligence to Patient*, 6 A.L.R.3d 704 (originally published 1966) (describing validity of waivers in most states).
7. *See* Clark C. Havighurst, Health Care Choices: Private Contracts as Instruments of Health Care Reform, 303-310 (1995) (discussing need to persuade courts to accept medical malpractice contracts). For an exploration of the difficulty of enabling private reform through the political process, see Eleanor Kinney, Book Review, *Health Care Choices: Private Contracts as Instruments of Health Care Reform*, 17 J. Legal Med. 331 (1996).
8. Symposium, Medical Malpractice: Can the Private Sector Find Relief?, Law & Contemp. Probs., Spring 1986, 1, 143-320.
9. *See* William H. Ginsburg et al., *Contractual Revisions to Medical Malpractice Liability*, 49(2) Law & Contemp. Probs. 253, 254 (1986) ("[M]ost [exculpatory agreements] were one-sided efforts by the health care provider to completely exculpate itself from tort liability."); Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49(2) Law & Contemp. Probs. 143, 165 (1986) (same).
10. Havighurst, *supra* note 9, at 165.
11. *See* Ginsburg et al., *supra* note 9, at 255-63; Havighurst, *supra* note 9, at 165; *see also* Clark C. Havighurst, Health Care Choices: Private Contracts as Instruments of Health Reform (1996) (outlining changes to contracts—notably greater information and menus of options—necessary to facilitate contracting over healthcare, including malpractice, and cautioning courts to enforce agreements). The requirement that there be "alternatives" does not mean a doctor can claim the patient could have simply sought out a different doctor—as observers have pointed out, such an arrangement can still threaten choice when *no* local doctor will treat a patient who refuses to sign. *See* Randy Cohen, *The Ethicist: Doctor, Bully*, The New York Times Magazine, March 30, 2008 ("If a single physician were so skittish about malpractice suits . . . that she would see only patients who would forgo access to the

courts, no problem. . . . But if all, or nearly all, doctors make the same demand, there's nowhere else to go; a fundamental right is eradicated.").

12. New York courts view themselves as following the majority rule. *See infra* note 32 and accompanying text.

13. REST. (2D) CONTRACTS CHAPTER 8 (Introduction) (1981). "In general, parties may contract as they wish, and courts will enforce their agreements without passing on their substance. Sometimes, however, a court will decide that the interest in freedom of contract is outweighed by some overriding interest of society and will refuse to enforce a promise or other term on grounds of public policy."

14. *E.g.*, *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 376 (N.Y.App. Div. 1st Dep't 1995) ("Contractual clauses which purport to exculpate a party from liability for his own negligence are disfavored, and invite close judicial scrutiny.") (quoting *Gross v. Sweet*, 49 N.Y.2d 102 (N.Y. 1979)); *Ash*, 564 N.Y.S.2d at 309–10 ("Our analysis begins with the long-settled general proposition that the law frowns upon an agreement intended to exculpate a party from the consequences of its own negligence and requires that such contracts be subjected to close judicial scrutiny.") (citing *Gross v. Sweet*, 49 N.Y.2d 102 (N.Y. 1979)); *see also Gross v. Sweet*, 49 N.Y.2d 102 (N.Y. 1979) (exculpatory agreement for parachute school did not specify and therefore did not cover negligence; setting policy for exculpatory agreements generally).

15. *Supra* note 5.

16. Swarthout, *supra* note 6, § 2, cited in, *e.g.*, *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 313 (N.Y. App. Div. 1st Dep't 1990); *Colton v. N.Y. Hosp*. 414 N.Y.S.2d 866, 872 (N.Y. Sup. Ct. 1979).

17. Swarthout, *supra* note 6, at § 2.

18. *See, e.g.*, *Ash*, 564 N.Y.S.2d at 308; *Rosenthal*, 211 A.D.2d at 437; *Creed v. United Hosp*., 190 A.D.2d 489, 492 (N.Y.App. Div. 2nd Dep't 1993); *Poag v. Atkins*, 806 N.Y.S.2d 448 (N.Y. Sup. Ct. 2005); *Belshaw v. Feinstein*, 65 Cal. Rptr. 788 (Cal. Ct. App. 1968).

