NYSBA WINTER 2003 | VOL. 8 | NO. 1

Health Law Journal

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

Published in cooperation with Albany Law School

Inside

NYSBA

HEALTH LAW JOURNAL

WINTER 2003

Vol. 8, No. 1

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

in cooperation with

ALBANY LAW SCHOOL

A Message from the Section Chair

Implementing the Agenda for the Future

I am pleased to both present my second written report to the membership and introduce yet another stellar issue of the *Health Law Journal*. The format of the *Journal* alternates between topic-specific editions and non-topic specific issues. This edition of the *Journal* covers a broad range of topics. The *Journal* under the superb direction of Robert Swidler and Professor Dale Moore continues to be timely, topical and practical for practitioners of health law. Additionally, the Section is now providing a limited number of complimentary subscriptions of the *Health Law Journal* to key legal professionals and policy-makers within the state.

I am delighted again to report that the state of the Section is good. The Section continues to remain in the black financially, while embarking on many new initiatives. As you may recall, in the previous edition of the *Journal* I announced a very ambitious agenda for the Section for this Association year. The agenda established nine tangible goals to challenge the Executive Committee and the Section for this year. The following are the goals which I have charted for the Section:

1. **Enhancing committee activity**
2. **Expanding membership involvement**
3. **Increasing visibility with the New York State Legislature**
4. **Focusing on one or more consumer/patient projects**
5. **Increasing the membership (Target 1,200 members)**
6. **Building upon the relationship with the state's Medical Society**
7. **Maintaining the high quality of the Section's *Journal***
8. **Maintaining the high quality of the Section's programs and MCLE programs**
9. **Improving the Section's Web site**

In this communication to the membership, I would like to review some of the steps taken by the Executive Committee to implement these goals, as well as some planned actions for fulfilling the Section's objectives.

Report on Recent and Ongoing Section Activities

Through various efforts of the Membership Committee and the Membership Department of the Association, the Section now has over 1,100 members, representing a growth of approximately 100 members in a little over three months. The Section held a very successful fall program at the Harvard Club on enforcing health care laws, featuring prosecutors from the offices of the United States Attorneys for the Southern and Eastern Districts. The highlight of the meeting was the luncheon address by James Coomey, the United States Attorney for the Southern District. There were approximately 120 attendees for this program. Based upon the feedback from the event, the program was well-received by the audience. Special thanks go to both Thomas D'Antonio, Chair of the Section's Fraud, Abuse and Compliance Committee, and Robert Borsody for conceiving, developing and organizing this seminar. The Section also owes its gratitude to the Association's Meeting's Department for its diligent efforts in advertising the meeting.

"I am delighted again to report that the state of the Section is good. The Section continues to remain in the black financially, while embarking on many new initiatives."

On October 10th, the Executive Committee of the Section hosted a cocktail reception for law school professors who teach health law within the metropolitan area. The reception was held in the elegant offices of Cadwalader, Wickersham & Taft in lower Manhattan. This event provided a comfortable social environment for the members of the Executive Committee and health law academia to meet and establish connections for future Health Law Section projects with the law school health law programs. In addition to providing the refined backdrop for this occasion, Cadwalader financially co-sponsored the cost of this reception. The Section is grateful to Cadwalader and Francis Serbaroli for its support.

On October 19th, several members of the Executive Committee and I went to the state capitol to participate in the Section's first "Lobbying Day." Section officers James Lytle, Phil Rosenberg, Lynn Stansel and I individually met with representatives from the Governor's Office, the Speaker's Office, the Offices of the respective Chairs of the Senate and Assembly Health Committees and the New York State Department of Health. At the various meetings we offered the Section's technical assistance in reviewing proposed legislation. The Section's leadership was well-received at each of the meetings, and the occasion presented an opportunity both to build upon the Section's fine reputation with officials within the state government and to enhance the Section's visibility in Albany.

On November 1st, an application for a grant from the New York Bar Foundation was filed on behalf of the Health Law Section. The grant requests that the Bar Foundation partially fund the development and distribution of a twelve- to fifteen-minute videotape for health care consumers on the importance of creating a health care proxy. This project is being spearheaded by Douglas Sansted, Co-Chair of Biotechnology and the Law Committee; Kathleen Burke, Co-Chair of Ethical Issues in the Provision of Health Care Committee; and me. The Radio Drama Network Foundation and its Board Chair Himan Brown are committed to provide technical and financial support for this noble project. The project is seeking a well-recognized and respected individual to introduce the video, as well as additional organizations to provide financial and technical support for this undertaking. Interest in the video has been expressed by both the respective Chairs of the Trusts and Estates Law Section and the Elder Law Section of the Association. Preliminary interest in the project has also been expressed by Edwin Mendez-Santiago, Commissioner of the New York City Department for the Aging.

The Section is in the process of finalizing a white paper on New York State's physician disciplinary process. In recognition of the diverse perspectives within the Section on this issue, the paper will not represent the unanimous position of all the members of the Section. However, through the herculean efforts of Mark Barnes, Karen Gallinari, Lynn Stansel and others within the Section, this paper will present a thought-provoking and considered exposition on the state's process, which seeks to balance the collective societal interests with the due process concerns of the individual subject physicians.

The Section's Web site is a continuing work-in-progress. Through the leadership of Section Vice-Chair Philip Rosenberg working with our Association liaison Lisa Bataille, Section Web site Director Stephanie Davis and Association Webmaster Barbara Beauchamp, the Section's Web site has pioneered some innovative enhancements. The enhancements include the following: the creation of a job posting site for members of the Section, a link to our listserve for Section members, a monthly listing of meetings of committees of the Section, and a photo gallery of Section events.

The Section has now established the "Barry A. Gold Memorial Student Health Law Writing Competition," an annual competition named for the founding Chair of the Health Law Section, who recently passed away. There will be a first prize of $1,000, and a second prize of $500; further details are available on the Section's Web site at www.nysba.org/health. The prizes were generously funded by Manatt, Phelps & Phillips—the firm which has merged with Kalkines, Arky, Zall and Bernstein, LLP, and I would like to express here the Section's gratitude to that firm.

"The Section's leadership was well-received at ['Lobbying Day'], and the occasion presented an opportunity both to build upon the Section's fine reputation with officials within the state government and to enhance the Section's visibility in Albany."

Report on Planned Section Activities

In January, as is the custom, the Section will hold a full-day MCLE accredited program on health law on Wednesday, January 22, 2003 at the Association's Annual Meeting. This year's program is co-chaired by Edward Kornreich and David Seay. The first part of the program will focus on not-for-profit health care delivery systems, their mission, structure and function. The second part of the program will cover topical issues in mental health. This component of the program will discuss updates in Kendra's Law, developments in the adult home issue and other important areas of mental health law. I urge you also to attend our Section's luncheon in which Donald P. Berens Jr., General Counsel for the New York State Department of Health, will offer some brief remarks to the Section. Additionally, we plan to have a few surprises at this luncheon.

Also at the time of the Association's Annual Meeting, the Section's first major publication, the *Legal Manual for New York Physicians*, will be available. This publication is the brainchild of the Section's past Chair, Robert Abrams. This 500-page book is a comprehensive but brief review of the laws affecting physicians in New York State. It is a must-purchase publication for all

physicians who practice in New York and their lawyers. This book is the product of a collaborative effort between the Health Law Section and the Medical Society of the State of New York. Donald Moy, a member of the Health Law Section and General Counsel for the Medical Society, was instrumental in orchestrating this joint project. The distinguished authors of this book are members of the Section who willingly gave countless hours of time in authoring and editing this book as a service to the Section. This book will be offered at a discount for members of the Section. This issue of the *Journal* contains a notice with more information about this valuable publication and how to obtain copies. The Section is indebted to Bob Abrams, Don Moy and all the authors and editors from the Section and the Medical Society.

In the springtime, the Section is planning to sponsor a program, in collaboration with the Association's Committee on Continuing Legal Education, with the working title of "An Introduction to Health Law." Also the Section is scheduling a Spring Meeting which will focus on professional discipline.

As you can see from this report, the Section is very active. As Chair, I am personally proud of my colleagues who serve as Section officers, chairs, co-chairs, members-at-large and liaisons. Their dedication and hard work is taking this Section to higher levels, and making my tenure as Chair particularly rewarding.

"As Chair, I am personally proud of my colleagues who serve as Section officers, chairs, co-chairs, members-at-large and liaisons. Their dedication and hard work is taking this Section to higher levels, and making my tenure as Chair particularly rewarding."

In closing, I wish to sadly acknowledge the passing of Barry Gold, the Section's founding father and first Chair. Barry was a great lawyer, a superb leader, a charitable individual and a good friend. He was very generous with both his time and his personal resources. He epitomized all that is the best about the lawyers who practice within the health law bar. Barry will be sorely missed by all of us, and we hope to honor his memory by continuing the good work he started when he founded this Section.

Salvatore J. Russo

In the New York State Courts

By Leonard Rosenberg

Court of Appeals Rules that Grand Jury Subpoena Does Not Overcome Doctor-Patient Privilege

In Re Grand Jury Investigation in New York County New York City Health & Hospitals Corp., 2002 WL 31303320, __ N.Y.2d __ (Oct. 15, 2002). The Court of Appeals recently reaffirmed the broad scope of the physician-patient privilege and quashed subpoenas which had been issued by the District Attorney's office and served on numerous New York hospitals in an endeavor to identify a criminal assailant in a two-and-a-half-year-old murder investigation.

In an attempt to identify a suspect who was believed to have suffered stab wounds during a deadly assault, the District Attorney of New York County served grand jury subpoenas on 23 local hospitals, including four operated by the New York City Health and Hospitals Corporation (HHC). The subpoenas ordered the production of hospital records pertaining to all males who met the physical description of the assailant who had sought or received treatment for puncture or slash wounds which were "plainly observable to a lay person without expert or professional knowledge" over a specified two-day period.

HHC invoked the physician-patient privilege and moved to quash the subpoenas, arguing that the nature and causes of patient injuries necessarily required the application of the professional skills, knowledge and medical expertise of its physicians. HHC thus argued that the subpoenas violated the physician-patient privilege codified under CPLR 4504(a), which, absent waiver, precludes disclosure of "information

. . . acquired in attending a patient in a professional capacity, and which was necessary to enable [the treating professional] to act in that capacity." After the trial court denied HHC's application to quash and ordered an *in camera* inspection, the Appellate Division reversed, concluding that the subpoenas implicated "an inherently medical evaluation."

The District Attorney obtained leave to appeal and presented the issue to the Court of Appeals. The Court rejected the contention that because the subpoenas expressly referred to injuries "plainly observable to a lay person," they fell outside the scope of the physician-patient privilege. The Court concluded that it would be untenable to require hospitals to review all of their records to ascertain "whether particular injuries and their causes would have been obvious to a layperson" and to subject them to "contempt proceedings merely because they cannot distinguish the indistinguishable."

Discussing the significant policy objectives underlying the statute, the Court determined that CPLR 4504(a) must be construed broadly in order to encourage treatment, to facilitate the exchange of vital medical information between medical staff and patients, and to safeguard patients' privacy expectations. Because the grand jury subpoenas sought the disclosure of records which called for a "medical determination as to causation 'through the application of professional skill or knowledge'" the Court determined that they implicated the precise "intrusion into the physician-patient relationship that CPLR 4504(a) seeks to prevent." Noting that none of the numerous statutory exceptions to the privilege—including disclosure of communicable diseases, suspected child abuse, bullet wounds and life-threatening stab wounds—applied, the Court of Appeals held that the records sought by the District Attorney fell within the scope of the physician-patient privilege. Accordingly, the Court directed that the subpoenas be quashed.

Hospital's Failure to Supply Second Interpreter Does Not Violate ADA

Alvarez v. New York City Health & Hospitals Corp., 2002 WL 1585637 (S.D.N.Y., July 2002). The U.S. District Court for the Southern District of New York recently determined that a hospital's failure to provide a hearing-impaired patient with a second sign language interpreter, after the patient rejected the first interpreter provided by the hospital, did not violate federal disability discrimination law because the patient could not establish that the hospital was "deliberately indifferent" to his legal right to obtain a sign language interpreter.

The case arose when a hearing-impaired person arrived one evening in the emergency room of a municipal hospital seeking treatment for a neck infection. Because the patient had regularly sought medical treatment at the hospital's emergency room over the past five years, he was familiar with the hospital's policies and procedures for obtaining sign language interpreters. These policies and procedures required that requests for sign language inter-

preters during regular business hours be made to the hospital's patient relations department and that requests at other times be made to the hospital's nursing office.

The patient alleged that, upon arrival at the emergency room, he attempted to call the patient relations department to request an interpreter, but the department's office was closed. Although it was after regular business hours, the patient did not call the nursing office, but instead started communicating with the hospital staff through written notes. Two days later, the patient asked the patient relations department, in writing, for an interpreter. The next day, the hospital provided an interpreter, which the patient rejected because he contended that the interpreter was not certified. Although the patient had used this same interpreter in the past for regular doctor visits, he "did not think [the interpreter] would work for the 'emergency' situation." The patient never requested another interpreter and the hospital did not provide one.

After his discharge, the patient sued the hospital for allegedly committing disability discrimination in violation of the federal Americans with Disabilities Act and the federal Rehabilitation Act. The court granted the hospital's motion for summary dismissal of the lawsuit, finding that "no reasonable juror could find that [the Hospital] deliberately discriminated against [the Patient] based on his disability."

The court noted that in order for the patient to establish disability discrimination under the circumstances of this case, he had to present facts demonstrating that the hospital was deliberately indifferent to his right to obtain an interpreter. The court found that the patient could not make this showing because it was undisputed that the hospital had policies and procedures in place governing the provision of sign language interpreters, which the patient was aware of, but inexplicably did not follow. The court further noted that the hospital provided him with an interpreter within one day of his first request under the policy, which interpreter the patient rejected, even though he had used the same interpreter in the past.

Second Circuit Holds that a Physician Whose Privileges Were Revoked Based on Allegations of Sexual Harassment Can File a Federal Lawsuit Without First Filing a Complaint with the Public Health Council

Tassy v. Brunswick Hospital Center, Inc., 296 F.3d 65 (2d Cir. 2002). A psychiatrist whose hospital privileges were revoked following accusations of sexual harassment brought an action alleging discrimination on account of race and national origin. Defendant Brunswick Hospital Center, Inc. (the "Hospital") moved to dismiss the complaint, arguing that the doctrine of primary jurisdiction required the physician to pursue his claims with the New York Public Health Council (PHC) before suing in federal court. The PHC, a fifteen-member body within the New York State Department of Health, is responsible by statute (Public Health Law § 2801-b) to determine whether there is medical justification for the withdrawal of a physician's privileges.

The United States District Court for the Eastern District of New York agreed with the Hospital, and dismissed the complaint. A majority of a three-judge panel of the Second Circuit Court of Appeals reversed, holding that the doctrine of primary jurisdiction, on which the District Court had relied, did not apply in this case.

The court noted that the doctrine of primary jurisdiction is a judge-made doctrine that serves two major functions. The first is uniformity in administrative agency rulings. The second is to allow the courts to defer to and rely upon the administrative agency's expertise in a particular area, where the court may lack the requisite factual knowledge. Generally, the doctrine requires that, where an administrative agency has been endowed with rule-making powers, certain complaints must be brought before the administrative agency before a lawsuit can be initiated in court. In this case, the court noted that "in determining whether to apply the primary jurisdiction doctrine, we must examine whether doing so would serve either of these [two primary] purposes."

The court found that the doctrine would not promote uniformity in this case, as the concern for consistency "is more prevalent in cases involving issues of broad applicability such as the reasonableness of rates or tariffs." Instead, this case was held to present a unique and narrow factual dispute that posed no risk of inconsistent interpretation of any broadly applicable rule or policy of the PHC.

The court next looked to whether deference to the PHC was necessary to promote "the resolution of technical questions of fact through the agency's specialized expertise." The physician argued in the court below that, as he was suspended for reasons unrelated to medical issues, there were no technical questions to address, and the PHC had no particular expertise. The Hospital had argued that the physician's suspension was based upon his character, and the PHC has the expertise to determine whether the physician's character rendered him unfit to practice medicine.

The Second Circuit held that its prior holding in *Johnson v. Nyack Hospital*, 964 F.2d 116 (2d Cir. 1992), upon which the Hospital had relied, is inapplicable to this case. In *Johnson*, the physician was suspended because his performance as a sur-

geon allegedly imperiled the hospital's patients, and the Second Circuit had held that the physician must file his complaint with the PHC before proceeding to federal court. In *Tassy*, the court held that PHC review was not required because the case did not involve allegations of technical incompetence, inadequate patient care, or implicate any medical data or complex records. In the court's view, because the primary factual issue was whether the physician committed the alleged sexual harassment, and the PHC has no expertise in determining whether the a physician committed sexual harassment, PHC review would be of no benefit.

In a strong dissent, Judge Walker argued that the PHC should have been required to hear the case first because the physician had claimed that he had been treated differently than similarly situated Caucasian physicians at the Hospital. The dissent noted that the PHC could likely shed light on such questions as whether the Hospital might have a legitimate, non-discriminatory reason for acting more vigorously against a psychiatrist accused of abusive conduct, because of the vulnerable nature of psychiatric patients, as opposed to similar allegations of misconduct against a pathologist or a surgeon.

The dissent also argued that the court had overlooked a third reason for invoking the primary jurisdiction doctrine—judicial economy. It noted that, while the Supreme Court has not yet relied on this factor, the Second Circuit has. Judicial economy would be served by allowing the PHC to attempt to mediate the dispute prior to the commencement of litigation, and a PHC proceeding may "avoid the unpleasant task of besmirching a physician's reputation by using its professional expertise to identify and discourage groundless claims, and to mediate and to conciliate disputes between health care professionals."

Appellate Court Upholds Commissioner of Health's Moratorium on Granting Applications for New Nursing Home Construction

Sheffield Towers Rehabilitation and Health Care Center v. Novello, 293 A.D.2d 182, 741 N.Y.S.2d 103 (2d Dep't 2002). In an action seeking a judgment declaring unconstitutional a moratorium on the approval of applications for new nursing home construction, the plaintiffs sought a preliminary injunction enjoining the Public Health Council (the "Council") and the Commissioner of Health (the "Commissioner") from enforcing the moratorium against their application, so that work could commence on their nursing home project. The Public Health Law requires that applications for the construction of all new nursing homes in the state of New York be approved by the Council and the Commissioner only after a determination that there is a "need" for the proposed new facility. The moratorium was issued by the Department of Health (DOH) after it concluded that new standards for determining the "need" for new nursing homes throughout the state were urgently needed.

The DOH's determination was based upon a 1997 report to the Council (the "Report") that cited various factors pointing to a potential future surplus of nursing home facilities in the state, which the DOH found not to be in the state's interest. Prior to the issuance of the moratorium, the plaintiffs' application had received "conditional approval" from both the Council and the Commissioner, but plaintiffs had not satisfied all of the nine contingencies necessary for final approval set forth by the Council and the Commissioner. Since construction of plaintiffs' project had not commenced at the time it was issued, the DOH advised the plaintiffs that their application was subject to the moratorium. The plaintiffs' motion for a preliminary injunction was granted by the Supreme Court.

