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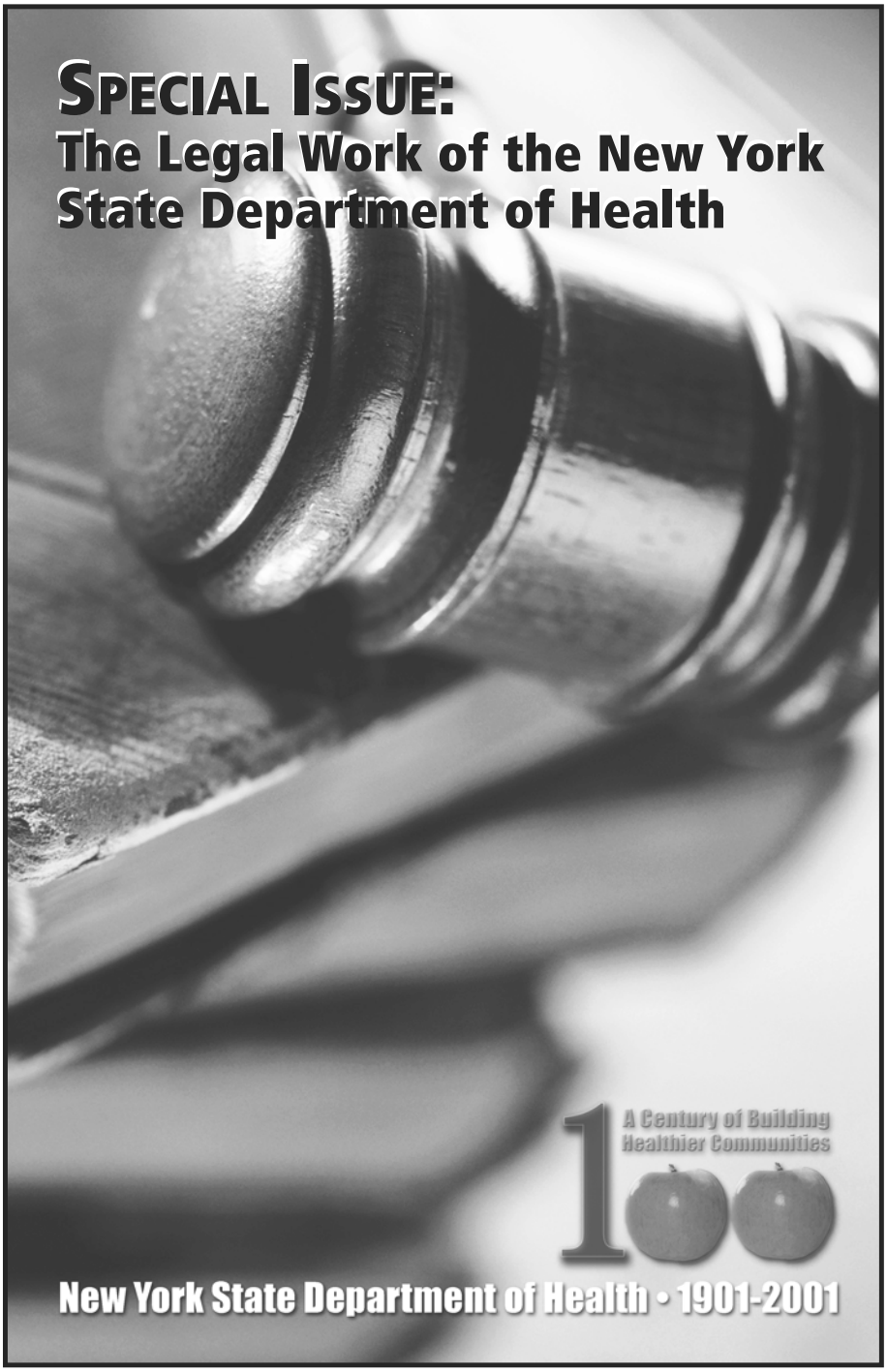
Health Law Journal

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

Published in cooperation with Albany Law School



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NYSBA 125 Years

HEALTH LAW JOURNAL

SUMMER/FALL 2002

Vol. 7, No. 3

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

in cooperation with

ALBANY LAW SCHOOL

A Message from the Section Chair

A Reflection from the Past and an Agenda for the Future

It is a privilege to present my first report to the membership in this special edition of the *Health Law Journal*. This issue of the *Journal* focuses exclusively on the structure and operation of one of the nation's finest and most sophisticated state health regulatory agencies, the New York State Department of Health. It is a collector's edition *Journal*, the value of which will long outlast my tenure as Chair. This theme was conceptualized by past Chair and Co-editor of the *Journal* Robert Swidler, and was jointly developed with the collaboration, cooperation, and support of the New York State Department of Health, principally through its Legal Department under the leadership of Donald P. Berens, Jr. The Section is indebted to Don and his office for their work on this issue as well as to Professor Dale Moore, the *Journal*'s Co-editor, who made this concept a reality.

I am honored to be the first Chair of the Section from the public sector. I have been active with the New York State Bar Association, and in particular with the Health Law Committee (the predecessor to the Health Law Section) and later the Health Law Section for approximately twenty years. Health law is an exciting and ever changing area of law. My work in health law has managed to keep me interested and excited about the law. We are all very fortunate to practice in a broad and very diverse specialty. It ranges from the mundane but important issues of health care finance law to the very sensitive issues of death and dying. In the end health law is about the patient, the consumer of health services. The patients are our parents, spouses, children, brothers, sisters, ourselves. We should never lose sight of this as we toil in the fields of health law.

My involvement with the Bar Association has helped my development as a health law practitioner through MCLE programs, publications, Committee meetings, and networking with other practitioners. The health law bar is a very friendly bar with many special people. I am fortunate to have encountered many health lawyers who have served as mentors, role models, and friends. Among them are Robert Kaufman, Susan Robfogel, George Kalkines, Robert Wild, Jeffrey Becker, Peter Nadel, Frank Serbaroli, Kathyrn Meyer, Gladys George, Michael McDonald, Michael Barnett, Edward Kornreich, Judge Daniel Lodato, Margaret Davino, Peter Millock, David Seay, Kenneth Larywon, and Bruce Gilpatrick. I urge each member to become more active with the Section. The time spent on Section activities and networking with colleagues yields benefits, both personal and professional.

"The patients are our parents, spouses, children, brothers, sisters, ourselves. We should never lose sight of this as we toil in the fields of health law."

The state of the Section is very good, thanks to the efforts of its distinguished past Chairs, officers, *Journal* Editors, and other members of the Executive Committee. We serve over 1,000 members. The Section's finances are in the black. The quality of the Section's *Journal*, MCLE programs, and Annual Meeting programs is superb. It is my charge to build upon the fine accomplishments of the past and move the Section even further. This is a daunting task. My predecessor Chairs, starting with the Section's first Chair, Barry Gold, through the immediate past Chair, Bob Abrams, have all advanced this Section's work and left their marks upon the Section. I am particularly humbled by the works of my immediate predecessor, whose creative efforts have again brought the Section to a new level with the development of a comprehensive health law manual produced jointly by the Section and the Medical Society of the State of New York.

Inspired by the accomplishments of the Section's past leadership, I have charted a very ambitious agenda for this Association year. With each member's support and the hard work of the Section's outstanding officers and other members of the Executive Committee, I am optimistic about realizing the goals for the Section this year. Set forth below are nine agenda goals for the Section and some preliminary plans designed to assist in fulfilling them.

Agenda for the Future and Some Preliminary Actions to Accomplish Each Goal

1. **Enhance Committee activity**
   Action—Each Committee Chair has agreed to conduct at least two Committee meetings and

undertake one major project, monitor each Chair's submitted work plan.

2. **Expand membership involvement**
   Action—Require that each Committee permit the option of attending meetings by use of telephone conference call, and expand participation in the Section's listserve.

3. **Increase visibility with the New York State legislature**
   Action—A visit with the key members and staff of the legislature in Albany by a small delegation of the Executive Committee, as well as increased appearances before legislative committee in public hearings.

4. **Focus on one or more consumer/patient projects**
   Action—Drafting of a consumer rights pamphlet, and the development of a film on the value of the health care proxy for dissemination to nursing homes, senior centers, etc.

5. **Increase the membership—Goal of 1,200 members**
   Action—Contact recently dropped members; contact attorneys who identify health law as a practice area; reach out to law students and government attorneys.

6. **Build upon the relationship with the State Medical Society**
   Action—Complete the publication of the health law manual, conduct at least one joint program with the Society.

7. **Maintain the high quality of the Section's *Journal***
   Action—Encourage greater numbers of experienced practitioners to submit articles, and support the fine work of the Co-editors.

8. **Maintain the high quality of the Section's programs and MCLE program**
   Action—Seek assistance from the members of the Executive Committee, past Chairs and other experienced practitioners on development of programs.

9. **Improve the Section's Web site**
   Action—Appointed Stephanie Davis as Web site Director, who will work with Philip Rosenberg in refining the Section's Web site.

In addition to the above, the Section has planned or is planning to take the following actions:

- For a pilot project, I have increased the membership of the Executive Committee through the use of more Co-chairs, the creation of two Special Committees (the Special Committee on Mental Health Issues and the Special Committee on Bylaws), the assimilation into the Executive Committee of the Chair of the Committee on AIDS and the Law, the appointment of a Web site Director, the appointment of liaisons with the Committee on Disabilities and with the Young Lawyers Section and the implementation of two at-large membership positions previously approved by the Section's membership.

- The Section will also get the benefits of the talents and experience of the past Chairs of the Health Law Committee and the Section by the creation of a Past Chairs' Advisory Committee. The past Chairs will have a standing invitation to attend the Executive Committee meetings.

These actions will increase the number of members involved in the leadership of the Section as well as increase the possibility of more Committee activities.

- The Committee on Securing Health Care for the Uninsured has been renamed the Committee on Health Care Finance and given a broader charge.

- As part of the Section's outreach to law students, the Section will be hosting a cocktail party at the offices of Cadwalader, Wickersham & Taft for the professors who teach health law at law schools in the metropolitan area. Additionally, the Section is planning to institute an annual law student writing competition.

In closing, I urge you to use one of the Section's great health law resources, the Section's listserve. The listserve provides you with access to other health law practitioners within the Section who are valuable sources of guidance on issues which you are confronting. I strongly recommend your joining the listserve. I also invite your input and suggestions as to the work of the Section. Please do not hesitate to call or e-mail me directly. Alternatively, you may wish to contact one or more of the distinguished Chairs or Co-chairs of Section Committees. Finally, I want to acknowledge the support that I receive from my employer, The New York City Health and Hospitals Corporation (HHC), and its general counsels past and present from John Linville to Alan Aviles for my Bar Association activities. While these activities have benefited me personally, they have also improved my effectiveness and value as a health lawyer for HHC.

Salvatore J. Russo

A Message from the Editors

It is hard to imagine a topic more useful for health lawyers in New York to know about than the legal activities of the New York State Department of Health (DOH). One way or another, whether we practice health law in a firm, in-house, government or academia, we health lawyers routinely deal with either DOH attorneys or the implications of their activities.

Yet it is our impression that most health lawyers don't have a clear sense of what those DOH lawyers *do*—i.e., how their office is organized and what their responsibilities are. Nor is there any publication or Web site we know of that describes this. As a result, health lawyers—particularly new health lawyers—who need to address a legal issue with the Department must feel like they have entered a disorienting labyrinth of divisions and bureaus.

Accordingly, in early summer we approached DOH General Counsel Don Berens and DOH Public Affairs Director Claire Pospisil, and asked them for the Department's help in telling health lawyers just what it is DOH lawyers do. Both enthusiastically supported the idea, and enlisted several DOH attorneys to submit articles. Those attorneys came through, in a very short period of time, with the excellent materials that are the heart of this special edition of the *Journal*.

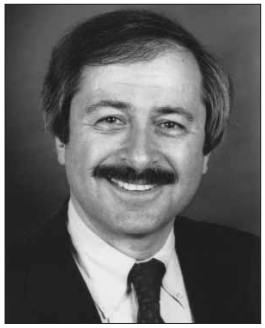
On behalf of the Section and the *Journal*, we want to express our thanks to Don Berens and Claire Pospisil, and to the several prominent and experienced DOH attorneys (in addition to Don) who contributed to this edition: Anna Colello, Terry Freedland, James Horan, Glenn Lefebvre and Michele Petruzzelli. It is fair to say that health lawyers throughout the state thank you as well for this invaluable primer on the legal activities of the Department.

Moreover, the *Journal* would also like to extend its congratulations to the Department of Health and its Commissioner on the Department's 100th anniversary. While private health lawyers struggle with DOH on a range of issues, we certainly recognize and are grateful for the Department's long-standing leadership role in fighting for quality of care, access to care, and cost-effectiveness of care for New Yorkers.

Finally, the Editors once again thank our dedicated regular columnists—Len Rosenberg, Claudia Torrey, Jim Lytle and Frank Serbaroli—for their critical contributions to this edition.

Dale L. Moore and
Robert N. Swidler

In Memory of Barry Gold, Esq.



Barry Gold, Esq., the founder and the first chair of the NYSBA Health Law Section, passed away on October 12, 2002—just as this edition went to print. Barry was 56 years old.

Barry was a mentor, a model and a friend to health lawyers across the state. We admired him for his knowledge and good judgment, and we loved him for his compassion and humor.

We in the Section offer our condolences to Barry's family. And we acknowledge to them the great debt we owe Barry. Without his vision and leadership, there would be no Health Law Section.

In the New York State Courts

Physician-Employees May Claim Exception to Employment-at-Will Doctrine

Horn v. New York Times, 739 N.Y.S.2d 679 (1st Dep't 2002). Plaintiff, a physician formerly employed by defendant New York Times, sued the Times for breach of an implied contract of employment. Dr. Horn alleged that she was wrongfully discharged for refusing to share with the Times confidential medical information she obtained while treating and providing medical advice to its employees. Dr. Horn alleged that she was employed as the Times' assistant medical director, and in such capacity, was required to provide "medical care, treatment and advice," to its employees, and to examine employees who were seeking Workers' Compensation benefits to verify that their claimed injuries were work-related.

Dr. Horn also alleged that she was frequently asked to provide the Times' department managers with the confidential medical records of employees without the employees' consent, and to misinform employees as to whether their injuries were covered under Workers' Compensation. Dr. Horn claimed that after consulting with the Department of Health as to the propriety of defendant's requests, she refused to comply, and was fired shortly thereafter. Dr. Horn claimed that the Times wrongfully discharged her for failing to comply with its requests, because her employment as a physician carried with it a corresponding obligation to conduct her practice in accordance with the ethical standards of the medical profession.

In response, the Times moved to dismiss, claiming that New York's employment-at-will doctrine does not recognize plaintiff's "implied contract" cause of action. The trial court rejected defendant's argument, and the Appellate Division, First Department affirmed, finding that "a physician may claim an exception to New York's employment-at-will doctrine based on an implied-in-law obligation of her employer to, at the very least, do nothing to prevent her from practicing medicine in compliance with the ethical standards of the medical profession."

The Appellate Division acknowledged that under New York law, it is well settled that "where an employment is for an indefinite term it is presumed to be a hiring at will which may be freely terminated by either party at any time for any reason or even for no reason." The court also found, however, that *Wieder v. Skala*[1] recognized an exception to the employment-at-will doctrine. In *Wieder*, the Court of Appeals found that a law firm's unfettered right to discharge its associate was limited due to an implied-in-law obligation on the part of the firm "to deal fairly and in good faith with the associate." In *Wieder*, the plaintiff-associate of defendant's law firm alleged that he was wrongfully discharged for his insistence that the firm report the professional misconduct of another associate under the attorney-disciplinary rules. In finding that the plaintiff stated a claim for breach of implied contract, the *Wieder* court found that the firm's insistence that Wieder "act unethically and in violation of one of the primary professional rules amounted to nothing less than a frustration of the only legitimate purpose of the employment relationship."

The Appellate Division found that the *Wieder* exception applied equally here, because there were sufficient similarities between the core characteristics of the legal and medical professions. Specifically, Mr. Wieder and Dr. Horn were employed for the specific purpose of practicing their corresponding professions, and each was bound by professional ethics in the practice of that profession. The Court distinguished numerous other cases that rejected application of this exception, finding that physicians and lawyers, unlike other professions, have ethical obligations to the public at large, which is at the very core of the professional services they provide as employees.

Finding that the plaintiff-physician was hired by the Times to perform medical services for employees, the defendant should have known that the plaintiff was ethically bound to her patients. This knowledge gave rise to an implied understanding that the defendant would, "at the very least, do nothing to prevent Dr. Horn from conducting her practice in compliance with that code." Accordingly, the Court found that plaintiff stated a claim against defendant for breach of an implied-in-law obligation to do nothing to interfere with the practice of her profession in accordance with the ethical standards of the medical profession.

Hospital Has Affirmative Duty to Safeguard Patients from Readily Perceivable Risk of Harm

N.X. v. Cabrini Medical Center, 97 N.Y.S.2d 247 (N.Y. 2002). A partially sedated female patient was sexually assaulted in the recovery room by a surgical resident employed by the hospital. Three nurses were present in the room attending another patient only a few feet away, but were unaware of the resident's assault on the patient. The assaulted patient sued the hospital for negligent hiring, negligence in failing to safeguard her adequately, and medical malpractice. She also asserted a cause of action for vicarious liability, alleging that the resident was acting in the scope of his employment or under the cloak of apparent authority. The Supreme Court dismissed the other claims, but ruled that questions of fact precluded the hospital's motion for summary judgment with regard to the failure of the hospital to adequately safeguard the patient from harm.

The Appellate Division reversed the lower court's decision, reasoning that the direct negligence claim must fail because the resident's conduct was not foreseeable as a matter of law, and practical and policy considera-

tions underlying the physician-nurse relationship further precluded liability. The Appellate Division agreed that the hospital could not be held liable under the doctrine of vicarious liability, as the resident was clearly not acting within the scope of his employment.

In this case, the Court of Appeals reversed the Appellate Division, and remanded the case for further proceedings on the issue of the hospital's negligence in failing to safeguard the patient. The Court found that the plaintiff had cited several unusual circumstances surrounding the resident's presence in the recovery room that should have alerted the nurses that the plaintiff was in jeopardy of imminent harm. One of the nurses testified, for example, that residents are not directly assigned to the recovery room. Additionally, she testified that she was familiar with all of the patient's attending physicians and knew that the resident was not one of them. Additionally, the recovery room was very small, and the nurses were easily able to observe all that happened at the plaintiff's bedside.

Most compelling, the nurses were all aware of the hospital's policy requiring the presence of a female staff member during a male physician's pelvic exam of a female patient, but did not intervene when an unknown resident wearing surgical gloves—usually worn for internal examinations—approached plaintiff's bedside apparently intent on examining her. The Court held that these facts provided a "sufficient basis" from which a jury could determine that the nurses unreasonably disregarded the risk of harm to the patient.

The Court went on to emphasize that

> [O]ur holding today does not establish a broader duty than that historically placed upon hospitals to their patients. Our holding does not impose a "gatekeeping" function upon nurses to stop and question physicians, ascertain reasons for their presence, or to stand guard and monitor their interactions with patients. We simply hold that observations and information known to or readily perceivable by hospital staff that there is a risk of harm to a patient under the circumstances can be sufficient to trigger a duty to protect. This commonsense approach safeguards patients when there is reason to take action for their protection and does not burden the practice of medicine or intrude upon the traditional relationship between doctors and nurses.

The Court of Appeals, however, upheld dismissal of the vicarious liability claim, noting that "[w]e refuse to transmogrify [the resident's] egregious conduct into a medical procedure within the physician's scope of employment. This was a sexual assault that in no way advanced the business of the hospital."

Nursing Homes Are Not "Hospitals" Under the Public Health Law and Thus Are Not Entitled to the Statutory Privilege Afforded Quality Assurance Materials; Privilege Provided Under Education Law § 6527(3) Does Not Apply in Grand Jury Investigations; Narrow Privilege Under Federal Law Did Not Apply to Documents Sought from Nursing Home by Grand Jury

In re Subpoena Duces Tecum to Jane Doe, 742 N.Y.S.2d 465 (4th Dep't 2002). A nursing home moved to quash a grand jury subpoena duces tecum issued in connection with an investigation by the New York State Attorney General's Medicaid Fraud Unit into the health care services provided by three nursing homes. The subpoena required the production of documents in the possession of one of the nursing homes' quality assurance committees. The movant asserted that the records sought by the subpoena were protected from disclosure to the grand jury pursuant to the privilege afforded to quality assurance records by New York State Public Health Law § 2805-m(1) and (2), New York State Education Law § 6527(3), and 42 U.S.C. § 1395i-(3)b(1)(B), a federal statute which protects certain materials generated by nursing home quality assessment and assurance committees. The motion court denied the motion to quash.

In affirming the order below, the Appellate Division first held that the nursing homes do not fall within the definition of "general hospital[s]" contained in the Public Health Law (PHL). Accordingly, the court reasoned, such facilities are not obligated under PHL §§ 2805-j and 2805-l to collect and maintain quality assurance materials, and thus the privilege afforded to those materials under the statute did not apply to the documents sought in the subpoena at issue. In addition, the court rejected the attorney's contention that a regulation promulgated by the New York State Department of Health, which requires nursing homes to maintain quality assurance materials, extended the Public Health Law privilege to cover the documents demanded by the grand jury. Because the court determined that the Public Health Law privilege did not apply to nursing homes, it did not reach the question of whether PHL § 2805-m prevents disclosure of materials to a grand jury or applies only in the context of discovery in civil lawsuits.

Although the court agreed that the privilege contained in Education Law § 6527(3) applies to nursing homes, it noted that the statute expressly provides that the privilege extends only to discovery in civil lawsuits and did not operate to bar disclosure of the documents to the grand jury.

The court further held that the documents sought by the grand jury were not protected by the privilege provided under the federal statute. Although it found that the privilege did extend to the nursing home because the nursing home was required to maintain quality assessment and assurance committees under federal law, the court concluded that the records sought by the grand jury did not fall within the scope of the privilege. In reaching its conclusion, the Appellate Division adopted the Supreme Court of Missouri's interpretation of the federal statute, which held that the privilege was "exceedingly narrow" in scope and applied only to a "committee's own records—its minutes or internal working papers or statements of conclusions" and not to "records and materials generated or created outside the committee and submitted to the committee for its review." Without describing the nature of the materials sought by the grand jury, the court determined that the documents were not the type of internal committee records that were protected from disclosure by the federal statute.