19. While these cases are difficult to find, they do exist. *See, e.g.*, *Morabito v. N.Y. Univ. Dental Ctr*. (N.Y.App. Div. 1st Dep't 1984) (affirming validity of NYU waiver without opinion); *Black v. Black*, NEW YORK L. J., March 8, 1986, at 6; *Fearns v. Columbia Univ*. (N.Y. App. Term. 1979).

20. "[M]ost [exculpatory agreements] were one-sided efforts by the health care provider to completely exculpate itself from tort liability." Ginsburg et al., *supra* note 9, at 253, 254; *see also* Havighurst, *supra* note 9, at 143, 165–170 (1986). "Adhesive" is not necessarily a synonym for "involuntary," especially when substitutes are readily available, but a contract's adhesiveness can be a basis for invalidation that is traditionally bound up with freedom of contract. This article does not take a position on this question. *See, e.g.*, Douglas A. Baird, *The Boilerplate Puzzle*, 104 MICH. L. REV. 933 (2006); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173 (1983).

21. "These legal positions have been developed, however, under a highly polarized framing of the issues, such as fully insured versus indigent patients or full liability versus complete waiver of liability." Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS. 159, 176 (2006), citing *Tunkl*.

22. *See supra* notes 8-11 and accompanying text (discussing arguments of Private Malpractice Symposium).

23. Those academic treatments that have touched on the commensurability of suggestions for contracting around malpractice via voluntary agreement with current doctrine have treated the case law in only a general manner, if at all, recognizing that courts typically disfavor exculpatory agreements in the health care context or discussing the majority rule in very general terms. *See, e.g.*, Havighurst, *supra* note 9 (stating that courts have resisted, but should stop doing so); Ginsburg et al., *supra* note 9 at 253–54; Mehlman, *supra* note 2.

24. *See* James Brock, *Contractual Disclaimer and Limitation of Liability Under the Law of New York*, 49 BROOK. L. REV. 1 (1982) (analyzing enforceability of exculpatory agreements generally through study of New York case law; does not discuss medical malpractice exculpatory agreements).

25. New York is a large state that has a rich case law on the topic of exculpatory agreements. In *Swarthout*, *supra* note 6, three of the seven cases discussed in reviewing the validity of exculpatory agreements under the majority rule are New York cases. Furthermore, New York is representative of the majority view. First, it views itself as in "full agreement" with the majority rule, *Ash v. N.Y. Univ. Dental Ctr*., 564 N.Y.S.2d 308, 313 (N.Y. App. Div. 1st Dep't 1990). Although *Ash* did not specifically refer to *Tunkl* as the source of the majority rule, it relied on a lengthy quotation from the decision. *Id.* at 312–13. *See also* Mehlman, *supra* note 2 at 401 ("The landmark decision is *Tunkl v. Regents of the University of California*.") Second, as in other jurisdictions, courts in New York have generally, but not uniformly, refused to enforce medical malpractice exculpatory agreements. *Compare, e.g.*, *Rosenthal v. Bologna*, 620 N.Y.S.2d 376 (N.Y. App. Div. 1st Dep't 1995) (invalidating exculpatory agreement) *with Morabito v. N.Y. Univ. Dental Ctr.*, 481 N.Y.S.2d 936 (N.Y. App. Div. 1st Dep't 1984).

26. For example, in *Glazer v. Lee*, the plaintiffs lost a summary judgment motion on a separate issue and thus the court never ruled on the validity of the exculpatory agreement they signed in their medical malpractice case. Brief of Plaintiff-Appellants at 19–21, *Glazer v. Lee*, 859 N.Y.S.2d 250 (N.Y. App. Dep't 2nd 2008) (No. 2006-07768). *See also Poag v. Atkins*, 806 N.Y.S.2d 448 (N.Y. Sup. Ct. 2005) (exculpatory agreement for unorthodox cancer treatment invalid); Brief of Plaintiff-Appellants at 13–14; *Dunham v. City of New York*, 766 N.Y.S.2d 854 (N.Y.A.D. 2d Dep't 2003) (No. 16451/98) (lower court failed to find ambulance company's waiver of liability void-for-public-policy). The inclusion of these terms in contracts, even when not enforceable, could have implications for the patient's decision to sue.