The Appellate Division reversed, holding that the plaintiffs had failed to make a *prima facie* showing that the Council and the Commissioner "violated or threatened to violate" the Public Health Law by issuing the moratorium and applying the same to the plaintiffs' application. Accordingly, the court found that the plaintiffs failed to demonstrate a "likelihood of success on the merits" of their underlying claims, which is a critical element necessary to obtain injunctive relief. In making this determination, the Appellate Division noted that the Public Health Law prevents both the Council and the Commissioner from approving an application for the construction of a new nursing home "unless [they] are satisfied . . . as to the public need for the existence of the institution at the time and place and under the circumstances proposed." Under this statutory mandate, the court held that, based upon the "uncertainty regarding anticipated demand for nursing home beds" generated by the Report, the DOH and the defendants properly exercised their discretion in issuing the moratorium in "order to study public need" for new facilities. The court thus determined that the moratorium was "imposed for a valid and reasonable purpose in keeping with the agencies' responsibilities" under the Public Health Law, and not in violation of that statute as the plaintiffs argued.

The Appellate Division also rejected the plaintiffs' claim that "conditional approval" of their application prior to the issuance of the moratorium was "tantamount to final approval" of the application. Noting that the defendants had the power to "re-evaluate" their "initial determination of public need" with respect to facilities that had not "received final approval," the court found that the plaintiffs' application

was still "pending and subject to the moratorium" at the time the moratorium was issued.

Court Determines that Order Authorizing Medication of Involuntarily Committed Patient Extends to Designee Facility

Mental Hygiene Legal Service, on behalf of Christine D. v. Bennett, 297 A.D.2d 308, 746 N.Y.S.2d 308 (2d Dep't 2002). Plaintiff, who had been admitted to a non-secure state psychiatric facility and, it had been determined, lacked the capacity to determine her own treatment, was subject to a court order which authorized the facility to administer anti-psychotic drugs. After she was transferred to a secure facility, she refused to take her medication and sought a judicial declaration that the order violated her statutory, common law and constitutional rights.

Citing *Rivers v. Katz*, the Appellate Division, Second Department acknowledged that although the due process clause of the state Constitution protects patients' rights to determine their own medical treatment, "the right to reject treatment with antipsychotic medication is not absolute and under certain circumstances may have to yield to compelling state interests."[1] Under the circumstances, the court found that "in the limited circumstances where an involuntarily-committed patient is transferred from a nonsecure state psychiatric facility, an order authorizing the nonsecure facility to medicate the patient over her objection implicitly extends to the secure facility as its designee."[2] The Appellate Division affirmed the Supreme Court's determination but noted that the lower court should have entered a declaratory judgment in favor of the defendants, rather than an order dismissing the complaint.[3]

Although the plaintiff had been returned to the nonsecure facility during the pendency of the action, the Appellate Division found that issue was nonetheless subject to judicial review. The court noted that because "the legal issues presented in this case are substantial and novel, likely to be repeated, and will typically evade review because of the limited duration of the patient's hospitalization at a secure State facility," the mootness doctrine did not apply.

U.S. District Court Lacked Subject Matter Jurisdiction over False Claims Act *Qui Tam* Suit that Was Based Upon "Publicly Disclosed" Information and Where Relator Was Not the "Original Source" of the Publicly Disclosed Information

U.S. ex rel. Woods v. Empire Blue Cross & Blue Shield, No. 99 Civ. 4968, 2002 WL 1905899 (S.D.N.Y. 2002). The relator brought an action under the *qui tam* provisions of the False Claim Act (FCA), which permit private citizens to prosecute civil actions on behalf of the federal government to recover damages and penalties on account of false claims made by the defendant. Under the *qui tam* provisions, the relator is entitled to a percentage of any monies recovered in the suit. In this case, the relator alleged that Empire Blue Cross & Blue Shield ("Empire") violated the FCA by making illegal Medicare payments to ambulance companies that were using unauthorized renal facilities and then seeking reimbursement from the federal government, and by failing to employ "certifying officers" and "disbursement officers," as required by its contract with the Medicare program. At his deposition, the relator, who had years ago owned and operated an ambulance company, freely acknowledged that he became aware of the transactions that provided the basis for the *qui tam* action, by watching a television program on ambulance fraud in New York. He further conceded that he had read a newspaper article that described an audit performed by Empire, which resulted in Empire seeking reimbursement of millions of dollars erroneously paid to several ambulance companies involving transports to renal facilities over a four period. Armed with this knowledge, the relator also gathered information through a Freedom of Information Act request to Empire and reviewed the court files of two pending Medicare fraud and abuse cases.

Empire moved for summary judgment dismissing the suit on the grounds that the U.S. District Court lacked subject-matter jurisdiction because the *qui tam* suit was based upon "publicly disclosed information" and the relator was not an "original source" of the information upon which the suit was based. In granting Empire's motion, the court noted that the FCA specifically provides that "[n]o court shall have jurisdiction over an action under this section based upon public disclosure of allegations or transactions . . ." and that the purpose of this "public disclosure" bar was to prevent "parasitic lawsuits" by *qui tam* relators seeking remuneration without contributing to the "exposure of the fraud." In determining whether the allegations or transactions in this instance were "publicly disclosed" within the meaning of the FCA, the court adopted an analysis employed by the D.C. Circuit Court, which focuses on whether the amount and quality of the publicly disclosed information is sufficient for an average "reader or listener" to conclude that fraud has been committed. The court determined that the television program viewed by the relator had indeed been the "impetus for the lawsuit" and that the relator had relied on information from the public court files to craft the allegations in his *qui tam* action. In the court's view, this was sufficient for the relator to conclude or infer that fraud had been committed by Empire. Thus, court held that the suit was based upon "publicly disclosed information."

With respect to the second prong of Empire's motion, the court held that the FCA's provision that a relator be an "original source" of information upon which a *qui tam* suit is premised is also a jurisdictional requisite. The court determined that a relator qualifies as an "original source" under the statute only where he has: (i) direct and independent knowledge of the information on which the allegations are based; (ii) voluntarily provided such information to the government prior to filing suit: or (iii) directly or indirectly been a source to the entity that publicly disclosed the information on which the suit is based. In this respect, the court noted that the relator had "no direct or independent knowledge of Empire's method of reporting claims"; did not assert that he "learned specific information about Empire's fraud while . . . working in the health care industry"; "was not the source of the television program or the newspaper article"; and was not involved in the court cases from which he gleaned information. Accordingly, the court concluded that the relator did not come under any of the definitions of an "original source" and that the suit should be dismissed for want of jurisdiction.

Court Upholds Preliminary Injunction Enjoining Criminal Prosecution and Enforcement of Medicaid Reimbursement Regulation, Pending Determination of Challenge to Constitutionality of Regulation

Ulster Home Care, Inc. v. Vacco, 296 A.D.2d 671, 746 N.Y.S.2d 64 (3d Dep't 2002). As a result of an audit, the New York State Attorney General's Medicaid Fraud Unit determined that a nursing home had billed for Medicaid services in excess of the rates charged to the "general public," pursuant to 18 N.Y.C.R.R. § 505.14(h)(7)(ii)(a)(1). Faced with the prospect of criminal prosecution, the nursing home and two of its executives commenced a declaratory judgment action, alleging that the regulation was unconstitutionally vague and seeking to preliminarily enjoin the prosecution and administrative enforcement of the regulation during the pendency of the action. The Supreme Court granted the preliminary injunction and the Appellate Division, Third Department affirmed the grant of such interim relief. Because the defendant did not advance its appeal, the preliminary injunction remained in effect.

The nursing home subsequently moved for summary judgment, seeking a permanent injunction and a declaration that the regulation was unconstitutional. When the Supreme Court denied its motion, the nursing home appealed. The Appellate Division reversed the lower court, granted the motion "and declared the regulation unconstitutional on its face." The Court of Appeals reversed and remitted, finding that the appellate court had erred in not requiring the plaintiffs "to show that the regulation was unconstitutional as applied to them."

Once again before the trial court, the defendant successfully moved to vacate the preliminary injunction. The Appellate Division found that the Supreme Court erred because, notwithstanding the Court of Appeals' discussion of the merits, the only relevant factor upon which the Supreme Court had granted the preliminary injunction was irreparable harm. Consequently, because neither the Supreme Court nor the Appellate Division had initially considered the likelihood of success on the merits in granting and affirming preliminary injunctive relief, there was no basis for the Supreme Court to depart from its prior order.

In reaching its determination, however, the Appellate Division rejected the plaintiffs' strict construction of the law of the case doctrine and noted that the doctrine "is sufficiently flexible" to allow a court to reconsider a grant of interim relief. The Appellate Division nonetheless concluded that because "the Court of Appeals' analysis of the possible merits of plaintiffs' claims did not constitute an attack on the basis upon which the preliminary injunction was granted," and any challenge to the issue of irreparable harm had been abandoned, the order granting preliminary injunctive relief should remain in effect.

Determination of Fraudulent Practice Upheld Against Physician Who Removed Healthy Kidney from Patient

Muncan v. State Board for Professional Medical Conduct, et al., 296 A.D.2d 721, 745 N.Y.S.2d 304 (3d Dep't 2002). In this case, the Bureau of Professional Medical Conduct charged a physician with gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, and fraudulent practice. The charges arose from the physician's removal of a patient's healthy kidney. After a hearing before the Hearing Committee of the State Board for Professional Medical Conduct, the Committee sustained the charges that the physician practiced with gross negligence and negligence on more than one occasion, and dismissed the remaining charges. The Committee suspended the physician's license to practice for 48 months, stayed that suspension for 42 months, and placed him on probation.

The physician appealed to the Administrative Review Board for Professional Medical Conduct (ARB), which affirmed the Committee's findings as to both guilt and penalty. The ARB also sustained the charge alleging fraudulent practice. The physician thereafter brought an Article 78 proceeding seeking to annul that part of the ARB's determination that upheld the charge of fraudulent practice.

The Appellate Division confirmed the ARB's determination. The court based its determination upon the facts that a preoperative CT scan report indicated the presence of a five-centimeter by seven-centimeter mass on the patient's left kidney, that the physician admittedly did not review either the CT scan or the MRI films prior to surgery, and that the physician did not have those films with him in the operating room. Had he done so, the physician would have found that the CT scan report erroneously indicated that there was a mass on the patient's left kidney when, in fact, such mass was located on the patient's right kidney. Moreover, upon exposing the left kidney of the patient, the physician did not observe any gross abnormalities or deformities and was unable to find any masses located on the kidney. Nonetheless, he removed the left kidney.

Furthermore, on the day of the operation, the physician was advised that he may have removed the wrong kidney but, despite this information, made no attempt to reconcile the results of the preoperative tests with what he had observed in the operating room. He then discharged the patient with a postoperative diagnosis of left renal mass, failing to note that he had in fact removed a tumor-free kidney.

After a subsequent CT scan revealed the presence of a six centimeter by seven centimeter mass on the same patient's right kidney, the physician deemed this to be a "new" tumor that was not present on the CT scan conducted four months earlier. The court found that such a diagnosis appeared highly suspect given the medical testimony that this "new" tumor was in the same location and had the same consistency and appearance as the tumor appearing in the CT scan prior to the patient's operation four months earlier. The record indicated that it was highly unlikely that a tumor of this dimension could have achieved such size during the relatively brief period between the two CT scans.

Given the foregoing, the court found that the evidence was sufficient to support an inference of fraud—that is, that the physician knew that he removed the wrong kidney, and instead of taking steps to rectify the situation, intentionally concealed his mistake. Accordingly, the court upheld the ARB's determination that the physician was guilty of fraudulent practice.

Court Upholds Maximum Limit of 48 Months for Physician to Practice Medicine in New York under Limited Permit

Ceran v. New York State Education Department, 745 N.Y.S.2d 643 (Sup. Ct., Albany Co. 2002). In this Article 78 proceeding, a physician challenged a New York State Department of Education (SED) refusal to renew his limited permit to practice medicine. The court dismissed the petition for failure to state a cause of action.

The physician is a medical doctor from Haiti who practiced psychiatry in New York for 48 months; 24 months under an initial limited permit, and an additional 24 months under a renewal limited permit. SED denied the physician's application for a second renewal on the grounds that his permit could not be extended in the aggregate beyond 48 months, under 8 N.Y.C.R.R. § 60.6 of the SED commissioner's regulations.

SED contended that the application and permit specifically advised Dr. Ceran that, pursuant to Education Law § 6525 and 8 N.Y.C.R.R. § 60.6, the limited permit may be renewed at the discretion of the department, "provided that such permit should not be renewed for more than 24 months" and that "no renewal may exceed 2 years in the aggregate." The physician argued that section 6525 of the Education Law places no restrictions on the number of times a limited permit may be renewed, and thus takes precedence over 8 N.Y.C.R.R. § 60.6. In response, SED argued that the statute grants the SED the authority to renew permits bi-annually at its discretion, and that the regulatory limit was a proper exercise of that discretion.

The court agreed with the SED, noting that Education Law § 6525 did not require any extension beyond the initial two-year period and, significantly, the decision to grant any such renewal was left to the discretion of SED. The court also noted that to protect the health and welfare of the citizens of New York State, the legislature had enacted laws requiring a certain standard of learning and training of those who undertake to preserve or repair the human body. Thus, until a physician has been licensed by the proper authorities, no person has an absolute, unqualified, or vested right to practice medicine or surgery in New York.

The court found that SED's underlying policy with respect to the renewal of limited permits—that is, to ensure that physicians practicing in New York were competent, licensed physicians—was neither irrational nor unreasonable. The court held that it was not unreasonable or irrational for the SED to determine that an individual who has failed or who has otherwise not passed the National Medical Licensing examination in four years is unqualified to practice medicine under a limited permit. The court stated that to hold otherwise would result in numbers of individuals, who have not proven their competency as physicians, practicing medicine within New York State and placing the public health, safety, and welfare in jeopardy.

Court Holds that Hospital Is Not Vicariously Liable for Malpractice by Private Attending Physician in Treating an Emergency Room Patient

Ventura v. Beth Israel Medical Center, et al., 747 N.Y.S.2d 595 (2d Dep't 2002). The decedent went to the hospital complaining of chest pain, dizziness, and shortness of breath. While at the hospital's emergency room, the decedent's wife telephoned her sister-in-law, who was employed in the hospital's EKG department, and asked her to recommend a cardiologist. Based upon the sister-in-law's recommendation, the decedent's wife asked a private physician to treat the decedent in the ER. Upon the decedent's admission to the hospital, that physician acted as the decedent's attending physician. After the decedent's release from the hospital, the treating physician scheduled a thallium stress test to determine whether the decedent's shortness of breath was related to heart or lung disease. The thallium test was administered and interpreted by other physicians, who found that there was no evidence of heart disease. Approximately one year later, the decedent died of a heart attack.

The decedent's wife brought this malpractice action against the hospital and the private physicians, claiming that they committed malpractice for failing to diagnosis and treat the decedent's cardiac disease. The hospital moved for summary judgment, contending that it could not be held liable for the acts of malpractice allegedly committed by the private physician, because he had been voluntarily selected by the decedent's family to be the decedent's private attending cardiologist.

The Supreme Court granted summary judgment and the Appellate Division affirmed. The court reaffirmed the general rule that a hospital is not vicariously liable for the malpractice of a private attending physician who is not the hospital's employee. The court noted that, although there is an exception to this rule recognized where a patient enters a hospital through its emergency room seeking treatment from the hospital and not a particular physician of the patient's choosing, such exception did not apply since the decedent's family selected the private physician.

Endnotes

1. *Mental Hygiene Legal Service, on behalf of Christine D. v. Bennett*, 297 A.D.2d 308, 746 N.Y.S.2d 308 (2d Dep't 2002) (quoting *Rivers v. Katz*, 67 N.Y.2d 485, 495, 504 N.Y.S.2d 74 (1986)).
2. *Id.*
3. *See id.* at 311.

Leonard Rosenberg is 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

By James W. Lytle

In a legislative session that contained a number of initiatives strongly supported by health care unions, a significant new statute was enacted at the end of the session that could prove to have considerable impact on health care providers and organizations across New York State. On September 30, 2002, Governor Pataki signed legislation that prohibits state funds from being utilized to encourage or to discourage union organizing. The so-called "union neutrality" legislation, which became chapter 601 of the Laws of 2002, takes effect ninety days after its enactment or on December 28, 2002.

Chapter 601 amends section 211-a of the Labor Law to augment already existing limitations on the use of state funds to discourage labor organizing. The current law, which dates back to 1996, precludes the use of state funds to "train managers, supervisors or other administrative personnel regarding methods to discourage union organization."[1] The new statute extends this prohibition to a wider array of union organizing activities and precludes the use of state funds either for encouraging or for discouraging unionization. The statute does not set a threshold amount of state funds received or utilized by the employer to trigger this prohibition: any amount of state funds used for these purposes violates the statute. Any health care entity that receives any state funds, including Medicaid and other public insurance and grant programs, will be subject to the new law.

Specifically, the statute prohibits the use of state funds:

- To train managers, supervisors or other personnel in methods to encourage or to discourage union organization or to encourage or discourage an employee from participating in a union organizing drive;[2]
- To hire or pay attorneys, consultants or other contractors to encourage or discourage union organization or to encourage or discourage an employee from participating in a union organizing drive;[3]
- To hire employees or pay the salary and other compensation of employees whose principal job duties are to encourage or discourage union organization or to encourage or discourage an employee from participating in a union organizing drive.[4]

Any employer that "utilizes funds appropriated by the state and engages in such activities" must maintain, for a three-year period, "financial records, audited as to their validity and accuracy, sufficient to show that state funds were not used to pay for such activities."[5] The employer must make such records available to the funding state agency and to the Attorney General within ten days of a request by either party. The Commissioner of the New York State Department of Labor is directed to promulgate regulations "describing the form and content of the financial records required."[6]

The statute authorizes the Attorney General to seek to enjoin violations of the statute and empowers the reviewing court to order the return of any unlawfully expended funds to the state.[7] The court may also impose civil penalties of $1,000 or three times the amount of money expended (whichever is greater) if the employer has been shown to have "knowingly engaged" in a violation of the statute or if the employer violated the statute in the preceding two years. In addition, the state Labor Commissioner is directed to "provide advice and guidance to state entities subject to the provisions of this section as to the implementation of contractual and administrative measures to enforce the purposes" of the statute[8]—a direction that suggests that state contracts may themselves contain provisions and contractual remedies that will be intended to secure compliance.

In assessing what might be necessary to satisfy the statute, the breadth of the bill's scope and the absence of any limiting definitions presents the risk that employers acting in good faith could find themselves inadvertently violating its terms. There is, as noted, no threshold amount of state funding that triggers its provisions. If any state funds are used to support activities regarded as either encouraging or discouraging unionization, the statute would be violated. Moreover, neither the New York statute nor the comparable California statute on which it was modeled provide any useful guidance as to what might constitute activities that "encourage or discourage union organization" or "encourage or discourage an employee from participating in a union organizing drive." The statute does not define these terms and nothing in the legislative intent, the bill memoranda or any other statements from the sponsors or supporters of the legislation clarifies the reach of those terms.

The statute's legislative intent section declares that "the use of state funds and property to encourage or discourage employees from union organization constitutes a misuse of the public funds and a misapplication of scarce public resources,"[9] but provides no guidance as to what

might constitute prohibited activities. The only example offered in the sponsor's memorandum related to testimony "from highly skilled health care workers forced to attend several mandatory anti-union meetings on company time, and against their will, while their patients were attended to by untrained personnel." At the time of the Governor's approval of the legislation, the state Labor Commissioner observed the "the legislation protects the integrity of the organization process by ensuring that State funds are not used to influence the process in any way." Thus, at least theoretically, an allegation that State funds have been used "in any way" to influence a unionization effort might be sufficient to trigger the statute's enforcement provisions.