Plaintiffs Held to Have Properly Stated a Negligence Claim Against Hospital That Failed to Discover Affiliated Doctor's Lack of Medical Malpractice Insurance

Megrelishvili v. Our Lady of Mercy Medical Center, 739 N.Y.S.2d 2 (1st Dep't 2002). Plaintiff sued a hospital for injuries sustained during an operation performed by a member of the hospital's medical staff. The plaintiff asserted, among other things, that the hospital was negligent for allowing the physician to maintain medical staff privileges, despite the fact that, in violation of the hospital's by-laws, he had failed to obtain medical malpractice insurance for nearly three years prior to the surgery alleged to have caused the injuries. The motion court denied the hospital's motion to dismiss, and the hospital appealed.

On appeal, the hospital's by-laws were noted as making numerous references to the requirement that physicians applying for appointment or reappointment to the medical staff maintain medical malpractice coverage, and submit verification of such coverage on an annual basis. The physician testified at his deposition that, although he was required to apply for medical staff privileges every year, he had failed to do so for the two years preceding the surgery, and thus the hospital never "found out" about his lack of malpractice insurance. Thereafter, he voluntarily terminated his affiliation with the hospital.

The Appellate Division ruled that "[t]he allegation that the [the hospital] was negligent in its failure to restrict Dr. Chiuten's staff privileges since he was no longer covered by such insurance is sufficient to state a cause of action . . ." Acknowledging that a hospital is not liable for the actual treatment of a patient by a private physician, it noted that "the failure of a hospital to develop and adhere to reasonable procedures for reviewing a physician's qualifications creates a foreseeable risk of harm . . ."

Applying that principle, the court found that "while the doctor's lack of coverage did not, in itself, cause the alleged physical injuries, had OLM met its own procedures in seeing that he met its affiliation requirements, the fact that he was unable to obtain coverage would have put OLM on notice that he had lost his privileges at other hospitals and, as the facts, when developed, are likely to show, that he had a history of medical malpractice claims against him, thus placing those patients of his using OLM's facilities at risk."

The court further held that questions of fact as to the adequacy of the hospital's review of Dr. Chiuten's credentials presented "significant issues" which precluded dismissal of the claim of negligence against the hospital.

The Appellate Decision found, however, that the lower court had properly granted the hospital's motion for a protective order shielding its quality assurance materials from disclosure, on the grounds that documents are exempt from disclosure under both the Public Health Law and the Education Law.

No Private Right of Action Exists Against Insurance Companies to Enforce Payment to Hospital Excess Liability Pool

HANYS Services Inc. v. Empire Blue Cross and Blue Shield, 737 N.Y.S.2d 140 (3d Dep't 2002). The Administrator of an excess malpractice liability pool and several excess medical malpractice insurers brought an action against private health insurers for failing to pay premiums into the pool. The court dismissed the action on the grounds that plaintiffs had no private right of action to enforce the statute requiring defendant insurers to make payments into the pool.

The Medical Malpractice Reform Act (the "Act") created a program for physicians and dentists practicing in New York to obtain excess malpractice insurance. Under the program, a Hospital Excess Liability Pool (the "Pool") was established to receive premiums paid by hospitals and third-party payors for distribution to excess medical malpractice insurers. The legislature named the Superintendent of Insurance and the Commissioner of Health as Administrators of the program, and responsible for collecting the premiums for distribution to the excess malpractice insurers. They, in turn, designated HANYS Services Inc. (HANYS) as Administrator responsible for collecting premiums.

Both HANYS and the excess medical malpractice insurers commenced an action against the defendant private health insurers, claiming that they failed to make required pool premium payments. The action was premised on theories of unjust enrichment and breach of fiduciary duties. The trial court dismissed the action on the grounds that the plaintiffs were not entitled to bring a private right of action under the Act. On appeal, the Appellate Division, Third Department, held that where, as here, the Act or statute is silent as to the availability

of a private right of action, a three-pronged analysis must first be satisfied to determine whether a private right of action should be implied.

First, the plaintiffs must show that they are a member of the class for whose benefit the statute was enacted. The Appellate Division found that plaintiffs did not satisfy this criterion, because the statute was not enacted to benefit HANYS or the excess malpractice insurers. The court noted that the legislature passed the Act in response to upward pressures on already high malpractice premiums. This premium inflation threatened the public health by discouraging physicians and dentists from initiating or continuing to practice in New York, and also increased the cost of health care as the premium increases were passed on to consumers. Thus, the Act was intended to benefit physicians and dentists, and the public through lower health care costs. Having failed to establish this prong, the Appellate Division did not consider the remaining two elements of the analysis—whether recognition of a private right of action would promote the legislative purpose and whether such a right would be consistent with the legislative scheme.

The Appellate Division also affirmed the dismissal of the complaint by the trial court on the ground that the Superintendent and the Commissioner could not legally delegate to HANYS their authority to enforce the Act.

Chiropractors Have No Private Right of Action to Challenge Health Plan Compensation Rates

Hudes v. Vytra Health Plans Long Island Inc., 744 N.Y.S.2d 80 (3d Dep't 2002). Chiropractors, a chiropractic association and chiropractic patients commenced an action against defendant health plans, alleging that they compensated chiropractors at rates disproportionately lower than those for other medical providers performing similar services. Plaintiffs alleged a violation of statutory amendments to New York Insurance Law, and improper restriction of patient access to chiropractic treatment. The trial court dismissed the action, finding that the Insurance Law conferred no private right of action. The Appellate Division affirmed.

Absent statutory authority to bring a private right of action, the plaintiffs must demonstrate that a private right of action arises by implication. A private right of action may be implied where the following factors are present: (1) plaintiff is one for whose benefit the statute was enacted; (2) recognition of a private right of action would promote the legislative purpose; and (3) creation of such a right would be consistent with the legislative scheme.

The Appellate Division found that the subject statute was intended to expand patient access to and coverage for chiropractic care, without impermissibly increasing the costs of health care coverage. Because the statute was not intended to protect the economic interests of chiropractors, the court dismissed the claims of the plaintiff chiropractors, and, by extension, the plaintiff chiropractic association.

Although the Appellate Division found that the plaintiff chiropractic patients were members of the class for whose benefit the statute was enacted, it found that these plaintiffs could not satisfy the remaining two prongs of the analysis. The legislature specifically gave the Superintendent of Insurance administrative oversight and power to enforce the statute. Further, the New York Public Health Law contains provisions affording health plan enrollees the right to an external appeal whenever coverage is denied upon the ground that it was medically unnecessary. Therefore, a private right of action in favor of patients would not advance the legislative purpose, and would be inconsistent with the legislative scheme.

Court Affirms State Board's License Revocation and $150,000 Fine Against Ophthalmologist

Steckmeyer v. State Board for Professional Medical Conduct, 744 N.Y.S.2d 82 (3d Dep't 2002). Following a disciplinary hearing, the State Board for Professional Medical Conduct (the "Board") sustained allegations of gross negligence, negligence on more than one occasion, excessive treatment, fraud and moral unfitness against an ophthalmologist regarding his treatment of nine patients over several years. The Board then revoked the ophthalmologist's license and imposed a $150,000 fine. The physician brought an Article 78 proceeding to appeal this determination.

Finding that the ophthalmologist had, over the course of several years, fraudulently exposed nine of his patients to unnecessary or excessive treatments, the court affirmed not only the revocation of his license but also the imposition of a $150,000 fine. It stated that in light of the numerous sustained allegations of misconduct stemming from the physician's care of multiple patients over the course of several years, neither the revocation or the fine shocked the court's conscience.

The court also held that the underlying statement of charges need not set forth each essential element of the alleged fraudulent misconduct. Rather the statement needed to be only reasonably specific so as to place the physician on notice that he was accused of practicing fraudulently. The statement's failure to state the exact misrepresentations allegedly made by the ophthalmologist to his patients did not invalidate the allegations of fraudulent conduct. The court also ruled that given the expert testimony at the hearing and the documented pattern of unwarranted procedures, fraudulent intent could be inferred from the surrounding circumstances.

Despite Statutory Definition of Misconduct as Negligence on More Than One Occasion, State Board's Initial Review Order May Cite Only Single Incident

Bell v. New York State Department of Health, 738 N.Y.S.2d 137 (3d Dep't 2002). Following a patient's

complaint, the State Board for Professional Medical Conduct (the "Board") filed six allegations of professional misconduct against a physician regarding his treatment of the patient. The physician denied the allegations and attended a hearing before the Board's Hearing Committee (the "Committee"), which concluded that the physician had failed to meet acceptable standards of care. The Committee then sustained the negligence allegations and suspended the physician's license to practice medicine.

In an Article 78 proceeding, the physician asserted that the Board had no jurisdiction over the matter. He argued that an initial comprehensive review order issued by the Board (directing examination of the physician's office records) asserted that evidence existed of a single incident of negligence or incompetence (one of the factors listed as necessary for triggering such a review). Because a single incident of ordinary negligence or incompetence is insufficient to constitute professional misconduct under Education Law § 6530(3), the physician argued that the language of the initial review order precluded the Board from issuing charges. The Appellate Division disagreed, holding that the Board could use the results of the review as the basis for subsequent charges.

The court also held that by referring the patient to a cardiologist and not to an emergency room immediately, despite knowing that the patient was exhibiting chest pains and had documented risk factors for cardiac disease, the Committee's determination that the physician was negligent on two occasions was supported by substantial evidence.

Court Will Redact Opinions from Department of Health Report Prior to Its Admission into Evidence Under Public Health Law § 10(2)

Cramer v. Benedictine Hospital, 737 N.Y.S.2d 520 (Sup. Ct., Ulster Co. 2002). In a medical malpractice action, the defendant hospital objected to the admissibility of a report published by the New York State Department of Health which summarized its investigation of the quality of medical care provided to the plaintiff's decedent while a patient at the hospital. The report contained both factual findings and opinions. The plaintiff argued that the report was admissible in its entirety under Public Health Law § 10(2), which provides that written reports of state and local health officials issued in connection with their investigations "shall be presumptive evidence of the facts so stated therein, and shall be received as such in all courts and places." The hospital contended that it was impossible, without proper redactions, to distinguish fact from opinion contained in the report, and that to allow admission of the full report would constitute an improper intrusion into the jury's function as the finder of fact.

Noting a paucity of case law applying Public Health Law § 10(2), the court looked to an Appellate Division case interpreting Rule 803(8)(C) of the Federal Rules of Evidence. That case held that admissibility of a government report hinges upon whether there is sufficient independent indicia of the report's reliability. The court determined that to admit the Department of Health's report in its full form would be unfair to the hospital in that it would "deprive [the hospital] of any meaningful way by which it could defend against the opinions contained in the report." In reaching its conclusion, the court stated that the purpose of the report was to identify and rectify deficiencies in the care provided to the decedent, not to assess liability or responsibility for negligent care. Moreover, the plaintiff failed to call anyone involved in the preparation of the report as witness to testify as to the report's contents. The court noted that the report failed to even identify its author or the sources of the information contained in it.

The court further stated that no hearing was held with respect to the contents of the report, at which the hospital had an opportunity to contest the allegations or present evidence regarding its version of the events that lead to decedent's death. Accordingly, the court held that the specific factual findings relating directly to the care of decedent were admissible, but that opinion contained in the report should be redacted.

Six-month Probation for Medical Resident Who Lied About Moonlighting Is Not Unduly Harsh

Gurvits v. Mount Sinai Hospital Center, 741 N.Y.S.2d 518 (1st Dep't 2002). A resident physician of a hospital worked one day at another hospital and then told her supervisor that she had been sick. Despite the fact that she then admitted that she had lied, her department chair made a determination to place her on six months probation, during which she would be paid but not permitted to work elsewhere. After a short delay, the hospital then held a hearing to review the decision, and affirmed. The physician then brought an action alleging that the six month probation period was too harsh, and that the hospital had delayed too long before giving her a hearing.

Despite the physician's claim that her lie was harmless and quickly admitted, the First Department affirmed the determination of the hearing panel based on the fact that the physician had lied, stating that the result was not unfair. The court also held that the physician was not prejudiced by the hospital's short delay in holding the hearing.

Endnote

1. 80 N.Y.2d 628 (1992).

Compiled by Leonard Rosenberg, a partner of Garfunkel, Wild and Travis, P.C. The firm represents health care clients in New York and beyond.

In the New York State Legislature

2002 Legislative Wrap-Up

The 2002 legislative session proved, at least by Albany standards, to be a relatively orderly undertaking: the budget was late, but only by six weeks or so, and the legislative session effectively concluded prior to the July 4th holiday. A combination of reduced state resources (leaving less opportunity for new spending initiatives) and the pressures of an election year may have contributed to the relative efficiency of the legislative session.

From the earliest days of the session, the health care legislative agenda was dominated by labor-related issues. The session was bracketed on one end by the enactment in early January of the Health Care Workforce Recruitment and Retention Act (A.9610/S.6084, Chapter 1, Laws of 2002)—the omnibus funding bill that utilized a variety of funding sources (including the still awaited proceeds from the for-profit conversion of Empire Blue Cross-Blue Shield) to finance wage increases for specified direct care health workers.[1] Legislation was enacted mid-session (A.9454/S.5813, Chapter 24, Laws of 2002) that extends special "whistleblower" protection to health care employees who provide certain information to government agencies and may face retaliatory action by their employers. And, at the very end of the session, legislation was passed (A.11784A/S.7822, Chapter 601, Laws of 2002) that would prohibit entities (including health care providers as well as other business entities) that receive state funds from using those funds to promote or to deter union organizing.

The whistleblower legislation and the labor neutrality bill were enacted with the strong support of the health care unions, which were also instrumental in securing passage of the Health Care Workforce Recruitment and Retention Act earlier in the session. The whistleblower legislation had been vetoed by Governor Pataki in 2001; the bill was narrowed somewhat to specify the nature of protected activity that would shield the health care employee from adverse employment action. The labor neutrality bill was vigorously opposed by health care associations, the Business Council and other groups, but faced very little opposition within the legislature. Modeled on a California law, the statute will, at a minimum, require any entity that receives state funds (including Medicaid funding) to establish accounting policies and procedures that would identify non-state sources for any arguably pro- or anti-union activity. The Labor Commissioner is authorized to promulgate regulations that would be intended to provide some guidance in this regard. Legal challenges to the new law have been threatened, premised on the potential preemption of the state law by the National Labor Relations Act and its alleged impairment of the First Amendment's guarantee of free speech. Nevertheless, the California experience may be instructive: although health care and business groups brought a challenge to the California statute before it took effect, no preliminary relief was ordered and the litigation remains pending—leaving California entities subject to the law with the obligation to comply in the interim.

A host of other health care personnel bills were considered but not passed by both houses, including bills that would have imposed maximum hours limitations or minimum staffing requirements. Legislation that establishes health education centers throughout the state (A.7244-B/S. 3732-B) to support the coordination of recruitment, training and retention of health care workers was passed by both houses but later vetoed by the Governor.

Another major health care initiative passed during the 2002 session was the long-debated Women's Health and Wellness Act (A.11723/S.7657, Chapter 554, Laws of 2002), which requires insurers to cover an array of health care services, including enhanced coverage for cancer and osteoporosis screening and coverage of contraceptives as part of the enrollee's drug coverage. In addition, legislation was enacted as part of the 2002 state budget that provides coverage of certain specified costs related to infertility treatment and that authorizes state funding of a demonstration program to assist in uncovered costs of such treatment. Also on the insurance front, legislation was enacted (A.7413-D/S.7360, Chapter 557, Laws of 2002) that clarifies the authority of insurers and HMOs to offer coverage to "sole proprietors" as a separate category of employee coverage, distinct from small groups (generally defined as 2-50 employees) and individuals insured in the so-called "direct-pay" market.

Two new laws affect hospice care in New York: S.7470/A.11503, Chapter 526, provides for hospice care to be a covered benefit under the Family Health Plus and Child Health Plus programs, and S.7005-B/A.11336-B, Chapter 195, authorizes hospices to provide palliative care to patients with advanced and progressive disease. Although the legislature did not address broader legislation that would authorize surrogate decision-making for patients, the legislature did enact legislation (S.4622-B/A.8466, Chapter 500, Laws of 2002) that authorizes guardians to make health care decisions for persons with mental retardation.

Next year's legislative session promises again to be dominated by health care issues, particularly given the expiration of the Health Care Reform Act next spring. A worsening state fiscal climate could prove to be particularly challenging for health care spending—leading some to worry that the state may even have

difficulty meeting the promises it made to the health care community during the 2002 legislative session.

Endnote

1. For a complete description of this legislation, see Eugene Laks, "Bounty Amid Scarcity: The Healthcare Workforce Legislation," 7 *NYSBA Health L.J.* 19 (Spring 2002).

Compiled by James W. Lytle, managing partner of the Albany offices of Kalkines, Arky, Zall & Bernstein, LLP. The firm, which is based in Manhattan, represents a wide array of health care and other regulated entities, and devotes a substantial part of its practice to the representation of health care clients before the legislature and state regulatory bodies.

In the New York State Agencies

Department of Health Regulations

Monetary Penalties and Tax Intercepts to Deter Medicaid Fraud

Notice of adoption. The Department of Health amended section 515.9 and added part 520 to title 18 N.Y.C.R.R. The purpose of the amendment and addition is to utilize monetary penalties and tax intercepts to recover Medicaid overpayments from providers in order to deter Medicaid fraud. Filing date: January 17, 2002. Effective date: February 6, 2002. *See* N.Y. Register, February 6, 2002.

Change in Ownership Language in Medicaid Rate Calculation

Notice of adoption. The Department of Health amended section 86-2.10(k) of title 10 N.Y.C.R.R. to allow for the recalculation of the nursing home Medicaid rate by utilizing a new base period cost report when there is a change of ownership between a parent and a child. Filing date: March 12, 2002. Effective date: March 12, 2002. *See* N.Y. Register, March 27, 2002.

Laboratory Services

Notice of proposed rule making. The Department of Health gave notice of its intent to amend section 505.7 of title 18 N.Y.C.R.R. in order to relax the prohibitions under the Medical Assistance Program on the designation of practitioner authority to complete laboratory test order form(s) and allows practitioners to engage in electronic laboratory test ordering and signature and standing orders. *See* N.Y. Register, April 3, 2002.

Hospice Residence Reimbursement

Notice of adoption. The Department of Health gave notice of its intent to amend sections 86-6.1 and 86-6.2 of title 10 N.Y.C.R.R. to establish a reimbursement rate for Medicaid-eligible hospice patients with special needs. The proposed reimbursement patients would take into account room and board fees in an amount equal to 94 percent of the weighted average Medicaid rate for the nursing facilities located in the region. Filing Date: May 10, 2002. Effective Date: May 10, 2002. *See* N.Y. Register, May 29, 2002.

Adult Care Facilities

Notice of proposed rule making. The Department of Health gave notice of its intent to amend parts 485-488 and 490 of title 18 N.Y.C.R.R. to allow the Department to expedite the enforcement process against adult care facilities that endanger or cause harm to residents. The proposed amendments also outline action that must be taken by a facility if a resident attempts suicide, dies, or is the victim or perpetrator of a felony. Additionally, the Department will be permitted to assess civil penalties against operators of adult care facilities for violations of Department regulations. *See* N.Y. Register, June 26, 2002.

Physician Profiling

Emergency rule making. The Department of Health added part 1000 to title 10 N.Y.C.R.R. to implement the Patient Health Information and Quality Improvement Act of 2000. The Act requires the Department to collect information and create individual profiles on physicians that shall be available for dissemination to the public. Information to be disseminated includes any criminal convictions and medical malpractice information. Filing date: June 13, 2002. Effective date: June 13, 2002. *See* N.Y. Register, July 3, 2002.

Adult Day Health Care Regulations

Emergency rule making. The Department of Health repealed parts 425, 426, and 427 of title 10 N.Y.C.R.R. and added part 425 to title 10 N.Y.C.R.R to ensure that individuals receive adult day health care when appropriate and that providers are accountable for providing necessary and appropriate care. The regulations (a) further define what constitutes adult day health care, (b) provide general operating requirements for adult health care programs, and (c) provide standards for programs designed as adult health care programs for AIDS patients. Filing date: June 27, 2002. Effective date: June 27, 2002. *See* N.Y. Register, July 17, 2002.

Hospice Residence Program

Notice of adoption. The Department of Health amended parts 700, 717, 790, 791, 793, and 794 of title 10 N.Y.C.R.R. to establish standards and procedures for hospice residences; update cost thresholds for the submission of construction applications; revise annual hospice reporting requirements; and eliminate outdated regulations. Filing Date: July 2, 2002. Effective Date: July 17, 2002. *See* N.Y. Register, July 17, 2002.

State Insurance Department Regulations

Standards for Safeguarding Customer Information

Notice of adoption. The Department of Insurance added part 421 to title 11 N.Y.C.R.R. The addition establishes standards for developing and implementing administrative, technical and physical safeguards to protect the security, confidentiality and integrity of customer information pursuant to the Gramm-Leach-Biley Act. Filing date: February 27, 2002. Effective date: February 11,

2002. *See* N.Y. Register, February 27, 2002.

Fraud Prevention

Notice of adoption. The Department of Insurance amended sections 86.4 and 86.6 of title 11 N.Y.C.R.R. to require as well as exempt certain health care providers from the requirement to submit fraud prevention plans. Additionally, the amendments revise the qualifications for individuals to serve as insurance fraud investigators. Filing date: April 10, 2002. Effective date: May 1, 2002. *See* N.Y. Register, May 1, 2002.

Healthy NY Standardized Applications

Emergency rule making. The Department of Insurance amended sections 362-2.3 and 362-4.3 of title 11 N.Y.C.R.R. to simplify the Healthy NY standard application process by requiring HMOs and participating insurers to accept simplified, standardized Healthy NY applications. The use of such applications seeks to facilitate the appropriate enrollment in the program and ease administrative processes. Filing date: May 16, 2002. Effective date: May 16, 2002. *See* N.Y. Register, June 5, 2002.

Physicians and Surgeons Professional Insurance Merit Rating Plans

Emergency rule making. The Department of Insurance amended part 152 of title 11 N.Y.C.R.R. The purpose of the amendment is to establish guidelines and requirements for medical malpractice merit rating plans and risk management plans. Filing date: June 12, 2002. Effective date: June 12, 2002. *See* N.Y. Register, July 3, 2002.

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

The assistance of Ms. Stacey Sarver, a summer associate at Cadwalader, Wickersham & Taft, in compiling this summary is gratefully acknowledged.