27. 564 N.Y.S.2d 308, 309–10 (N.Y. App. Div. 1st Dep't 1990).

28. *Abramowitz*, 494 N.Y.S.2d at 722 (invalidating agreement because language not specific).

29. Moore & Gaier, *supra* note 6 (generally describing validity of waivers in New York).

30. *See Abramowitz v. N.Y. Univ. Dental Ctr. Coll. of Dentistry*, 345 N.Y.S.2d 721, 722 (N.Y. App. Div 2nd Dep't 1985) ("Parties will not be presumed to have intended to exempt themselves from the consequences of their own negligence in the absence of express and unmistakable language to that effect."); *Schneider v. Revici*, 817 F.2d 987 (2d Cir. 1987) (Miner, J.) (New York allows exculpatory agreements but they are strictly construed, agreement before court was not clear enough as to negligence); *DeVito v. N.Y. Univ. Coll. of Dentistry*, 544 N.Y.S.2d 109 (N.Y. 1989) (language not clear enough to exculpate negligence, did not say "negligence" or words of "similar import." Those cases that upheld agreements, such as *Fearns*, involved "considerably stronger language.").

31. 564 N.Y.S.2d at 309-10. The Supreme Court in *Morabito* had validated the NYU agreement, and the court of appeals affirmed without opinion. *Morabito v. N.Y. Univ. Dental Ctr*. (N.Y. App. Div. 1st Dep't 1984).

32. *Ash*, 564 N.Y.S.2d at 313 ("We are in full agreement with the foregoing conclusions and analyses which are consistent with the majority view in this country that an exculpatory clause of the type here in issue must be held invalid as a matter of public policy.") (internal citation omitted). For examples of similar holdings in other states, *see, e.g.*, *Clark v. Brooks*, 377 A.2d 365 (Del. Super. Ct. 1977); *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977); *Tunkl v. Regents of University of Cal.*, 60 Cal. 2d 92 (Cal. 1963).

33. *Ash*, 564 N.Y.S.2d 308.

34. *See Rosenthal v. Bologna*, 620 N.Y.S.2d 376 (N.Y. App. Div. 1st Dep't 1995); *Creed v. United Hosp*., 190 A.D.2d 489 (N.Y.App. Div. 2d Dep't 1993); *Poag v. Atkins*, 806 N.Y.S.2d 448 (N.Y. Sup. Ct. 2005).

35. *Cf.* Mehlman, *supra* note 2, at 401 ("[T]here is no consistency in the rationales offered by the courts, little practical guidance for future cases, and no way to distinguish cases that have invalidated such agreements as a matter of law from those that have upheld them or permitted their validity to be decided by the jury.").

36. *Rosenthal v. Bologna*, 620 N.Y.S.2d 376 (N.Y. App. Div. 1st Dep't 1995); *Creed v. United Hosp.*, 190 A.D.2d 489, 492 (N.Y. App. Div. 2d Dep't 1993).

37. *Rosenthal*, 620 N.Y.S.2d 376 at 376.

38. *Creed*, 190 A.D. at 492 (citing *Ash*).

39. *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 308–13 (N.Y. App. Div. 1st Dep't 1990).

40. *Id.* at 310.

41. *Id.* at 313. It is unclear what "type" the *Ash* court was referring to—on a broad reading this line may be read in favor of a categorical rule against enforcement of medical malpractice exculpatory agreements. *See* Brief of Plaintiff-Appellants at 13–14, *Dunham v. City of New York*, 766 N.Y.S.2d 854 (N.Y.App. Div. 2 Dep't 2003) (No. 16451/98) (attempting to make this argument).

42. *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 376 (N.Y. App. Div. 1st Dep't 1995).

43. *Poag v. Atkins*, 806 N.Y.S.2d 448 (N.Y. Sup. Ct. 2005) (emphasis added).