Much of the support for the legislation seemed to be focused on its provisions prohibiting the hiring of attorneys or consultants if they are hired "to encourage or discourage union organization." When Governor Pataki signed the measure, he publicly endorsed the sentiments contained on a sign held by one of the bill's supporters, which read "Money For Consumer Care *Not* Lawyers," acknowledging that "I'm a lawyer, but I agree with that sign."[10] The legislation provides, however, no guidance as to how, consistent with the attorney-client privilege, an allegation that an attorney has been hired with state funds for these purposes could be proved or disproved. One can envision labor relations counsel's guidance being characterized as either encouraging or discouraging unionization, even when it may merely be intended to advise the client of its rights and obligations in connection with the unionization process.

Unlike the California statute, the New York law does not exempt certain activities, such as handling routine personnel or grievance matters, voluntarily recognizing a labor organization, or implementing a collective bargaining agreement, from the scope of the statute. Given the potential tactical use of the statute by unions, employers may wish to consider identifying non-state funding sources for a wide array of lawful (and not necessarily either pro- or anti-union) activities to reduce the likelihood of any issue arising over the source of funding of these activities.

In fairness, the statute does not preclude employers from engaging in activities that either actually encourage or discourage unionization or are perceived that way. All it does is prohibit entities that receive state funds from using those funds for these prohibited purposes. At least theoretically, an employer that manages to document that its expenditures on these prohibited activities derive entirely from non-state revenues will remain beyond the scope of the statute. For some employers, their nearly total reliance on state resources may make that task impossible.

The statute, in addition, directs the state Labor Commissioner to promulgate regulations that will describe the form and content of financial records that should be maintained by employers. At the time of this writing, the Department of Labor regulations were in the drafting stage and may now be available. The statute makes clear that the financial records must be "audited as to their validity and accuracy" and "sufficient to show that state funds are not used" for the prohibited activities. The California statute, by contrast, provides that "nothing in this chapter requires employers to maintain records in any particular form."[11] The California law does provide, however, that if state and non-state funds are commingled, any prohibited expenditures will be presumed to include a *pro rata* share of state funds.[12]

Even before the legislation was signed by Governor Pataki, a number of organizations authorized and began planning a legal challenge to the new state law. It is expected that a request for a preliminary injunction would be made on or about the law's effective date to try to enjoin the implementation and/or enforcement of the new statute until the legal issues are resolved.

Litigation was brought against the similar California statute by the Chamber of Commerce of the United States, the California Chamber of Commerce, the California Manufacturers and Technology Association, the California Association of Health Facilities, the California Healthcare Association, the California Association of Homes & Services for the Aging and a number of other commercial, non-profit and health care entities. These plaintiffs sought a preliminary injunction on the eve of the implementation of the California statute. On December 27, 2000, a federal district court judge denied the request, concluding that the plaintiffs had not met their burdens of showing a likelihood of success or "irreparable injury." As a result, the California statute took effect on January 1, 2001, and remained in effect until mid-September 2002, when the federal district court ruled that the California statute was, in large part, preempted by the National Labor Relations Act.[13]

Like the New York statute, the California law prohibits the use of state funds or property to assist, promote, or deter union organizing, allows remedies for such violations and requires recipients of state funds to maintain sufficient records to show that state funds were not improperly used. Plaintiffs moved for summary judgment, arguing that the California law is unconstitutional under both the federal and California Constitutions and is preempted by the National Labor Relations Act (NLRA) and the Medicare Act.

A series of procedural and jurisdictional issues were raised in the case that consumed the lion's share of the court's opinion, including 11th Amendment issues, standing and abstention. After disposing of these procedural and jurisdictional issues, the court turned to the principal issue of whether the California law was preempted by the federal National Labor Relations Act (NLRA).

The NLRA § 8(c) states: "the expressing of any views, argument, or opinion, or the dissemination thereof . . . shall not constitute or be evidence of an unfair labor practice . . . if such expression contains no threat of reprisal or force or promise of benefit."[14] This has been interpreted by the Supreme Court as ". . . a congressional intent to encourage free debate on issues dividing labor and management."[15] The Court concluded that this intended free debate would be impermissibly constrained by the implementation and enforcement of the California union neutrality law. The statute defines "assist, promote or deter union organizing" to mean "any attempt by an employer to influence the decision of its employees" relating to labor organizations. Both parties agreed that any attempt by an employer to influence employee decisions through speech is included in the definition and that such speech is prohibited by the California statute while the employer is being compensated with state funds or while the employer is on state property. Therefore, the Court found that the NLRA preempts the California law because its purpose is to regulate employer speech regarding union organizing under specified circumstances, which contravenes the interest in free debate that Congress had intended should be part of labor-management relations.

The defendants argued that the state is simply controlling the use of state funds and is acting as a "market participant" in a proprietary, rather than in a regulatory, capacity. Where the state is protecting its own proprietary interests, preemption does not apply.[16] The Supreme Court held that a state is permitted to act without conflicting with the NLRA when it acts as a proprietor, rather than as a regulator or policymaker.[17] The Court rejected this argument because, unlike the requirements at issue in *Boston Harbor*, this statute is not "specifically tailored to one particular job." Rather, the California statute was "a traditional legislative enactment, not a proprietary act," and, like a Wisconsin statute that debarred repeat offenders of the NLRA from doing business with the state, the "rigid and undiscriminating manner in which the statute operates" required its preemption.[18]

In sum, in light of the recent California decision, the New York statute is likely to be closely scrutinized in any litigation that might be undertaken. It should be noted that, even if the challenge to the legislation proved to be ultimately successful, there may be (as in California) a prolonged period during which the law would be in effect. Consequently, it would be prudent to undertake the necessary steps to comply with the statute, whatever may be the outcome of the legal challenge.

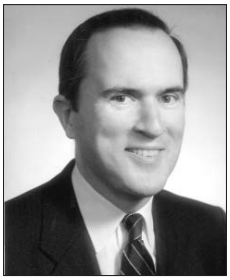
Endnotes

1. Labor Law § 211-a.
2. Labor Law § 211-a(2)(a).
3. Labor Law § 211-a(2)(b).
4. Labor Law § 211-a(2)(c).
5. Labor Law § 211-a(3).
6. Labor Law § 211-a(5).
7. Labor Law § 211-a(4).
8. Labor Law § 211-a(5).
9. Labor Law § 211-a(1).
10. *Pataki Signs Pro-Labor Union Bill*, Newsday, Oct. 2, 2002.
11. Cal. Code § 16648.
12. Cal. Code § 16646(b).
13. *Chamber of Commerce of the U.S., et al. v. Lockyer, et al.*, 2002 U.S. Dist. LEXIS 19877 (C.D. Cal., Sept. 16, 2002).
14. 29 U.S.C. § 158(c).
15. *Linn v. United Plant Guard Workers of America, Local 114*, 383 U.S. 53, 62 (1966).
16. *Building & Trades Council v. Associated Builders ("Boston Harbor")*, 507 U.S. 218, 113 S. Ct. 1190 (1993).
17. This proprietary/regulatory distinction was not lost on the drafters of the New York statute: the statute's legislative intent refers to the risk that "the proprietary interests of this state" would be adversely affected by the misuse of state funds for pro- or anti-unionization purposes. *See* Labor Law § 211-a(1).
18. *Wisconsin Dep't of Industry v. Gould*, 475 U.S. 282, 287 (1986).

Compiled by James W. Lytle, managing partner of the Albany offices of Kalkines, Arky Zall and 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

By Frank Serbaroli



Chemical Dependence Outpatient Services

Notice of continuation. The Department of Health gave notice of the continuation of the amendment of section 505.27 of title 18 N.Y.C.R.R. and addition of section 505.26 to title 18 N.Y.C.R.R. which authorize the Department to provide Medicaid reimbursement for the new outpatient chemical dependence programs licensed under Article 32 of the New York Mental Hygiene Law. *See* N.Y. Register, August 7, 2002.

Reportable Communicable Disease List and Quarantine Authority

Notice of emergency rulemaking. The Department of Health amended sections 2.1 and 2.5 of Title 10 N.Y.C.R.R. to expand the list of potential bioterrorist agents in the communicable disease reporting system which permits local authorities to utilize quarantine measures in the event of a bioterrorist disease outbreak in New York State. These new bioterrorist agents include: glanders, melioidosis, Q Fever, smallpox, staphylococcal enterotoxin B poisoning and viral hemorrhagic fever. Filing date: August 12, 2002. Effective date: August 12, 2002. *See* N.Y. Register, August 28, 2002.

Physician Profiling

Notice of emergency rulemaking. 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 will be available for dissemination to the public. Information to be disseminated about the physicians includes any criminal convictions and medical malpractice information. Filing date: September 10, 2002. Effective date: September 10, 2002. *See* N.Y. Register, September 25, 2002.

Environmental Laboratory Standards

Notice of emergency rulemaking. The Department of Health amended section 55-2.13 of title 10 N.Y.C.R.R. to establish minimum standards for laboratory testing of biological and chemical agents of terrorism. Filing date: September 18, 2002. Effective date: September 18, 2002. *See* N.Y. Register, October 9, 2002.

Adult Care Facilities

Notice of emergency rulemaking. The Department of Health amended parts 485, 486, 487, 488 and 490 of title 18 N.Y.C.R.R. to allow the Department to expedite the enforcement process and assess civil penalties against adult care facilities which endanger or cause harm to residents. Filing date: September 30, 2002. Effective date: September 30, 2002. *See* N.Y. Register, October 16, 2002.

Adult Day Health Care Regulations

Notice of emergency rulemaking. The Department of Health repealed parts 425, 426, and 427 of title 10 N.Y.C.R.R. and added a new 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, (c) contain requirements for the assessment of individuals for admission and retention in the program, and (d) provide standards for programs designated as acquired immune deficiency syndrome (AIDS) adult health care programs. Filing date: September 25, 2002. Effective date: September 25, 2002. *See* N.Y. Register, October 16, 2002.

Insurance Department

Professional Health Services

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to amend section 68.1(b) of part 68 of title 11 N.Y.C.R.R., which relates to charges for professional services, in order to delete outdated provisions and fee schedules and make editorial changes to the regulation. *See* N.Y. Register, August 14, 2002.

Healthy NY Standardized Applications

Notice of emergency rulemaking. 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 health maintenance organizations 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: August 13, 2002. Effective date: August 13, 2002. *See* N.Y. Register, August 28, 2002.

Physicians and Surgeons Professional Insurance Merit Rating Plans

Notice of emergency rulemaking. 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: September 6, 2002. Effective date: September 6, 2002. *See* N.Y. Register, September 25, 2002.

Address Confidentiality Program for Victims of Domestic Violence

Notice of continuation. The Department of Insurance gave notice of the continuation of its Address Confidentiality Program protocols to guard against the disclosure of addresses of insureds who are victims of domestic violence. *See* N.Y. Register, September 25, 2002.

Francis J. 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 Section. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care," published by BNA as part of its Business and Health Portfolio Series.

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

In the Law Journals

Compiled by Dale L. Moore

***Annals of Health Law* (Loyola University, Chicago), volume 11 (2002):**

- Kathy L. Cerminara, *Taking a Closer Look at the Managed Care Class Actions: Impact Litigation as an Assist to the Market.*
- Robert John Kane, *Information Is the Key to Patient Empowerment.*
- John V. Jacobi, *Competition Law's Role in Health Care Quality.*
- Linda Reneé Baker, *The Government's Role in Health Care Delivery.*
- Alexander D. Eremia, *When Self-Regulation, Market Forces, and Private Legal Actions Fail: Appropriate Government Regulation and Oversight Is Necessary to Ensure Minimum Standards of Quality in Long-Term Health Care.*
- James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*
- Sharon King Donahue, *Health Care Quality Information Liability and Privilege.*
- Randi Heitzman, *The Business Associate Brain Teaser: A Look at Problems Involving the Business Associate Regulations Under the Health Insurance Portability and Accountability Act of 1996.*
- Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law.*

***Texas Law Review*, June 2002. Symposium: What We Know and Do Not Know About the Impact of Civil Justice on the American Economy and Policy.**

- Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform.*
- David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*
- Thomas O. McGarity & Ruth Ruttenberg, *Counting the Cost of Health, Safety, and Environmental Regulation.*

***Wake Forest Law Review*, volume 37 (2002): Symposium:**

- Mark A. Hall & Michael D. Green, *Empirical Approaches to Proving the Standard of Care in Medical Malpractice Cases.*
- William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology to Guide Expert Testimony in Medical Negligence Allegations.*
- Mark A. Hall, Roger Anderson, Rajesh Balkrishnan, Steven R. Feldman, Alan B. Fleischer, David Goff, & William Moran, *Measuring Medical Practice Patterns: Sources of Evidence from Health Services Research.*
- John E. Wennberg & Philip G. Peters, *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies?*
- Hon. Michael B. Dann, *Jurors as Beneficiaries of Proposals to Objectify Proof of the Standard of Care in Medical Malpractice Cases.*
- Hon. Thomas Penfield Jackson, *Observations on the Search for Objective Proof of the Standard of Care in Medical Malpractice Cases.*

In Other Journals:

- Carl F. Ameringer, *Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority*, 5 DePaul J. Health Care L. 187 (2002).
- Mary R. Anderlik & Mark A. Rothstein, *DNA-Based Identity Testing and the Future of the Family: A Research Agenda*, 28 Am. J.L. & Med. 215 (2002).
- Kenneth Baum, *"To Comfort Always": Physician Participation in Executions*, 5 N.Y.U.J. Legis. & Pub. Pol'y 47 (2002).
- Kathleen Boozang, *The Therapeutic Placebo: The Case for Patient Deception,* 54 Fla. L. Rev. 687 (2002).
- Gene Stephens Connolly, *Hidden Illness, Chronic Pain: The Problems of Treatment and Recognition of Fibromyalgia in the Medical Community*, 5 DePaul J. Health Care L. 111 (2002).
- Patti Dobbins, *Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations,* 3 N.C.J.L. & Tech. 353 (2002).

- Jennifer S. Geetter, *Coding for Change: The Power of the Human Genome to Transform the American Health Insurance System*, 28 Am. J.L. & Med. 1 (2002).
- Michele Goodwin, *Race and Urban Health: Confronting a New Frontier*, 5 DePaul J. Health Care L. 181 (2002).
- Jennifer Kulynych & David Korn, *Use and Disclosure of Health Information in Genetic Research: Weighing the Impact of the New Federal Medical Privacy Rule*, 28 Am. J.L. & Med. 309 (2002).
- Gerard Magill, *The Ethics Weave in Human Genomics, Embryonic Stem Cell Research, and Therapeutic Cloning: Promoting and Protecting Society's Interests*, 65 Alb. L. Rev. 701 (2002).
- Greg Radinsky, *The Compliance Officer Conundrum: Assessing Privilege Issues in a Health Care Setting*, 5 DePaul J. Health Care L. 1 (2002).
- Mark A. Rothstein, Serge A. Martinez, & W. Paul McKinney, *Using Established Medical Criteria to Define Disability: A Proposal to Amend The Americans With Disabilities Act*, 80 Wash. Univ. L.Q. 243 (2002).
- Bonnie Schreiber, Andrea Prasow, & Rachel S. Martin, *Health Care Fraud*, 39 Am. Crim. L. Rev. 707 (2002).
- L. Darnell Weeden, *HMOs, ERISAs "Relate to" Preemption and a Patient's Right to an External Review of Medical Necessity Decisions and the Implications of Field and Conflict Preemption*, 5 DePaul J. Health Care L. 207 (2002).
- Cynthia Donley Young, *Comment: A Comparative Look at the U.S. and British Approaches to Stem Cell Research*, 65 Alb. L. Rev. 831 (2002).

Dale L. Moore is Associate Dean of Academic Affairs and Professor of Law, Albany Law School, and co-editor of the NYSBA *Health Law Journal*.

For Your Information

By Claudia O. Torrey

"Study the past if you would divine the future," states Confucius.[1] Wise words which prompted this author to attempt an historiography of the Health Law Section. To be sure, the events of September 11, 2001, have reinforced the importance of relationships and history (our past and our beginnings)!

Ironically, this column is written with bittersweetness because during its preparation the Section's founding Chair, Barry A. Gold, died on October 12, 2002.[2] During a conversation with Barry in September 2002, this author asked him if the Section has evolved into what he had envisioned. His reply was that "the Section has become what I envisioned from the concept of being an entity that provides a forum for expanding one's knowledge and background in health law." Indeed, when one reads the October 12, 1995, report submitted to the New York State Bar Association (NYSBA) House of Delegates by the Steering Committee for a proposed Section, the prophetic report expressly states that "[t]he number, complexity and scope of law-related issues involving health have grown tremendously in recent years. The rapid advancements in medicine and technology have raised new concerns, and underscored the need to reshape laws and procedures, an . . . provide the bench and bar with the educational resources to keep pace with these developments."[3] When these words were stated in 1995, the world was coming to terms with both a terrorist attack that occurred in a Tokyo subway using the nerve gas sarin, and the shock of the Oklahoma City bombing of a federal office building that killed 168 people (including children).[4] Americans were also putting behind them the terrorist truck bombing below Manhattan's World Trade Center in February 1993.[5] Thus, the evolution of the Section, as well as the creation of the NYSBA in 1876,[6] has shared the stage with other critical, historically key world events.

According to the 1952 Annual Meeting Proceedings of the NYSBA, it appears that the Section's genesis hearkens back to a Committee on Alcoholism (COA) formed in 1951. The COA was chaired by Harold Riegelman, who was also the Chair of a State Coordinating Committee on Alcoholism. These committees were attempting to examine existing penal and health laws as they related to chronic alcoholism. The goal was to create more services for alcoholics in order to decrease their rising numbers in penal institutions.

The Committee on Public Health (COPH) first appears in the 1954 Annual Meeting Proceedings of NYSBA regarding committee reports for 1953. Thus, one can assume that the COPH was created in 1953.[7] Accordingly, this author was informed by L. Beth Krueger, Director of Administrative Services for NYSBA, that records reflect identical rosters for both the COA and the COPH committees. One can surmise that the COA was subsumed under the COPH to reflect a growing interest in public health issues.[8] The late Harold Riegelman served as Chair of the COPH from approximately 1953 through 1964.[9]

The COPH tackled high-profile public health issues such as narcotics addiction, air pollution, and alcoholism. In fact, the second Chair of the COPH, Hortense F. Mound, drafted the statute that authorized creation of the Special Division on Alcoholism, now known as the Office of Alcoholism and Substance Abuse within the State Department of Mental Hygiene. Quoting Mound, "at that time, this was considered a phenomenal achievement."[10] NYSBA records indicate that Mound chaired the COPH from 1965 until approximately 1968.

According to Krueger, there does not appear to be documentation for COPH Chairs from 1968-1974. The following people chaired the COPH and the subsequent Committee on Health Law[11] (COHL): Robert P. Borsody (1974-1978); Barry A. Gold (1978-1982); Susan S. Robfogel (1982-1986); Robert R. Grew (1986-1987); John K. Armstrong and Robert R. Grew, co-chairs (1987-1989); Judith M. Norman (1989-1992); and Jerome T. Levy (1992 through December 31, 1995).