Request for Articles

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

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Albany, NY 12208

or

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

In the Law Journals

***Albany Law Journal of Science & Technology*, volume 12, number 2 (2002):**

- Erin P. George: *The Stem Cell Debate: The Legal, Political and Ethical Issues Surrounding Federal Funding of Scientific Research on Human Embryos*.
- P. Greg Gulick, *E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Obstacles Facing Telemedicine and Cybermedicine Programs.*

***Journal of Health Law*, volume 35, number 1 (2002):**

- LaVerne Woods and Michele Osborne, *Healthcare Organizations and the Internet: Impact on Federal Tax Exemption.*
- Kristen B. Rosati, *HIPAA Privacy: The Compliance Challenges Ahead.*
- Matthew S. Yeo, *Distance Health Services Under the General Agreement on Trade in Services.*
- David L. Trueman, *The Liability of Medical Directors for Utilization Review Decisions.*
- Kerry Toth Rost, *What You Don't Know Can Hurt You: Why Managed Care Organizations Have Legal Duty to Disclose the Use of Financial Incentives to Limit Medical Care.*
- Bernadette M. Broccolo, *Outline of Terms and Conditions of Typical Web Site Development Agreements* (Practice Resource).

***Journal of Health Law*, volume 35, number 2 (2002):**

- *Articles on Patient Safety Standards: Analyzing the JCAHO Revisions:*
  - Harold J. Bressler, *Safety Issues as Exemplified by the Activities of the Joint Commission on Accreditation of Healthcare Organizations: Context for the Safety and Disclosure Standards.*
  - Nancy LeGros and Jason D. Pinkall, *The New JCAHO Patient Safety Standards and the Disclosure of Unanticipated Outcomes.*
  - Daniel Mulholland, *Unanticipated Consequences of Unanticipated Outcomes Disclosures.*
- Michael W. Peregrine, James R. Schwartz, James E. Burgdorfer, and David C. Gordon, *The Fiduciary Duties of Healthcare Directors in the "Zone of Insolvency."*
- Howard Burde, *The Implementation of Quality and Safety Measures: From Rhetoric to Reality.*
- Mark F. Tatelbaum, *Checklist of Federal and State Privacy Issues* (Practice Resource).

***The Journal of Legal Medicine*, volume 23, number 1 (2002):**

- *Symposium*
  - W. Eugene Basanta, *Rural Health Care Now and Tomorrow: A Symposium Introduction and Overview.*
  - Mary Wakefield, *Patient Safety and Medical Errors: Implications for Rural Health Care.*
  - Charles W. Fluharty, *Refrain or Reality: A United States Rural Policy?: Implications for Rural Health Care.*
  - Jeffrey C. Bauer, *Rural America and the Digital Transformation of Health Care: New Perspectives on the Future.*
- Cheryl M. Plambeck, *Divided Loyalties: Legal and Bioethical Considerations of Physician-Pregnant Patient Confidentiality and Prenatal Drug Abuse.*
- Jacob B. Nist, *Liability for Overprescription of Controlled Substances: Can It Be Justified in Light of the Current Practice of Undertreating Pain?*
- Ellen J. Scott, *Punitive Damages in Lawsuits Against Nursing Homes.*
- Curt Richardson, *Physician/Hospital Liability for Negligently Reporting Child Abuse.*

In Other Journals:

- James Thuo Gathii, *The Legal Status of the DOHA Declaration on TRIPS and Public Health Under the Vienna Convention on the Law or Treaties*, 15 Harv. J.L. & Tech. 291 (2002).
- Thomas L. Greaney, *Whither Antitrust: The Uncertain Future of Competition in Law in Health Care*, 21 Health Affairs 185 (2002).
- Nicholas P. Terry, *An eHealth Diptych: The Impact of Privacy Regulation on Medical Error and Malpractice Litigation*, 27 Am. J.L. & Med. 361 (2001).
- Nicholas P. Terry, *When the "Machine That Goes `Ping'" Causes Harm: Default Torts Rules and Technologically Mediated Health Care Injuries*, 46 St. Louis U. L.J. 37 (2002).

Compiled by Dale L. Moore, Associate Dean of Academic Affairs and Professor of Law, Albany Law School.

For Your Information

By Claudia O. Torrey

On June 11, 2002, the Board of Directors of the Accreditation Council for Graduate Medical Education (ACGME) put forth proposed requirements for institutions that sponsor medical resident programs. The proposed requirements, entitled *Common Duty Hour Standards for Programs*, and *Institutional Requirements Relating to Duty Hours*, are the product of the Work Group on Resident Duty Hours (the "Work Group"). The proposed requirements represent the current public scrutiny of medical errors, and as such relate to patient care quality and safety, and to the training of medical residents. All comments regarding these proposed requirements were to have been submitted to the Work Group by August 1, 2002.

As a matter of background information, the ACGME is a private professional organization responsible for the accreditation of nearly 7,800 resident education programs.[1] Residency education is considered the period of clinical education in a medical specialty that follows graduation from medical school, and prepares physicians for the independent practice of medicine.[2] According to the ACGME, stakeholders in ACGME's accreditation process and standards are: residency programs, their sponsoring institutions, residents, medical students, patients, the specialty boards of the American Board of Medical Specialties, government, payers, and the general public.[3]

The proposed requirements mandate that sponsoring institutions have written policies governing resident duty hours that promote and enhance patient safety and education. Needless to say, these policies are to be available to the medical residents and to the Residency Review Committees of the ACGME. Duty assignments are to reflect a joint responsibility by the residents and the sponsoring institution regarding the welfare and safety of the patient.

"According to the New York State Department of Health, New York is the only state in the nation that limits resident work hours and also attempts to ensure that residents have adequate rest."

Some of the proposed requirements for residents include: not working more than eighty hours per week over a four-week period; having at least one twenty-four hour day free of patient care duties averaged over four weeks; and a minimum rest period of ten hours between duty periods. These proposed requirements are similar to what New York State has instituted for all hospitals, particularly the teaching hospitals. According to the New York State Department of Health (DOH), New York is the only state in the nation that limits resident work hours and also attempts to ensure that residents have adequate rest.[4]

The New York State Health Care Reform Act of 2000 (HCRA 2000) includes funding for inspections regarding resident duty hours. The inspections are conducted by the Island Peer Review Organization pursuant to a contract with the DOH (the contract is valid through September 2004.) Under HCRA 2000, the DOH may impose a maximum fine of $6,000 per violation against institutions that violate the state's medical resident duty requirements.[5] Subsequent second offenders face a maximum fine of $25,000, and a triple offender can yield a fine of $50,000.[6]

New York State's requirements for resident duty hours include: working no more than eighty hours per week over a four-week period; working no more than twenty-four consecutive hours in a given day; and, working no more than twelve consecutive hours without time off if the resident is working in an emergency department with more than 15,000 unscheduled annual visits.[7] Regarding ACGME's mission to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training, New York State is in the vanguard!

Endnotes

1. ACGME (www.acgme.org) is one of the largest private accrediting agencies in the country.
2. *Id*.
3. *Id*.
4. *State Health Department Cited 54 Teaching Hospitals for Resident Working Hour Violations*, (June 26, 2002), available at www.health.state.ny.us/nysdoh/commish/2002/resident_working_hours.html.
5. *See id*.
6. *See id*.
7. *See id*.

Claudia O. Torrey, Esq. is a sustaining member of the New York State Bar Association and a member of both the American Bar Association and the American Health Lawyers Association.

The Work of the Division of Legal Affairs

By Donald P. Berens, Jr.

Headquartered in Albany, with staff in five counties, is a firm of over one hundred health law attorneys plus affiliated staff. It represents an enterprise with over 6,400 employees and an annual budget over $33 billion. This firm shares clients, but no profits. It has associates and supervisors, but no partners or shareholders. It is the Division of Legal Affairs (DLA) of the New York State Department of Health (DOH).

DLA's mission is to assist the Governor and the Commissioner of Health to carry out their responsibilities under the Public Health Law, the Social Services Law, and other laws. Those duties include protection of public health through conduct of medical and scientific research, epidemiology, immunization, and public education about healthy practices, and through its cooperative relations with local health departments in the counties and New York City. DOH provides access to quality health care by its administration of the state Medicaid program and other programs of publicly subsidized health care such as the Child Health Plus (CHP), Family Health Plus (FHP), and Elderly Pharmaceutical Insurance Coverage (EPIC) programs. The Department oversees the establishment, licensure, and operation of hundreds of hospitals, nursing homes, diagnostic and treatment centers, home health agencies, and other institutions and facilities providing health care. It is responsible for the discipline of physicians, physicians' assistants, and specialists' assistants, as well as for oversight of emergency medical services and investigation of allegations of patient abuse or neglect by nursing home staff. The Department regulates and maintains vital records of births and deaths and regulates controlled substances. It also operates the Wadsworth Center's laboratories, a rehabilitation hospital, and four nursing homes. Because the work of its clients is so diverse, the legal expertise of DLA is necessarily broad as well.

DLA is organized in seven bureaus, each reporting to the General Counsel and Deputy General Counsel and concentrating in work with recurring substantive or functional themes. Five bureaus focus on common functions for a wide variety of DOH programs; they are the Bureau of House Counsel, the Office of Regulatory Reform, the Bureau of Administrative Hearings, the Bureau of Adjudication, and the Bureau of Litigation. Two bureaus handle functions for a single respective program; they are the Bureau of Medicaid Law and the Bureau of Professional Medical Conduct.

Bureau of House Counsel

The Bureau of House Counsel (BHC) provides advice to the Commissioner of Health, DOH program managers, the Division of the Budget and the Governor's Office on the options available to solve problems or address issues. The Bureau is organized in five groups that loosely parallel DOH's organization. They are the Public Health Group, the Certificate of Need and Facility Licensure Group, the Continuing Care Group, the Managed Care Group, and the Health Care Finance Group. Attorneys are usually assigned to more than one group in order to ensure that a broad perspective on the interlocking legal authorities and program policies is brought to bear on any particular cluster of questions. BHC attorneys attend meetings of, and provide advice to, the various councils, boards, and advisory committees associated with DOH, such as the Public Health Council and the State Hospital Review and Planning Council. BHC attorneys review contracts and license applications about which program managers have questions concerning the applicability of, or compliance with, state and federal law. They review proposed regulations and legislation for clarity and for consistency with other statutes. They counsel their clients about the applicability of the Freedom of Information Law,[1] the Open Meetings Law,[2] and the Ethics in Government Act.[3]

"DLA's mission is to assist the Governor and the Commissioner of Health to carry out their responsibilities under the Public Health Law, the Social Services Law, and other laws."

Office of Regulatory Reform

The Office of Regulatory Reform is the only bureau in DLA that has no attorneys. It nonetheless performs the important function of working with DOH program managers to move and track DOH's proposed regulations through the steps required by the Governor's Office of Regulatory Reform and the rule-making provisions of the State Administrative Procedures Act

(SAPA) Article 2, including the writing of regulatory impact statements and publication by the Secretary of State for public comment or promulgation. DOH regulations cover such topics as the State Sanitary Code, vital records, laboratories, AIDS testing, environmental health, funeral directing, emergency medical services, controlled substances, the State Hospital Code, health maintenance organizations, public water supplies, physician profiling, and many more. They take up six volumes (title 10) of the New York Code of Rules and Regulations (N.Y.C.R.R.). The state Medicaid regulations take up much of another two of the four volumes (title 18) of the N.Y.C.R.R.

"DOH takes care to ensure that in all cases, ALJs exercise their responsibilities independently, professionally and objectively."

Bureau of Administrative Hearings

Many statutes and DOH regulations provide for the opportunity of a party aggrieved by a proposed or actual DOH regulatory action to request an administrative hearing. The Bureau of Administrative Hearings (BAH) represents the DOH program managers in such hearings, which must comply with SAPA, particularly Articles 3, 4 and 5, and DOH regulations.[4] BAH handles all DOH administrative hearings except Medicaid rate audit or overpayment cases and unacceptable Medicaid provider practice cases, which are handled by the Bureau of Medicaid Law, and professional discipline cases, which are handled by the Bureau of Professional Medical Conduct. BAH caseloads include charges of patient abuse and neglect against certified nurse aides, charges of deficiencies against operators of nursing homes, hospitals, home health care agencies, hospices and adult care facilities, licensure cases against emergency medical service providers, cases seeking to remove providers from programs such as the Women, Infants and Children (WIC) program and the Child and Adult Care Food Program (CACFP), and enforcement of the Adolescent Tobacco Use Prevention Act (ATUPA). BAH attorneys often negotiate stipulations resolving those administrative issues, but failing settlement they proceed to hearings before DOH Administrative Law Judges.

Bureau of Adjudication

The Bureau of Adjudication is made up of DOH Administrative Law Judges (ALJs) who conduct administrative hearings. DOH and the respondent are entitled to be represented by counsel at these hearings, to present evidence, and to cross-examine witnesses.[5] The ALJs make evidentiary rulings. In many cases, the ALJs recommend to the Commissioner of Health findings of fact and conclusions of law, but the Commissioner or her designee makes the final administrative determination. In some cases, such as Medicaid provider overpayment cases or adult care facility operational deficiency cases, the final administrative determination is made by the ALJ. In professional discipline cases, the ALJ rules on objections, but a three-member hearing committee of the Board of Professional Medical Conduct makes the findings and decides what penalty to impose.[6] DOH takes care to ensure that in all cases, ALJs exercise their responsibilities independently, professionally and objectively.

Bureau of Litigation

With the broad scope of DOH jurisdiction, and the significant stakes involved, it should be no surprise that DOH and its officers are defendants in extensive litigation in state and federal courts. There are numerous challenges to the constitutional, statutory, and regulatory bases for DOH actions including, of course, CPLR Article 78 challenges to DOH administrative actions, in the fields of rate-making, licensure, benefits eligibility, discipline, and enforcement, among others. Generally, the defense of such litigation is committed by statute[7] to the control of the Attorney General, who in fact defends DOH and its officers and employees in over 1,350 cases at any given time. Within DLA, the Bureau of Litigation is devoted to providing liaison between DOH and the Attorney General, by providing access to witnesses and documents, and to explanations of the history, law and policy behind DOH determinations.

Bureau of Medicaid Law

Since 1996, administration of the state Medicaid program has been committed to DOH.[8] Within DLA, the Bureau of Medicaid Law performs for the Medicaid program most of the functions of advice, representation at administrative hearings, and litigation liaison with the Attorney General that are performed by the Bureaus of House Counsel, Administrative Hearings and Litigation for most other DOH programs. The Medicaid program has an annual budget of over $30 billion, nearly 3 million enrolled recipients, and over 40,000 billing health care providers, as well as managed care arrangements. The enormous volume of transactions, eligibility decisions, provider relationships and legal issues accounts for the creation in 2001 of a separate bureau in DLA to provide most legal support to the Medicaid program. The Health Care Finance Group of the Bureau of House Counsel continues to provide legal support for the rate-making function of the Medicaid program.

Bureau of Professional Medical Conduct

Professional discipline of physicians, physicians' assistants and specialists' assistants is committed to the Board for Professional Medical Conduct (the "Board"), currently consisting of over 160 volunteer members, both physicians and lay members of the public.[9] The Board is supported by staff in the DOH Office of Professional Medical Conduct (the "Office"), which provides investigative and analytical services to the Board. Within DLA, the Bureau of Professional Medical Conduct provides legal advice to the Board and Office about general matters of professional misconduct, disciplinary procedure and confidentiality and about particular investigations selected from about 7,000 cases annually. When the Board and Office determine to make charges against a licensee (which happens in about 400 cases each year), the Bureau represents the Office in administrative proceedings before hearing committees of the Board and its Administrative Review Board.

"Their work, including the examples described here, is of great importance, not only to the Department of Health, but also to the patients, consumers, health care providers and taxpayers of New York State."

Conclusion

The DOH Division of Legal Affairs has one of the most diverse practices of any New York State agency counsel's office. The issues are varied and significant. The staff of the division are among the most dedicated and accomplished lawyers working in public service. Their work, including the examples described here, is of great importance, not only to the Department of Health, but also to the patients, consumers, health care providers and taxpayers of New York State.

Endnotes

1. Public Officers Law, art. 6, §§ 84–90 ("Pub. Off. Law").
2. Pub. Off. Law, art. 7, §§ 100–111.
3. Pub. Off. Law, art. 4, §§ 73–74.
4. N.Y.C.R.R., tit. 10 §§ 51.1–51.17, 76.1–76.14.
5. State Administrative Procedure Act, arts. 3, 4 and 5, §§ 301–501; 10 N.Y.C.R.R., pts. 51, 76.
6. Public Health Law § 230(10)(e)–(g).
7. Executive Law § 63(1) and Pub. Off. Law § 17.
8. Laws of 1996, ch. 474.
9. Public Health Law § 230.

Donald P. Berens, Jr. is General Counsel, New York State Department of Health.

Navigating the World of Health Care Facility Surveillance in New York State

By Anna Colello

Who oversees the care and services provided by health-care facilities in New York State? The answer is the New York State Health Department's Office of Health Systems Management (OHSM). The Office of Health Systems Management inspects all hospitals, diagnostic and treatment centers, adult care facilities, nursing homes, home care agencies, hospice programs, and licensed assisted living programs in New York State. It also regulates the dispensing, manufacture, and administration of controlled substances, is responsible for the discipline of physicians for professional misconduct, and regulates the practice of funeral directing. This narrative, however, will focus on New York's surveillance of hospitals, adult care facilities, and nursing homes. This guide will also provide you with details regarding the structure of the OHSM and regional contacts for information regarding the state's latest surveillance of specific health-care facilities.

Office of Health Systems Management (OHSM)

The OHSM consists of six Divisions:

- Division of Health Care Financing
- Division of Health Standards & Surveillance
- Division of Health Facility Planning
- Office of Professional Medical Conduct
- Division of Quality & Surveillance for Nursing Homes & Intermediate Care Facilities
- Division of Home and Community Based Care

Each of these Divisions has a Central Office location where executive staff review and implement policies for the surveillance of health-care facilities. The Central Offices are located in the Capital Region (Albany, Troy or Delmar). The Central Office supervisors consult with regional offices to initiate new policies, protocols, and components of surveillance initiatives.

The State Health Department's Metropolitan Area Regional Office (MARO) is comprised of three regional locations in New York City, New Rochelle, and Hauppauge. The other state regional offices are located in Troy (the Capital District Regional Office), Syracuse (the Central Regional Office), and Rochester and Buffalo (the Western Regional Offices).

Hospital Surveillance

The Bureau of Hospital and Primary Care Services (BHPCS), within the Division of Health Standards and Surveillance, manages the statewide hospital and diagnostic and treatment center surveillance programs. These surveillance activities are carried out to ensure that hospitals and diagnostic and treatment centers, licensed pursuant to Article 28 of the Public Health Law, comply with all pertinent statutes and regulations designed to assure the provision of quality patient care services. There are 262 hospitals and approximately 800 diagnostic and treatment centers licensed under Article 28. The majority of the Bureau's responsibilities are carried out through on-site investigations and inspections of licensed facilities. The Bureau has a staff of health professionals, including physicians, nurses, social workers, sanitarians, and nutritionists, as well as administrators and support personnel. Surveillance activities are carried out through a combination of direct use of DOH personnel and through management of a series of contracts.

"The Office of Health Systems Management inspects all hospitals, diagnostic and treatment centers, adult care facilities, nursing homes, home care agencies, hospice programs, and licensed assisted living programs in New York State."

The Bureau manages a very active complaint investigation program. This program provides a direct service to the public and has a case-specific focus. Complaints regarding the care provided to individual patients are generally investigated through on-site reviews. The focus of the investigation is to make a determination as to the facility's compliance with pertinent regulations in the care and treatment of patients who are the subject of complaints. All patient care related complaints are investigated, including anonymous complaints. Where the identities of the complainants are known, reports of the Department's findings and actions taken are provided to them upon completion of the investigations. Intake of complaints is primarily done through the seven field offices. Annual complaint investigation activity involves between 2,000 and 2,500 cases.

The Bureau also manages the statutorily based incident reporting and investigation program, known as the New York Patient Occurrence Reporting and Tracking System (NYPORTS). Through this program hospitals report 54 defined categories of adverse events involving patients, ranging from procedure-related complications to unexpected deaths. Hospitals are required to conduct a root cause analysis (RCA) when there is an adverse event with the most serious impact on patients. The RCA involves a hospital system analysis and improvement as appropriate, which are intended to prevent recurrence of the event. Case specific reports made by hospitals, and RCAs conducted in response, are kept confidential by New York State Public Health Law § 2805-m. Through surveillance activities, the Bureau ensures complete reporting of events into the NYPORTS system as well as manages the investigation of select cases. In addition, the Bureau conducts analysis of the information in the NYPORTS system and provides feedback to hospitals across the state in an effort to share "best practices," which in turn provides useful systems improvement information. On an annual basis, approximately 30,000 adverse events are reported to NYPORTS by hospitals statewide.

In addition, the Bureau manages a range of on-site survey activities conducted in hospitals and diagnostic and treatment centers. Focused surveys of hospitals are carried out based on information compiled from a range of sources where concerns are identified within a service or unit of the facility. Routine surveys are conducted periodically in diagnostic and treatment centers. Acting as the agent of the federal government, DOH performs surveys as directed by the U.S. Centers for Medicare and Medicaid Services (CMS) to ensure compliance with the Conditions of Participation in the Medicare Program.

The Bureau also manages contracts to indirectly carry out survey activities. Among those contracts are: statewide Medicaid utilization review and resident working hours limitation compliance with the Island Peer Review Organization (IPRO), and routine hospital surveillance on a triennial basis with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Through these contractual relationships, these organizations effectively function as the oversight agents of the Department carrying out surveillance activities in accordance with state and federal laws and regulations.

Where surveillance activities identify non-compliance with pertinent statutes and regulations, facilities are cited through a Statement of Deficiencies (SOD). Plans of Correction (POC) must be submitted, subject to DOH acceptance, to rectify all situations of non-compliance identified. Follow-up surveillance is conducted to ensure implementation of acceptable corrective actions. Documents associated with DOH surveillance activities are a matter of public record and are available to requesters under the Freedom of Information Law (FOIL), except for those portions that fall into the list of exemptions.[1] The Bureau provides the public with an overall summary of survey activities, which is published on the Department's Web site (www.health.state.ny.us).

"Documents associated with DOH surveillance activities are a matter of public record and are available to requesters under the Freedom of Information Law, except for those portions that fall into the list of exemptions."

Adult Care Facilities

The Bureau of Adult Care Facility Quality and Surveillance within the Division of Home and Community Based Care is responsible for the surveillance of adult care facilities (ACFs), including adult homes, residences for adults, and assisted living programs. There are currently 544 licensed ACFs statewide.