44. "[T]he 'agreement' consists of several sentences in the middle of the informed consent form signed by the plaintiff's decedent; no separate heading or caption was present to alert the decedent that she was foregoing the right to bring suit. Thus, the 'agreement' is unenforceable." *Id.*

45. *See Dedely by Dedely v. Kings Highway Hosp. Ctr., Inc.*, 617 N.Y.S.2d 445, 447 (N.Y. Sup. Ct. 1994) (citing *Ash* for "higher standard of responsibility" and finding contract invalid because signed by parent on behalf of minor).

46. "This is not to say, however, that one may not, by agreement, relinquish a present right or claim or one which subsequently accrues." *Colton*, 385 N.Y.S.2d at 65; "Does it include negligence and medical malpractice as defendants claim? Is it void in its entirety on public policy grounds, as plaintiffs claim? These questions must both be answered in the negative." *Colton*, 414 N.Y.S.2d at 874.

47. *Supra* note 28. A number of other cases have similarly refused to read a release as having exculpated negligence without very specific—and centrally placed—language. These courts require that agreements be not only "clear and unambiguous on [their] face but . . . understandable to the particular patient." *DeVito,* 544 N.Y.S.2d at 145, citing *Abramowitz,* 494 N.Y.S.2d 721.

48. *Supra* notes 29–33 and accompanying text.

49. *Ash*, 564 N.Y.S.2d at 311. The dental clinic was no ordinary hospital or clinic, but a teaching clinic where the students were not "sufficiently prepared and supervised so that the treatment which is provided to human patients is at least at the minimally acceptable reasonable level of skill and care." *Ash*, 564 N.Y.S.2d at 311. A crucial implied element of the public interest holding was that the negligence waiver made clear that the result would be reduced-quality care for the less affluent. "It is clear that the State's substantial interest in protecting the welfare of all of its citizens, irrespective of economic status, extends to ensuring that they be provided with health care in a safe and professional manner." *Id.* at 310–11. *See also id.* at 311 (a patient may give up wait times, certain amenities, or other inconveniences in exchange for reduced–cost care, but "there cannot, however, be any justification for a policy which sanctions an agreement which negates the minimal standards of professional care which have been carefully forged by State regulations and imposed by law").

50. First, exculpatory agreements need not go directly to the *quality of care to be received*. They might instead determine *who bears the risk of negligent conduct*. Second, although the issue is hotly debated, there is reason to believe that the threat of malpractice liability has little to do with quality of treatment. *See* Lori L. Darling, Note, *The Applicability of Experience Rating to Medical Malpractice Insurance*, 38 CASE W. RES. L. REV. 255 (1987) (malpractice premiums not connected to quality); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 6 (1991) (physicians view malpractice judgments as accidents, not evidence of quality); Stephen D. Sugarman, *Doctor No, Review of Medical Malpractice on Trial by Paul C. Weiler*, 58 U. CHI. L. REV. 1499, 1500–02, 1504 (1991) (very small fraction of those harmed by malpractice bring suit) *See* Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625, 642 (2001) (malpractice liability essentially random). *But see* Jennifer Arlen & W. Bentley Macleod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1941 n. 36 (2003) (Weiler study featured sample too small to draw statistically significant conclusion that malpractice liability is random). Third, even assuming the role the malpractice system is traditionally thought to play in ensuring quality, to the extent that "quality" is not a treatment-by-treatment decision and at least some patients choose to retain the possibility of suing for malpractice, an incentive for the doctor to meet the malpractice standard remains. *See*, *e.g.*, LAW & POLAN, *supra* note 1 at 18–19, 61–62, 251–52 notes 18–21 (1978) (quality of outcomes largely influenced by choice of treatment, unnecessary treatment); Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?*, 258 J. AM. MED. ASS. 2533, 2536 (1987) (17 to 32 percent of studied procedures unnecessary). Furthermore, informed patients might refuse to sign contracts that negatively affect quality. Law, *supra* note 1, at 305, 317. Finally, even if a voluntary exculpatory agreement did affect quality, the *Ash* court's concern was with a departure from the minimal standard of care *for less affluent patients who could not afford otherwise*, and a doctor might provide evidence that the patient had the financial wherewithal to pay the higher fee and not sign.

51. *Id.* at 310–11.

52. 15 WILLISTON ON CONTRACTS § 1751 (3rd ed. 1972).