The COHL built up a stellar reputation for being very active, especially legislatively. The COHL regularly advised the NYSBA on pending state and federal legislation. It definitely lived up to its stated purpose to "consider the manner in which the law can and does relate to and impact on the delivery, regulations, and administration of health services, and . . . submit to governmental and other appropriate bodies such comment and proposals as the committee deems appropriate." When the COHL came to its end in 1995, it consisted of fifty-six collegial members. As of January 1996, the COHL turned a new chapter—Section status!

Section status was eagerly anticipated. In a March 1995 cover letter attached to a questionnaire concerning a proposed Section, it is stated that ". . . a section would provide opportunity for participation of more members . . . , only a limited number of individuals can be appointed to the various Association committees." The letter further states that the "development of a section is seen as a means of sharing knowledge and perspectives, involving more members, and providing

increased resources to act on matters of concern."[12] The response to the questionnaire yielded 88 percent in favor of creating a Section.

Initially, eleven subject areas were slated to inaugurate the Section. The Special Committee on AIDS and the Law, however, requested not to be merged into the proposed Section. Applauding the creation of a Section, a letter dated October 12, 1995, from Steven L. Kessler to M. Catherine Richardson eloquently lays out why the Special Committee on AIDS and the Law would lose both its multidisciplinary and multisubstantive nature if merged into the Section. According to the NYSBA records, the Special Committee on AIDS and the Law was created in 1988 with Salvatore J. Russo serving as its first Chair. Records show the Special Committee on AIDS and the Law existing through 1999. The subject is now covered within the Section.[13]

The Section continues to grow and to explore new depths and vistas. One of those vistas included the creation of a *Health Law Journal* (formerly the *Health Law Newsletter*). Along with an executive committee, the Section has been led by Barry A. Gold (1996-1998); Jerome T. Levy (1998-1999); Robert N. Swidler (1999-2000); Tracy E. Miller (2000-2001); Robert Abrams (2001-2002); and Salvatore J. Russo (2002-2003).

This historiography of the Section's evolution reveals that it has existed for more than half a century! Its legacy continues to flourish.[14]

Endnotes

1. J. Legge., The Analects in Sacred Books of the East (1895).
2. Obituary of Barry Gold, Albany Times Union, Oct. 13, 2002, at www.timesunion.com (last visited Oct. 14, 2002).
3. The report listed the following people as the Steering Committee on Proposed Health Law Section: Barry A. Gold—Albany (Chair); Steven L. Kessler—New York; Ross P. Lanzafame—Rochester; Jerome T. Levy—New York; Peter Millock—Albany; and Ruth L. Scheuer—New York. *See also* excerpts from NYSBA House of Delegates Minutes 6-7 (Nov. 4, 1995) (hereinafter "Minutes").
4. Richard B. Stolley, Life: Our Century in Pictures 393, 401 (1999) (hereinafter "Stolley").
5. *Id*. at 396 (Experts believe that if the truck had been positioned differently, one twin tower would have fallen into the other).
6. During this period, capitalism and imperialism were on the rise. Although the Enlightenment era had ended (17th and 18th centuries), one of its enduring legacies was the belief that human history is a record of general progress. In 1876, Alexander Graham Bell invented the telephone; Johns Hopkins University opened; famous cellist Pablo Casals was born; and Mark Twain's *The Adventures of Tom Sawyer* was out in print. Also, Korea had become an independent nation, and the United States presidential election between candidates Tilden and Hayes was in dispute over 20 votes. *See* The Encyclopedia Britannica (Micropaedia) vol. 4 (2002); Bernard Grun, The Timetables of History: A Horizontal Linkage of People and Events (1st Touchstone ed. 1982) (hereinafter "Timetables").
7. *See* NYSBA, Proceedings of the Seventy-Seventh Annual Meeting . . . and Committee Reports for 1953, 337–339 (1954) (The main tenet of the 1953 COPH report concerned the devastating effect of chronic alcoholism on the alcoholic, his family, and the community).
8. It appears that the COA ceased existence in 1953. Both the COA and the COPH started during a dynamic time in American history—post-World War II. Indeed, it made excellent sense that the COPH started in 1953, because Congress created the new cabinet position of Secretary of Health, Education and Welfare in the same year. Other world events of interest included: the inauguration of President Eisenhower; the signing of the Korean Armistice; a World Series win for New York over Brooklyn; and the wedding of John F. Kennedy to Jacqueline Bouvier. *See* Timetables; Stolley at 281.
9. A cursory Internet search indicates that Mr. Riegelman was very politically connected. His appointment as Chair of the State Coordinating Committee on Alcoholism was probably by the Governor.
10. Telephone interview with Hortense F. Mound (Oct. 10, 2002). Mound was the first female chair of the COPH. Her late husband was a founding partner of the New York City law firm now known as Mound, Cotton, Wollan & Greengrass.
11. These dates are approximate based upon existing NYSBA records and oral conversations with colleagues. Krueger states that NYSBA records indicate a name change from the COPH to the COHL became official on June 1, 1983.
12. The letter listed former NYSBA President M. Catherine Richardson as the Chair (at that time) of the Steering Committee on Proposed Section on Health Law and Related Issues. The other letter signers were the Chairs of the COHL and other health-related committees: Jerome T. Levy (COHL); Lawrence R. Faulkner and Lisa K. Friedman (Committee of Mental and Physical Disability); Barry Gold (Committee to Confer with Committee of the Medical Society of the State of New York); Ruth L. Scheuer (Special Committee on Biotechnology and the Law); and Steven L. Kessler (Special Committee on AIDS and the Law). The Section status process evolved under former NYSBA Presidents G. Robert Witmer (1994-1995) and Maxwell A. Pfeifer (1995-1996).
13. The NYSBA Committee on Mental and Physical Disability remained as such along with the Special Committee on AIDS and the Law. *See* Minutes at 7.
14. This author wishes to thank the many colleagues who gave their time toward this written endeavor by sharing their memories. Also, much gratitude and appreciation is extended to L. Beth Krueger of the NYSBA.

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

Barry A. Gold

1945 - 2002

On October 12, 2002, Barry Gold passed away at the all-too-young age of 56 after a valiant struggle against cancer. The loss to both the medical and legal communities cannot be overstated. We at Thuillez, Ford, Gold and Johnson—the law firm where Barry practiced for fourteen years—would like to share our own remembrances of Barry and to acknowledge his many accomplishments and contributions to his profession as well as to his colleagues, partners, family and friends.

Throughout his career, Barry enjoyed a national reputation as a health law attorney. As many of you are aware, Barry was the founding Chairman of the Health Law Section of the New York State Bar Association (1996-1998). Barry recognized that the field of health law in New York had matured, and required a permanent forum for its practitioners to meet, exchange ideas, improve their knowledge and skills. So he designed the Section and convinced the State Bar Association to sponsor it. Then he recruited prominent health lawyers from across the state to chair the Section's committees, and led the Section during its first two years. Today, the Health Law Section that Barry launched has over 1,000 members.

Barry was also a member of the American Health Lawyers Association and was on the editorial board of the *Journal of Legal Medicine*. In addition to many other appointments, in 1997, Barry was appointed to serve on the New York State Task Force on Life and the Law—a nationally respected multidisciplinary panel that recommends public policies on bioethical issues. Over the years Barry shared his knowledge and expertise on a wide range of health law issues through not only his numerous publications, presentations and speeches, but in his many appearances before legislative committees to testify on various health law topics, including legal barriers and solutions to assist persons at the end of life, barriers to effective treatment of patients in pain, the Family Health Care Decision Making Act, managed care, surrogate decision-making and guardianship of the mentally disabled. He has been listed in *The Best Lawyers in America* as a health law attorney every year since 1993.

Always an advocate, Barry was the recipient of numerous awards, including the Partners in Cancer Control Award from the American Cancer Society, the President's Award for Pro-Bono Services and an award for "Improving the Professional Competence of the Bar Concerning Disabled Persons," the latter two from the New York State Bar Association. Barry was the Chairman of the Board of Directors for The Myasthenia Gravis Foundation of America. Among his many accomplishments, Barry worked to compel insurance companies to fund new and innovative treatments for cancer such as bone marrow transplants.

Barry was an experienced and talented trial lawyer defending doctors, nurses and hospitals in medical malpractice litigation in both federal and state court. He argued numerous appeals especially relating to health law issues such as credentialing and peer review.

Throughout his career, Barry counseled physicians, nurses, hospitals and nursing homes on all manner of health law issues including professional misconduct, credentialing, compliance programs, malpractice, ethics, contracts, managed care and a multitude of day-to-day practice issues. He answered scores of questions by phone and e-mail every day until, finally, he was physically unable to do so. Here in the office, his door was never closed and he would always take the time to talk through our professional questions and even our personal problems, with knowledge, common sense and understanding.

Barry possessed the unusual gift of being able to maintain balance. He was able to truly succeed in both his professional and personal life. Married to his childhood sweetheart, Sherry, with whom he had two children, Ben and Sari (of whom he was very proud), he managed to leave his work at the office and to really be there for his family. He was, throughout his life, a devoted father, husband, son and brother. He was also a good and loyal friend. Despite his busy schedule, Barry took the time to contribute to his community. He was a prime supporter of "Two Together," an after-school literacy program. He was a member of the Board of Trustees of the Capital Repertory Theater and past president of Congregation B'nai Shalom. Barry will be remembered for the way he treated all those who came into his life with empathy, respect and honesty.

Barry learned of his illness in June 2002. Throughout the summer he underwent treatment, including chemotherapy, while still coming into the office several days a week. Barry bore his illness and died as he lived, with dignity and grace.

We will miss him.

—Karen Butler
Thuillez, Ford, Gold & Johnson, LLP
Albany, NY

Institutional Licensing in New York State: Ownership by Public Companies

By Robert P. Borsody

This will be an examination of the current state of the law in New York as administered by the various agencies that license health and mental health care institutions with respect to ownership of those institutions by publicly traded corporations. There are three broad categories of licensed institutions: those that can be owned by publicly traded corporations; those that may not be owned by publicly traded corporations; and, as might be expected in the interesting area of health law, a gray area where the law is unclear. The author will examine the state of the law here as revealed by the law, regulations, conversations with the regulators and experienced practitioners, and his own experience in this area.

This article, however, will commence a new initiative of continuing education by the Health Law Section which will solicit the input of members online to update and amplify the article. This is the way it will work: The article will be published online as well as in the Health Law Section *Journal*. The article (and others like it in the future) will contain an invitation for readers to e-mail corrections, amplifications or additional experiences to the Health Law Section's listserve where they will then be posted to the Health Law Section's Web site along with the article. In a sense, therefore, the article will have a "pocket part" or supplement which will consist of the accumulated and pooled wisdom and experience of the thousand or so Section members who will be encouraged and invited to amplify and supplement the research and information in the article with their own considerable information and experience.

Facilities that Can Be Publicly Owned

To begin, we will examine the smaller group of facilities: those that can be owned by public corporations. First, however, some definitions and distinctions should be made. Almost all licensed entities can be owned by virtually any kind of legal entity with a couple of exceptions. The first exception is: most licensed facilities may not be owned by a corporation whose stock is then, in turn, owned by another corporation, the so-called holding company arrangement. Also, as will soon be seen, some licensees may not be owned by publicly held corporations.

However, most licensed entities may be owned by a natural person, a partnership of natural persons, a business corporation, a not-for-profit corporation or a limited liability corporation. Certain trusts can also own licensed entities and, under limited circumstances for a limited period of time, estates may operate licensed entities.

A common misconception should be cleared up. Some, who don't practice in this area, think that hospitals can only be operated by not-for-profit corporations. This is not so. Indeed, at one time there were dozens of proprietary hospitals owned by business corporations, partnerships or individuals. Inquiry by this author has revealed only the following remaining proprietary general hospitals: Long Island Medical Center (formerly Hempstead General), which is applying to change to a not-for-profit; Brunswick Hospital Center; and Parkway Hospital.

Hence, there is the common misconception that only a not-for-profit corporation can operate a hospital. In fact, the majority of hospital beds in this country are owned by not-for-profit or "voluntary" corporations; according to recent statistics, about 80 percent. In New York, the proportion is much higher. Curiously, almost the converse ratio prevails in the nursing home area, where about three-quarters of the beds in the country and about half of those in the state are operated by the proprietary sector; the remainder is voluntary.

We should make clear what we mean by the term "public ownership." As used in this article, it is intended to mean ownership by a publicly traded business corporation. As will be seen, this does not necessarily mean a company listed on the New York Stock Exchange but, rather, a company with a very large number of stockholders and which company needs and enjoys the necessity of a "public market" or free transferability of shares.

This is not to be confused with so-called "public hospitals," a term usually used to refer to hospitals operated by the federal, state, county or municipal governments, such as Veterans Administration hospitals, the SUNY-operated hospitals, Erie County Medical Center, and Helen Hayes Hospital.The term "public hospital" might also be used to refer to hospitals operated by legislatively created public benefit corporations, such as New York City Health and Hospitals Corp., Nassau County Medical Center or Westchester County Medical Center.

HMOs

Health maintenance organizations licensed under Article 44 of the New York State Public Health Law ("Public Health Law") may be publicly owned. There are a number of examples of these facilities, such as Oxford Health Plans, Inc. and Aetna U.S. Healthcare, Inc. The licensure requirements for an HMO are not significantly different than the licensure requirements for an Article 28 licensed facility which, as will be seen, may not be owned by a public company. There is a subtle but significant difference in the wording. In Article 4401(1) a health maintenance organization is defined as "any person, natural or corporate. . . ." The Department of Health Office of Counsel has interpreted the language "any person" to include publicly owned companies or a corporation the stock of which may owned by a publicly owned company.

The regulations speak to this issue in a somewhat roundabout way as follows: 10 N.Y.C.R.R. § 98-1.5(b)(3)(ii) requires disclosure on an application of sister subsidiaries owned by the applicant's "holding company" or other persons "in the holding company system." The same kind of language appears elsewhere in the required provisions in the application. Further, 10 N.Y.C.R.R. § 98-1.6(d) provides that where an applicant is "controlled" the commissioner must be satisfied "that the holding company has conducted itself in a manner that is consistent with the public interest . . ." and further that in considering the application "of applicants and holding companies . . ." the commissioner shall consider various items including services provided by any facility "or its holding company . . ." This language certainly supports the approach and present method of treatment of HMOs by New York State regulators as entities which may be owned by public companies or by a public company through a wholly owned New York State subsidiary.

Home Health Agencies

Home health agencies licensed under Article 36 of the Public Health Law can also be owned by public companies. Examples of publicly owned home health agencies are National Home Health Care Corp., Staff Builders and Olsten. Here, again, there is no explicit prohibition or permission discussing or regarding ownership by public companies. The language is a little more specific than HMOs *implying* that ownership by a public company is permitted. For example, in Public Health Law § 3611(1)(a) it is provided that an applicant for establishment of either a licensed home care agency or certified home health agency which will be operated by an entity (e.g., LLC or corporation) whose members will not be natural persons or an applicant which will be operated by a corporation which has a corporate stockholder must "establish a corporation or limited liability company within the state" and such applicant must also submit for review "any parent or health related subsidiary corporation."

It should be noted that ownership by public companies is permitted of all types of home health agencies, including the so-called "nursing home without walls." This type of agency is defined in Public Health Law § 3610 as a "long term home health care program" which may only be owned by a nursing home, a hospital or a certified home health agency. A certified home health agency, according to Public Health Law § 3611, can also be publicly owned.

Continuing Care Retirement Communities

According to the regulators, a public company can own a Continuing Care Retirement Community (CCRC). The law and regulations under Article 46 of the Public Health Law contain no limitation of ownership to "natural persons" or, of course, any specific bar on publicly traded corporations. In Public Health Law § 4604(2)(j)(iv), which provides for issuance of a Certificate of Authority, it is stated that, amongst other disclosure information, there must be a statement as to whether the applicant or a "parent or subsidiary corporation" has been subject to certain actions. In addition in Public Health Law § 4606(9) it is provided that in the initial disclosure statement that must be filed with the state, certain information must be disclosed "if the applicant is the subsidiary corporation or the affiliate of another corporation, as well as a statement identifying the parent corporation or other affiliate corporation . . .," and further, "the extent to which the parent corporation will be responsible for the financial and contractual obligations of the subsidiary." Even if an adult home is part of a CCRC, public ownership is still permitted despite the fact that, as will be seen below, an adult home cannot be owned by a public company because section 4604(3) of the Public Health Law, governing CCRCs, states that "the provisions of paragraph (a) of subdivision one . . . of [461-b] of the Social Services Law . . . shall not apply . . ." The list of operational CCRCs shows most of them to be made up of a combination of independent living units, enriched housing units and "Nursing Home Beds." As will be seen below and as is well known, nursing homes cannot be publicly owned. None of the existing CCRCs are publicly owned. This explains how they can contain nursing home beds.

There has been very little regulatory experience in this area because of the small number of licenses so far, only five. The small number is attributed to the fact that reserve requirements for a licensed entity in Public Health Law § 4611 are viewed as onerous by potential applicants. Indeed it is the author's experience and information from other practitioners that most of the

legal effort in this area is exercised in avoiding the requirement of licensure as a CCRC while still being able to create a business that will offer the amenities of a retirement community for the elderly.

Conversations with the relevant regulators indicate that the perception of unnecessarily high reserve requirements may not be well founded. Moreover, there is a 1,000-bed nursing home "set aside," i.e., not subject to Certificate of Need requirements for CCRCs. There is virtually no possibility of securing a Certificate of Need for nursing home beds in New York, especially downstate. Since the nursing home business in New York continues to be profitable and, hence, attractive, this should act as a powerful incentive for those considering a CCRC.

Facilities that May Not Be Publicly Owned

Most institutional facilities licensed in New York may not be owned by publicly traded corporations. This is not because of any specific or clear-cut prohibition (with two exceptions) but simply because of the impracticality of complying with certain licensure requirements. To be specific, the common characteristic of those facilities that may not be publicly owned is that each shareholder of such a facility applying for licensure is required to go through a "character and competence" review process by the licensing agency. A moment's thought will immediately reveal the inconsistency with this requirement and the free transferability of stock.

There is no prohibition against even a large national for-profit corporation such as HCA owning a hospital in New York if each existing shareholder of HCA and anyone who wishes to buy shares from an existing shareholder submitted an application for and was approved for character and competence by the New York State Department of Health. The easy and obvious way of avoiding this problem, by having the public company set up a wholly owned subsidiary to apply for licensure, is also prohibited because of the above mentioned prohibition on the holding company or parent subsidiary arrangement. Specifically, no corporation licensed under, for example, Article 28 of the Public Health Law may have its stock owned by another corporation.

Adult Homes

The exception to this *inferential* exclusion of public companies from institutional ownership is the adult home which is licensed under section 461-b of the Social Services Law. Here, there is specific language prohibiting a public company from owning a facility licensed as an adult home. Until 1996, adult homes could only be owned by a "natural person or partnership composed only of natural persons or a not for profit corporation . . ." or various governmental type facilities. In 1996 the law was amended[1] to allow business corporations to be licensed to operate adult homes with the following specific exception for public companies

> other than a corporation whose shares are traded on a national securities exchange or are regularly quoted on a national over-the-counter market or a subsidiary of such corporation or a corporation any of the stock of which is owned by another corporation, a limited liability company provided that if a limited liability company has a member that is a corporation, a limited liability company or a partnership, the shareholders of the member corporation the members of the member limited liability company, or the partners of the members partnership must be natural persons.

Assisted Living Facilities

Assisted living programs which are regulated under section 461-l had similar language which was similarly amended at the same time to permit business corporations other than publicly traded corporations to be licensed to operate assisted living facilities.[2] There is some question why this limitation was imposed specifically by amendment on assisted living facilities since a requirement of an assisted living facility in section 461-l(a) is that it must also be licensed as an adult home.