Pursuant to section 461-a of the Social Services Law, the DOH is responsible for the inspection of adult care facilities.[2] Inspectors (sanitarians, social workers, and dietitians) in regional offices conduct at least one unannounced inspection in a period of 12-18 months. The result of the inspection is contained in an inspection report, which identifies violations in specific areas of operation. The facility is required to submit a POC in response to the violations.

Another type of inspection, which is conducted in an adult home, is a joint inspection with the State Office of Mental Health (OHM) and/or the State Commission on the Quality of Care for the Mentally Disabled (CQC). These inspections take place with respect to facilities providing care to a significant number (25 percent or more) of residents with histories of mental illness and/or psychiatric care. As part of these joint-agency focused surveys, all inspectors concentrate on personal care, incident reporting of attempted suicides and all deaths, as well as mental health services provided to residents, specifically case management, medication management, and coordination of mental health services administered by outside providers.

The state may also conduct other types of focused surveys. For example, the State Health Commissioner

recently issued a letter to all adult home operators regarding the requirements they must meet to ensure that residents remain cool when outside temperatures rise above eighty degrees Fahrenheit. Inspectors randomly inspected homes to ensure compliance with the state regulation that was the subject of the focused survey.

Inspectors triage all complaint allegations and conduct on-site investigations when appropriate. Inspection reports are issued to those homes cited for violations related to the care and services provided to residents. Homes cited for serious violations are required to submit a written corrective action plan detailing how they will address the deficiencies and make sure that similar incidents and/or conditions do not recur.

Nursing Homes

The Division of Quality and Surveillance for Nursing Homes and Intermediate Care Facilities (DQS) has responsibility for the surveillance of nursing homes. Nursing homes are surveyed by DOH both as licensed facilities and as providers of Medicare and Medicaid services. Federal protocols govern the Department activities both in the central and regional offices.

The DQS consists of five bureaus, three of which focus on nursing home surveillance: Quality, Data Management, and Complaints. The other two bureaus are: Professional Credentialling, which is responsible for Nursing Home Administrators and Certified Nurse Aides; and the Bureau of Surveillance for ICFs, which is responsible for surveying and certifying fourteen developmental centers and certifying 738 ICFs surveyed by the Office of Mental Retardation and Developmental Disabilities (OMRDD).

The DQS sets the policies regarding nursing homes surveys and serves as liaison with the CMS. As the DOH is the contract agency, it performs the surveys and abides by the federal reporting requirements.[3]

Under both state and federal law, nursing homes must receive at least one unannounced survey not later than fifteen months after the previous survey.[4]

The regional offices are composed of teams of surveyors, which may include nurses, social workers, dietitians, sanitarians, pharmacists, physical therapists, and physicians. The survey process is conducted in accordance with federal guidelines prescribed in the State Operations Manual (SOM). The DOH is also held to specific performance standards as described in a State Performance Report issued by the U.S. Centers for Medicare and Medicaid Services (CMS) under the U.S. Department of Health and Human Services (HHS). New York is part of CMS's Region II jurisdiction, along with New Jersey, Puerto Rico and the Virgin Islands.

While the regional surveyors conduct the surveys and issue SODs, it is the DQS that institutes enforcement referrals. These enforcement recommendations are made to CMS for federal penalties or to the DOH Division of Legal Affairs for the imposition of a state fine.[5] The Bureau of Quality within the DQS reviews the SODs, which identify deficiencies at Immediate Jeopardy of the Substandard Quality of Care level before the SOD is issued. The Bureau also reviews all SODs which cite deficiencies after the regional office issues the SOD to the provider, to determine the appropriate enforcement action to take.

"Homes cited for serious violations are required to submit a written corrective action plan detailing how they will address the deficiencies and make sure that similar incidents and/or conditions do not recur."

The Bureau of Data Management in DQS assures that the SODs are reported to CMS through an electronic system know as the Online Survey Certification and Reporting (OSCAR) system. The OSCAR system is used by CMS to monitor the completion and timeliness of surveys and that the appropriate enforcement action is taken when warranted. The data entry of the survey deficiency information was previously done by DQS. The regional staff who oversee the inspections of specifically designated homes enter the survey result information.

Statements of Deficiencies (SODs) are written into a software program known as ASPEN (designed by a federal contractor, ALPINE Technologies). The ASPEN survey information gets uploaded to OSCAR for CMS review. In early 2003, an additional feature will be added to the system, to allow for the receipt of complaint information. Complaint information will be entered into the ASPEN Complaint Tracking System (ACTS) and will be part of the comprehensive information DOH and CMS have regarding each nursing home.

Nursing Home Complaints

The DOH investigates nursing home complaints of resident abuse, mistreatment, or neglect against individuals under section 2803-d of the Public Health Law. It investigates violations of the state and federal nursing home code against nursing home operators.[6] Since 1999

there has been an increase of 37 percent in the number of complaints against individuals and an increase of 184 percent against facility operators. Approximately 8,000 complaints were received during a 14-month period (May 2001 through July 2002).

The DOH has had an aggressive, well-developed nursing home complaint investigation program since 1977. Previously a complaint hotline existed in each regional office for the intake and investigation of complaints. To strengthen this surveillance initiative, in May 2001, the DOH created the Central Complaint Intake Program (CCIP). Callers may dial a toll free hotline—(888) 201-4563—to register complaints. Complaints are also received in writing through correspondence or e-mail and may be made anonymously.

When the CCIP receives a complaint, the allegation is entered into the DOH electronic complaint tracking system. Staff triage each and every case based on the information provided and share those details with regional staff for investigative action. The intake operators include experienced nurses who understand the importance and sensitivity of the information coming into the centralized hotline.

A Director of Investigations within the DQS reviews the system of intake and investigation statewide and implements the case resolution system. The Case Resolution Unit addresses the less serious cases, prioritizes the most serious cases, and directs regional staff to investigate those cases within 2-10 days of the initial call when the allegation involves serious harm.

Nursing home investigations that validate complaints result in either a finding against an individual or an SOD against the facility. Investigations resulting in individual culpability are sent directly from the regional office to the Bureau of Administrative Hearings within the Division of Legal Affairs. SODs issued as a result of complaint investigations are sent to the nursing homes administrators, who, in turn, must provide a written Plan of Correction (POC) to the Department within 10 days of receiving the initial survey report.

All SODs involving resident harm are referred to DQS for an enforcement action. As in the hospital program, where the identities of complainants are known, the final actions taken are provided to them upon completion of the investigations.

Conclusion

The DOH carries out its surveillance responsibility of licensed entities through a system that includes periodic routine on-site surveys and complaint investigations. Both the Central Office's monitoring and the regional offices' investigations assure the public that the license issued to an entity represents compliance with health and safety regulations. Likewise, the licensed health facility and the legal practitioner providing consultation know that the DOH system of surveillance is based on a process that is guided by federal regulations and guidelines, but is understandable and may be navigated by providers throughout New York State.

Endnotes

1. Public Officers Law § 87.
2. In April 1997 the Department of Health became responsible for the Adult Home program previously regulated by the Department of Social Services. *See* ch. 436 of the Laws of 1997 § 122(c).
3. Social Security Act § 1864.
4. N.Y. Pub. Health Law § 2803(1)(a); Social Security Act §§ 1819(g)(2)(A)(iii), 1919(g)(2)(A)(iii); 42 C.F.R. § 488.308.
5. N.Y. Pub. Health Law § 12.
6. These investigations are pursuant to 10 N.Y.C.R.R. part 415 and 42 C.F.R. § 483.

Anna Colello is the Director of the Division of Quality Assurance and Surveillance for Nursing Homes and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). **She wishes to acknowledge the assistance of Fred Heigel, Director of the Bureau of Hospital Services, in connection with the information relating to hospitals in this article.**

Practice Before the Administrative Review Board for Professional Medical Conduct

By James F. Horan

In 1991, the New York legislature enacted Public Health Law (PHL) § 230-c, creating the Administrative Review Board for Professional Medical Conduct (ARB), to serve as the final administrative appeal in the New York disciplinary process for physicians and physician assistants.[1] The legislature created the ARB to streamline and improve the efficiency of the disciplinary process.[2] This article will discuss (1) the ARB's authority, (2) the procedures for the review notices, briefs, and the ARB's Determinations and (3) issues that arise in practice before the ARB.

Authority

The ARB may review Determinations by Hearing Committees from the Board for Professional Medical Conduct (BPMC), which the Committees render pursuant to either PHL §§ 230(10)(e) or 230(10)(p).[3] The ARB lacks the authority to review summary orders that the Commissioner of Health issues.[4]

In reviewing a Committee's Determination, the ARB decides: whether the Determination and penalty are consistent with the Committee's findings of fact and conclusions of law; and whether the penalty is appropriate and within the scope of penalties that PHL § 230-a permits.[5] The ARB may also consider whether a party has filed a timely review notice.[6] The ARB may remand a case to the Committee for reconsideration or further proceedings.[7] The ARB's Determinations result from a majority concurrence among the ARB's members.[8] The ARB consists of five members, three physicians and two lay persons, who are appointed by the Governor from BPMC membership and confirmed by the Senate.[9] The ARB may consider a case with a quorum of less than all members, but a majority of the ARB, or three members, must concur in any Determination.[10]

The ARB may substitute its judgment for that of the Committee in deciding upon a penalty,[11] in determining guilt on the charges,[12] and in determining credibility.[13] The ARB may choose to substitute its judgment and impose a more severe sanction than the Committee on its own motion.[14] In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation, and deterrence.[15]

Procedures

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules.[16] The provisions in PHL § 230-c and the interpretation of that statute by the ARB and the courts provide the rules for ARB reviews. There are no Health Department regulations that pertain to the ARB process.

Following a Determination by a BPMC Hearing Committee, either party to the hearing, the licensee or the Office for Professional Medical Conduct (OPMC), may request a review.[17] The appealing party must serve a review notice on the ARB and the adverse party, by certified mail, within fourteen days from service of the Committee's Determination.[18] The ARB has ruled that it lacks the authority to extend the 14-day period for filing the review notice.[19] The courts have enforced strictly the statutory time lines for taking administrative appeals under other statutes, ruling that the courts also have no power to extend the time for taking appeal.[20] The courts may, however, overlook the failure to use certified mail in filing the ARB request, if the ARB and the adverse party receive actual notice and if the adverse party suffers no prejudice.[21]

The service of a Committee's Determination becomes effective on the parties at receipt or seven days after mailing by certified mail, whichever comes earlier.[22] A one-line letter will suffice as a review notice, as long as the letter identifies the case name and number and states the intent to seek administrative review.[23] The party requesting the review may withdraw the review notice at any time prior to the ARB's deliberations in the case, by filing a one-line letter withdrawing the review notice.[24]

Service of the review notice stays any penalty the Committee imposed automatically, other than a penalty of annulment, revocation, or suspension.[25] The failure to provide a stay for such penalties as annulment, suspension, or revocation comports with due process, as a licensee holds no constitutionally protected right to receive a stay.[26]

The parties have 30 days from service of the review notice to submit briefs, even though only one party may have filed a review notice.[27] The ARB measures the 30 days for submitting briefs from the date the ARB receives the review notice and a letter to the parties advises the parties as to the submission date. That letter also advises the parties to serve all documents by certified mail. As the parties must serve documents by certified mail, service is complete with mailing, rather than with receipt by the ARB. A notice is perfected only if a brief is timely submitted.[28] The non-appealing party

may file a brief raising issues for review, or if the non-appealing party wishes to raise no issues, that party may wait and file only a reply brief. In *In re Jacob Neuman, M.D.*,[29] the ARB discussed procedures for filing briefs:

> The controlling statute allows both parties to file briefs and replies [N.Y. Pub. Health Law § 230-c(4)(b)(McKinney's Supp. 1997)] . A recent amendment to the statute provides that "a notice of review shall be perfected only if a brief is timely submitted" (see 1997 N.Y. Laws, Chapter 627), but nothing in the statute requires a non-appealing party to file a brief or provides that a non-appealing party loses the opportunity to file a reply, if the party files no brief. In practice before the Board, once either party files a review notice, the Board allows both parties to file briefs raising issues for review. If the non-appealing party has no review issues, they need file only a reply brief responding to their adversary's review issues. If the non-appealing party files a reply brief responding to their adversary's brief and raising review issues for the first time, as occurred in this case, the Board will consider the party's arguments in response and refuse to consider the review issues that the party raises for the first time in the reply brief.

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs,[30] so the ARB will consider no evidence from outside the hearing record.[31] As the statute allows the parties to submit only briefs and/or reply briefs, the ARB will consider no further submissions from the parties.[32]

The statute provides that the ARB must render a written determination within 45 days from receiving the briefs and a stipulated record.[33] There is no need for parties to submit a stipulated record to the ARB. The Administrative Officer for the ARB receives the hearing record from the Administrative Officer who presided at the hearing. As to the 45-day rule for rendering ARB determinations, the statute provides no limitation on the ARB's authority to act after that time period has passed. The Appellate Division for the Third Judicial Department has ruled that the forty-five day time period is directory rather than mandatory in nature and that the ARB retains jurisdiction to act after the 45-day time period has passed.[34] Undue delay in rendering an administrative determination can provide the grounds for annulling an administrative determination, but only if the delay handicapped or caused prejudice to a party in mounting a defense to an administrative proceeding.[35]

Other than the requirement in PHL § 230-c(4)(a) that the ARB render a written Determination, the statute sets no standards for the ARB's Determination. State Administrative Procedure Act (SAPA) § 307(1) requires a final agency determination to state the reasons for that determination. In *Berges v. Chassin*,[36] the Appellate Division for the Third Department upheld a Determination by a hearing committee and the ARB to revoke a physician's license, following the physician's criminal conviction for deviant sexual intercourse with a patient during a gynecological examination. The Court found the committee Determination in *Berges* complied with the requirements under SAPA § 307(1) by stating that the committee revoked the physician's license because the physician "severely violated the trust placed in a physician by a patient which resulted in a criminal conviction." In *Berges*, the Court also indicated that the ARB may issue an order correcting a factual error in a Determination, following the Determination, on motion by one of the parties.

Determinations by the ARB, dating back to the first Determination in 1992, are available on Westlaw at the database NYDOH-ARB.

Practice Issues

Under PHL § 230-c(4)(a), either the licensee or OPMC may seek an ARB review. The licensee may also choose to bypass the ARB review and seek judicial review immediately in an action before the Appellate Division for the Third Department, pursuant to Civil Practice Law and Rules (CPLR) Article 78.[37] This provision granting the licensee immediate judicial review constitutes an exception to the usual requirement that a party exhaust administrative remedies before seeking judicial review,[38] and to the provision in CPLR 7801(1) that bars Article 78 review when some other body or officer can review a Determination adequately. For OPMC, administrative review constitutes the only remedy for challenging a BPMC Committee Determination.

In considering whether to request administrative review, the parties should remember that the ARB may substitute its judgment for a Committee's on the ARB's own motion and may render a Determination that leaves the appealing party in a worse position than the party found itself in under the hearing Committee Determination.[39] In *Kabnick v. Chassin*,[40] a BPMC Committee found Dr. Kabnick guilty of professional misconduct due to his conviction for Medicaid fraud, and the Committee voted to suspend Dr. Kabnick for two years and to impose a monetary fine. Dr. Kabnick then filed a notice asking the ARB to reduce the suspension and fine. Although OPMC filed no cross-notice seeking a higher penalty, the ARB found the Committee's penalty

inappropriately lenient and voted to revoke Dr. Kabnick's medical license. Both the Third Department and the Court of Appeals held that once the ARB found the Committee's penalty inappropriate, the ARB possessed the authority to impose a more severe sanction, even if the ARB imposed the penalty sua sponte, when considering Dr. Kabnick's request to reduce the penalty. In *Selkin v. State Board for Professional Medical Conduct*,[41] a Committee voted to revoke Dr. Selkin's license and to fine him for engaging in consensual sexual relationships with two patients. Following the Committee's Determination, OPMC sought administrative review and requested that the ARB sustain additional charges against Dr. Selkin. On review, the ARB found the penalty the Committee imposed too harsh and voted to sustain the fine, but to overturn the revocation and substitute a three-month actual suspension.

As OPMC may seek ARB review on a Determination from which OPMC feels aggrieved and an aggrieved licensee may bypass the ARB and seek Article 78 review, a question arises concerning what happens if the parties both seek review from the same decision, but in different forums. If OPMC requests administrative review and the licensee files an Article 78 proceeding, does one action take precedence or is there a race to the courthouse to see who files first? In *Weg v. DeBuono*,[42] the Third Department ruled that the courts must yield to the ARB's jurisdiction if OPMC has filed a timely ARB notice, regardless of whether the licensee may have filed a prior request for judicial review.

A licensee who seeks ARB review may still seek Article 78 review following the ARB Determination, if the licensee stills feels aggrieved following the ARB review.[43] The question then arises whether this licensee should raise all issues for review with the ARB, or whether the licensee may raise issues for the first time in the Article 78 proceeding. The usual practice in an Article 78 proceeding bars a petitioner from raising in an Article 78 proceeding a new issue that the petitioner failed to raise before the agency whose Determination is under the Article 78 review.[44]

Endnotes

1. 1991 N.Y. Laws, ch. 606.
2. Mem. of State Exec. Dep't, 1991 McKinney's Session Laws of N.Y., at 2077.
3. Public Health Law §§ 230(10)(i), 230-c(1) (PHL).
4. PHL §§ 230(12), 230-c(1).
5. PHL §§ 230(10)(i), 230-c(1), 230-c(4)(b).
6. *Weg v. DeBuono,* 269 A.D.2d 683, 703 N.Y.S.2d 301 (3d Dep't 2000).
7. PHL § 230-c(4)(b).
8. PHL § 230-c(4)(c).
9. PHL § 230-c(2).
10. *Wolkoff v. Chassin*, 89 N.Y.2d 250 (1996).
11. *Bogdan v. Med. Conduct Bd.* 195 A.D.2d 86, 606 N.Y.S.2d 381 (3d Dep't 1993).
12. *Spartalis v. State Bd. for Prof'l Med. Conduct,* 205 A.D.2d 940, 613 N.Y.S.2d 759 (3d Dep't 1994).
13. *Minielly v. Comm'r of Health,* 222 A.D.2d 750, 634 N.Y.S.2d 856 (3d Dep't 1995).
14. *Kabnick v. Chassin,* 89 N.Y.2d 828 (1996).
15. *Brigham v. DeBuono,* 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).
16. *Rooney v. N.Y. State Dep't of Civil Serv.,* 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Sup. Ct., Westchester Co. 1984).
17. PHL § 230-c(4)(a).
18. *Id.*
19. *In re Llorens,* ARB 92-52, 1992 WL 881084 (N.Y.D.O.H. Admin. Rev. Bd.).
20. *State Div. for Human Rights v. Merante,* 35 A.D.2d 652, 312 N.Y.S.2d 1015 (3d Dep't 1970); *State Div. of Human Rights ex rel. Green v. Shenango, Inc.*, 55 A.D.2d 852, 390 N.Y.S.2d 345 (4th Dep't 1976).
21. *Ross v. N. Y. State Dep't of Health,* 226 A.D.2d 863, 640 N.Y.S.2d 359 (1996).
22. *Weg v. DeBuono,* 269 A.D.2d 683, 703 N.Y.S.2d 301 (3d Dep't 2000).
23. *Id.*
24. *In re Saltiel,* ARB 92-57-A, 1992 WL 881095 (N.Y.D.O.H. Admin. Rev. Bd.).
25. PHL § 230-c(4)(a).
26. *Selkin v. State Bd. for Prof'l Med. Conduct,* 63 F. Supp. 2d 397 (S.D.N.Y. 1999).
27. PHL § 230-c(4)(a).
28. *Id.*
29. ARB 97-34, 1997 WL 1053262 (N.Y.D.O.H. Admin. Rev. Bd.).
30. PHL § 230-c(4)(a).
31. *Ramos v. DeBuono,* 243 A.D.2d 847, 663 N.Y.S.2d 361 (3d Dep't 1997).
32. *In re Jacob Neuman, M.D.,* ARB 97-34, 1997 WL 1053262 (N.Y.D.O.H. Admin. Rev. Bd.).
33. PHL § 230-c(4)(a).
34. *Ross v. N.Y. State Dep't of Health,* 226 A.D.2d 863, 640 N.Y.S.2d 359 (1996).
35. *Cortlandt Nursing Home v. Axelrod*, 66 N.Y.2d 169, *cert. denied* 476 U.S. 1115; *Gold v. Chassin,* 215 A.D.2d 18, *lv. denied* 87 N.Y.2d 805.
36. 216 A.D.2d 698, 627 N.Y.S.2d 855 (3d Dep't 1995).
37. PHL § 230-c(5).
38. *Watergate II Apts. v. Buffalo Sewer Auth.*, 46 N.Y.2d 52 (1978).
39. *Kabnick v. Chassin*, 89 N.Y.2d 828 (1996); *Selkin v. State Bd. for Prof'l Med. Conduct*, 279 A.D.2d 720, 719 N.Y.S.2d 195 (3d Dep't 2001).
40. 89 N.Y.2d 828.
41. 279 A.D.2d 720.
42. 269 A.D.2d 683, 703 N.Y.S.2d 301 (3d Dep't 2000).
43. PHL § 230-c(5).
44. *Levine v. State Liquor Auth.*, 23 N.Y.2d 863 (1969).

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The Medicaid Rate Appeal Process in New York

By Terry Freedland

The Department of Health establishes Medicaid rates of reimbursement for medical facilities and other health care providers. Rates are established pursuant to certain statutory and regulatory standards. Health care providers may appeal for a change or revision in their rates of reimbursement.

The Bureaus that process Medicaid rate appeals are the Bureau of Primary and Acute Care Reimbursement and the Bureau of Long Term Care Reimbursement in the Division of Health Care Financing. The Bureau of Primary and Acute Care Reimbursement establishes rates for general hospitals and freestanding diagnostic and treatment centers. The Bureau of Long Term Care Reimbursement establishes rates for residential health care facilities, long term home health care programs and certified home health agencies. The Bureau of Long Term Care Reimbursement also establishes personal care services rates.

Under 18 N.Y.C.R.R. § 505.14(h)(7)(v), a social services district may request an exemption from the Department's established methodology for personal care services and establish its own alternative rate methodology. The Department also establishes rates for hospice care, out of state nursing homes and medical foster care. No formal appeal process exists for these last three categories of providers. Such rates are fixed in law or negotiated with the Department.