53. *Id.*

54. *Id.*

55. The Court seemed to base its holding on *both* justifications. The court explicitly states that the "greater responsibility" of the doctor in the patient-provider relationship is a concern, citing the above quoted treatise for this proposition. *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 311–12 (N.Y. App. Div. 1st Dep't 1990), *citing* 15 WILLISTON ON CONTRACTS § 1751 (3rd ed. 1972). But after an inconclusive line on the subject, it then turns to the "bargaining power" justification. This inconclusive line is that: "In the context of that professional relationship . . . a provision avoiding liability is peculiarly obnoxious." (15 *Williston on Contracts* (3rd ed. 1972) § 1751.) Also significant in evaluating the provision's validity are the unequal positions of the parties entering into this agreement, creating a substantial opportunity for abuse." *Id.*

56. The *Ash* court's analysis of why the special relationship justified non-enforcement makes this clear: "[T]he individual responsibility bestowed upon defendants by the physician-patient relationship, *in the context of the disadvantageous position from which plaintiff necessarily entered into the agreement*, militates strongly against its propriety. *Id.* at 312 (emphasis added). Furthermore, the court in *Ash* used the adhesive nature of the contract to distinguish the case law upholding voluntary exculpatory agreements, stating that: "[The clinic's patients] must either accept what is offered or be deprived of the advantages of the relation. . . . [They] cannot be considered to have freely bargained for a sub-standard level of care in exchange for a financial savings." *Id.* at 311–12.

57. Thus courts have compared healthcare services to those of other services invalidated under this prong, such as common carriers or public utilities, industries in which the provider effectively has a monopoly, and might impose the contract on the consumer even when it is not in the consumer's best interest. *Devito v. N.Y. Univ.*

Coll. of Dentistry, 544 N.Y.S.2d 109, 110–11 (N.Y. Sup. Ct. 1989) ("In these relationships, the consumer's need for the service creates an inequality in bargaining strength which enables the purveyor to insist upon a release, generally on its own prepared form, as a condition to providing the service.").

58. Elizabeth Hoffman, Kevin McCabe & Vernon L. Smith, *Social Distance and Other-Regarding Behavior in Dictator Games*, 86(3) AM. ECON. REV. 653 (1996) (fairness-regarding behavior depends on process, "social distance"); Todd L. Cherry, Peter Frykblom, & Jason F. Shogren, *Hardnose the Dictator*, 29 AM. ECON. REV. 1218 (2002) (attempting to devise game in which people would not treat others fairly).

59. *See, e.g.*, Richard A. Posner, *Rational Choice, Behavioral Economics, and the Law*, 50 STAN. L. REV. 1551 (1998).

60. D. Kahneman, J.L. Knetsch, R. Thaler, *Fairness as a Constraint on Profit Seeking: Entitlements in the Market*, AM. ECON. REV. 76, 728–741 (1986) (monopoly pricing constrained by fairness costs); A. Blinder, D. Choi, *A Shred of Evidence on Theories of Wage Stickiness*, 105 Q. J. ECON. 105, 103–113 (1990); T.F. Bewley, *A Depressed Labor Market as Explained by Participants*, AM. ECON. REV. PAPERS AND PROCEEDINGS 85, 250–254 (1995), C.M. Campbell & K. Kamlani, *The Reasons for Wage Rigidity: Evidence from a Survey of Firms*, 112 Q. J. ECON. 759–789 (1997).

61. *See* Gary Charness & Matthew Rabin, *Expressed Preferences and Behavior in Experimental Games*, 53 GAMES & ECON. BEHAVIOR 151 (2005). For example, in a two-player "Ultimatum game" in which the first player offers some allocation of money between the players and the second player either accepts (in which case both players receive the allocated sum) or rejects (in which case both players receive nothing), second players are more likely to accept an extremely low offer if they know that the preferred allocation was randomly assigned and not the result of the first player's self-interested decision. *Id.* at 154. In short, "people are less concerned with fairness than the *appearance* of fairness." John R. Hibbing & John R. Alford, *Accepting Authoritative Decisions: Humans as Wary Collaborators*, 48 AM. J. POLI. SCI. 62, 64 (2004). *See also* Sally Blount, *When Social Outcomes Aren't Fair: The Effect of Causal Attributions on Preferences*, 63(2) ORG. BEHAVIOR & HUMAN DECISION PROCESSES 131 (1995) (attribution matters for fairness concerns); Gary Charness, *Attribution and Reciprocity in an Experimental Labor Market*, 22(3) J. LAB. ECON. 665 (2002); Catherine C. Eckel & Philip J. Grossman, *Altruism in Anonymous Dictator Games*, 16 GAMES & ECON. BEHAVIOR 181 (1996) ("the appearance of fairness is enough"). *Cf.* Jason Scott Johnston, *Strategic Bargaining and the Economic Theory of Contract Default Rules*, 100 YALE L.J. 615 (1990) (signaling effect of decision to bargain away from default rule a source of status quo bias).