These two types of licensed facilities (the adult home and the assisted living facility) are the only facilities licensed in New York which, by their specific statutory language, may not be owned by publicly traded corporations.

Hospice

Another facility which, through the legislative language and statements by the regulators, cannot be owned by a public company is a hospice. Hospices are defined and regulated under Article 40 of the Public Health Law, and in section 404(3)(a) it has provided that no hospice may be owned by a corporation any of the stock of which is owned by another corporation (the standard parent subsidiary prohibition). Further, the regulations in 10 N.Y.C.R.R. § 790.11 require that "only a natural person may own, hold or have the power to vote the stock in a corporation that operates a hospice." The statute also in section 404(2)(b), requires that all the stockholders submit to a character and competence review.

Psychiatric Facilities

The Office of Mental Health, which regulates psychiatric hospitals under the New York State Mental Hygiene Law, has Certificate of Need requirements and procedures similar to the New York State Department of Health under Article 28 of the Public Health Law. There is the identical requirement of individual character and competence review for each shareholder. This is found in 14 N.Y.C.R.R. §§ 551.7(a)(1) and 557, and section 31.22 of the Mental Hygiene Law.

Most of the psychiatric beds in New York are units in Article 28-licensed general hospitals and, as such, they are licensed by both the Department of Health and Office of Mental Hygiene. There were formerly a number of "private" psychiatric hospitals which were owned by individuals or small corporations. At least two remain—Four Winds Hospital and Rye Psychiatric Institute, both in Westchester County. Another private psychiatric hospital, Holliswood Hospital in Queens, New York City, was operated and listed as one of the hospitals owned by Mediplex, a publicly traded company about ten years ago. Upon close examination of the historical documents, it appears that this actually was a management contract relationship, about which more will be said later.

Rehab Centers

Drug and alcohol rehabilitation centers, again, appear to follow the same Certificate of Need procedure as the New York State Department of Health; however, there is much less precedent and experience here. Most of the facilities (beds and treatment slots) regulated by the Office of Alcoholism and Substance Abuse under Article 32 of the Mental Hygiene Law are New York not-for-profit corporations. Some of the better-known ones are Daytop Village and Odyssey House.

Section 32.31(c)(3) of the Mental Hygiene Law has the same provisions as § 31.22(b) of the same law requiring individual character and competence review of each shareholder.

There were once a large number, and still a few remain, that are operated by individuals, partnerships or closely held corporations. There are two facilities, Conifer Park in the Albany area and Arms Acres in Carmel, Putnam County, which also were listed as being owned by Mediplex a number of years ago. The present regulators recall that those, too, were operated under management contracts.

Hospitals and Nursing Homes

Hospitals and nursing homes licensed under Article 28 of the Public Health Law may not be publicly owned for the reasons already discussed and described, i.e., (i) each shareholder must go through a character and competence review,[3] and (ii) no parent/subsidiary relationship is permitted.[4]

Other facilities are also licensed under Article 28 of the Public Health Law. There is the generic diagnostic and treatment center and then several specific types of diagnostic and treatment centers, including ambulatory surgery facilities and dialysis centers. There have been some interesting recent developments in this area which will be discussed in more detail.

It should be noted that, at one point, the "chains" such as HCA or Humana were very interested in coming into New York and acquiring hospitals. This interest has waned with the fortunes of the chains. The nursing homes chains, such as Beverly Enterprises or Manor Care, have never evidenced significant interest in coming into New York State. This is somewhat to the dismay of a certain section of the proprietary nursing home industry. As mentioned, about half of the nursing home beds in New York are owned by proprietary corporations, usually closely held corporations. Some of the older holders of nursing home licenses have tried to encourage the interest of the nursing home chains as an "exit strategy." There has, obviously, never been any enthusiasm by the voluntary sector, either nursing home or hospital, in the entry of the chains into New York.

Representative Governance Approaches

In the last couple of years, publicly traded corporations have evidenced a strong interest in somehow "acquiring" New York ambulatory surgical facilities and dialysis facilities. Because of the prohibitions on direct ownership, there have been attempts to achieve this end by using management contracts and asset acquisition. These attempts have been the same approaches used by publicly traded corporations when "acquiring" physicians' practices, which in most states cannot be acquired, owned or operated by a business corporation.

These approaches basically are the following: first, the assets of the medical practice, or in the case of the New York facilities, such as the dialysis center or the ambulatory surgery center, are acquired. These would include the equipment, furniture and fixtures. In addition the building or the lease for the building is taken over by the "acquiring entity." The second step is to put in one or more "nominees" to hold ownership. These could be stockholders of the licensed surgi-center corporation or the dialysis center; in the case of a medical practice acquisition by a public company, it would be a doctor who owns a professional corporation. These

"nominees" are usually affiliated in some way with the acquiring entity—often an employee and perhaps, as well, a stockholder of the acquiring entity.

The final step is a management contract from the acquiring entity to the acquired entity or, more specifically and very often, to a successor shell corporation. The original entity, having sold all of its assets, is left simply holding cash and perhaps debt of the acquiring entity and is a non-operating entity. The new entity, having applied to secure the license of the selling entity (and having its location, assets, personnel, etc.) operates under the ownership of the "nominees" and pursuant to a management contract with the acquiring entity or, more usually, a subsidiary of the acquiring entity.

When these contractual acquisitions started there was considerable study of the issue by the Public Health Council, the State Hospital Review and Planning Council and the New York State Department of Health staff. The first result of this work was a memo by the then-Counsel of the Department of Health, Henry Greenberg, dated September 21, 1999. This memo basically said that these kinds of acquisitions were permissible as long as the final operational decisions and some irreducible minimum of powers, something along the lines of the reserved powers of a parent or management contract powers under section 405.3(f)(3) of the Health Code, were respected. Because of the thoroughness of research and analysis in this memo and, as well, its broader application to and significance for management contract relationships generally, it is annexed as Exhibit A to this article.

There was then the study by the Representative Governance Workgroup of the Establishment Committee of the Public Health Council and the Planning Committee of the State Hospital Review and Planning Council. There was a report issued, dated March 7, 2001, which basically says that this type of "acquisition" is permitted for dialysis centers but not for ambulatory surgery facilities. This report is annexed as Exhibit B.

While there's not a complete closure of the door, the requirements imposed by the Representative Governance memo has made ambulatory surgery acquisition economically unattractive. This is the result of the requirement, among other things, that all contracts with the managed Article 28 licensed entity, for example, an ambulatory surgery facility, must be at "fair market value." This makes it very difficult for the acquiring entity to get its hoped-for return on investment. This, added to the considerable constraints on outside authority over operations, e.g., the requirement of majority control by persons not associated with an outside or acquiring entity, has resulted in a complete halt to, at this writing, any such applications.

Dialysis centers, on the other hand, may be "acquired," and the apparent public policy reason is that because of decreased Medicare reimbursement rates for dialysis, there are fewer interested owners in New York and it was deemed necessary to "open the gates" to public companies with their greater resources and economies of scale to "acquire" dialysis facilities in New York.

It is interesting to note that management contracts per se are only permitted for Article 28 licensed hospitals (and HMOs).[5] The content and limitations of management contracts are set out in detail in 10 N.Y.C.R.R. § 405.3(f) but they are limited to hospitals. There once were more management contracts in New York but now there are only _____ , and _____ of these are between New York hospitals. In the first paragraph of Exhibit A, it is noted that the outside or acquiring entity will provide "consulting and administrative services" to the "acquired" Article 28 licensed entity. These contracts are reviewed by the state for compliance with the provisions of Exhibits A and B. These provisions are quite similar to the requirements of 10 N.Y.C.R.R. § 405.3(f) noted above, with the difference that the contracts cannot be called "management" contracts, for such is permitted only for hospitals.

Conclusion

There is no conclusion, only a continuation of the accretion of experience and information on how these licensing laws are interpreted and administered in this state. It is believed that this state is unique in its episodic exclusion of the public companies from ownership of some, but not all, licensed facilities.

As mentioned in the early part of this article, the reader is invited to e-mail to the author any information that could further elucidate this area for his fellow practitioners of health law.

Endnotes

1. 1996 N.Y. Laws, ch. 543, § 2, effective Aug. 8, 1996.
2. 1996 N.Y. Laws, ch. 543, § 5, effective Aug. 8, 1996.
3. *See* Public Health Law § 2801-a(3); 10 N.Y.C.R.R. § 790.11.
4. Public Health Law § 2801-a(4)(e); 10 N.Y.C.R.R. § 790.11(c)(3).
5. *See* 10 N.Y.C.R.R. § 98-1.11(g)-(n).

Robert Borsody practices health law in his firm, Robert P. Borsody, P.C. He can be reached as follows: email: rborsody@fbwhlaw.com; phone: (212) 453-2727; fax: (212) 644-7485; mail: 909 Third Avenue, 17th floor, New York, NY 10022.

EXHIBIT A

To: Public Health Council
State Hospital Review and Planning Council

From: Henry M. Greenberg, General Counsel

Date: September 21, 1999

Subject: Certificate of Need Applications: Representative Governance of Article 28 Facilities

Background

The Council is presented with a number of Certificate of Need ("CON") applications, involving ownership changes of dialysis facilities, that share certain common structural characteristics.[1] In these applications, an entity (hereinafter referred to as an "Outside Entity"), which has not itself received establishment approval, has a significant role in facility acquisition and operation. The applicant is a business corporation, with a single shareholder, officer and director, which owns the "Article 28 assets"[2] of the facility. The applicant's sole shareholder is an employee of or has some other contractual arrangement with, the Outside Entity.[3] The Outside Entity owns or leases the "non-Article 28 assets,"[4] which are then leased to the applicant. The Outside Entity may also be the tenant under the facility's lease, which is then subleased to the applicant. Additionally, the Outside Entity provides consulting and administrative services to the facility and may provide partial or total financing. Through these various relationships, a significant amount of the facility's revenue may flow to the Outside Entity. As part of the consideration, the shareholder agrees with the Outside Entity that, under certain circumstances and upon specified conditions, the shareholder will sell the stock to a designee or representative of the Outside Entity. We understand these types of arrangements are increasingly being used in the dialysis field to provide a source of capital and as a means of permitting an Outside Entity to offer its economies of scale and expertise to New York facilities.

Notably, while this describes certain salient features of the applications for operational changes for dialysis facilities which are now before the Council, there may be other possible structures for these types of arrangements. Additionally, there will be similar applications on future agendas, and there has been one already, for the establishment of ambulatory surgery centers. These types of arrangements are increasingly being used in the ambulatory surgery field for the same reasons as in the dialysis field.

Question Presented

In light of the operational restrictions set forth in PHL, Article 28, and given that the Outside Entity is not itself the established operator, is the arrangement described above between an Outside Entity and an established operator of a dialysis facility or ambulatory surgery center ("ASC") legally permissible?

Brief Answer

Yes. The representative governance arrangement described above is legally permissible provided that: (i) the established operator of the dialysis facility or ASC retains ultimate power and authority over, and responsibility for, the facility's operations; (ii) the approved shareholder is the sole beneficial owner of the stock; (iii) any subsequent transfers of stock or voting rights of ten percent or more, or transfers resulting in a person owning ten percent or more of stock or voting rights, are approved by the Public Health Council; and (iv) the project does not involve an improper sharing of facility revenue. It bears emphasis that we address herein only those "representative governance" arrangements that the Council has seen to date for dialysis facilities and ASCs and that our conclusions apply only to these types of Article 28 facilities.

Discussion

I.

State law and regulation provide certain essential elements for Article 28 establishment and ownership, unique to New York. Applicants are required to receive establishment approval through a clearly prescribed process and, as Article 28 operators, must maintain accountability for, and ultimate authority over, facility operations. In order for an applicant to receive establishment approval, the Council must be satisfied as to the applicant's "character, competence, and standing in the community"[5] and as to the project's financial feasibility.[6] Additionally, as part of the establishment process, owners of an applicant are required to affirm that they are the "sole beneficial owner" of the ownership interest held in their name.[7] On an ongoing basis, certain governing powers, sometimes described as "reserved powers," and ultimate authority and responsibility, must be retained by the established operators.[8] Finally, no person, other than the established operator, may share in facility revenue.[9]

The "representative governance" arrangement complies with all of these essential elements and, therefore,

the overall arrangement for dialysis facilities and ASCs is legally permissible. We will discuss each element in turn.

II.

A. Character and Competence

In each application, the person who will be the sole shareholder has undergone satisfactory character and competence review, which will also be required of any subsequent holder of ten percent or more of the stock.[10] Additionally, and in recognition of the participation of the Outside Entity in the facility's operation, the Outside Entity itself has undergone satisfactory "organizational" character and competence review).[11]

Regardless of whether the Outside Entity directs to whom the shareholder may sell shares, when the shares may be sold, and for what consideration,[12] the transfer itself must comply with applicable law and the stock may only be transferred to a permissible Article 28 operator.[13] If the amount of stock transferred is greater than ten percent or if the transfer results in the ownership of ten percent or more of the stock by a permissible owner who has not undergone character and competence review, the Council's approval would be necessary for the stock transfer.[14]

B. Sole Beneficial Ownership

Beneficial owners of stock must possess the rights to vote and to receive dividends.[15] By exercising the right to vote, a shareholder elects the Board of Directors, who are vested with the authority to conduct the corporation's business.[16] In each application, the established operator retains these essential rights[17] and has provided an affidavit of sole beneficial ownership.

C. Reserved Powers

The integral components of ultimate operational authority have been identified by regulation and include overall responsibility for the management and operation of the facility in compliance with applicable laws, rules and regulations.[18] These powers must be reserved to the governing authority (which, in the case of a corporation includes the Board of Directors, officers and shareholders)[19] of the established operator and cannot be delegated to a non-established entity. For each application, we are working with the applicant to ensure that all pertinent legal documentation (such as loan agreements, consulting agreements, etc.) reflect the retention of these reserved powers and overall responsibility by the applicant and the need for compliance with applicable law for transfers of stock or voting rights.

D. Financial Feasibility and Revenue Sharing

A project must be financially feasible in order to receive CON approval.[20] In reviewing the financial feasibility of a project, the impact of the fact that revenue flows through to the Outside Entity must be considered. No person, other than the established operator, may share the revenue of an Article 28 facility.[21] Therefore, compensation arrangements cannot be based on a percentage of revenue and must be commercially reasonable under the particular circumstances.

Conclusion

We expect to see in the future similar CON applications from dialysis facilities and ASCs. If the Council approves, the principles outlined in this memorandum will serve as a guide for review of such applications, each of which must be reviewed on a case-by-case basis. The use of these principles will insure the integrity of the establishment process, while allowing dialysis facilities and ASCs the flexibility needed to provide high quality, cost-efficient health care services in the current health care marketplace. There have been a small number of similar projects, which received contingent approval, on past agendas. These have been defined in purchase and sale agreements as those assets which only a person who has received establishment approval can own. Such assets would include the CON itself, the facility name and contracts with professionals and key management employees. In the current applications, the Outside Entity is a publicly-traded company which is not itself a permitted Article 28 operator. *See* Public Health Law ("PHL") § 2801-a(4)(e). These would include furniture, fixtures, equipment and supplies for the facility. PHL § 2801-a(3)(b). *See* PHL § 2801-a(3)(c). *See* Title 10 (Health) of the Official Compilation of the Codes, Rules and Regulations of the State of New York (10 NYCRR § 620.1(b)(1)). *See* 10 NYCRR § 405.1(c). *See* 10 NYCRR § 600.9(c). *See* PHL § 2801-a(4)(b)(i) and (c). *See* PHL § 2801-a(3)(d). Shareholders may enter into agreements (such as rights of first refusal, put/call options, etc.) with other shareholders and/or third parties regarding the transfer of stock and voting rights, provided that such transfers are in compliance with PHL § 2801-a(4)(b). If the Outside Entity is a publicly-traded corporation, as it is in this instance, absent legislative change, the stock could not be transferred to the Outside Entity itself. *See* PHL § 2801-a(a)(e). *Id.* at 11. *See* 14A NYJur.2d (Business Relationships) §§ 832, 903 and 1016. *See* Business Corporation Law § 701; 14A NYJur2d (Business Relationships) §§ 829, 832. Retention of these rights does not necessarily mean that such rights cannot be encumbered. For exam-

ple, lenders may require that a certain key individual remain involved with a borrower and may prohibit the issuance of dividends depending on such matters as the cash flow of the business and whether loan payments are current. These are commercially reasonable restrictions which do not extinguish the fundamental fights to vote and receive dividends. *See* 10 NYCRR §§ 405.1(c) and 751.2, 600.9(b). *See* PHL § 2801-a(3)(c). *See* 10 NYCRR § 600.9(c).

Endnotes

1. There have been a small number of similar projects, which received contingent approval, on past agendas.
2. These have been defined in purchase and sale agreements as those assets which only a person who has received establishment approval can own. Such assets would include the CON itself, the facility name and contracts with professionals and key management employees.
3. In the current applications, the Outside Entity is a publicly-traded company which is not itself a permitted Article 28 operator. *See* Public Health Law ("PHL") § 2801-a(4)(e).
4. These would include furniture, fixtures, equipment and supplies for the facility.
5. PHL § 2801-a(3)(b).
6. *See* PHL § 2801-a(3)(c).
7. *See* Title 10 (Health) of the Official Compilation of the Codes, Rules and Regulations of the State of New York (10 NYCRR) § 620. 1(b)(1).
8. *See* 10 NYCRR § 405.1(c).
9. *See* 10 NYCRR § 600.9(c).
10. *See* PHL § 2801-a(4)(b)(i) and (c).
11. *See* PHL § 2801-a(3)(d).
12. Shareholders may enter into agreements (such as rights of first refusal, put/call options, etc.) with other shareholders and/or third parties regarding the transfer of stock and voting rights, provided that such transfers are in compliance with PHL § 2801-a(4)(b).
13. If the Outside Entity is a publicly-traded corporation, as it is in this instance, absent legislative change, the stock could not be transferred to the Outside Entity itself. *See* PHL § 2801-a(a)(e).
14. *Id.* at 11.
15. *See* 14A NY Jur.2d (Business Relationships) §§ 832, 903 and 1016.
16. *See* Business Corporation Law § 701; 14A NYJur2d (Business Relationships) §§ 829 and 832.
17. Retention of these rights does not necessarily mean that such rights cannot be encumbered. For example, lenders may require that a certain key individual remain involved with a borrower and may prohibit the issuance of dividends depending on such matters as the cash flow of the business and whether loan payments are current. These are commercially reasonable restrictions which do not extinguish the fundamental rights to vote and receive dividends.
18. *See* 10 NYCRR §§ 405.1(c) and 751.2.
19. *See* 10 NYCRR § 600.9(b).
20. *See* PHL § 2801-a(3)(c).
21. *See* 10 NYCRR § 600.9(c).

EXHIBIT B

New York State Department of Health Interoffice Memorandum

To: Members of the Public Health Council
Members of the State Hospital Review and Planning Council

From: Susan Regan, Esq.
Chair, PHC Establishment Committee

Thomas J. Sinatra, M.D.
Chair, SHRPC Planning Committee

Subject: Representative Governance

Date: March 7, 2001

This is to present the recommendations of the Workgroup on Representative Governance, a joint endeavor of the Establishment Committee of the Public Health Council and the Planning Committee of the State Hospital Review and Planning Council. These recommendations are a product of the Workgroup's meetings, which began in April, 2000, and of background work by Department staff, especially in the area of renal dialysis. We present these recommendations for consideration as a policy to guide the councils and the Department in reviewing applications for representative governance for Article 28 providers.