Regulatory Basis for the Appeal

The right to appeal for an adjustment to an established Medicaid rate is contained in the following regulations:

(1) General Hospital Reimbursement—Title 10 N.Y.C.R.R., Part 86, Subpart 86-1, section 86-1.61 for inpatient appeals and section 86-1.17 for outpatient appeals (currently the operating cost component of hospital outpatient rates is capped by law).

(2) Certified Home Health Agency—10 N.Y.C.R.R., Part 86, Subpart 86-1, section 86-1.17.

(3) Diagnostic and Treatment Centers—10 N.Y.C.R.R., Part 86, Subpart 86-4, section 86-4.16.

(4) Nursing Home Reimbursement—10 N.Y.C.R.R. Part 86, Subpart 86-2, section 86-2.14.

(5) Long Term Home Health Programs—10 N.Y.C.R.R., Part 86, Subpart 86-5, section 86-5.14.

(6) Personal Care Services—18 N.Y.C.R.R. § 505.14h(7)(iii) (for the Department's established rates).

Grounds for Appeal—General

One common basis for appealing Medicaid rates (except for personal care services) is a claim for an adjustment to rates due to errors made by the Department or the medical facility. If the facility wishes to submit revised data, this revised data must meet the same certification requirements set forth in regulations as the original data submitted.

"The Bureaus that process Medicaid rate appeals are the Bureau of Primary and Acute Care Reimbursement and the Bureau of Long Term Care Reimbursement in the Division of Health Care Financing."

Another issue common to many types of providers is an appeal for increases in operating costs not included in payment rates resulting from the implementation of additional staff or services specifically mandated by the State Commissioner of Health. (For both common issues see 10 N.Y.C.R.R. §§ 86-1.17, 86-1.61, 86-2.14, 86-4.16, 86-5.14.)

Other Grounds for Appeal—Provider Specific

Other specific grounds for appeal differ by provider and are found in law and regulation for general hospitals (see section 2807-c (9) of the Public Health Law and 10 N.Y.C.R.R. §§ 86-1.17 and 86-1.61) and the following Department regulations for other health care providers:

1. 10 N.Y.C.R.R. § 86-4.16—Diagnostic and Treatment Centers:
2. 10 N.Y.C.R.R. § 86-2.14—Nursing Homes; and
3. 18 N.Y.C.R.R. § 505.14—Personal Care Services.

Procedure

The common appeals procedure for the above identified health care providers is contained in Department of Health regulations by provider type. See 10 N.Y.C.R.R. §§ 86-1.17(c), 86-2.14(b), 86-4.17 and 86-5.14(b). Appeals are to be submitted to the Health Department, on forms provided by the Department. The provider must give the reason the facility is appealing, and provide documentation, where appropriate, supporting the facility's appeal.

Following Department staff review and Division of Budget approval where required, the affirmation or revision of rates is final unless the provider requests, within thirty (30) days of receipt of the rate decision, a hearing before a rate review officer. The provider must request the hearing by certified or registered mail, return receipt requested, on forms supplied by the Department. A hearing is not provided with regard to personal care services rates. The request for a hearing must contain a statement of the factual issues to be resolved. The provider may submit a memorandum on legal issues which it deems relevant to the appeal.

"The Department establishes Medicaid rates of reimbursement for medical facilities and other health care providers. The administrative appeal process allows providers to obtain revisions to those rates where justified."

Where the rate review officer determines that there is no factual issue, the request for a hearing will be denied and the facility notified of such determination. No administrative appeals are available from this determination. Where the rate review officer determines that a factual issue exists, the Department will issue a notice of hearing establishing the date, time and place of the hearing and setting forth the factual issues as determined by such officer. The hearing must be held in conformity with the provisions of Public Health Law, section 12-a and the State Administrative Procedure Act.

A recommendation, after hearing, is submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

Any modified rate is effective on the first day of the month in which the respective change is operational. In reviewing appeals for revisions to certified rates previously approved, the Commissioner may refuse to accept or consider an appeal from a medical facility or program:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the Department that this management is providing an unacceptable level of care in one of its facilities as determined after review by the State Hospital Review and Planning Council;

(3) where it has been determined by the Commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law; or

(4) where a fine or penalty has been imposed on the facility or program and such fine or penalty has not been paid. In such instances a rate revision shall not be effective until the date the appeal is accepted by the Commissioner.

Conclusion

The Department establishes Medicaid rates of reimbursement for medical facilities and other health care providers. The administrative appeal process allows providers to obtain revisions to those rates where justified. This process helps avoid unnecessary litigation and legal expenses.

Terry Freedland is a Senior Attorney with the New York State Department of Health.

Approval and Oversight of Provider Entities

By Michele Petruzzelli

I. Article 28 Entities

Hospital: "a facility or institution engaged principally in providing services by or under the supervision of a physician . . . for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition . . ."—Public Health Law § 2801(1) (PHL).

Type of Entity	Approval Process	Construction Standards	Operational Standards	Ownership Changes
General Hospital	Certificate of Need (CON) [PHL §§ 2801-a and 2802]	10 N.Y.C.R.R. Parts 711 and 712	10 N.Y.C.R.R. Part 405	PHL § 2801-a(4)
Residential Health Care Facility	CON [PHL §§ 2801-a and 2802]	10 N.Y.C.R.R. Parts 711 and 713	10 N.Y.C.R.R. Part 415	PHL § 2801-a(4)
Diagnostic and Treatment Centers	CON [PHL §§ 2801-a and 2802]	10 N.Y.C.R.R. Parts 711 and 715	10 N.Y.C.R.R. Parts 750 -759 (depending on services offered)	PHL § 2801-a(4)

II. Article 36 Entities

Certified home health agencies (CHHAs): provide, directly or by contract, a minimum of the following services: nursing services, home health aide services, medical supplies, equipment and appliances suitable for home use and at least one additional service, such as physical therapy, occupational therapy, speech pathology, nutritional services or medical social services. PHL § 3602(3).

Licensed home care services agencies (LHCSAs): provide, directly or by contract, one or more of the following services: nursing services, home health aide services and other services, such as physical therapy, speech therapy, occupational therapy, nutritional services, medical social services, personal care services, homemaker services or housekeeper or chore services. PHL § 3602(2) and (13).

Type of Entity	Approval Process	Construction Standards	Operational Standards	Ownership Changes
CHHA	CON [PHL §§ 3606 and 3606-a]	Not applicable	10 N.Y.C.R.R. Part 763	PHL § 3611-a
LHCSA	Licensure by Commissioner of Health (COH) [PHL § 3605]	Not applicable	10 N.Y.C.R.R. Part 766	PHL § 3611-a

III. Article 40 Entity

Hospice: coordinated, multi-disciplinary program which provides palliative and supportive care to meet the physical, psychological, spiritual, social and economic needs of terminally ill patients and their families. Services may be provided in a patient's home, in a residential health care facility, or in an in-patient program. PHL § 4002(1).

	Approval Process	Construction Standards	Operational Standards	Ownership Changes
Hospice	CON [PHL §§ 4004, 4006, and 4008]	10 N.Y.C.R.R. Parts 711 and 717 (inpatient component, if any)	10 N.Y.C.R.R. Parts 793 and 794	PHL § 4004(3)(b)

IV. Article 44 Entities

Health maintenance organizations (HMOs): provide or offer comprehensive health services to each member of an enrolled population in consideration for a basic advance or periodic charge. "Comprehensive health services" are generally

defined by statute to be "all those health services which an enrolled population might require in order to be maintained in good health." PHL § 4401(1), (2), and (3).

Integrated delivery systems (IDS): "deliver a full array of health care services, from primary and preventive care through acute inpatient hospital and post-hospital care to a defined population for a determined price." PHL § 4408-a.

Independent practice associations (IPA): "[arrange] by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment . . ." 10 N.Y.C.R.R. § 98-1.5(b)(6)(iv)(*a*).

Type of Provider	Approval Process	Construction Standards	Operational Standards	Ownership Changes
HMO	Certificate of Authority issued by COH [PHL §§ 4402 and 4403]	Not applicable	10 N.Y.C.R.R. Part 98	10 N.Y.C.R.R. §§ 98-1.9 and 98-1.10
IDS	Certificate of Authority issued by COH [PHL § 4408-a]	Not applicable	10 N.Y.C.R.R. Part 98	10 N.Y.C.R.R. §§ 98-1.9 and 98-1.10
IPA	Certificate of Incorporation or Articles of Organization approved by COH, the State Education Department and the State Insurance Department [10 N.Y.C.R.R. § 98-1.5(b)(6)(iv)(*d*)]	Not applicable	10 N.Y.C.R.R. §§ 98 -1.5(b)(6)(iv) and 98-1.18	10 N.Y.C.R.R. § 98-1.5(b)(6)(iv)(*d*)

V. Article 7 Entities[1]

Adult Homes: Provide long term residential care, room, board, housekeeping, personal care and supervision. Social Services Law (SSL) § 2(25).

Enriched Housing Programs: Provide long term residential care, primarily to persons over the age of 65, in community-integrated settings resembling independent housing units; must provide or arrange for provision of room, and provide board, housekeeping, personal care and supervision. SSL § 2(25).

Residence for Adults: Provide long term residential care, room, board, housekeeping, personal care and supervision. SSL § 2(25).

Type of Provider	Approval Process	Construction Standards	Operational Standards	Ownership Changes
Adult Homes	Certification by Department of Health (DOH) [SSL §§ 460-a, 460-b, and 461-b]	18 N.Y.C.R.R. § 487.11	18 N.Y.C.R.R. Part 487	SSL § 461-b 18 N.Y.C.R.R. § 485.6
Enriched Housing Programs	Certification by DOH [SSL §§ 460-a, 460-b, and 461-b]	18 N.Y.C.R.R. § 488.11	18 N.Y.C.R.R. Part 488	SSL § 461-b 18 N.Y.C.R.R. § 485.6
Residences for Adults	Certification by DOH [SSL §§ 460-a, 460-b, and 461-b]	18 N.Y.C.R.R. § 490.11	18 N.Y.C.R.R. Part 490	SSL § 461-b 18 N.Y.C.R.R. § 485.6

Endnote

1. Pursuant to ch. 436 of the laws of 1997, oversight of facilities established and operated pursuant to art. 7 of the Social Services Law, and implementing regulations, was transferred from the Department of Social Services to the Department of Health.

Michele Petruzzelli is a Senior Attorney with the New York State Department of Health.

Legislative Health Policy: The Role of the Office of Governmental Affairs

By Glenn R. Lefebvre

Introduction

The mission of the New York State Department of Health (DOH) is to protect and promote the health of New Yorkers through prevention of accidents and disease, promotion of science, and the assurance of quality health care delivery. DOH is committed to making health care accessible and affordable and ensuring that all New York residents receive the highest quality health care in the world. One of the most important ways that the Department can fulfill this mission is by facilitating and promoting the enactment of sound legislative policies that support the health, safety, and welfare of New Yorkers. The New York State Department of Health plays a key role in the development and enactment of many statutes that have a major impact on health policies that influence hospitals, nursing homes, home care agencies, and health plans and the services they provide to New Yorkers.

In this article, I will review the role of the Office of Governmental Affairs (OGA) in the Health Department and how the OGA relates to the Executive Chamber (the Governor's Office), the New York State legislature, and the United States Congress. I will describe the procedure for development of the Department's legislative agenda for the state and federal legislative bodies; the process for development of Governor's Program Bills, departmental bills and budget bills; and the method for identifying, reviewing, and commenting on bills before the state and federal legislatures and the Governor.

The Office of Governmental Affairs was created in 1995 at the direction of the New York State Health Commissioner, who is appointed by the Governor.[1] This new organization was established as part of the Commissioner's Office and is directly responsible to the Commissioner of Health. Prior to this change, the majority of legislative and government relations functions for the Health Department were vested in the Bureau of Legislation, formerly a part of the Division of Legal Affairs (DLA). The new organizational arrangement was designed to permit the Commissioner of Health and her executive staff to play a greater role in directing the day-to-day affairs of the Office of Governmental Affairs, particularly as they related to the development and execution of health policies that required statutory changes on the state and federal levels.

State Legislative Agenda

The Department of Health each year reviews the need for statutory changes that are necessary to address emerging public health issues (HIV/AIDS, West Nile Virus, and bioterrorism); proposed reforms of health care programs (Medicaid, health care worker recruitment and retention, assisted living facilities and adult home reform); and compliance with applicable federal laws. The Office of Governmental Affairs initiates the internal review process that is used to solicit proposals from the Department's program staff for inclusion in the Department's legislative agenda. Generally, in the early fall, OGA requests that all major offices and Divisions in the Department review their programs for any outstanding legal and policy issues, as well as recommending any legislative initiatives that should be presented to the Commissioner and Executive Staff for review. OGA reviews these proposals and prepares its own recommendations to the Commissioner and Executive Staff. This permits OGA to provide the policy makers with the benefit of our analysis regarding the history of such proposals, similar bills introduced by the legislature and the background of any statements or positions taken by the Governor or others relating to the issue. The Commissioner then meets with the executive staff and they decide which of these legislative proposals will be forwarded to the Governor's Office for review and approval. Since the Department of Health is an executive agency subject to gubernatorial control, the Governor's Office retains the final authority to approve any proposals to be sent to the legislature.[2]

The Department submits a proposed list of legislative initiatives to the Governor's Counsel in early October. The Office of Governmental Affairs, in conjunction with the Division of Legal Affairs, begins developing the bill language. OGA coordinates development of the memorandum of support with the Department program office that recommended it. The proposed bill and memorandum are approved for transmittal to the Governor's Office by the Commissioner's office. The Department will also identify which legislative proposals are recommended for introduction as Governor's Program Bills, Departmental bills, or Article VII[3] bills. The completed drafts of these bills and supporting memoranda are due to the Governor's Counsel in early November for review and approval for introduction.

Governor's Program Bills

Some bills recommended by the Department or other proposals initiated by the Governor's Office are adopted as Governor's Program Bills and are submitted to the legislature as part of the Governor's legislative program. The Governor's Office, including the Gover-

nor's Counsel's staff and the Office for State Operations, assumes the lead responsibility for negotiations with the legislature and interested parties and groups on these bills. OGA supports these efforts by providing substantive and technical assistance, including drafting, revising and reviewing the bill and memorandum; coordination of participation by the Department's program and legal staff; and necessary legal and issue research. OGA also is responsible for keeping the Commissioner and Executive Staff informed of the progress and status of Governor's Program Bills and departmental bills.

Departmental Bills

Departmental bills are introduced in the legislature at the request of the Department of Health. These initiatives are also approved by the Governor's Office after thorough review and analysis by the Governor's staff, Division of the Budget (DOB), and other state agencies. OGA assumes responsibility for guiding these bills through the legislative process. The Office negotiates the bills with legislators and their staffs, contacts relevant interest groups for their positions and input, briefs legislative staff, and negotiates changes to the bill. OGA also keeps the Governor's Counsel Office and the Office for State Operations apprised of the progress of departmental bills. Further, OGA develops the Health Department's positions on other state agencies' legislative proposals and provides the Governor's Office of Counsel with the Department's positions and comments. OGA negotiates proposed changes or recommendations with the affected agencies.

Budget Bills

New York State's budget process follows a format dictated by the state constitution.[4] Additional details and actions are prescribed by state laws and practices established over time. New York's system of executive budgeting places responsibility for the preparation and execution of the budget in the hands of the state's Chief Executive.[5] The state constitution requires that the Governor seek and coordinate requests from state agencies, and develop a complete and balanced plan of proposed expenditures, including the revenues available to support them. This plan is submitted to the legislature along with the appropriation bills and other legislation required to carry out the Governor's budgetary recommendations.[6] The Department of Health and OGA often play a prominent role in assisting the Division of the Budget (DOB) in developing Article VII bills in support of the Governor's budget recommendations to the legislature. The Division of the Budget, OGA, and Department staffs work jointly to develop the initiatives that are proposed to the Governor and senior DOB staff. The recommendations for these Article VII bills often affect the major programs administered by the Department, including Medicaid,[7] the Child Health Insurance Program,[8] the Family Health Plus Program,[9] and the Program for Elderly Pharmaceutical Insurance Coverage (EPIC).[10] OGA and Division of Legal Affairs staffs, in cooperation with relevant program staff, generally draft proposals that are approved for inclusion in the budget package. The Department staff and OGA attend briefings with the legislative staffs on these Article VII bills. Finally, OGA and the Division for Legal Affairs actively participate in the negotiations on these bills and draft necessary amendments agreed upon to Article VII bills.

Legislative Bills

The Office of Governmental Affairs has the primary responsibility for identifying, tracking, researching, and commenting on bills introduced during the legislative session that affect Department programs. The Office maintains a bill tracking system that identifies all bills introduced in the session that may affect DOH programs or are of interest to relevant DOH staff on matters relating to Medicaid, public health, health systems management, or health care coverage. Bills are shared with the program staff that administers the impacted program or whose subject areas are affected for review and comment. OGA receives and reviews all comments and recommendations received from DOH staff on bills of interest. Pursuant to this review, OGA may communicate with the Governor's Office, legislative member offices, groups of interest, or other agencies, as appropriate. In connection with some bills, OGA may meet with legislative members and their staff to provide them with the Department's input on their bills. OGA staff also regularly attend relevant legislative committee meetings in the Senate and Assembly (Health, Social Services, Codes, Ways & Means, Finance and Rules) and public hearings on topics of interest to the Department. OGA assists DOH staff with written and oral testimony in those cases when the Department is invited to testify formally at such legislative hearings. The Office will also coordinate and develop the Department's position on bills that have passed both houses and have been presented to the Governor for executive action. These memoranda to the Governor's Counsel are drafted by OGA and approved by the Commissioner.

Federal Relations

The Office of Governmental Affairs also plays a prominent role in the area of federal affairs. OGA interacts very closely with the Governor's Washington office, which is under the direction of James Mazzarella. The Office includes a federal coordinator, who works with the Governor's Washington office on relevant federal health-related legislation that impacts New York State. OGA works closely with the New York Congres-

sional delegation and Committee staffs in the House of Representatives and Senate to offer language, amendments, or ideas to promote New York's interests. The Office of Governmental Affairs works to keep appropriate DOH staff apprised of any federal activity, including in Congress and the federal agencies, which affects DOH programs or activities. It also provides language, memoranda, and other bill-related information to DOH staff for review and analysis to determine the impact of pending federal legislation. Other administrative actions may be considered and analyzed in preparation for meetings with congressional and federal agency officials. OGA closely coordinates these activities with the Governor's Office, Division of the Budget and other state agencies. The Office of Governmental Affairs serves as the central point of contact for all inquires from federal agencies or Congressional staff received by the Department.

OGA develops a federal agenda for the Department of Health, in conjunction with the Governor's Office, which is distributed to the New York Congressional delegation and other policy makers in Washington, D.C., for their use and information. OGA actively lobbies Congress, particularly the New York Congressional delegation, on health issues of importance to New York State and the Department. We work with Department of Health staff to develop "white papers" or other background briefs for distribution to Congressional staffs during visits with staff and members on Capitol Hill. OGA, in conjunction with the Governor's Washington office, coordinates the Department's participation in or response to congressional hearings, which includes identification of appropriate witnesses and development of testimony. Occasionally, OGA also coordinates meetings for public health officials from outside the United States on topics ranging from AIDS to emergency medical assistance. OGA acts as a liaison between federal agencies and DOH in resolving problems relating to DOH-administered programs or other matters affecting the Department. OGA provides updates on all federal actions to various Department offices and officials regarding the latest status on important federal Congressional and agency actions. Finally, OGA assists congressional staff members with constituent issues under the jurisdiction of the state Health Department.

Other Legislative Matters

OGA also handles a wide range of other state and federal legislative matters that relate to the Department's mission to protect and promote the health of New Yorkers through prevention of accidents and disease, promotion of science, and the assurance of quality health care delivery. OGA responds to questions and inquires from members of the state legislature and their staffs relating to constituent matters, policy advice, and technical information regarding matters relative to diseases, program standards, and accountability for public programs in the Health Department's jurisdiction. OGA receives, coordinates, and assists appropriate DOH staff in responding in a timely and accurate way to the hundreds of requests received each year. The Department, through OGA, is responsible for reviewing and analyzing legislative proposals submitted by other state agencies to the Governor's Office for approval for introduction in the legislative session. OGA provides its comments and recommendations on these proposals to the state agency and Governor's Office.

Conclusion

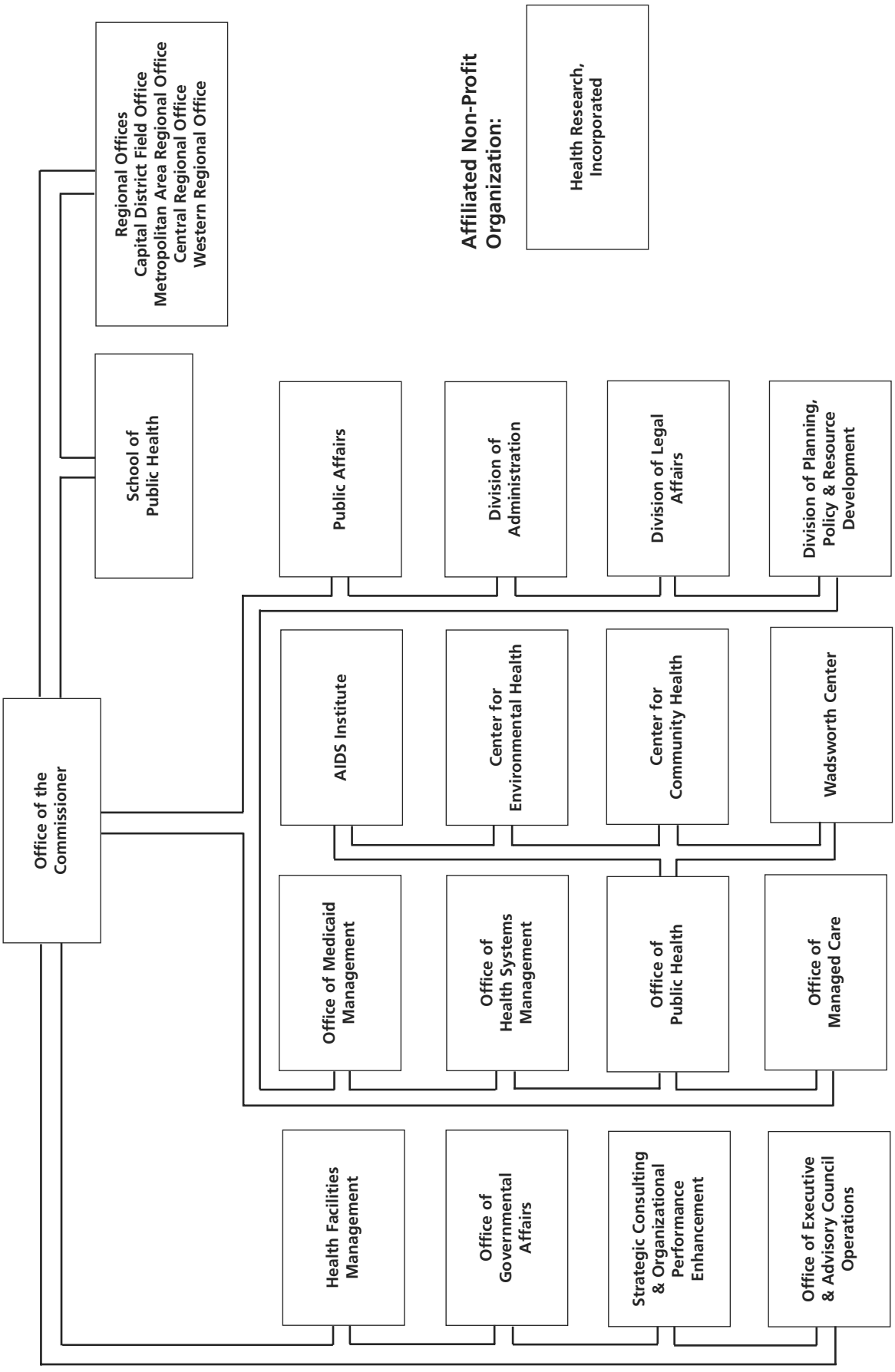
State legislatures are important partners in protecting the health and safety of the public. The laws they create and the funds they appropriate are critical in ensuring the health of all the states' constituents. The Health Department has a long and productive history of working in collaboration with the state legislature. This partnership has allowed DOH to play a significant and productive role in the legislative process by proposing and seeking enactment of needed legislative programs and providing the critical funding to support one of the state's fundamental government functions. OGA provides unique support to the Commissioner of Health and executive staff in the design and execution of legislative policies and programs that benefit and protect the state's citizens.