62. Rabin, *Incorporating Fairness into Game Theory and Economics*, *in* ADVANCES IN BEHAVIORAL ECONOMICS 298 (C.F. Camerer, G. Loewenstein, & M. Rabin, eds., 2003) (respect for "fairness" actually dependent on process by which decision made, signaling).

63. Mark A. Hall, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 659 (2008) (cites interview with woman saying it would insult doctor to ask about costs, possibility of retaliation).

64. Matthew J.B. Lawrence, *Forcing Patients to Do What They Really Want to Do: The Case for Excuse Paternalism* (January 20, 2009) (unpublished manuscript, on file with the *New York University Law Review*).

65. "The most striking fact regarding *all* voluntary [second-surgical-opinion programs] is that few people choose to use them." Alan S. Friedlob, *Medicare Second Surgical Opinion Programs: The Effect of Waiving Cost-Sharing*, 4 HEALTH CARE FINANCING REV. 99, 104 (1982), quoted in David A. Hyman, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439, 1458 (1998) (discussing possibility of second opinions in legal profession).

66. Stephen N. Rosenberger et al., *Patients' Reactions and Physician-Patient Communication in a Mandatory Surgical Second-Opinion Program*, 27 MED. CARE 466 (1989).

67. Lawrence, *supra* note 64.

68. *Id.* at 26.

69. Arbitration agreements are different from exculpatory agreements in a few fundamental ways, most importantly because the Federal Arbitration Act, 9 U.S.C. §§ 1 *et seq*., explicitly favors arbitration, raising complicated preemption questions and changing the issues at stake in determining enforceability. *See generally* Carol A. Crocca, *Arbitration of Medical Malpractice Claims*, 24 A.L.R.5th 1 (originally published 1994). Some scholars have attempted to apply the same type of analysis to both arbitration and exculpatory agreements. *See* Mehlman, *supra* note 2, at 405-08.

70. LAW & POLAN, *supra* note 1 at 135 (1978), citing ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, COMMITTEE ON LAW AND MEDICINE, REPORT ON MEDICAL MALPRACTICE ARBITRATION PLAN 8 (Feb. 4, 1976) (emphasis added).

71. *See supra*, Part I.B. (New York courts still engage in case-by-case approach).

72. The difficulty of separating individuals who are boundedly rational —including those who consider fairness costs—from those who are not is the motivating force behind the discussion in Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 U. PENN. L. REV. 1211 (2003). Actually determining whether a given patient had only consented because of fear of hurting her doctor's feelings would require a determination of whether the consideration the patient received—the reduction in price that accompanied signing away negligence liability or punitive damages—was adequate. But pricing the "value" of malpractice liability, or the availability of punitive damages, is no less complicated than pricing the value of medical services in the first instance.

73. *Cf. Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 351 n. 23 (1982) ("Whatever economic justification particular price-fixing agreements may be thought to have, the law does not permit an inquiry into their reasonableness. They are all banned because of their actual or potential threat to the central nervous system of the economy."), *quoting United States v. Socony-Vacuum Oil Co*., 310 U.S. 150, 226, n. 59 (1940).

74. *Cf.* LAW & POLAN, *supra* note 1 at 135 (describing such a suggestion in arbitration context).

75. *See, e.g.*, Aaron-Andrew P. Bruhl, *The Unconscionability Game: Strategic Judging and the Development of Arbitration Doctrine*, 83 NYU L. REV. (forthcoming 2008). *But cf.* LAW & POLAN, *supra* note 1 at 135 (describing such a suggestion in arbitration context).