1. Providers of Chronic Renal Dialysis Services

Because of the significant decline in real terms of Medicare reimbursement for ESRD services since the inception of the program in 1973, the access to capital and the efficiencies offered by the national and international firms can provide a positive benefit to the provision of quality dialysis services. Therefore, the Workgroup recommends that the SHRPC and the PHC continue to consider, and where appropriate approve, applications for representative governance arrangements between dialysis providers and outside entities not eligible for establishment under Article 28, provided that any such arrangements are consistent with the principles set forth in the memorandum of DOH General Counsel to the SHRPC and the PHC of September 21, 1999:

- The established operator retains the ultimate authority over and responsibility for the facility's operations (the so-called "reserve powers")
- The approved shareholder is the sole beneficial owner of the stock
- Any subsequent transfers of stock or voting rights of 10 percent or more are approved by the PHC
- The project does not involve an improper sharing of facility revenue.

2. Other Article 28 Providers

Unlike providers of chronic renal dialysis, other Article 28 facilities—hospitals, nursing homes, general D & T centers and ambulatory surgery centers (ASCs)—are not dependent on an exclusive funding source, nor do they offer a single, discrete service to a population with a common diagnosis. Therefore, they are viewed differently for representative governance purposes. For example, the status of the voluntary general hospital as a resource to the local community may make the preservation of local control of the institution advisable.

The Workgroup recommends that, for the immediate future, the Public Health Council and the State Hospital Review and Planning Council consider, on a case-by-case basis, applications that involve representative governance arrangements for types of Article 28 providers other than renal dialysis facilities, provided that such proposals are not inconsistent with the general principles set forth in the cited September 21, 1999 memorandum and also maintain, at a minimum:

- Local control of the Article 28 provider and its operations
- Accountability of the Article 28 provider to the community
- Preservation of the use of the assets of the Article 28 provider exclusively for the community it serves.

Local control and accountability of the provider shall mean:

- Effective decision making authority and control over the operation and management of the facility, and the majority of the economic and ownership interest in the Article 28 operator, must be vested in persons not associated with or controlled by, either directly or indirectly, the outside entity. The activities over which the persons not affiliated with the outside entity must retain authority and control include:
  1. appointment or dismissal of facility management level employees and medical staff;
  2. approval of facility operating and capital budgets;
  3. adoption or approval of facility operating and management policies and procedures;

4. the filing of certificate of need applications on behalf of the facility;
5. approval of facility debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
6. approval of facility contracts for management or clinical services;
7. maintenance of the facility's books and records;
8. authority over the disposition of assets and the incurring of liabilities associated with the operation of the facility;
9. approval of settlements of administrative proceedings or litigation to which the operator is a party;
10. patient billing activities and all receivables and facility bank accounts.

Preservation of the use of the assets of the Article 28 provider for the community shall mean:

- All contracts between the Article 28 operator and the outside entity for goods or services must be at fair market value;
- Any lease or sale agreement between the Article 28 operator and outside entity relating to the facility real estate or equipment must be at fair market value;
- No income or profits from the Article 28 facility may be distributed to any person affiliated with the outside entity in a percentage that exceeds the outside entity's representative's minority ownership interest in the facility.
- Any change in the outside entity's representative's share of ownership interest in the Article 28 facility operator shall be subject to approval by the Public Health Council.

3. Short-Term and Long-Term Considerations

The Workgroup notes that non-dialysis Article 28 providers vary widely in their organization, financial needs, services offered and populations served. The approach we have recommended for review of local control, accountability and preservation of assets should therefore be applied on a case-by-case basis. We also suggest that the councils consider applying these criteria for an interim period. We further recommend that the councils appoint a new joint workgroup to evaluate whether to make the review criteria for local control, accountability and preservation of assets permanent, through regulation or legislation. The workgroup could also consider the question of whether representative governance should be restricted to certain categories of providers. At the end of the interim period, the full PHC and SHRPC could evaluate the impact of the recommended review criteria for local control, accountability and preservation of assets, in light of the types of representative governance applications brought before each council for consideration.

Mandatory Reporting of Suspected Abuse, Neglect or Mistreatment: Understanding Some of the Perils for Long-Term Care Providers

By Ari J. Markenson

Federal and state statutes and regulations require the reporting of suspected abuse, neglect or mistreatment of residents of long-term care facilities or nursing homes ("Providers"). While these statutory and regulatory requirements have been in place for quite some time, current enforcement and an overall push by regulators to increase reporting has led to a better understanding of the perils for Providers. Additionally, the frequency by which Providers are visited by the Medicaid Fraud Control Unit of the New York State Office of the Attorney General and/or the Bureau of Surveillance and Quality Assurance of the New York State Department of Health has changed dramatically in recent years. As a result, Providers are facing significant scrutiny in the reporting and investigative process, some of which may seem unwarranted.

Federal Requirements

Federal statutes and regulations set forth minimum standards for Providers participating in both the Medicare and Medicaid programs. Additionally, they set forth requirements and standards for state agencies administering the Medicaid program. The minimum standards include mandatory reporting and investigation requirements regarding suspected abuse, neglect and mistreatment of persons receiving services in a facility. The requirements for states address a state agency's obligation to collect complaints, and to document and investigate suspected abuse, neglect or mistreatment. The federal requirements, however, primarily leave the process and specifics of investigation and enforcement up to the state agency responsible for enforcement.

Acting as an agent of the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (DOH), is required by 42 U.S.C. §§ 1395i-3(g)(1)(C) and 1396r(g)(1)(C) to investigate allegations of resident neglect and abuse or misappropriation of resident property.

Providers participating in Medicare/Medicaid, as a component of their obligations to protect and promote resident rights, must provide residents with a "statement that . . . [they] may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility . . ." pursuant to 42 U.S.C. § 1395i-3(c)(1)(B)(iii), 42 U.S.C. § 1396r(c)(1)(B)(iii) and 42 C.F.R. § 483.10(b)(7)(iv).

In addition to advising residents of their rights, Providers must generally, pursuant to 42 C.F.R. § 483.13(c): (1) develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property; (2) prohibit the use of verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; (3) not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents; (4) ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported; (5) have evidence that all alleged violations are thoroughly investigated; and (6) report the results of all investigations in accordance with state law within five working days.

State Requirements

New York State statutes and regulations, while substantially similar to the federal requirements, require a stricter time frame for reporting and are more detailed in some respects concerning when and how to report suspected abuse, neglect or mistreatment.

The primary reporting obligations for Providers can be found in Public Health Law § 2803-d (PHL). This statute requires that certain specified persons and entities report "when they have reasonable cause to believe that a person receiving care or services in a residential health care facility has been physically abused, mistreated or neglected." Reports under the statute must be made "immediately by telephone and in writing within forty-eight hours." The issue of what constitutes "reasonable cause to believe" has been the subject of debate in the Provider community for quite some time. Regulations defining the abuse, neglect and mistreatment requirements and specifically what represents "reasonable cause" can be found in 10 N.Y.C.R.R. part 81. Additionally, further clarification of Provider reporting requirements can be found in a "Dear Administrator" letter written by the DOH on March 1, 2000 (DAL 00-04).

In addition to the requirements of PHL § 2803-d and 10 N.Y.C.R.R. part 81, and similar to 42 C.F.R. § 483.13, 10 N.Y.C.R.R. § 415.4 requires Providers general-

ly to: (1) develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents and misappropriation of resident property; (2) prohibit verbal, mental, sexual or physical abuse, including corporal punishment, or involuntary seclusion of residents; (3) not employ individuals who have been found guilty of abusing, neglecting or mistreating residents; (4) ensure that alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, are reported; (5) document that all alleged violations are thoroughly investigated; and (6) report the results of all investigations to the administrator or to other officials in accordance with Public Health Law § 2803-d.

Perils of Mandatory Reporting

Compliance with the regulatory requirements mentioned is not voluntary. Recently, however, Providers have begun to more critically evaluate whether or not an incident should be reported under the statutes and regulations mentioned due to significant concerns over the process by which reports are investigated and the consequences of making a report. Perils involved in reporting include the investigative targeting of the Provider, staff shortages, and the imposition of "Strict Liability" survey deficiencies.

The Provider community has experienced serious negative consequences as a result of appropriately performing its reporting obligations. With increasing frequency, Providers who have reported potential abuse, neglect or mistreatment and have provided concrete evidence to investigators are facing inquiry into the ownership, administration, and operation of the facility rather than a focused investigative effort on the suspected abuser. Investigators seem to be taking an approach that focuses on suspecting facility-wide issues first and then analyzing the suspected individual. Unfortunately, this wide-reaching approach has created an adversarial culture in which many Providers are considering whether or not it is wise to open up "Pandora's Box" by reporting questionable cases.

Providers are also presently facing serious and sustained staff shortages. The current climate, which encourages reporting of even the slightest suspicious event, is depriving Providers of an adequate workforce in certain circumstances. Nurse aides with thirty years of experience who have dedicated a career to a Provider are increasingly being suspended on the spot simply as a result of an allegation. Provider administration is less likely to retain an employee involved in a suspicious event whether or not the investigation has been completed. The risks of adverse media and other consequences as a result of retaining such an employee are serious enough that they have created a "rush to judgment" mentality.

In addition, New York Providers continue to be subject to "Strict Liability" survey deficiencies. This occurs despite several reported administrative appeal cases that specifically reject such an application of the regulatory requirements. Providers have been cited with deficiencies, indicating Provider liability, in cases where the Provider appropriately trained the staff member and screened them prior to employment. Despite screening and appropriate training, the staff member committed an act of abuse.

The three points mentioned above do not represent the entirety of the issues facing Providers, but rather they seem to be the most prevalent currently. An awareness of these issues is important to Providers and their counsel. Counsel to Providers can and should initiate a discussion with clients about these issues. There are some several ways in which counsel can assist Providers with these issues. For example, counsel can (1) provide effective assistance with the investigating and reporting of suspected cases; (2) establish boundaries to a investigation and get a "read" on investigators to determine the scope of an investigation; (3) assist a Provider in determining the appropriate approach to an employee alleged to have committed abuse; (4) evaluate whether the facts and findings of a deficiency actually sustain a violation; and (5) if necessary assist a Provider in disputing a survey deficiency both with the informal dispute resolution process and/or, if applicable, administrative appeals. This assistance can be invaluable to a Provider facing more of an investigation than they bargained for and potential penalties as a result.

Conclusion

Unfortunately, a change in the enforcement climate seems unlikely. However, counsel that advise and assist Providers to appropriately manage the reporting and investigation process will likely see a corresponding change in the risks Providers expose themselves to. Providers should be made aware of the potential perils that exist and how to best approach them to minimize the potential for burdensome investigation, retain staff and prevent survey deficiencies.

Ari J. Markenson, J.D., M.P.H. is an associate in the National Health Law Practice of Epstein Becker and Green, P.C. (New York). His areas of practice focus on regulatory and transactional matters for health care providers, particularly sub-acute and long-term care providers. Mr. Markenson is also the editor-in-chief of *The Long Term Care Survey and Certification Guide*, a comprehensive publication on the federal survey process for long-term care facilities.

Third World Health Care in 2002: Observations from a Trip to Nicaragua

By L. Susan Scelzo Slavin

I am an attorney in private practice, and the former Chair of the Health Law Section Committee on Consumer/Patient Rights. In the fall of 2001, I was asked to accompany a group traveling to Nicaragua to render assistance to a local community. I made this humanitarian mission with members of my church, Our Lady Queen of Martyrs in Centerport, New York, in February 2002. The twelve members consisted of a variety of professionals, including a newspaper editor, banker, parish priest, financial analyst, nurse, teacher, psychologist, etc. All of us took time from our jobs and had no particular expertise on the issues of poverty in the Third World. We paid our own way down and each carried two suitcases filled with school supplies which had been previously donated. The only personal items we brought were those that fit in our backpacks.

"[T]he level of poverty in Nicaragua is simply indescribable. There is no running water, no bathrooms, no showers, little electricity, little health care and few, if any, vehicles. . . . They obtain their drinking water via wells which, in many instances, are rancid. Yet, incredibly, these people are full of hope and faith."

We were in the village of Amatitan for the purpose of completing the building of a church begun over 20 years ago and assessing the needs of this impoverished community. I have never witnessed such poverty as exists in this country. In contrast, I was in Appalachia the previous summer to help repair homes for the poor and "thought" I witnessed poverty. Unfortunately, the level of poverty in Nicaragua is simply indescribable. There is no running water, no bathrooms, no showers, little electricity, little health care and few, if any, vehicles, etc. They obtain their drinking water via wells which, in many instances, are rancid. Yet, incredibly, these people are full of hope and faith.

While there, we met with the Pastoral Committee who, at our request, articulated the community's needs in terms of housing, education and health care. We also met a 32-year-old man, Cayetano Hernandez, who had metastatic cancer. He had surgery in June of 2001 with a one-week cycle of chemotherapy. The medical care in this country is basically non-existent. A doctor visits the town every eight days. When I met Mr. Hernandez, he had not received any treatment since November 2001. He did, however, have prescriptions for pain as well as chemotherapy to be administered via IV. We also met a teenager who was suffering from a tooth abscess. He was bandaged from head to chin and the wound was in need of cleaning. He also had a prescription for an antibiotic. The prescriptions for these men were essentially worthless since there was no money to pay for them, nor a way to administer them. Since the gentleman with cancer had no pain medication, we had that prescription filled as well as the antibiotics for the teenager. To help relieve the suffering, on the day we left, we filled a large bag with all the prescription medications and over-the-counter medicines we had brought with us, with instructions on how to use them.

While I was there, I simply knew that when I returned to the United States, I could ask my colleagues in the Health Law Section to assist in any way in helping to bring this dying man to the United States for treatment. In anticipation of this assistance, I brought his medical records back with me. I sent out an e-mail and gratefully, in a matter of days, I received assistance from two of our colleagues, Barry Gold and Robert Wild. Both of these men reacted immediately to the plight of this young man. Bob was able to obtain the services of two hospitals in New York who immediately, upon review of his medical records, translated same into English, had them reviewed by an oncologist and offered to bring him to this country to treat him. Since Bob had the treatment "covered," Barry continued to monitor the progress and give me much-needed emotional assurance. Unfortunately, the oncologist advised that there was nothing left to treat since the medical records were at least three months old and the cancer had spread to such a great degree. At my request, in a desperate effort, the hospitals volunteered to donate the pain medication he needed and shipped them to Nicaragua as expeditiously as possible. Unfortunately, Mr. Hernandez died in the interim.

At the time, both Barry and Bob requested that their participation be anonymous. It is only after Barry's tragic death a few weeks ago that I felt it would be important to reveal these two names—two of our colleagues, tough litigators and adversaries, who quick-

ly and selflessly took that "step up to the plate" simply because, I am sure, they felt it was the "right thing" to do. In fact, after Mr. Hernandez's death, they both told me to come back to them if further medical assistance was needed for anyone else.

We at Our Lady Queen of Martyrs have a continuing relationship with this community. In the past eight months, we have established over 60 educational sponsors between members of our community and students in Amatitan for elementary, high school and college tuitions. On our return trip this February, we plan to build two cinderblock homes for the most needy community members (at a cost of $1,000 each). We have also applied for and obtained a grant for one-third of the cost of building a storage tank and mechanized pump to provide potable water to the school and twenty of the nearest homes. The funding for the remaining cost of the project came from various community fund-raisers such as car washes, etc. This will be the first time this community will have running water.

At our request, they have forwarded medical records of another seriously ill young man, Luis Ramirez. Mr. Ramirez is suffering from a severe eye disorder and is going blind. There is absolutely no available treatment for him in Nicaragua and his physician's only solution is to refer him to a hospital in Guatemala. To me, that was simply no choice at all. As with Mr. Hernandez, as soon as I received his medical records and they were translated into English, I requested that a local ophthalmologist and the Ophthalmology Department at the State University Hospital at Stony Brook review these medical records, assess the situation and, if possible, help this young man. After months of bureaucracy, a passport and visa have just been issued and we expect Luis and his father to arrive in mid-November. He will be treated at Stony Brook Hospital as a "teaching case."

In these past few months, we have tried to educate ourselves as much as possible about health care issues in Nicaragua. Some members of our committee met with a professor from Columbia University's School of Public Health who was incredibly generous with his time. He spent a considerable amount of time in Nicaragua in the early '90s and validated what we had done so far in terms of priorities, i.e., education and potable water, and focused us on the health care issues. Unfortunately, whereas the medical conditions of Mr. Hernandez and Mr. Ramirez were the ones that caught the attention, we were advised by the professor as well as experienced missionaries in Nicaragua that we need to get more "bang for the buck." In other words, instead of spending thousands of dollars for one case, our goal should be to raise everyone in the community "up a notch" in terms of health care. This is a very difficult concept for me. I know intellectually it is the only way to reach the greatest number of people. It does, however, feel that such decisions are beyond the scope of our mortal capabilities. When we return in February, we intend to take an abandoned railroad station, a wonderful sturdy building, clean it up and outfit it as a community medical center. We also plan to train members in the community in basic first aid and clean water testing.

"When I met Mr. Hernandez for the first time and was made aware of his suffering, I simply 'knew' that somehow we would be able to get help. It was Barry Gold and Bob Wild who became the vehicles that translated my faith into action."

My experience in Nicaragua was indescribable in many ways since a large part was based on faith. When I met Mr. Hernandez for the first time and was made aware of his suffering, I simply "knew" that somehow we would be able to get help. It was Barry Gold and Bob Wild who became the vehicles that translated my faith into action. It was unfortunate that it was too late to help Mr. Hernandez. We are awaiting Luis and his father's arrival with anxious anticipation.

I know that I can always come back to my colleagues in the Health Law Section for help for cases like these two young men. There are no easy answers or explanations for any of the suffering that exists in this world. I'm also a believer that there are "no accidents" when it comes to these situations. I have been asked many times, "Why the Third World, what about the poor in this country?" I can only respond that poverty exists everywhere and if you are fortunate enough to be touched personally, and are lucky enough to get the opportunity to connect, it should not matter where this connection takes place.

May Barry rest in peace. His humanity was well known to all who had the privilege and honor to know him.

L. Susan Scelzo Slavin practices at the Slavin Law Firm, PC in Jericho, NY, and formerly co-chaired the Consumer/Patient Rights Committee of the Health Law Section.

Recent Developments Relating to Physician-Assisted Suicide[1]

By Professor David Pratt

In June 1997, the U.S. Supreme Court held unanimously that New York and Washington state criminal laws prohibiting assisted suicide did not violate the U.S. Constitution.[2] The Court also made clear, however, that its decisions did not foreclose further debate,[3] and Justice O'Connor, in her concurring opinion, stressed that determinations as to the legality of assisted suicide should initially be made at the state level.[4]

". . . a majority of the Court . . . accepted that dying individuals have a right to be free of unnecessary pain and suffering at the end of life."

The most interesting portions of the decisions are the discussions of palliative care in the concurring opinions. Taking into account the tenor of Justice Souter's opinion, a majority of the Court (Justices Stevens, O'Connor, Souter, Ginsberg and Breyer) accepted that dying individuals have a right to be free of unnecessary pain and suffering at the end of life. Robert Burt concludes from this that "a Court majority has found that states must not impose barriers on the availability of palliative care for terminally ill patients" and that state laws "restricting the availability of opioids for the management of pain are the most likely targets for judicial invalidation by this criterion."[5]

This article discusses important developments since the Supreme Court decisions, including the recent attempt by Attorney General John Ashcroft to eviscerate the Oregon Death With Dignity Act by administrative fiat.