Endnotes

1. Dr. Barbara DeBuono was New York State's Commissioner of Health at the time the OGA was created. Her appointment was confirmed by the New York State Senate on Jan. 31, 1995.
2. *See* N.Y. Const., art. V, § 4.
3. *See* N.Y. Const., art. VII, § 3.
4. *See* N.Y. Const., art. VII.
5. *See* N.Y. Const., art. VII, §§ 1 & 2.
6. *See* N.Y. Const., art. IV, § 7.
7. *See* N.Y. Soc. Serv. Law (SSL), art. 5, tit. 11.
8. *See* N.Y. Pub. Health Law (PHL), art. 25, tit. 1-A.
9. *See* SSL art. 11-D.
10. *See* N.Y. Exec. Law, art. 19-K.

Glenn R. Lefebvre is the Director of the Office of Governmental Affairs.

New York State Department of Health Organization Chart



Horn v. The New York Times

Editors' Note: Each issue, the Journal *reprints one court decision of particular interest to health lawyers in New York. This issue features* Horn v. NY Times, *in which the Appellate Division, First Department, ruled that a hospital could not fire a physician for refusing to divulge confidential patient information.*

New York Appellate Division Reports
HORN v. NEW YORK TIMES,
4354 (1st Dept 2002)
___ N.Y.S.2d ___

SHEILA E. HORN, PLAINTIFF-RESPONDENT, v. THE NEW YORK TIMES, DEFENDANT-APPELLANT. MEDICAL SOCIETY OF THE STATE OF NEW YORK, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE AND AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES, INC., *AMICI CURIAE*.

Appellate Division of the Supreme Court of the State of New York, First Department.
March 21, 2002.

Defendant appeals from an order of the Supreme Court, New York County

(Edward Lehner, J.), entered December 18, 2000, which denied its motion to dismiss the first cause of action for breach of an implied contract and granted its motion to dismiss the second cause of action for punitive damages.

Pearl Zuchlewski, of counsel (Geoffrey A. Mort, on the brief, Goodman & Zuchlewski LLP, attorneys) for plaintiff-respondent.

Bernard M. Plum, of counsel (John F. Fullerton III and Michael R. Marra, on the brief, Proskauer Rose LLP, attorneys) for defendant-appellant.

Donald R. Moy and Rita Menchel, attorneys on behalf of the Medical Society of the State of New York, as *Amicus Curiae*.

Leonard A. Nelson and Anne M. Murphy, attorneys on behalf of the American Medical Association, as *Amicus Curiae*.

Douglas J. Polk and William F. Walsh, of counsel, (Vedder Price Kaufman and Kammholz, attorneys) on behalf of the American College of Occupational and Environmental Medicine, as *Amicus Curiae*.

David N. Wynn, of counsel (Arent Fox Kintner Plotkin & Kahn, attorneys) on behalf of the American Association of Occupational Health Nurses, Inc., as *Amicus Curiae*.

Before: Sullivan, J.P., Rosenberger, Ellerin, Wallach, Marlow, JJ.

ELLERIN, J.

The question presented by this appeal is whether a physician whose employment is terminated because she refuses to share patients' medical records with individuals not authorized to have them has a cause of action against her employer for wrongful discharge. We cannot accept defendant's argument that nothing in the law prevents it from firing the associate director of its medical department for refusing to divulge confidential patient information. Instead, we hold that a physician may claim an exception to New York's employment-at-will doctrine based on an implied-in-law obligation of her employer to, at the very least, do nothing to prevent her from practicing medicine in compliance with the ethical standards of the medical profession.

Contrary to the contention of defendant *The New York Times*, we conclude that this holding is consistent with the exception to New York's employment-at-will doctrine enunciated by the Court of Appeals in *Wieder v. Skala* (80 N.Y.2d 628), limiting a law firm's unfettered right to discharge its associate on the basis of an implied-in-law obligation on the part of the firm to deal fairly and in good faith with the associate. In light of the core characteristics shared by the legal and medical professions as alleged in *Weider* and here—i.e., the individual practitioner's employment for the purpose of practicing the profession and the importance of professional ethical obligations both to the practitioner's profession and to the public—we conclude that a physician is equally protected by such an exception.

Dr. Horn alleges that in 1996 she became the full-time associate medical director of *The New York Times*' medical department where her primary duties were to provide "medical care, treatment and advice" to the company's employees, and she was also responsible for

examining employees who were seeking Workers' Compensation benefits to verify that their claimed injuries were work-related. Dr. Horn further alleges that on "frequent occasions" various named departments of the company directed her to provide them with confidential medical records of employees "without those employees' consent or knowledge," and that the vice president for human resources instructed her to "misinform employees regarding whether injuries or illnesses they were suffering were work-related so as to curtail the number of Workers' Compensation claims filed against The Times." Understandably concerned about the propriety of such requests, Dr. Horn sought advice from the New York State Department of Health, which advised her that such conduct would violate legal and ethical duties to patients. She therefore refused to accede to the requests to turn over patients' medical records to other department heads without the patients' consent and asserts that it was this refusal that shortly thereafter resulted in the termination of her employment, notwithstanding defendant's assertions that such was due to economically induced restructuring of the department.

Relying on *Wieder* (*supra*, 80 N.Y.2d 628), Dr. Horn alleges that implicit in her employment relationship with The Times was an understanding that, having been hired to serve as a physician, she would conduct her practice in accordance with the ethical standards of the medical profession and that, in discharging her for refusing to engage in conduct irreconcilable with those standards, The Times breached this implied term of their employment agreement. The Times moved to dismiss Dr. Horn's complaint of breach of contract for failure to state a cause of action. The IAS court, in a comprehensive opinion (186 Misc. 2d 469), denied the motion and this appeal ensued.

On a motion directed to the pleadings, the court's task is to determine only whether the facts as alleged, accepting them as true and according the plaintiff every possible favorable inference, fit within any cognizable legal theory (*Leon v. Martinez*, 84 N.Y.2d 83, 87-88).

We recognize, of course, that prior to the decision in *Wieder* (*supra*) it had been New York's long-settled rule, first judicially enunciated in *Martin v. New York Life Ins. Co.* (148 N.Y. 117 [1895]), that "where an employment is for an indefinite term it is presumed to be a hiring at will which may be freely terminated by either party at any time for any reason or even for no reason" (*Murphy v. American Home Prods. Corp.*, 58 N.Y.2d 293, 300). Thus, in *Murphy*, the Court rejected the plaintiff's assertion that the law imposes in every employment contract the requirement that the employer deal with its employees fairly and in good faith and that a discharge in violation of that implied obligation exposes the employer to liability for breach of contract (58 N.Y.2d at 304). The plaintiff argued that by discharging him for disclosing accounting improprieties, which his employer's internal regulations required him to do, his employer failed to act in good faith and thus breached the employment contract. The Court found, however, that the law imposes an obligation of good faith and fair dealing only when such an obligation is "in aid and furtherance of other terms of the agreement" and, where one such term is the employer's unfettered right to terminate the employment, that situation does not arise (*id.*).

While in *Murphy*, the Court of Appeals acknowledged a trend in other jurisdictions "to temper what is perceived as the unfairness of the traditional rule" (58 N.Y.2d at 301), "being of the opinion that such a significant change in our law is best left to the Legislature" (*id.*), it declined to "judicially engraft[]" a good faith limitation on "the unfettered right of termination lying at the core of an employment at will" in New York (*id.* at 305, n2). It was noted by the dissent, however, that "[t]he at-will rule was created by the courts and can properly be changed by the courts but, more importantly, . . ., the rule has for at least a century been subject to the `universal force' of the good faith rule. The Legislature, therefore, had no reason before the present decision to believe that action on its part was required" (*id.* at 314, Meyer, J., dissenting).

Not long after deciding *Murphy*, the Court declined to overrule its rejection of an implied covenant of good faith in an employment relationship and reaffirmed the employer's right to terminate the employment at any time for any reason, in a case in which the employee argued, not unreasonably, that the law imposes "an obligation on the employer [arising from the latter's express policies] not to fire him for doing what he may be fired for failing to do" (*Sabetay v. Sterling Drug*, 69 N.Y.2d 329, 337-38, Hancock, Jr., J. concurring on constraint of *Murphy*). In *Sabetay*, the employee had refused to participate in certain illegal activities also involving accounting improprieties.

It is in this setting that the case of *Wieder v. Skala* (*supra*, 80 N.Y.2d 628) came before the Court of Appeals. Wieder alleged that the law firm where he was employed as an associate wrongfully discharged him for his insistence that the firm report the professional misconduct of another associate to the Disciplinary Committee as required by DR-1-103(A) of the Code of Professional Responsibility. While noting that Wieder's employment was at will and therefore could be "freely terminated by either party at any time for any reason or even for no reason" (*id.* at 633) in accordance with the decision in *Murphy*, *supra* (58 N.Y.2d at 300), the Court nevertheless held that Wieder's complaint stated a cause of action for breach of contract based on an implied-in-law obligation in his relationship with the firm (*Wieder* at 638). The Court derived this implied

obligation from "the law that in `every contract there is an implied undertaking on the part of each party that he will not intentionally and purposely do anything to prevent the other party from carrying out the agreement on his part'" (*id.* at 637, quoting *Patterson v. Meyerhofer*, 204 N.Y. 96, 100). The firm's insistence that Wieder act "unethically and in violation of one of the primary professional rules amounted to nothing less than a frustration of the only legitimate purpose of the employment relationship" (*id.* at 638). Giving effect to an understanding that both Wieder and the firm would comply with professional rules and standards, and that the firm would do nothing to impede or discourage Wieder's compliance, was "in aid and furtherance of [the central purpose] of the agreement" (*id.* at 637-38, paraphrasing *Murphy, supra*, 58 N.Y.2d at 304).

In light of its narrowly constructed parameters, there has been a reluctance by trial and intermediate appellate courts to interpret the *Wieder* exception as applicable to other occupations or professions (*see, e.g., Civiletti v. Independence Sav. Bank*, 236 A.D.2d 436 [bank employee]; *Leibowitz v. Party Experience*, 233 A.D.2d 481 [chief financial officer]; *DeFilippo v. Xerox Corp.*, 223 A.D.2d 846, *lv dismissed* 87 N.Y.2d 1056 [salesman]; *Haviland v. J. Aron & Co.*, 212 A.D.2d 439, *lv denied* 85 N.Y.2d 810 [commodities broker]; *Mulder v. Donaldson, Lufkin & Jenrette*, 208 A.D.2d 301 [auditor]; *McConchie v. Wal-Mart Stores*, 985 F. Supp. 273 [pharmacist]; *Fry v. McCall*, 945 F. Supp. 655 [public employee]; *McGrane v. Reader's Digest Ass'n*, 822 F. Supp. 1044, *affd* 60 F.3d 811 [auditor]).

It has been suggested that "the New York courts have limited the harshness of the at-will rule's effect especially as to lawyers with no firmer foundation than heightened empathy towards colleagues in their own profession" (*Wolde-Meskel v. Tremont Commonwealth Council*, 1994 WL 167977 *6, fn 3 [US Dist Ct, SDNY]. The case now before us, however, involves the obligations of a physician, which are significantly different from the obligations that the plaintiffs in the above-cited cases claimed caused their terminations. With all due respect to the other occupations and professions, we find that Dr. Horn's obligation, as a physician, to comply with the Principles of Medical Ethics established by the American Medical Association (and with applicable provisions of the Education Law, *see, e.g.*, § 6530 [definitions of professional misconduct], and rules promulgated by the Board of Regents, (*see, e.g.*, 8 N.Y.C.R.R. § 29.1[b] [unprofessional conduct]) is analogous to the obligation upon lawyers to comply with the Code of Professional Responsibility (and disciplinary rules [22 N.Y.C.R.R. § 1200 *et seq.*]).

Particularly relevant to the case before us involving a physician is the Court's analysis in *Wieder* that provided the rationale for exempting a lawyer from the general rule that governed the cases of *Murphy* and *Sabetay*. The Court drew the distinction that "[t]he plaintiffs in those cases were in the financial departments of their employers, both large companies. Although they performed accounting services, they did so in furtherance of their primary line responsibilities as part of corporate management. In contrast, plaintiff's performance of professional services for the firm's clients as a duly admitted member of the Bar was at the very core and, indeed, the only purpose of his association with defendants. Associates are, to be sure, employees of the firm but they remain independent officers of the court responsible in a broader public sense for their professional obligations" (*Wieder*, *supra*, at 635).

The Times argues that the *Wieder* exception to the employment-at-will doctrine is not properly extended beyond the legal profession and that, even if it were, Dr. Horn's complaint must be dismissed because she failed to allege facts sufficient to demonstrate that the medical profession shares the unique characteristics of the legal profession and that her particular situation is substantially identical to Howard Wieder's.

Contrary to The Times's assertions as to the nature of Dr. Horn's employment, she alleges that her primary responsibilities were the provision of medical care, treatment and advice to employees of The Times, and that, among other things, she was responsible for determining whether employees' injuries were work-related and thus rendered the employees eligible for Workers' Compensation. The Times argues that the latter was an evaluative and administrative corporate function and that Dr. Horn is comparable to the plaintiffs in *Murphy* and *Sabetay*, who performed professional services in furtherance of their corporate responsibilities. However, taking Dr. Horn's allegations to be true and resolving all inferences that reasonably flow from them in her favor, and construing such allegations as generally understood, we find the determination of whether an injury is work-related to be a diagnostic function and an integral part of the practice of medicine. Accordingly, Dr. Horn's allegations are sufficient to demonstrate that the practice of medicine was "at the very core" of her employment (*Wieder, supra*, at 635).

Any employer who hires a physician to provide medical care knows, or should know as a matter of common knowledge, that the physician is bound by the patient confidentiality provision of the ethical code of the medical profession. That the employer is not a medical entity and therefore is not itself bound by the governing rules and standards of the medical profession does not negate the implied understanding in their relationship that the employer will not impede or discourage the physician's compliance with those particular rules and standards (*Wieder, supra*, at 638). In place of the mutual obligation is the equally powerful universal

understanding that, without a patient's consent, a physician will not disclose to others information obtained in rendering care to the patient. Thus, in hiring Dr. Horn as associate director of its medical department and providing the services of a specific physician to its employees, The Times knew not only that Dr. Horn was bound by patient confidentiality but also that her patients would rightfully presume that she would honor that obligation. It is this knowledge that gives rise to an implied understanding that The Times will, at the very least, do nothing to prevent Dr. Horn from conducting her practice in compliance with that code. As the Court observed in *Wieder*, implying an omitted term in an agreement "is but a recognition that the parties occasionally have understandings or expectations that were so fundamental that they did not need to negotiate about those expectations" (80 N.Y.2d at 637, quoting 3 Corbin, Contracts § 570, 1992 Supp, at 411).

We must reject The Times's contention that confidentiality is not part of the professional code that is essential to the survival of the medical profession. Quite to the contrary, it is a time-honored, deeply embedded axiom that a physician, like a lawyer, will preserve confidentiality of information acquired from patients. Indeed, the confidentiality rule that Dr. Horn refused to violate is a primary tenet of the medical profession and one of profound importance to patients and to the public.

The obligation to safeguard patients' confidences directly affects the quality of medical care (*cf., Finley v. Giacobbe*, 827 F. Supp. 215, 221). The Times argues that, unlike behavior "central to the *physical practice* of medicine that could actually endanger lives," e.g., drunkenness, gross incompetence or gross negligence, the confidential treatment of medical files is not one of those duties that "truly go to the core of medical treatment." To the contrary, without assurance of the confidential treatment of medical files, patients may suffer equally grievous harm. Patients frequently are reluctant to disclose information that is personal, embarrassing or potentially incriminating, but effective medical treatment often depends on the physician's possessing precisely that information. Patients who have no confidence that private information will remain between themselves and their physicians may be reluctant to disclose critical facts relating to their complaints or to seek medical attention at all. It is largely for this reason that in 1828 New York State enacted a physician-patient privilege into law (*see, Dillenbeck v. Hess*, 73 N.Y.2d 278, 284-85).

Most of the other States also passed such statutes in the 19th century when legislatures were looking for ways to encourage people with venereal diseases to communicate freely with their doctors (*see*, Clark, *Confidential Communications in a Professional Context: Attorney, Physician, and Social Worker*, 24 J Legal Prof 79, 84 [1999/2000]). More recently, New York State's AIDS Confidentiality Law (Public Health Law §§ 2780-2787), assured strict confidentiality in order to persuade infected people to go into treatment, alter their behavior, and report their status to their sexual and needle-sharing partners (*see*, Salmon, *The Name Game: Issues Surrounding New York State's HIV Partner Notification Law*, 16 NYL Sch J Hum Rts 959, 973-74). These two examples of the importance of physician-patient confidentiality in the care and control of particular diseases demonstrate that the physician's obligation to maintain the confidentiality of patient information has a significant impact on public health as well.

Equally unavailing is The Times's argument that the physician-patient confidentiality obligation cannot be considered a rule essential to the medical profession where, as here, "the employee-patient is fully aware that the physician is employed by the employer and thus has some duty to the employer as well, and is perfectly free to see their own physician rather than the company physician." The patient may know that the physician is also an employee of their mutual employer, but that is hardly a basis upon which to assume that the patient will expect the physician to unethically divulge confidential information or that the employer will improperly seek to obtain that information. Moreover, the directive to provide other department managers with confidential medical records of employees, as alleged, i.e., without those employees' consent or knowledge, belies the implication that an employee who consults the company physician tacitly consents to the physician's disclosure of that employee's medical files to other departments.

The New York Times, by engaging and holding out a licensed physician to provide medical care, treatment and other related benefits to its employees, in their mutual interest, has, at the very least, implied that its physician's services will meet basic standards of professional ethics. No one can reasonably dispute that these employees have a right to rely on the integrity and confidentiality of those proffered medical services. To allow the same employer to provide, and then simultaneously undermine, such a fundamental, personal and vital human service in the manner this defendant suggests, without the knowledge or consent of its employees, is inimical to the foregoing public policy considerations.

In any event, the Council on Ethical and Judicial Affairs of the American Medical Association has stated that "industry employed physicians," i.e., those employed by businesses to perform "an isolated assessment of an individual's health or disability for an employer, business, or insurer," have the same obligation to maintain patient confidentiality as physicians who are independent contractors (Brief of Amicus Curi-

ae, Appendix A at 1-2). The Council's Opinion E-5.09 elaborates on this obligation:

Where a physician's services are limited to performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, the information obtained by the physician as a result of such examinations is confidential and should not be communicated to a third party without the individual's prior written consent, unless required by law. If the individual authorized the release of medical information to an employer or a potential employer, the physician should release only that information which is reasonably relevant to the employer's decision regarding that individual's ability to perform the work required by the job [Brief of Amicus Curiae at 8].

Moreover, as to the importance of the confidentiality provision of the ethical code, a physician's "[r]evealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law," is professional misconduct (Education Law § 6530 Educ. [23]; *see also*, 8 N.Y.C.R.R. § 29.1[b][8]) grave enough to be grounds for the suspension or revocation of her license to practice medicine (Public Health Law § 230-a Pub. Health).

Much is made of the fact that, unlike the situation in *Wieder* (*supra*), where both the plaintiff employee and the defendant employer were engaged in the practice of law, in this case the defendant employer is not engaged along with the plaintiff employee in the practice of medicine. It is significant, however, that The Times, a universally respected news organization, itself provides an essential service to the public that entails conforming to certain standards of truth, integrity and confidentiality of its news sources (*see, e.g.*, the Shield Law [Civil Rights Laws 79-h]). That its employee refuses to violate parallel rules of confidentiality governing her practice of medicine can hardly be said to be "inconsistent with" and "destructive of" the core purpose of their agreement, the rationale underlying the decisions in *Murphy* and *Sabetay* (*see, Wieder, supra*, at 638).

We conclude by noting that we believe physicians are, no less than lawyers, entitled to the trust, respect and esteem that an implied-in-law obligation of their employers to deal with them fairly and in good faith bespeaks. Associates who are employees of a law firm "remain independent officers of the court responsible in a broader public sense for their professional obligations," the Court of Appeals said in *Wieder* (at 635). Physicians too are independent professionals responsible in a broader public sense for their professional obligations. The Principles of Medical Ethics of the American Medical Association state that "a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self." Physicians are responsible for maintaining the public's confidence in their integrity and the medical profession (*see, e.g.*, Education Law § 6530 Educ. [17], which makes it professional misconduct to "exploit the patient for the financial gain . . . of a third party"). Thus, contrary to the dissent, the rules governing the medical professional are not addressed solely to the relationship between practitioner and patient but have a far broader public impact, comparable to that of the rules regulating the legal profession. A physician hired to practice medicine is as different from a corporate manager as is an associate of a law firm.