76. *See, e.g.*, *Schneider v. Revici*, 817 F.2d 987 (2d Cir. 1987) (upholding exculpatory agreement waiving suit for experimental non-negligent treatment; citing New York cases).

77. Several policy arguments have been made in favor of contracting with managed care organizations in this way. *Arlen*, *supra* note 2 at 24 (citing literature). The insight of this article, then, provides a new argument in favor of these arrangements.

78. REST. (SECOND) CONTRACTS § 50 (1981).

79. Indeed, Restatement § 54 actually specifies that "no notification is necessary to make []an acceptance effective" and that notice is *never* necessary if "the offer indicates that notification of acceptance is not required." REST. (2D) CONTRACTS § 54 (1981).

Matthew J. B. Lawrence is a third year law student at NYU Law School.

Recent Events

- **Annual Meeting**. The 2009 Health Law Section Annual Meeting, held at the Marriott Marquis Hotel in Times Square, NYC, included a program on Legal Issues in Health Care Reimbursement The program was co-chaired by Ellen Weissman of Hodgson Russ (Rochester) and Margaret Davino of Kaufman Borgeest & Ryan (NYC). The luncheon speaker was Deborah Bachrach, Deputy Commissioner of the Office of Health Insurance Programs (OHIP) and NYS State Medicaid Director.

Upcoming Programs—Save these Dates

- **Mini-MPH: May 15-16.** This two-day program will offer lawyers exposure to a mix of health care management, administrative, policy and legislative issues. Presenters will include prominent health care business leaders and policymakers. The program, chaired by Ari Markenson of Cypress Health Care Management, will be held at New York Medical College in New York City. For more information, go to www.nysba.org/health.
- **Fall Section Meeting: October 24.** Save the date. The Fall Retreat will held at the Sagamore Hotel on Lake George. The overall topic "Health Law in Hard Times," will examine legal issues that arise when providers, payors, goverment, patients—and health care lawyers—are under financial pressure.

Upcoming *Journal* Edition

The upcoming Spring '09 edition of the *Health Law Journal* will be a special edition called "Panel Discussions." The *Journal* will organize expert panel discussions on a range of issues, and edit and publish the results. The issues will include: Medicaid fraud, end-of-life decision-making, health care reform, regional health information systems, health care privacy and security, health care consolidation. Peter Millock of Nixon Peabody will be the Special Editor.

Notable Committee Activities

- **Special Committee on E-Health & Information Systems**. The Section's Special Committee on E-Health & Information Systems, chaired by Raul Tabora of Ruffo, Tabora, Mainello and McKay of Albany, has been notably active. In addition to tracking e-health and information legislation on the federal and state levels, the committee is organizing teleconferences on a number of issues including electronic medical records, e-signatures, e-archives and electronic document retention and regional health information systems. The Committee is also seeking to create a compendium of emerging case law on e-health and information systems. Persons interested in joining the committee should contact Raul Tabora at rtabora@ruffotabora.com.

Recent Supraspinatus Blurb Topics:

- AMA Sues Aetna, Cigna over Ingenix
- New State Ethics Rules Coming
- More on Ingenix: AG Reaches Agreement with MVP, Threatens CDPHP
- VA Settles Security Lawsuit for $20 Million
- Daschle Withdraws Nomination
- iSCNT'—interspecies somatic cell nuclear transfer: Animal eggs sources for patient specific stem cells
- Paterson's Health Proposals Draw Fire
- 1/26/09 ESSCB Ethics Committee meeting (includes funding report update)
- U.S. Senate Resolution: National Data Privacy Day 1/28/09
- Rule Changes on Spousal Assets in Long Term Home Care
- HEALTHeLINK Lifts Off in Western New York
- 1/23/09 World's first HESC-based therapy in man by Geron
- Pres. Obama's Proclamation for Inauguration Day, Jan. 20, 2009
- Nurses in Walkoff Cleared of Abandonment Charges
- United/Ingenix and AMA Settle Out—Roundup

Supraspinatus, the Health Law Section's blog, may be viewed at http://nysbar.com/blogs/healthlaw. The site is supervised by Paul Gillen of Capital District Physicians Health Plan.