The Oregon Experience

Background

In 1994, Oregon became the first state expressly to legalize physician-assisted suicide (PAS) when the voters approved Measure 16, subsequently enacted as the Death With Dignity Act.[6] Implementation of the Act was enjoined by a federal district court judge, who held that the statute violated the Fourteenth Amendment.[7] Although this decision was subsequently vacated on procedural grounds,[8] implementation of the Act was further deferred, because opponents of the Act sought to have it overturned. For the first time in the state's history, a ballot initiative was resubmitted to the voters. Measure 51 (to repeal the Act) appeared on the ballot in November 1997, and was defeated by a much wider margin (60% to 40%) than the majority that originally supported Measure 16.[9]

Also in 1997, Sen. Orrin Hatch and Rep. Henry Hyde—chairmen of, respectively, the Senate and House Judiciary Committees—wrote to Thomas Constantine, administrator of the Drug Enforcement Administration, to inquire whether writing a prescription under the Oregon law would violate the federal Controlled Substances Act (CSA). In a November 5, 1997, letter to Hatch, Constantine stated that[10] "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide" would not be a "legitimate medical purpose"[11] and that a physician who did so could lose the privilege to prescribe controlled substances.

Attorney General Reno subsequently indicated that the letter was sent without her approval, that the Justice Department was reviewing the Oregon law,[12] and that Constantine should have waited for the full Justice Department review before warning doctors about prescribing lethal medication.[13] The Justice Department ultimately concluded in June 1998 that the DEA does not have the authority to punish doctors who write prescriptions under the Oregon statute.[14]

Opponents of PAS did score one legislative success when, on April 30, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide. In June 1998, Sen. Nickles and Rep. Hyde introduced The Lethal Drug Abuse Prevention Act,[15] whose purpose was "To clarify Federal law to prohibit the dispensing or distribution of a controlled substance for the purpose of causing, or assisting in causing, the suicide, euthanasia or mercy killing of any individual." The bill died when Congress adjourned.

In June 1999, Sen. Nickles and Rep. Hyde introduced a revised bill, the Pain Relief Promotion Act,[16] which was supported by several organizations that had opposed the 1998 bill, including the AMA. Opponents included the Oregon Medical Association, the Oregon Hospice Association, Oregon Gov. Kitzhaber and most of Oregon's Congressional delegation. Despite early support, the bill went nowhere, largely because of a filibuster threat by Oregon Sen. Wyden.

Enter Ashcroft

On June 27, 2001, deputy assistant attorney general Sheldon Bradshaw sent to Attorney General John Ashcroft a memorandum[17] concluding that PAS is not a "legitimate medical purpose" under the CSA. On November 6, 2001, Ashcroft sent a letter to the DEA, determining that assisting suicide is not a "legitimate medical purpose" and that a physician's license to prescribe is subject to suspension or revocation if he or she prescribes lethal medication for assisting suicide.[18] Ashcroft directed the DEA to enforce and apply this determination, stating that the determination "makes no change in the current standards and practices of the DEA in any State other than Oregon," and claimed that the Justice Department has the authority to obtain copies of confidential documents filed with Oregon Health Services when an assisted suicide occurs.

Ashcroft's ruling has been opposed by all of Oregon's five members of the House of Representatives and by Sen. Wyden. It is supported by Sen. Smith. Medical groups, including some who oppose PAS, fear that the ruling may undermine efforts to improve pain management.

On November 7, 2001, the state of Oregon filed a complaint in the U.S. District Court for the District of Oregon, seeking a declaratory judgment and injunctive relief. On November 8, Judge Robert E. Jones granted a temporary restraining order preventing enforcement of Ashcroft's ruling for 10 days, on the ground that "irreparable injury" might otherwise occur to "Oregon physicians, terminally-ill patients, and the sovereign and regulatory interests of Oregon."[19] On November 20, the parties stipulated to an extension of the TRO to allow the court to proceed directly to consideration of the request for a permanent injunction.

Judge Jones also ordered:

> The directive of Attorney General Ashcroft issued on or about November 6, 2001, shall be unenforceable and of no legal effect pending further order of this court. Physicians, pharmacists, and other health care providers in Oregon shall not be subject to criminal prosecution, professional disciplinary action or other administrative proceedings for any actions taken in compliance with the Oregon Death with Dignity Act while this temporary restraining order remains in effect.

On April 17, 2002, Judge Jones issued a written decision that permanently enjoined the defendants from "enforcing, applying, or otherwise giving any legal effect to" the Ashcroft directive. He also ordered that health care providers shall not be subject to criminal prosecution, professional disciplinary action or other administrative proceedings for any actions taken in compliance with the Oregon Act.[20] The decision was based entirely on statutory grounds. Judge Jones held that neither the CSA, nor its legislative history, nor the cases supported the defendants' argument that Congress intended to delegate "to the Attorney General or the DEA the authority to decide, as a matter of national policy, a question of such magnitude as whether physician-assisted suicide constitutes a legitimate medical purpose or practice."[21] In view of this holding, the Judge found it unnecessary to address the state's argument that the directive also violated the Tenth Amendment to the Constitution.

In May 2002, the defendants filed a notice of appeal: the decision on appeal is unlikely to be issued before late 2003.[22]

Experience Under the Death with Dignity Act

The state of Oregon publishes an annual report summarizing the experience under the Act, and summaries of these reports are published in the *New England Journal of Medicine*. For the first four years, the reported activity under the Act was as follows:

	Patients Receiving Prescriptions	Deaths After Taking the Prescription	Deaths from Underlying Disease	Alive at End of Year
1998	23	15	6	2[23]
1999	33	27 (1 received it in 1998)	5	2[24]
2000	39	27 (1 received it in 1999)	8	5[25]
2001	44	21 (2 received drugs in 2000)[27]	14	11[26]

Supporters of PAS argue that the reports indicate that the statute is working as was intended, and that the Oregonians using the Act are motivated by a desire for autonomy rather than being coerced by inadequate palliative care or lack of health insurance. According to the most recent annual report:

> All patients, except one, died at home; that patient died in an acute-care hospital with the hospital's consent. As in previous years, most (76%) of the patients who used PAS in 2001 were enrolled in hospice care; the others were offered hospice but declined. All patients had some form of health insurance . . .

> Prescribing physicians were present while nine (43%) of the 21 patients ingested the lethal medications. Other health care providers were present while 11 of the remaining patients (52% of the total) ingested the medications . . .
>
> Physicians were asked if, based on discussions with patients, any of six end-of-life concerns might have contributed to the patients' requests for lethal medication. . . . In all cases, physicians reported multiple concerns contributing to the request. The most frequently reported concerns included: losing autonomy (94%), decreasing ability to participate in activities that make life enjoyable (76%), and losing control of bodily functions (53%).[28]

Opponents, such as Americans for Integrity in Palliative Care (whose founders include C. Everett Koop and Herbert Hendin), criticize the Oregon Health Division's reports on PAS, contending that insufficient evidence exists to establish that patients did receive adequate pain relief and were not motivated by financial concerns.

Oregon has also sought to improve palliative care in the state. In December 1998, the Task Force on Pain and Symptom Management made recommendations that focused on the treatment of chronic pain, and surveys suggest that palliative care in Oregon is better than in the nation as a whole. A survey mailed to 3,981 Oregon physicians in 1999 found that 51% supported the Act, 32% opposed it, and 17% neither supported nor opposed it.[29]

Other State Legislation

Since 1994, numerous bills and ballot initiatives to decriminalize PAS have been introduced in various states, but none have been enacted. In November 1998, voters in Michigan (Dr. Kevorkian's home state) defeated by 71% to 29% Proposal B, that would have legalized PAS. In November 2000, Maine voters defeated the proposed Maine Death With Dignity Act, which was largely based on the Oregon statute, by 51.3% to 48.7%.

Several states (including Maryland, Michigan and Oklahoma) have enacted new statutes criminalizing PAS. Accordingly, it appears likely that, for the foreseeable future, Oregon will continue to be the only state with a statute specifically permitting PAS. Future legislative efforts in the states are more likely to succeed if they focus on removing barriers to adequate pain relief, and generally improving palliative care, at the end of life. Thus, Michigan Gov. Engler has signed several bills reflecting the recommendations of the Commission on End of Life Care. In California, A.B. 791 requires pain management and end-of-life care to be part of the medical school curriculum. A.B. 487 requires physicians to take classes in pain management and end-of-life care, and the California Division of Medical Quality is to develop standards for pain management. In August 2001, Oregon Gov. Kitzhaber signed S.B. 885, establishing the Pain Management Commission within the Department of Human Services. Licensed health professionals will be required to take a pain management education program, beginning in 2006.

Reports

Reports have been issued by several governmental and non-governmental bodies, most of which focused on improving end-of-life care.

The Florida Panel for the Study of End of Life Care, a study group created by the legislature, issued its final report in August 1999.[30]

The report issued by Hawaii Gov. Ben Cayetano's Panel on Living and Dying With Dignity is unusual, in that it recommended that the legislature authorize PAS and euthanasia for "mentally-alert patients who either are terminally ill or suffer intractable and unbearable illness that cannot be cured or successfully palliated." It appears unlikely that the legislature will implement the recommendation.

In Massachusetts, the Special Subcommittee on End of Life Care issued a report in January 1999, recommending formation of a permanent governor's task force on end-of-life care.

In January 2000, Michigan Gov. Engler appointed a new Commission on End of Life Care, which has issued a report on ways to improve end-of-life care in Michigan.[31]

In June 2001, the National Cancer Policy Board of the Institute of Medicine and the National Research Council issued a report, *Improving Palliative Care for Cancer* (Kathleen M. Foley and Hellen Gelband, eds.).[32]

Under-Treatment of Pain

Beverly Bergman filed a complaint with the Medical Board of California, asking that Dr. Wing Chin be disciplined for failing to provide adequate pain relief to her father, William Bergman, before his death from cancer. The Board found that the pain management "was indeed inadequate," but declined to take any action. The family sued, and in June 2001 a jury awarded $1.5

million in damages. The hospital had already settled out of court for an undisclosed amount. In August 2001, the judge reduced the jury award to $250,000, after finding that the California cap on medical malpractice awards applied.[33]

In March 1999, the Oregon Medical Board charged Dr. Paul Bilder, a pulmonary disease specialist, with misconduct and negligence for failing to give adequate pain medication. The parties agreed to an order acknowledging that his treatment constituted misconduct and negligence, and he was required to complete a disciplinary plan. According to the Federation of State Medical Boards, this was the first state action against a physician that was primarily for under-treating pain. In August 2002, the Oregon Board of Medical Examiners again charged Dr. Bilder with failing to properly treat the pain of dying patients.

End-of-Life Care

In July 1997, the Institutes of Medicine issued a report[34] which calls for reforms to improve end-of-life care, including better training of health care professionals in palliative care; the inclusion of more palliative care experts on health care teams; and changes to laws that contribute to the underuse of opioids to relieve pain. The report also called for reforms to health care reimbursement rules, to encourage high-quality end-of-life care.

At the American Medical Association's annual meeting in June 1997, a patient's "bill of rights" for end-of-life care was released by the AMA's Ethics Standards Division.[35] The eight specified rights include:

> Trustworthy assurance that physical and mental suffering will be carefully attended to and comfort measures intently secured. Physicians should be skilled in the detection and management of terminal symptoms, such as pain, fatigue, and depression, and able to obtain the assistance of specialty colleagues when needed.[36]

In March 1998, the AMA announced The Education for Physicians on End-of-Life Care Project, designed to educate physicians in essential end-of-life care skills. The curriculum includes palliative care, ethical decision making, symptom management, communication skills and psychosocial skills.[37] In October 1998, the AMA launched the project, with the first of four programs to train 250 physicians on hospice care.

In January 1999, the New York State Partnership to Improve End-of-Life Care received a grant from the Robert Wood Foundation to improve care of the dying. The lead organization is the New York State Department of Health.

Several state medical associations and the JCAHO have endorsed a set of core principles for end-of-life care.[38]

Pain Management and Palliative Care

In August 1999, the JCAHO adopted new standards on pain management that went into effect on January 1, 2001.

In April 2001, the National Comprehensive Cancer Network and the American Cancer Society introduced new Cancer Pain Treatment Guidelines for Patients, which integrate palliative care into cancer therapy. The section on PAS and euthanasia states that "the most appropriate response to a request for assistance in suicide is to intensify palliative care."[39]

Effective January 1, 2002, Medicare will recognize and pay for pain management. A new reimbursement code allows physicians to identify themselves as specialists in pain management.

The American Society of Law, Medicine & Ethics and the Center for Health Law Studies at St. Louis University have launched the Pain and the Law Web site.[40]

In May 2002, the American Geriatrics Society released new clinical guidelines on "The Management of Persistent Pain in Older Persons."[41]

International Developments[42]

In May 2001, at its annual meeting in Geneva, the World Medical Association called on physicians in the Netherlands and elsewhere not to participate in euthanasia, on the basis that it violates the ethical principles of the medical profession.

Belgium

Euthanasia is widely practiced in Belgian hospitals, but physicians have been subject to prosecution. In December 1999, the ruling coalition introduced a bill to legalize euthanasia for (1) competent adults with an incurable illness causing unbearable and constant suffering and (2) patients in a PVS who had made a request within the prior five years before two witnesses to have their lives ended in such circumstances. The bill was passed in May 2002. In September 2002, the government established a national committee of lawyers and physicians to ensure that the new law is followed. The first case arising under the law has led to an intense controversy, with the national medical association saying that the patient was not legally eligible to die under the new law.[43]

Canada

In 1995, the Canadian Senate issued *Of Life and Death: Report of the Senate Special Committee on Euthanasia and Assisted Suicide.* In February 2000, a subcommittee began conducting hearings intended to result in the filing of a new report, and its Final Report was tabled in June 2002.[44]

In March 2001, Dr. Balfour Mount published an article in *Annals*, the journal of the Royal College of Physicians and Surgeons of Canada, saying that Canada must dramatically improve palliative care for the dying to provide an alternative to euthanasia and assisted suicide. He said that good palliative care is available to only 5% of the Canadian population.[45]

In May 2001, the Canadian Pain Society launched the Patient Pain Manifesto.[46] The group said that more than half of patients in Canadian hospitals suffer moderate to severe pain, partly because they are not aware of their right to adequate pain treatment.

The Netherlands

PAS and euthanasia were, until recently, technically illegal in the Netherlands, but physicians were not prosecuted provided that certain conditions were satisfied.

The evidence from the Netherlands, the one society which has extensive documented experience with physician-assisted death, is cited by both sides in support of diametrically opposed conclusions. Proponents of PAS say of their opponents, "Many of their claims are empirically false and grossly distorted. There is no evidence of conscious, competent patients being euthanized against their will. . . . New evidence from the Netherlands . . . show that reporting has increased and the frequency of cases regarded as problematic has decreased."[47]

The Executive Editor of the *New England Journal of Medicine* concluded in a 1996 editorial: "Are the Dutch on a slippery slope? It appears not. . . . As far as we can tell, Dutch physicians continue to practice physician-assisted dying only reluctantly and under compelling circumstances."[48]

The contrary view is expressed most vehemently by Herbert Hendin, who asserts that ". . . in more than one thousand cases a year, doctors actively cause or hasten death without the patient's request. Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity."[49]

Even were the evidence unequivocal, it is not clear how relevant the Dutch experience would be for the United States, given the cultural differences between the two countries, not least in the delivery of health care.[50]

A new Dutch law, The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which legalizes both euthanasia and PAS, subject to certain safeguards, took effect on January 1, 2002. The law requires that

1. the physician know the patient well,
2. the physician determine that the patient's request is voluntary and well-considered,
3. the patient face unbearable suffering with no prospect of improvement,
4. the patient understand his or her medical situation and prognosis,
5. the physician and patient agree that there is no reasonable alternative acceptable to the patient,
6. the physician consult at least one other independent physician who has examined the patient, and
7. the physician exercise due medical care and attention in carrying out the termination of life.

The physician must report the death to a regional three-person committee consisting of a physician, a lawyer and an ethicist. The committees will publish annual reports which provide as much information as possible, while preserving anonymity, concerning the way in which they have tested actual cases against the criteria of due care. A patient's written advance directive may be a valid request for euthanasia.

Under the new bill, minors have the capacity to request termination of life. Sixteen- and 17-year-olds can in principle decide independently, though their parents must be involved in a decision to terminate their life or assist with their suicide. In the case of children aged between 12 and 16, the consent of the parents or guardian is required.[51]

According to the Dutch Embassy Web site:

> The main aim and characteristic of the Dutch policy on euthanasia is to regulate euthanasia and to bring euthanasia into the open as much as possible. Dutch policy is distinctive as it attempts to publicly regulate complex actions and decisions, which in the rest of the world are mostly conducted without public scrutiny . . .
>
> Humiliation, pain and the longing to die with dignity are the main reasons why patients request euthanasia. The right to self-determination is something the Dutch people value very highly.

> Individuals should be free to decide how they live and ultimately how they die.
>
> Since a doctor's principal duty is to preserve life, euthanasia is not a medical duty. However, doctors are obliged to do everything they can to enable their patients to die with dignity. It should be noted in this respect that two thirds of the requests for euthanasia are refused by doctors . . .
>
> People from other countries are not eligible for euthanasia in the Netherlands. The proper procedure for consideration and application of euthanasia implies that the doctor has treated the patient for some time resulting in a close doctor-patient relationship; this can not be the case with visitors from other countries.[52]

Switzerland

The organization Exit reported that it helped 120 terminally ill patients commit suicide during 1999. Switzerland does not prosecute non-physicians who assist in suicides unless they act with a selfish motive. No Exit member has ever been prosecuted, but in 1998 the authorities did stop Exit from supplying an overdose to a 30-year-old chronically depressed woman.

United Kingdom

In the case of Diane Pretty, the British House of Lords held in November 2001 that the European Convention on Human Rights did not allow a family member to help a loved one to die. In April 2002, the European Court of Human Rights unanimously ruled against her.[53]

A leading medical ethicist, Baroness Warnock, wrote an article in the legal journal *Counsel*, saying that physicians should be able to apply for court approval of euthanasia where a terminally ill patient's life cannot be made tolerable by palliative care.[54]

Criminal and Disciplinary Actions

In September 1998, Dr. Kevorkian gave Thomas Youk a lethal injection. In March 1999, Dr. Kevorkian was convicted of second-degree murder and illegal delivery of a controlled substance. He was sentenced to 10 to 25 years on the murder charge and 3 to 7 years on the lesser charge, to be served concurrently. Kevorkian's conviction was affirmed in November 2001.[55] The Michigan Supreme Court declined to review the case, and the U.S. Supreme Court denied certiorari in October 2002.[56]

In March 1999, the Oregon Court of Appeals affirmed the decision of the Oregon Board of Medical Examiners to reprimand Dr. James Gallant and suspend his license for 60 days for engaging in active euthanasia with respect to a patient who died as a result of a lethal injection administered by a nurse.[57] No criminal charges were filed.

In Washington, the state Medical Quality Assurance Commission held a hearing in May 1999 on a proposal to revoke the license of Dr. Eugene Turner, charged with suffocating a 3-day-old child who began to revive after being declared dead. In July 1999, the Board voted to censure him.