Accordingly, the order of the Supreme Court, New York County (Edward Lehner, J.), entered December 18, 2000, which denied defendant's motion to dismiss the first cause of action for breach of an implied contract and granted its motion to dismiss the second cause of action for punitive damages, should be affirmed, without costs.

All concur except Sullivan, J.P. and Wallach, J. who dissent in an Opinion by Wallach, J.

WALLACH, J. (dissenting)

Plaintiff, a licensed physician, was hired by oral contract, ordinarily terminable at will, to serve as a doctor and medical administrator for the company's personnel. The complaint alleges that in the course of this employment, defendant directed plaintiff to disclose the contents of confidential medical records, without employee knowledge or consent, pertaining to worker compensation claims, purportedly in violation of various ethical guidelines governing her profession (*see, e.g.*, Education Law § 6530 Educ. [23]; 8 N.Y.C.R.R. 291 [b][8]). Her employment was terminated, allegedly because she refused to comply.

Defendant moved to dismiss for failure to state a cause of action. The IAS court ruled that since such unauthorized disclosure of confidential patient information would have constituted professional misconduct, plaintiff's discharge for her ethically premised conduct sustained a viable cause of action for breach of an implied provision of her contract of employment. We disagree, and would reverse and grant defendant's motion to dismiss the complaint.

Absent a constitutionally impermissible purpose, a statutory proscription or a fixed term contained in the individual employment contract itself, an employer's right to terminate an employment at will remains unimpaired in New York (*Murphy v. American Home Prods. Corp.*, 58 N.Y.2d 293). An employee at will has no implied contractual right to continued employment, and thus the relationship can be terminated at any time by the employer, for virtually any reason.

The Court of Appeals has carved out one very limited exception to this rule in the case of an associate attorney who claimed wrongful discharge by his law firm after he had notified his senior partners about unethical conduct by another member of the firm and had urged them to report the matter to the Appellate Division's Departmental Disciplinary Committee (*Wieder v. Skala*, 80 N.Y.2d 628). When the law firm failed to act, Mr. Wieder reported his colleague to the disciplinary authorities, whereupon the law firm *a)* also reported the matter, and *b)* then fired Wieder, allegedly in retaliation. The IAS court in the case at bar concluded that the *Wieder* rationale entitled plaintiff herein to a similar exception.

Obviously, Dr. Horn's claim here strikes a sympathetic, and even a seductive, chord. In one Federal case involving an at-will employee's action for wrongful discharge (*Wolde-Meskel v. Tremont Commonwealth Council*, 1994 U.S. Dist LEXIS 5464 [SDNY]), the court noted (at *8, fn 3):

Although it might be argued that the New York courts have limited the harshness of the at-will rule's effect especially as to lawyers with no firmer foundation than heightened empathy towards colleagues in their own profession, such a limitation would be nonetheless within the province of the state courts.

While whimsical in tone, the subtext of this observation is clear enough. And, to the extent that such a thought could be perceived as an operational rationale to any degree, an immediately attractive and surely remedial response might be to enlarge membership in the favorably protected class to include the medical practitioner. In good time, other professional employees might well be invited to seek shelter under the ever expanding *Wieder* big tent. But in light of existing law in this State, we, as an intermediate appellate court, must resolutely resist that temptation.

Any rule of law purporting to regulate at-will employment contracts has the widest application and economic impact. For example, courts are legislatively bound to address certain discriminatory activity, under Constitutional equal protection principles (age, race, sex, disability). All the more reason that when an employee seeks regulation of an employer's ethical conduct by means which have far-reaching economic implication, the judgment as to the best method of restraint requires the broad investigatory resources of the Legislature. In other words, the area of economic consideration is one far better left to legislative remedy (*Wieder v. Skala, supra*, at 639; *Sabetay v. Sterling Drug*, 69 N.Y.2d 329, 336-337). The Legislature has so moved to protect employees from employer actions in certain narrow circumstances, e.g., Executive Law § 296(1)(e) (retaliation against an employee who objects to, or blows the whistle about, an employer's violation of the Human Rights Law), Labor Law § 740 (retaliation against an employee who objects to, or blows the whistle about, an employer's health and safety violations) or § 215 (any other violations of the Labor Law), Civil Service Law § 75-b (retaliatory action by public employers), and Judiciary Law § 519 Jud. (penalizing an employee for answering a call to jury duty). Each of these narrow areas of prohibition clearly resulted from extensive Legislative study and action. For our Court now to extend the protective umbrella over a much broader class of employees for other unspecified employer improprieties would seemingly exceed the appropriate judicial role.

As the Court of Appeals noted in *Sabetay* (*supra*), the desire for stability and predictability in the sensitive area of employment contractual relations has resulted in the erection of a protective wall against judicial intervention, breach of which has traditionally been envisaged as solely a legislative prerogative. To date, *Wieder* is the only exception to this rule (*see, Lichtman v. Estrin*, 282 A.D.2d 326), and courts have resisted the invitation to expand that exception to other licensed businesses or professions (*see, e.g.*, *Civiletti v. Independence Sav. Bank*, 236 A.D.2d 436 [bank employee]; *Leibowitz v. Party Experience*, 233 A.D.2d 481 [chief financial officer]; *DeFilippo v. Xerox Corp.*, 223 A.D.2d 846, 848, *lv dismissed* 87 N.Y.2d 1056 [salesman]; *Haviland v. J. Aron & Co.*, 212 A.D.2d 439, *lv denied* 85 N.Y.2d 810 [commodities broker]; *Mulder v. Donaldson, Lufkin & Jenrette*, 208 A.D.2d 301 [auditor]; *McConchie v. Wal-Mart Stores*, 985 F. Supp. 273 [pharmacist]; *Fry v. McCall*, 945 F. Supp. 655 [public employee]; *McGrane v. Reader's Digest Assn.*, 822 F. Supp. 1044, 1048-1049, 863 F. Supp. 183, 185, *affd* 60 F.3d 811 [investigator]). Plaintiff has not established that the status of her profession demands similar treatment.

It should also be noted that viewed from the perspective of any licensed professional, the *Wieder* exception to the *Murphy* rule provides a double-edged sword. While it may be a boon to the employed professional, it simultaneously creates a severe constraint upon the *employer*-professional's freedom of action, a consideration that must give pause to proponents of a *Wieder* expansion.

The *Wieder* exception makes it clear that the outcome in a wrongful discharge case depends less on the details of the employer's alleged misconduct than on the nature of the professional relationship between employer and employee. In *Sabetay v. Sterling Drug* (*supra*), an accountant serving as in-house director of corporate financial projects asserted he had been fired after refusing to condone slush-fund payments to foreign officials and other illegal tax-avoidance activities. Notwithstanding provisions in Sterling's employee manual requiring reportage of illegal activities, the Court of Appeals held that the plaintiff still had not sat-

isfied his burden to establish an express limitation on the company's virtually unfettered authority to discharge an at-will employee.

Ethical rules governing the medical profession are primarily addressed to the relationship between practitioner and patient. By contrast, the *Wieder* exception found an implied-in-law obligation of fair dealing and good faith, *unique to the practice of law,* in the distinctive relationship between a lawyer- associate and his firm. Intrinsic in every such relationship, the Court of Appeals held, is "the unstated but essential compact that in conducting the firm's legal practice both [the associate] and the firm would do so in compliance with the prevailing rules of conduct and ethical standards of the profession." (80 N.Y.2d at 637-638.) A law firm's insistence that its employed attorney violate those rules would frustrate the very essence of the common enterprise they share, in a profession whose disciplinary self-regulation is essential to its very survival in our society.

The parties presently before this Court—a newspaper publisher and the associate director of its medical department—were not engaged in a common professional enterprise. By no characterization were plaintiff and her employer professionally joined in the practice of medicine or the delivery of health-care services. As we see it, the major flaw in the majority argument sustaining this complaint rests in its denigration of this "common enterprise" component that is so essential to the *Wieder* exception. The contract cause of action sustained herein rests entirely upon an alleged breach of the implied covenant of good faith and fair dealing; this covenant need not be expressed, precisely because the common enterprise upon which both parties are embarked triggers its *mutual* application. The implied covenant, as indicated by the majority's reliance upon Professor Corbin's dictum, is that there is a silent but overarching term of ethical conduct recognition only where the parties' shared understandings or expectations are so fundamental that they need not even be negotiated. No such expectations can be found to operate with equal force upon both parties in this context.

Responding to this serious departure from the *Wieder* rationale, the majority offers as a viable substitute defendant's ethical obligation to conform to the lofty standards of "truth, integrity and confidentiality" (referencing the journalist's privilege to protect confidential news sources) in delivering its "essential service to the public." To adopt this standard would be to expand application of the *Wieder* exception to any situation where assertion of an employee's ethical obligations results in retaliatory discharge, as long as the employer's business is arguably subject to another, completely unrelated, set of ethical standards. We would be surprised if the *Wieder* court ever contemplated even the possibility of such an extraordinary enlargement.

The IAS court granted defendant's motion only to the extent of dismissing the second cause of action, asserting a claim for punitive damages. The first cause of action, alleging breach of an implied contract, should also have been dismissed.

Motions seeking leave to appear as *Amici Curiae* granted.

THIS CONSTITUTES THE DECISION AND ORDER OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

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NEWS flash

What's Happening in the Section

Rear (l to r): Jim Ayers (Exec. Committee Liaison), J. David Seay, Kenneth Larywon, James Fouassier, James Horan, Hermes Fernandez, James Lytle, Nancy Halleck
Middle: Anne Maltz, Lynn Stansel, Salvatore Russo (Chair), Karen Gallinari, Randye Retkin
Front: Douglas Sansted, Sally True, Philip Rosenberg and Robert Swidler

Many New Committee Chairs Appointed for 2002-03

Health Law Section Chair Salvatore Russo has appointed a new roster of Committee Chairs for 2002-03. As a result of his decision to appoint Co-chairs for several Committees, and to add two new Committees (see below) there are now 28 Committee Chairs, as opposed to 14 in 2001-02. Russo explained that the use of Co-chairs promises several advantages: "It lets Chairs share the burden, and it makes it easier to attract prominent but busy health care attorneys into leadership positions in the Section. It also gives the Executive Committee a great many new participants, with fresh ideas and energy."

The list of new Committee Chairs, along with biographical summaries, appears on the subsequent pages of the *Journal*.

Committee on AIDS and the Law Joins the Health Law Section

The Committee on AIDS and the Law, which had been a freestanding NYSBA Committee since its formation in 1987, recently agreed to become one of the committees of the Health Law Section. Ross Lanzafame, the newly appointed Committee Chair, noted that the Committee will continue to address a broad range of legal and policy issues raised by AIDS, beyond those falling within a traditional conception of "health law." However, joining the Section gives the Committee a compatible and influential home, and a greater ability to collaborate with other attorneys on projects of importance to people with HIV and AIDS.

Health Law Journal Offers Writing Prize to Law Students

The *Health Law Journal* is pleased to announce that it will award a prize of $500 for the best article submitted by a law student on a health law topic.

Articles must be submitted by May 15, 2003, and should be 7-15 typed double-spaced pages. More information about the prize and the judging process and criteria can be found on the Section's Web site, www.NYSBA.org/sections/health.

Special Committee on Mental Health Issues Created

A Special Committee on Mental Health Issues has been created, and two Co-chairs appointed: J. David Seay of the National Alliance for the Mentally Ill of New York State, and Henry Dlugacz, a prominent mental health attorney. The Co-chairs expressed their expectation that the Committee will draw upon the resources and expertise of the Section in its work to improve mental health law, and will in turn help inform and sensitize the Section and the health law bar to the unique issues faced by persons with mental illness.

Executive Committee Members: Biographical Summaries

Elected Officers

Salvatore J. Russo
Chair

Salvatore J. Russo is the Executive Senior Counsel for Medical-Legal and Mental Health Affairs within the Office of Legal Affairs of the New York City Health & Hospitals Corporation. Mr. Russo is also Counsel to the Metropolitan Health Administrators' Association. He previously served as the in-house Counsel for Maimonides Medical Center of Brooklyn, and as the Director of Legal Affairs for the Greater New York Hospital Association. Mr. Russo is a Phi Beta Kappa graduate of New York University (NYU) and has his J.D. from Hofstra University School of Law. Mr. Russo is an Adjunct Assistant Professor of Health Management and Co-faculty Advisor for the Health Care Certificate Program of the NYU School of Continuing and Professional Studies. He writes and lectures extensively in the area of medical/legal topics. His most recent publications include, "All Right, Mr. DeMille, I Am Ready for My Closeup (A Health Care Lawyer's Practical Guide to Considerations to Negotiating a Film/TV Contract)," published in the New York State Bar Association's *Health Law Journal*, and *The Complete and Easy Guide to Health Law*, an ABA-sponsored book, published by Three Rivers Press.

James W. Lytle
Chair-Elect

James W. Lytle is a partner in the New York City-based firm of Kalkines, Arky, Zall & Bernstein and is the partner responsible for the firm's Albany office. Prior to joining the firm, he was a partner in the firm of Whiteman Osterman & Hanna in Albany, where he was a member of that firm's health care and government relations practices. Between 1983 and 1986, Mr. Lytle served as Assistant Counsel for Health and Human Services to Governor Mario M. Cuomo. He is a graduate of Princeton University, with a degree from the Woodrow Wilson School of Public and International Affairs, and he received his law degree from Harvard Law School. He has lectured on behalf of the American Health Lawyers Association, the American Society of Law, Medicine and Ethics, the Hospital Education and Research Fund, and other groups. Mr. Lytle has represented a wide array of health care facilities, agencies and professionals in navigating through the legal, regulatory and political challenges of the modern health care environment.

Philip Rosenberg
Vice-Chair

Philip Rosenberg is a partner at Wilson, Elser, Moskowitz, Edelman & Dicker LLP. Mr. Rosenberg's practice encompasses representing health care providers with respect to a range of transactional, regulatory and litigation matters, with particular emphasis in reimbursement, fraud and abuse, licensure, tax-exemption, managed care and ERISA. Mr. Rosenberg has authored dozens of articles on health law, and is a frequent lecturer before national and state bar associations and health industry groups. He is also an Adjunct Professor of Health Law at Union College (MBA Program). Mr. Rosenberg is a graduate of Cornell University (School of Industrial and Labor Relations) and Benjamin N. Cardozo School of Law at Yeshiva University.

Lynn Stansel
Secretary

Lynn Stansel has been Associate General Counsel for Montefiore Medical Center, Bronx, New York, since 1996. Prior to Montefiore, she was an attorney with Memorial Sloan-Kettering Cancer Center for four years. She began her legal career in 1985 as a commercial litigator in Manhattan. Ms. Stansel has a broad-based health practice, which includes serving on internal compliance committees, acting as counsel on federal and state audits and investigations, and advising on regulatory issues and reimbursement. She also represents the hospital in connection with professional discipline matters. Ms. Stansel formerly chaired the New York State Bar Association (NYSBA) Health Law In-house Counsel Committee, and is a member of the In-house Counsel Section of the American Health Lawyers Association. Ms. Stansel has lectured to industry groups on issues related to commercial and health insurance and has published articles on related topics. Ms. Stansel earned a Master's degree in Health Administration (M.H.A.) and a law degree (J.D.) from Duke University in Durham, North Carolina, in 1985. She holds a Bachelor's degree in biology from Wittenberg University, in Springfield, Ohio.

Mark Barnes
Treasurer

Mark Barnes, a partner at Ropes & Gray, has practiced and taught law and has administered governmental programs in the health care field for over 15 years. Educated at Yale Law School and Columbia University School of Law, Mr. Barnes taught full time at Columbia

for four years, and more recently has served as an Adjunct Professor of Law at a number of law schools, including Brooklyn Law School and New York University School of Law. Mr. Barnes served as the Director of Policy for the New York State Department of Health AIDS Institute in the early 1990s. In 1993, he was a consultant to the White House National Health Care Reform Task Force, and he served from 1992 to 1994 as Associate Commissioner for Medical and Legal Policy for the New York City Department of Health. In the mid-1990s, Mr. Barnes was the Executive Director of the AIDS Action Council, where he lobbied and advocated on AIDS funding and policy before Congress, federal agencies, and the Office of the President. He represents health care providers and associations in regulatory, reimbursement, research, HIPAA compliance, and litigation matters. Mr. Barnes has served as a member of the National Human Research Protections Advisory Committee of the United States Office of Human Research Protections. His recent articles on HIPAA compliance and conflicts of interest in human research have appeared in *BNA Health Law Reporter*.

Committee Chairs

Kathleen M. Burke
Ethical Issues in Health Care

Kathleen M. Burke is Vice President, Secretary and Counsel for NewYork-Presbyterian Hospital (NYPH) and NewYork-Presbyterian Healthcare System. Under the aegis of the CLO/GC, Ms. Burke handles legal matters pertaining to the boards of the Hospital and System, as well as to the boards of some of the System members. She is a trustee or corporate secretary of several NYPH System institutions and affiliated corporations. She also works with other members of the NYPH legal staff to handle matters relating to not-for-profit corporations/tax issues, patient rights/ethics committees, and gifts, estate and trusts. She was a faculty member of Concern for Dying in the 1980s and is a participant in the Medical Ethics course of the Weill Medical College of Cornell University. She has served on bar association health-law related committees. Prior to working in-house, she was a litigation associate with Donovan Leisure Newton & Irvine (New York and California) and Kelley Drye & Warren. She graduated from Marymount Manhattan College (on whose board she later served for nine years) and from the University of Virginia Law School.

Carl H. Coleman
Ethical Issues in Health Care

Carl Coleman is an Associate Professor of Law at Seton Hall University Law School, where he is also Associate Director of the Health Law and Policy Program. Professor Coleman received his J.D., *magna cum laude*, from Harvard Law School, where he served as Supervising Editor of the Harvard Law Review. He also holds an A.M. in East Asian Studies from Harvard University and a B.S.F.S., *cum laude*, from Georgetown University's School of Foreign Service. After law school, Professor Coleman served as law clerk to then-Chief Judge James L. Oakes of the U.S. Court of Appeals for the Second Circuit. He then worked as a litigation associate at Leventhal Slade & Krantz in New York City. In 1993, Professor Coleman was appointed Counsel to the New York State Task Force on Life and the Law, a nationally recognized interdisciplinary commission with a mandate to recommend public policy on bioethical issues. He was made Executive Director of the Task Force in 1995. Professor Coleman has served on numerous governmental and bar association committees, including the New York State Attorney General's Commission on Quality of Care at the End of Life, the Elder Law, Bioethics, and Health Law Committees of the Association of the Bar of the City of New York, and several working groups convened by the New York State Department of Health. He is a member of the Institutional Review Board of the University of Medicine and Dentistry of New Jersey.

Thomas S. D'Antonio
Fraud, Abuse and Compliance

Thomas D'Antonio is a partner in the Ward Norris Heller & Reidy firm, located in Rochester. Mr. D'Antonio's focus is on health care litigation, and the representation of hospitals, nursing homes, academic medical centers and institutions of higher learning. He routinely is involved with Medicare and Medicaid reimbursement issues, the creation and implementation of institutional compliance programs, various fraud and abuse matters, governmental and third-party payor investigations, False Claims Act and *qui tam* litigation, staff privilege and credentialing matters, licensure proceedings and employment-related claims in the health care setting. Currently, he is acting as lead counsel for a group of more than 170 New York hospitals, and the Healthcare Association of New York State, in a lawsuit seeking to recover from the tobacco industry for the costs of uncompensated and undercompensated care that has been provided to victims of tobacco-related illnesses. Mr. D'Antonio also represents a large group of New York hospitals challenging the calculation of the so-called Statewide Case Mix Adjustment for five selected rate periods. Mr. D'Antonio lectures frequently on various legal issues, and is active in numerous community projects. He lives with his wife Kathleen and their four children in Rochester.

Henry A. Dlugacz
Special Committee on Mental Health Issues

Henry A. Dlugacz is an attorney in private practice in New York City, specializing in mental disability issues. His work includes the monitoring of complex federal class action litigations related to forensic psychiatric hospitals and correctional mental health systems. His practice includes work in the guardianship and hospital retention areas, as well as mediation. Mr. Dlugacz has served as a consultant to governmental organizations, as well as to private consulting and auditing firms. He has also conducted trainings and inspections for international human rights organizations. He is an Adjunct Professor of Law at St. John's University School of Law, where he teaches Mental Health Law, an Assistant Clinical Professor of Psychiatry and Behavioral Science at New York Medical College, and mentor-professor at New York Law School. In addition to his law degree, Mr. Dlugacz has a graduate degree in psychiatric social work, and has developed and directed complex mental health programs. Mr. Dlugacz has lectured extensively both nationally and internationally.

Hermes Fernandez
Professional Discipline

Hermes Fernandez is a partner in Bond, Schoeneck & King, LLP, one of the largest firms in upstate New York. He practices primarily in the areas of administrative, health, regulatory, and legislative law, and litigation. He regularly represents clients in a broad range of administrative proceedings before state agencies and in Article 78 proceedings, and in actions in state and federal courts. He also regularly advises clients on the requirements of and compliance with state statutes and regulations, on state contracts, and represents clients before the state legislature. Prior to joining Bond, Schoeneck & King, Mr. Fernandez served from 1986-90 as Assistant Counsel to Governor Mario Cuomo. He was particularly involved in legislation regarding health, social services and other human services issues. Before coming to Albany, Mr. Fernandez was a trial attorney with the Civil Division of the U.S. Justice Department in Washington, D.C. Mr. Fernandez was involved in the drafting of numerous statutes, including the Child Support Standards Act, the creation of the Office of Substance Abuse Services, and the Community Mental Health Reinvestment Act.

Kenneth K. Fisher
Special Committee on Medical Information

Kenneth K. Fisher is a partner of Phillips Nizer, LLP in New York City. Mr. Fisher has a broad-ranging practice that includes general corporate and corporate litigation, with an emphasis on public policy, including administrative and regulatory law, government contracting, health care, labor and employment and real estate development. Mr. Fisher served as a Member of the New York City Council from 1991-2001 from Brooklyn. As Chair of the Council's Land Use Subcommittee on Landmarks, Public Siting & Maritime Uses, Mr. Fisher helped shape the landscape of New York and oversaw the approval of hundreds of millions of dollars of public works. Mr. Fisher also chaired the Youth Services Committee of the Council and is credited with creating the New York City Childhood Asthma Initiative. Mr. Fisher received his law degree from the Syracuse University College of Law in 1976 and his Bachelor of Arts from the University of the Pacific in 1973.