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

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.

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

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

Hospitals and Health Systems
James D. Horwitz
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
jhorwitz@glensfallshosp.org

Marguerite A. Massett
Hancock & Estabrook, LLP
1500 Axa Tower I
100 Madison Street
Syracuse, NY 13202
mmassett@hancocklaw.com

Long Term Care Providers
Richard T. Yarmel
Nixon Peabody LLP
1100 Clinton Square
Rochester, NY 14604
ryarmel@nixonpeabody.com

Managed Care, Insurance and Consumer/Patient Rights
Harold N. Iselin
Greenberg Traurig, LLP
54 State Street
Albany, NY 12207
iselinh@gtlaw.com

Mark Scherzer
Law Offices of Mark Scherzer
7 Dey Street, Suite 600
New York, NY 10007-3105
mark.scherzer@verizon.net

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

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

Keith J. Brennan
New York State
Office of Mental Health
Associate Attorney, Counsel's Office
44 Holland Ave
Albany, NY 12229
colekjb@omh.state.ny.us

Payment and Reimbursement
Ellen V. Weissman
Hodgson Russ LLP
140 Pearl Street, Suite 100
Buffalo, NY 14202-4040
eweissma@hodgsonruss.com

Physicians and Licensed Health Care
Alexander G. Bateman Jr.
Ruskin Moscou & Faltischek PC
1425 Rexcorp Plaza
East Tower, 15th Floor
Uniondale, NY 11556
abateman@rmfpc.com

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

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

Public Health/Policy
Margaret J. Davino
Kaufman Borgeest & Ryan LLP
120 Broadway, 14th Floor
New York, NY 10271-1699
mdavino@kbrlaw.com

Publications and Web Page
Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
swidlerr@nehealth.com

Special E-Health and Information Systems
Raul A. Tabora Jr.
Ruffo Tabora Mainello & McKay PC
300 Great Oaks Boulevard, Suite 311
Albany, NY 12203
rtabora@ruffotabora.com

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

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

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

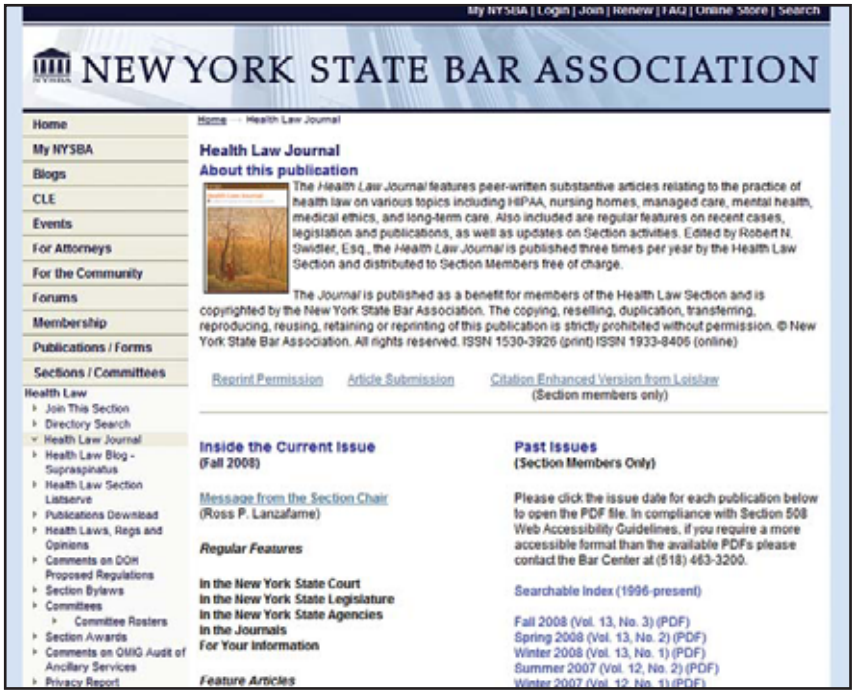
Your key to professional success…

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.**

The *Health Law Journal* is also available online!



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

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

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 2009 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)