Patrick Formato
Membership

Mr. Formato is a partner in the law firm of Abrams, Fensterman, Fensterman & Flowers, as well as the Director of the firm's Health Law Department. Mr. Formato, who earned his law degree at Albany Law School, represents a variety of health care providers, including skilled nursing facilities, diagnostic and treatment centers, home health care agencies, adult homes, and physicians and physicians groups in connection with legal, regulatory, ethical, and transactional matters. He has authored articles published in professional and industry journals and newsletters on issues affecting health care providers and has presented programs to various health care professional organizations on such topics as fraud and abuse, corporate compliance, reimbursement and provider contracting.

James G. Fouassier
Special Committee on Medical Information

James Fouassier is Assistant Attorney General in Charge, Stony Brook University Hospital Unit of the Civil Recoveries Bureau, New York State Department of Law. The Unit represents the Finance Division and Business Offices of University Hospital, State University of New York at Stony Brook, as well as the Business Offices of the Long Island State Veterans Home and the School of Dental Medicine on the Stony Brook campus. Directing a staff of twenty-five employees, Mr. Fouassier is responsible for the overall management of bad debt collections, receivables and the review and appeal of selected claims denials. He serves as legal counsel to University Hospital in the preparation and negotiation of managed care agreements, as well as in the resolution of significant revenue issues between the hospital and major managed care payers. Mr. Fouassier was a recipient of the Attorney General's prestigious Louis J. Lefkowitz Memorial Award, recognizing outstanding service to the Office of the Attorney General and the people of the state of New York. He is a graduate of Saint John's University School of Law, Jamaica, New York.

Karen I. Gallinari
In-House Counsel

Karen L. Illuzzi Gallinari, Esq. is Vice President of Legal Affairs and General Counsel for Staten Island University Hospital (SIUH). Prior to joining SIUH in October 1996, Ms. Gallinari was a litigator with the firm of Anderson Kill Olick & Oshinsky, P.C. where she concentrated on, among other things, representing policyholders in insurance coverage disputes. Ms. Gallinari applied the firm's insurance coverage expertise to patients and medical institutions seeking to secure insurance coverage for state-of-the-art medical treatments. She also organized a national network of attorneys experienced in handling health insurance disputes. Participating attorneys share work-product, to increase their ability to assist patients who cannot afford their medical expenses, let alone legal assistance to obtain the treatment they need. Ms. Gallinari has authored articles on this issue, and has assisted state legislators and attorneys general, both in New York and elsewhere, in their efforts to address proper access to insurance coverage for medically necessary treatments. She has continued her patient advocacy work by serving as the New York State Chairperson for the National Patient Advocate Foundation.

James F. Horan
Membership

James F. Horan has served as an Administrative Law Judge for the New York State Department of Health since 1991. Previously he worked as a Senior Attorney for the Health Department and as Law Assistant to Fulton County Judge Robert P. Best. Currently, he volunteers on Surrogate Decision Making Panels for the New York State Commission on the Quality of Care for the Mentally Disabled. He is the former chair of the Professional Discipline Committee of the NYSBA Health Law Section and serves on the Section's Executive Committee. He also chairs the Administrative Law Judges Subcommittee within the NYSBA Committee on Attorneys in the Public Service. He received his A.B. from the University of Notre Dame and his J.D. from Albany Law School.

Edward S. Kornreich
Health Care Providers

Ed Kornreich is a partner in Proskauer Rose LLP's Health Care Department and serves in the New York City office. Mr. Kornreich has practiced health care law for over twenty years. He represents not-for-profit and for-profit hospitals, academic medical centers, physician groups, physician management companies, HMOs, venture capitalists and health care entrepreneurs in, among other things, regulatory compliance matters, mergers and acquisitions regarding health care entities, managed care contracting, the development of integrated health systems and physician organizations, hospital purchases of physician practices, and joint venture arrangements. Prior to joining Proskauer as a partner in 1990, Mr. Kornreich served as General Counsel of the St. Luke's-Roosevelt Hospital Center, one of the largest teaching hospitals in New York. He frequently writes and lectures on Medicare and Medicaid reimbursement, health care integration, and the application of federal and state anti-kickback and "Stark" laws to health care transactions. Mr. Kornreich, a graduate of Harvard Law School, is a past Chair of the Health Law Committee of the Association of the Bar of the City of New York.

Ross P. Lanzafame
AIDS and the Law

Ross Lanzafame, a partner in the Rochester-based law firm, Harter, Secrest & Emerey, LLP, counsels long-term and acute health care providers and health care professionals with regard to business, corporate and government regulatory matters. He advises clients on federal and state regulations governing facility operation, financing, medical records and data confidentiality, patient accounts management, and reimbursement programs such as Medicare and Medicaid. He prepares and appeals certificate of need applications for hospitals and nursing homes and handles special matters such as AIDS in the health care workplace. Mr. Lanzafame also develops corporate compliance plans and programs for facilities and professionals so as to assure compliance with regulatory and statutory mandates, in particular the fraud, anti-kickback, and "Stark" provisions of federal and state law, and HIPAA compliance. In addition, he focuses on reimbursement issues affecting health care providers: he analyzes provider reimbursement rates, prepares and prosecutes rate appeals and hearings, and defends providers on rate audits. Mr. Lanzafame received his J.D., *cum laude,* from the State University of New York at Buffalo in 1986.

Kenneth R. Larywon
Professional Discipline

Kenneth R. Larywon is a partner of the firm, Martin, Clearwater & Bell**,** focusing on the defense of professional liability cases and health care law matters. For over 16 years, Mr. Larywon has defended physicians and hospitals in claims arising out of the delivery of medical care. He has also represented health care professionals in disciplinary proceedings before the Office of Professional Medical Conduct and the Department of Education, and has extensive experience in counseling and defending hospitals, and in physician and nursing staff credentialing matters. Prior to joining MC&B, Mr. Larywon was an Assistant District Attorney in Bronx County, and has utilized his criminal experience in advising health care clients on matters involving investigations being conducted by both federal and state

prosecutors. Mr. Larywon earned his law degree in 1978 from Notre Dame Law School. He is a 1974 graduate of the College of Santa Fe in New Mexico. Mr. Larywon was an Adjunct Associate Professor of Business Law at Iona College from 1981 to 1991.

Paul F. Macielak
Managed Care

Paul F. Macielak is president and CEO of the New York Health Plan Association (HPA), an Albany-based organization that represents 29 managed care health plans across New York State. Prior to joining HPA, Mr. Macielak was Vice President and Vice Provost for Government, Community and Public Affairs for the New York Presbyterian Hospital and Weill Medical College of Cornell University. Before that, he served as Counsel to the Majority Leader of the New York State Senate (1989-1992) and Chief Counsel to the Assembly Minority Leader (1983-1988). Mr. Macielak is also Vice Chair of the New York State Hospital Review and Planning Council (SHRPC), which is charged with the review and recommendation of establishment applications for new health care entities and applications for facility construction. A graduate of Albany Law School, Mr. Macielak received his undergraduate degree at the University of Rochester.

Vincent F. Maher
Ethical Issues in the Provision of Health Care

Vincent F. Maher was born in Dublin, Ireland, and spent his early years on Long Island. He attended Regis High School in New York City and thereafter attended a variety of colleges, earning a number of degrees and licenses including Nursing, Nurse Anesthesia, International Political Economy and Development, and Law. He also holds a postgraduate certificate in International Comparative Bioethics awarded by Girton College, University of Cambridge, U.K. Mr. Maher has been associated with Gair, Gair, Conason, Steigman and Mackauf since 1985 in the representation of victims of medical negligence. He is a Fellow of the New York Academy of Medicine and serves as Co-chair of the Ethics in the Provision of Health Care Committee of the NYSBA Health Law Section. Mr. Maher, a tenured full professor at Iona College and a Senior Lecturer at New York Medical College, has published over 200 articles in peer-reviewed journals, and has taught law, ethics, management, and health policy throughout the U.S., Europe and Japan.

Anne Maltz
Healthcare Internet

Anne Maltz is a nurse attorney in the Health Law Department of Herrick, Feinstein LLP. Ms. Maltz's practice encompasses representing health care providers with respect to transactional and regulatory matters, with particular emphasis on corporate formation, fraud and abuse, managed care and the HIPAA privacy regulations. Ms. Maltz is the author of numerous articles on health law and is a frequent lecturer before state bar association and health industry groups. Ms. Maltz graduated from Brooklyn Law School. She received her B.S. in Nursing and her M.A. in Nursing Administration from New York University.

Kathryn C. Meyer
Special Committee on Bylaws

Kathryn Meyer is currently Senior Vice President for Legal Affairs at Continuum Health Partners, Inc., New York, the parent corporation of Beth Israel Medical Center, St. Lukes-Roosevelt Hospital Center, Long Island College Hospital and The New York Eye and Ear Infirmary. Ms. Meyer is an Assistant Clinical Professor at Albert Einstein College of Medicine and co-author of *Health Care Law: A Practical Guide*, published by Matthew Bender. She is a former Chairman of the Committee on Health Law of the Association of the Bar of the City of New York and a member of the New York State Task Force on Life and the Law. Ms. Meyer is a graduate of Brown University, summa cum laude, and the Yale Law School.

Charles A. Mele
Health Care Internet

Mr. Mele is Executive Vice President and General Counsel of WebMD Corporation, a leading provider of information, transaction and technology solutions for healthcare entities. Prior to WebMD's mergers with Medical Manager Corporation and CareInsite, Inc., he was General Counsel for Medical Manager and a Director of CareInsite. Mr. Mele was also General Counsel of Medco Containment Services, a leading pharmacy benefit management company, prior to its merger with Merck in 1993. Mr. Mele has a B.S. from New York University College of Business and Public Administration and a J.D. from New York University.

Peter J. Millock
Special Committee on By-Laws

Peter Millock focuses his practice on transactions among health care providers, regulatory matters involving health care mental health and related matters, and legislative lobbying on behalf of health care clients. Between 1980 and 1995, Mr. Millock served as general counsel to the New York State Department of Health. He was the chief legal advisor to the Commissioner of Health, managed the department's litigation and administrative enforcement actions involving nursing homes and hospitals, led the development of the state's policies on medical malpractice reform and conducted

investigations of ethics violations, health fraud, and public health threats. Mr. Millock is a frequent speaker on health care issues. In 1993, he served on the President's Task Force on Health Care Reform as a member of the Legal Audit Team. Mr. Millock is an Associate Professor at the State University of New York at Albany, School of Public Health. He graduated Harvard Law School, *cum laude,* in 1973.

Dale L. Moore
Health Law Journal

Dale L. Moore is the Associate Dean of Academic Affairs and a Professor of Law at Albany Law School. She is serving as the Law School's Interim Dean for the summer of 2002. Dean Moore, who worked as a registered nurse in critical-care units for several years prior to attending law school, has been teaching and writing in the health law area since joining Albany Law School's faculty in 1983. She has an appointment as an adjunct faculty member at Albany Medical College, where she served on the I.R.B. for fourteen years (twelve as its Vice Chair). She regularly teaches a course about legal issues for student registered nurse anesthetists and participates in Albany Medical College's Graduate Medical Education program for its resident physicians. She was the first Editor for the Health Law Section's newsletter (the fledgling forerunner for the current *Journal*).

Steven H. Mosenson
Consumer/Patient Rights

Steven Mosenson is General Counsel to United Cerebral Palsy Associations of New York State, Inc., a network of 25 providers of services to individuals with disabilities and their families throughout New York State, where he advocates for the enhancement of programs and services, and for the expansion of rights of people with disabilities. Mr. Mosenson is former Chair of NYSBA's Committee on Issues Affecting People With Disabilities, and serves as a member of the Executive Committee of the Corporate Counsel Section, and as an elected delegate to the Association's House of Delegates, representing the Ninth Judicial District. He is also a member of the Association of the Bar of the City of New York's committee on Legal Issues Affecting People With Disabilities, and served as co-editor of that committee's recent publication, *Rights of People With Disabilities, 2nd Edition*. Mr. Mosenson served as an Assistant Corporation Counsel in the New York City Law Department from 1985-1989, and currently is on the Adjunct Faculty of New York University's School of Continuing and Professional Education. He received his Master's in Public Administration from New York University (1979), and is a *cum laude* graduate of Benjamin N. Cardozo School of Law of Yeshiva University (1982).

Randye S. Retkin
Consumer/Patient Rights

Randye Retkin is Director of the Medical-Legal Assistance Project at the New York Legal Assistance Group. Prior to starting this Project she served as Director of Legal Services for Gay Men's Health Crisis. She is nationally recognized for her work on building collaborations between professionals working with chronically ill populations, and on helping this population access medical and legal systems. She is the co-author of one of the first significant articles addressing collaborative care for chronically ill populations (*Attorneys and Social Workers Collaborating in HIV Care: Breaking New Ground,* Fordham Urban Law Journal, Vol. XXIV, Number 3, 1997). She is one of the drafters of New York's Standby Guardianship Law and is a founder of the New York Immigration Coalition.

Douglas R. Sansted
Biotechnology and the Law

Douglas Sansted is an associate at Kalkines, Arky, Zall & Bernstein LLP. Mr. Sansted practices corporate law with an emphasis on entities in the health care and biotechnology sectors. In his health care practice, Mr. Sansted represents providers and payors in transactional and regulatory matters. In his biotechnology practice, Mr. Sansted primarily represents early-stage companies on a wide range of matters, including formation, financing and intellectual property licensing. Mr. Sansted is a graduate of Hunter College and New York University School of Law.

J. David Seay
Special Committee on Mental Health Issues

J. David Seay is Executive Director of the National Alliance for the Mentally Ill of New York State, a 20-year-old statewide grassroots mental health support, education and advocacy organization. NAMI-NYS has 56 affiliate organizations around the state with more than 5,000 families as members, and is part of a nationwide movement with nearly 250,000 families. The mission of NAMI is to eradicate the brain diseases referred to as mental illness and, until then, to improve the quality of life for all those affected by mental illnesses. Prior to joining NAMI-NYS in 2001, Mr. Seay had been an attorney in private practice; Vice President, Secretary and General Counsel of the United Hospital Fund of New York; a senior executive with a major national health insurer and professional staff for the Executive Office of the President in Washington, D.C. He has taught health law at various law and graduate schools, served on the boards of directors of numerous local, state and national nonprofit organizations and has published over thirty books and articles, including *Mission Matters* and *In Sickness and in Health: The Mission of Vol-*

untary Health Care Organizations. Mr. Seay received his B.A. degree from Oklahoma City University and his law degree from the Catholic University of America in Washington, D.C.

Francis J. Serbaroli
Nominating

Francis Serbaroli, a partner in the New York City office of Cadwalader, Wickersham and Taft, has many years of experience in the field of health care law. Following three years as an Assistant Attorney General of the State of New York, Mr. Serbaroli served from 1980 to 1985 as Vice President and General Counsel of Our Lady of Mercy Medical Center in New York City, a major teaching hospital affiliated with New York Medical College. From 1985-1986, he served in a dual capacity as Deputy County Attorney of Westchester County and General Counsel to The Westchester County Medical Center in Valhalla, New York. At Cadwalder, Mr. Serbaroli's clients have included numerous teaching and community hospitals, ambulatory care centers and clinics; clinical laboratories; home health agencies; imaging service providers; individual physicians and group practices; and numerous other health care-related entities, as well as health insurers and managed care organizations. In 1995, Mr. Serbaroli served as a member of Governor George Pataki's Ad Hoc Task Force on New York's Prospective Hospital Reimbursement Methodology (NYPHRM), which issued a major report recommending deregulation. In addition to writing a regular Health Law column for the *New York Law Journal*, Mr. Serbaroli teaches and lectures on health care topics. Mr. Serbaroli is a graduate of the Fordham University School of Law.

Robert N. Swidler
Health Law Journal

Robert Swidler is General Counsel and Vice President for Legal Affairs for Northeast Health, a health care system in New York's Capital Region that includes Albany Memorial Hospital, Samaritan Hospital, several primary centers and "The Eddy"—a network of nursing homes, home care, and independent and assisted living residences. Prior to joining Northeast Health in 1998, Mr. Swidler was partner of Hiscock & Barclay, LLP (1995-98); Deputy Commissioner and Counsel to the New York State Office of Mental Health (1992-95), Assistant Counsel to Governor Cuomo (1990-92), Staff Counsel to the New York State Task Force on Life and the Law (1985-90), an associate of Webster & Sheffield (1984-85) and Law Clerk to U.S. District Judge Neal P. McCurn (1982-84). Mr. Swidler is the author of numerous articles on health law topics and was Chair of the Health Law Section in 1999-2000. He is a graduate of Columbia Law School (J.D. '82), SUNY-Binghamton (M.A. '78, B.A. '77) and Stuyvesant High School.

Sally T. True
Biotechnology and the Law

Sally True is a partner in the Ithaca law firm, True, Walsh & Miller. Ms. True's practice focuses on health law, as well as corporate and trusts and estates. She serves as counsel for and sits on the Board of Directors of several not-for-profit corporations in the health care industry. She serves as a panelist on symposia on health care law and other issues, and lectures at Cornell University on health law and throughout New York State on health care topics. She is a member of the Tompkins County, New York State and American bar associations, the National Health Lawyers Association, and the American Academy of Hospital Attorneys. Ms. True is also a current member of the New York State Task Force on Life and the Law.

Joseph V. Willey
Health Care Finance

Joseph V. Willey is a partner in the Health Care Department of Katten Muchin Zavis Rosenman. He concentrates his practice in health care and health care litigation. Mr. Willey has extensive experience in a wide range of health care matters, including Medicare and Medicaid reimbursement, audits, and federal and state frauds and abuse laws. He advises hospitals and other providers on compliance with federal anti-kickback and physician self-referral laws, and represents providers in investigations and litigation under the False Claims Act. Prior to joining the firm, Mr. Willey was Assistant Regional Counsel for the U.S. Department of Health and Human Services. Mr. Willey earned his undergraduate degree (B.A., 1976) from the University of Kansas and his law degree (J.D., 1980) from the University of Kansas School of Law.

Other Executive Committee Members

Robert Abrams
Immediate Past Chair

Robert Abrams, the immediate-past chair of the Health Law Section, is an executive member of the law firm of Abrams, Fensterman, Fensterman, Flowers & Eisman, LLP located in Lake Success, New York. The law firm provides services to well over 100 healthcare providers and physicians throughout New York State. Bob is Co-Editor for the *Legal Manual for Physicians,* a joint publication of NYSBA and the Medical Society of the State of New York. He was Editor-in-Chief of *Guardianship Practice*, a 1,712-page treatise, and is co-author of *Boomer Basics*. In 1995, Bob was selected by former New York

State Governor Mario Cuomo to serve as a New York State delegate to the White House Conference on Aging (WHCOA). In addition to his law degree, which he received as an evening division student at New York Law School, Bob earned a Master's Degree in Public Administration from New York University. He is also a New York State licensed nursing home administrator.

Stephanie L. Davis
Web Site Coordinator

Stephanie L. Davis is currently pursuing her J.D. with a concentration in Health Care Law from Seton Hall University where she serves as Vice President of the Health Law Forum. She most recently completed a summer clerkship with the health law department of Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone in Roseland, New Jersey. Prior to returning to law school, Ms. Davis served as the Corporate Compliance Officer for Mountain States Healthcare Alliance in Johnson City, Tennessee, an integrated health delivery system serving Tennessee, Virginia, Kentucky, and North Carolina. Ms. Davis is a Certified Internal Auditor and has worked as a hospital internal auditor as well as serving as an auditor for the public accounting firm of Rodefer Moss & Co. in Greeneville, Tennessee.

Catherine A. Gursky

Catherine A. Gursky, R.N., J.D. is Associate General Counsel for NewYork-Presbyterian Hospital (NYPH) where she represents and advises the hospital on a variety of issues including credentialing, quality assurance and peer-review matters, disciplinary proceedings, regulatory issues, JCAHO compliance, and patient-related issues. Prior to NYPH, Ms. Gursky was an attorney for the New York City Health and Hospitals Corporation. In addition to her vast health law experience, Ms. Gursky is also a registered nurse. Ms. Gursky is a member of the American Bar Association, the American Health Lawyers Association and NYSBA's Health Law Section. She frequently lectures and has published a newsletter and articles on a variety of health law issues. Ms. Gursky received her J.D. in 1991 from Touro College Jacob D. Fuchsberg Law Center and her B.S.N. from Adelphi University in 1988, where she graduated *magna cum laude*.

Nancy H. Halleck
Liaison

Nancy H. Halleck is an attorney with the New York State Department of Education, where she handles a broad range of legal and regulatory matters. Prior to that, Ms. Halleck had been an attorney for the New York State Office of Mental Health. Ms. Halleck has her B.A. from the University of Wisconsin-Madison, and her J.D. from Duke University.

Tracy E. Miller
Former Chair

Tracy Miller is General Counsel and Senior Vice President of the Catholic Health Care System (CHCS), a health care system comprised of five hospitals and seven nursing homes in the Archdiocese of New York. Prior to joining CHCS, Ms. Miller served as Vice President for Quality and Regulatory Affairs at the Greater New York Hospital Association. At Greater New York, Ms. Miller conducted advocacy, analysis, and programs on key health care issues, including health care quality, human subjects research and medicine online. From 1999-2000, Ms. Miller was a member of the faculty of the Mount Sinai School of Medicine and Project Director of the National Quality Forum Planning Committee, a group of national leaders in health care delivery and quality convened by Vice President Gore to build a new national organization to set standards for quality measurement and improvement. Ms. Miller also served as the founding Executive Director of the New York State Task Force on Life and the Law. In that capacity, she developed law and policy on issues raised by medical advances, including New York's health care proxy law, the do-not-resuscitate law, and the law on procurement and distribution of organs for transplantation. Ms. Miller is the former Chair of the Health Law Section, and the former Chair of the Section's Committee on Ethical Issues in the Delivery of Health Care. She graduated from Brown University and Harvard Law School.

Claudia O. Torrey
Member-at-Large

Claudia O. Torrey is a member of the New York State Bar Association (NYSBA), the American Bar Association, and the American Health Lawyers Association. As a member of NYSBA's Health Law Section, Ms. Torrey has authored a column, entitled *For Your Information*, since the birth of the Section in 1996. Also, Ms. Torrey chaired a year-long health information study group project for the Section from Spring 1998-Spring 1999. The project report, *Who Needs to Know?—The Search for a Balance Between Health Information Privacy and Confidentiality*, was sent to selected members of Congress, and spawned a Section Special Committee on Medical Information. Her efforts have been recognized by the American Health Lawyers Association and the National Reference Center for Bioethics Literature of the Georgetown University Kennedy Institute of Ethics.

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.

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