In July 1999, a Manhattan grand jury declined to indict veterinarian Dr. Marco Zancope, who had admitted injecting a 33-year-old terminally ill cancer patient with a fatal dose of phenobarbitol, at her request. Her family supported his actions.

In July 2000, Utah psychiatrist Robert Weitzel was convicted of two counts of manslaughter and three counts of negligent homicide in connection with the death of five elderly patients in a geriatric psychiatric unit. The prosecution contended that Weitzel killed them with lethal doses of morphine: Weitzel argued that he merely provided comfort care. He was sentenced to serve up to 15 years. In January 2001, he was granted a new trial.

In 1999, the Illinois medical board suspended the license of cardiologist Dr. Lance Wilson. He was charged with causing the death of Henry Taylor by an injection of potassium chloride. Wilson claimed the injection was intended merely to slow Taylor's heart. In April 2002, Cook County Judge Bernetta Bush ordered the reinstatement of his license.

Conclusion

The number of elderly people in America is projected to increase significantly over the next 30 years, so the adequacy of end-of-life care, and whether there is a "right to die" will continue to be hotly debated. The most positive outcome of the PAS cases has been a renewed focus by the medical profession on end-of-life care, including pain relief and other palliative care, and it is to be hoped that the new attention given to educating health professionals on these issues will result in greatly improved care for the dying. As Sherwin Nuland has pointed out in his wonderful book,[58] dying is generally unpleasant, but we owe it to our fellow humans to ease their suffering to the greatest extent possible.

Endnotes

1. Prof. Valerie Vollmar's Physician Assisted Suicide Web site is an invaluable resource, to which I acknowledge my debt. The site is updated quarterly. *See* www.willamette.edu/wucl/pas.
2. *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Washington State statute did not violate the due process clause of the 14th Amendment); *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (New York State statute did not violate the equal protection clause of the 14th Amendment); *see* Dale L. Moore, *The Supreme Court Speaks on Physician-Assisted Suicide*, 2 N.Y. St. B.A. Health L.J., Fall 1997, at 10; David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After* Glucksberg/Quill, 9 Alb. L.J. Sci. & Tech. 161 (1999).
3. "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997) (opinion of Rehnquist, C.J.).
4. "States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. . . . In such circumstances, 'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the "laboratory" of the States . . . in the first instance'" *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring) (citations omitted).
5. Burt, *The Supreme Court Speaks*, N. Engl. J. Med., Oct. 23, 1997; 337(17):1234, 1235.
6. Measure 16 was approved by a vote of 618,751 to 586,702 (51% to 49%). The Act is codified at Or. Rev. Stat. §§ 127.800 *et seq*. There is no minimum period of residency in Oregon before a person can use the law, and "It is up to the attending physician to determine whether or not the patient has adequately established residency." FAQs about Physician-Assisted Suicide, *available at* www.ohd.hr.state.or.us/chs/pas/faqs.htm.
7. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Ore. 1995).
8. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied*, 118 S. Ct. 328, 139 L. Ed. 2d. 254 (1997).
9. Garrow, *The Oregon Trail*, N.Y. Times, Nov. 6, 1997.
10. Egan, *Threat From Washington Has Chilling Effect on Oregon Law Allowing Assisted Suicide*, N.Y. Times, Nov. 19, 1997, at A18; *Impact of Oregon's Assisted Suicide Law on Federal Programs Is Under Investigation*, 66 U.S. Law Week 2315 (Nov. 25, 1997).
11. *Id.*
12. Egan, note 10 *supra*.
13. *Justice Dept. Re-reviewing Suicide Law*, N.Y. Times, Nov. 14, 1997, at A24.
14. *Justice Dept. Bars Punishing Doctors Aiding Suicides*, N.Y. Times, Jan. 24, 1998, at A7; Barnett, Hogan & Green, *DEA Policy on Suicide Law in Doubt: A Preliminary Review by the Justice Department Would Clear Doctors to Participate*, The Oregonian, Jan. 25, 1998.
15. S. 2151, H.R. 4006.
16. H.R. 2260, S. 1272.
17. "Whether Physician-Assisted Suicide Serves a 'Legitimate Medical Purpose' Under The Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act." The attachment containing the opinion dated June 27, 2001, does not appear in the Federal Register. It is available from the DEA.
18. The Ashcroft directive is published as AG Order No. 2534-2001, Dispensing of Controlled Substances To Assist Suicide, at 66 Fed. Reg. 56607, Nov. 9, 2001. As Judge Jones noted, "Before publication, defendants did not consult with Oregon public officials, provide any notice to them or to the Oregon general public, or provide any opportunity for any public comment anywhere." *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1084 (D. Ore. 2002).
19. Sam Howe Verhovek, *Federal Judge Stops Effort To Overturn Suicide Law*, N.Y. Times, Nov. 9, 2001, at A16.
20. *Oregon v Ashcroft*, 192 F. Supp. 2d 1077 (D. Ore. 2002).
21. *Id.* at 1089.
22. The Department of Justice (DOJ) filed its brief with the 9th Circuit on Sept. 23, 2002. The brief is available at www.compassionindying.org, as were briefs filed by the amici supporting the DOJ. Reply briefs are due November 6, 2002. *See also* Marcia Coyle, *U.S., Oregon To Renew Suicide Fight*, Nat'l L.J., Aug. 19, 2002, at A1; Todd Zwillich, *Group Slams Ashcroft on Oregon Assisted Dying Case*, Reuters, Washington, Oct. 30, 2002.
23. *See* Chine et al., *Legalizing Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 N. Eng. J. Med. 577 (1999).
24. *See* Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 N. Eng. J. Med. 598 (2000). *See also* Bascom & Tolle, *Responding to Requests for Physician-Assisted Suicide*, 288 JAMA 91 (2002) (suggesting that, if patients' underlying concerns are identified and addressed directly, suffering can be alleviated and, in almost all cases, the patients' wishes can be met without PAS); Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance With Suicide*, 347 N. Eng. J. Med. 582 (2002) (reporting that desire for control is a very important reason for requests for PAS).
25. *See* Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon, 1998-2000*, 344 N. Eng. J. Med. 605 (2001).
26. Hedberg et al., *Legalized Physician-Assisted Suicide in Oregon, 2001*, 346 N. Eng. J. Med. 450 (2002).
27. "The 21 patients who participated in PAS during 2001 were demographically similar to patients who participated in previous years, except that a slightly higher percentage were women. Cancer was the predominant underlying illness." Ore. Dep't of Human Servs., Fourth Annual Report on Oregon's Death With Dignity Act, Summary, *available at* www.ohd.hr.state.or.us/chs/pas/.
28. Ore. Dep't of Human Servs., Fourth Annual Report on Oregon's Death With Dignity Act, Results.
29. Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act*, 285 JAMA 2363 (2001).
30. *See* www.pepperinstitute.org.
31. *See* www.mdch.state.mi.us/eol/EOLreport.pdf, Aug. 2001. The Executive Summary states: "Many of these recommendations were made in response to barriers to care the Commission identified early in its study of end-of-life care."
32. See www.national-academies.org, stating that coverage of palliative and hospice care for cancer patients is undermined by a system that focuses either on active treatment or on palliative or hospice care, and does not readily allow these approaches to be integrated.
33. *See* Kathryn L. Tucker, *A New Risk Emerges: Provider Accountability for Inadequate Treatment of Pain*, 9 Annals Long-Term Care 52 (2001).
34. *Approaching Death: Improving Care at the End of Life, available at:* www.national-academies.org.
35. *AMA Lists Rights of the Dying*, UPI, Chicago (June 22, 1997).
36. The other rights listed are:
    1. The opportunity to discuss and plan for end-of-life care.
    2. Trustworthy assurance that preferences for withholding or withdrawing life-sustaining intervention will be honored.

3. Trustworthy assurance that there will be no abandonment by the physician.
4. Trustworthy assurance that dignity will be a priority.
5. Trustworthy assurance that burden to family and others will be minimized.
6. Attention to the personal goals of the dying person.
7. Trustworthy assurance that care providers will assist the bereaved through early stages of mourning and adjustment.

37. *AMA Announces Plan to Educate Physicians in End-of-Life Care*, Am. Med. News, (Mar. 8, 1998), www.ama-assn.org.

38. *See* Cassel & Foley, Principles for Care of Patients at the End of Life: An Emerging Consensus Among the Specialties of Medicine (Milbank Memorial Fund, 1999). *See also Oregon Death With Dignity, Improvements in End-of-Life Care*, *available at* www.dwd .org.

39. *See also* Foley, *Dismantling the Barriers: Providing Palliative and Pain Care*, 283 JAMA 115 (2000).

40. www.painandthelaw.org.

41. *See* www.americangeriatrics.org and www.healthinaging.org.

42. For a summary of foreign laws regarding PAS, see Derek Humphry, *Assisted Suicide Laws Around the World*, *available at:* www.assistedsuicide.org.

43. Andrew Osborn, *Belgian Outcry Over First Mercy Killing Under New Law*, The Guardian (London), Oct. 9, 2002.

44. Quality End-of-Life Care: The Right of Every Canadian. For a summary of its recommendations, *see* Mount, note 45 *infra*.

45. Mount, *End-of-Life Care: Recent Developments in the Netherlands and Canada, available at:* http://rcpsc.medical.org/english/annals/vol34-2e/endoflife_e.php3, saying that "It is estimated that five per cent of dying Canadians receive integrated, interdisciplinary palliative care. More than 90 per cent of these are cancer patients. Palliative-care access is uneven, and funding is inadequate." He also wrote that "The Dutch choice of implementing euthanasia before palliative care was pragmatic and perhaps born out of cultural and historic factors. They now are adding palliative care. Thus, in the Netherlands, both options will be available. In Canada, however, where palliative care is available to five per cent of the dying, we have chosen neither. On the one hand, our courts voted against euthanasia by the narrowest of margins, while on the other hand, our governments have failed to give adequate support to palliative care."

46. *See* www.canadianpainsociety.ca/manifesto/manifesto1.stm.

47. Brief of Amicus Curiae, Bioethicists Supporting Respondents in *Washington v. Quill*.

48. Angell, *Editorial - Euthanasia in the Netherlands - Good News or Bad?* 335 N. Eng. J. Med. 1676, 1677 (1996).

49. Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure 23 (1997).

50. *See, e.g.*, Battin, *Euthanasia: The Way We Do It, The Way They Do It*, 6 J. of Pain & Symptom Mgmt. 298 (1991).

51. In the Netherlands, "patients from the age of twelve have the right to refuse treatment. This principle is universally accepted in the Netherlands, and Minister Borst feels that it should also apply to requests for euthanasia. 'I believe—and this is a view I share with practically every paediatrician in this country—that there is never, or very rarely, disagreement between young people and their parents on a request for euthanasia. Anyone who knows how very seriously people in the Netherlands take the matter will understand that a conflict like this is really hypothetical.'" de Vries, note 52 *infra*.

52. Dutch Policy on Euthanasia, www.netherlands-embassy.org. See also Bill Passed in Parliament, on the same web site (stating *inter alia*, that "The new statutory rules will not make any substantive changes to the grounds on which life may be terminated on request or on which assistance with suicide is permitted. The requirements of due care have however been formulated in somewhat more detail"). *See also* Rijk de Vries, Euthanasia in the Netherlands (2000), available on the same web site (stating that "According to a study recently commissioned by the government, some 9,700 patients a year request euthanasia. It is performed on approximately one out of three of them—some 3,200 patients. This accounts for 2.4% of all deaths in the Netherlands. Doctors say that they usually cut short the lives of their patients by only a few hours or days . . . doctors terminate the lives of patients who are unable to make their wishes known . . . about one thousand times a year in the Netherlands, and the patients in question are usually in a coma or the final stages of senile dementia, or they are newly born babies with very serious handicaps. Doctors are not permitted to terminate the lives of patients who are unable to make their wishes known. Criminal proceedings have recently been brought against a number of doctors who did so. Their cases were ultimately dismissed, since the doctors were acting in circumstances beyond their control. Their patients were suffering so unbearably that morally speaking they had no other choice. There are approximately 400 cases of assisted suicide every year.")

53. *See Pretty v. United Kingdom*, www.echr.coe.int/Eng/Judgments.htm. "The Court cannot but be sympathetic to the applicant's apprehension that without the possibility of ending her life she faces the prospect of a distressing death. It is true that she is unable to commit suicide herself due to physical incapacity and that the state of law is such that her husband faces the risk of prosecution if he renders her assistance. Nonetheless, the positive obligation on the part of the State which is invoked in the present case would not involve the removal or mitigation of harm by, for instance, preventing any ill-treatment by public bodies or private individuals or providing improved conditions or care. It would require that the State sanction actions intended to terminate life, an obligation that cannot be derived from Article 3 of the Convention. The Court therefore concludes that no positive obligation arises under Article 3 of the Convention to require the respondent Government either to give an undertaking not to prosecute the applicant's husband if he assists her to commit suicide or to provide a lawful opportunity for any other form of assisted suicide. There has, accordingly, been no violation of this provision."

54. Robert Verkaik, *Warnock Calls for Courts to Sanction Mercy Killings*, The Independent (London), Aug. 6, 2002, http://news.independent.co.uk/uk/legal/story.jsp?story=321942.

55. *People v. Kevorkian*, 639 N.W.2d 291 (Mich. App. 2001).

56. James Vicini, *Kevorkian Murder Conviction Upheld by Supreme Court*, Reuters, Washington, Oct. 7, 2002.

57. *Gallant v. Board of Medical Examiners*, 974 P.2d 814 (1999).

58. Sherwin B. Nuland, How We Die (Vintage Books, 1995).

David Pratt, Esq., is Professor of Law at Albany Law School, where he teaches the course in Elder Law. His expertise extends to, among other topics, employee benefits and deferred compensation.

Editors' Note—This article is one of the 46 chapters in the forthcoming Legal Manual for New York Physicians, *which is being published by the Health Law Section in cooperation with the Medical Society of the State of New York.*

Physician Advertising

By James F. Horan and Gregory J. Naclerio

Overview

In days gone by, physician advertising typically was limited to announcements about the opening of a new practice or the creation of a new group practice. Today, physicians advertise their services for everything from hair transplants to bunionectomies. Although a physician is permitted to advertise, he or she must do so in conformity with the state Education Law or face potential charges of professional misconduct. This chapter explores the limits of physician advertising.

"Today, physicians advertise their services for everything from hair transplants to bunionectomies."

Advertising Standards

Advertising Contrary to the Public Interest

Advertising or soliciting for patronage that is not in the public interest constitutes professional misconduct.[1] Advertising or soliciting that is contrary to the public interest includes, but is not limited to, advertising or soliciting that

- is false, fraudulent, deceptive, misleading, sensational or flamboyant;
- represents intimidation or undue pressure;
- uses testimonials for guarantees of any service;
- makes any claim relating to professional services or products or the cost or price thereof which the licensee, who has the burden of proof, cannot substantiate;
- makes claims of professional superiority which the licensee, who has the burden of proof, cannot substantiate;
- offers bonuses or inducements in any form other than a discount or reduction in the established fees or prices for professional services or products.

A physician may not compensate or give anything of value to representatives of the press, radio, television or other communications media in anticipation of or in return for professional publicity in a news item. In addition, physicians are not allowed to use demonstrations, dramatizations or other portrayals of professional practice when advertising on radio or television.

The following types of advertising are considered appropriate means of informing the public about the availability of professional services:

- informational advertising not contrary to the prohibitions set forth above.
- advertising in a newspaper, periodical or professional directory or on the radio or television of fixed prices or range of prices for specified routine professional services, provided the advertisement includes information about any additional charges for related services that are an integral part of the overall service the licensee provides and the advertisement indicates the period of time for which the advertised prices are in effect.

All physicians who place advertisements, whether they use newspapers, radio, television or any other medium, must ensure that an exact copy of each advertisement, transfer, tape or videotape is maintained for one year after its last appearance. Such copy must be available for inspection upon demand by the New York State Department of Health.

Fraud

Fraud in medical practice also constitutes professional misconduct.[2] Fraud in practice means

- a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed,
- the licensee knew the representation was false, and
- the licensee intended to mislead through the false representation.[3]

A false or an arguably misleading advertisement can lead to professional disciplinary charges alleging that a physician engaged in both false advertising and fraud.[4] A finding that a licensee engaged in fraudulent conduct in practice constitutes a much more serious charge than false advertising and is grounds for revoking a professional license.[5]

Medical Society Standards

The Medical Society of the State of New York also provides guidance on proper advertising. Specifically, physicians may ethically engage in advertising or solicitation so long as the communication is not materially false or deceptive.[6] For example, a physician may not make materially false or deceptive statements or claims relating to either the results the physician can achieve or his or her skill or ability. Physicians may advertise or solicit using the news media, directories, announcements, professional cards, office signs or any other medium or means. The use of intimidation or undue pressure in connection with the uninvited, in-person solicitation of actual or potential patients, who because of their circumstances are vulnerable to undue influence, is unethical.

Example of Deceptive Advertising

Saunders v. Administrative Review Board for Professional Medical Conduct[7] illustrates one set of circumstances in which a physician's advertisement may result in a disciplinary action and penalty. Dr. Saunders ran an advertisement that read: "Subspecially [sic] trained in Allergy, Immunology and Rheumatology—Children and Adults." The Office for Professional Medical Conduct brought charges against Dr. Saunders based on that advertisement and certain other conduct.[8] The charges alleged that the advertisement constituted both practicing fraudulently and engaging in false, fraudulent or deceptive advertising.

Following a hearing, a three-member panel from the Board for Professional Medical Conduct (BPMC) found that Dr. Saunders committed fraud and engaged in fraudulent advertising because he had completed only one-third of the training for the fellowship in allergy, immunology and rheumatology and held no privileges at any hospital in those fields. The BPMC voted to fine Dr. Saunders $5,000 for the advertisement and imposed additional sanctions for other misconduct.

On administrative appeal to the Administrative Review Board for Professional Medical Conduct (ARB), the ARB found that the BPMC failed to prove that the advertisement demonstrated Dr. Saunders' knowledge of and intent to commit fraud and overturned the BPMC's finding as well as the fine the BPMC imposed. The ARB did, however, affirm the finding that the advertisement constituted deceptive advertising insofar as the advertisement's "subspecially trained" language implied that Dr. Saunders received full training in allergy, immunology and rheumatology when, in fact, he had failed to complete the training. The ARB also found Dr. Saunders guilty of ordering unnecessary medical tests in treating three patients. It held that the deceptive advertising and the unnecessary tests warranted a six-month license suspension.

Dr. Saunders then challenged the ARB determination in court. The Appellate Division, Third Department of the New York State Supreme Court affirmed the ARB's finding that Dr. Saunders' advertisement was deceptive.

Resources

New York State Department of Health Web site (contains, as well as other information, summaries of misconduct findings against physicians): www.health.state.ny.us

New York State Senate Web site (contains the text for all New York statutes, including the Education Law provisions on fraud and false advertising): www.senate.state.ny.us

Endnotes

1. N.Y. Education Law § 6530(27) (hereinafter "Educ. Law").
2. Educ. Law § 6530(2).
3. *Sherman v. Board of Regents*, 24 A.D.2d 315, 266 N.Y.S.2d 39 (3d Dep't 1966), *aff'd*, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967).
4. *Saunders v. Administrative Review Bd. for Prof'l Med. Conduct*, 265 A.D.2d 695, 695 N.Y.S.2d 778 (3d Dep't 1999).
5. *Chong v. Sobol*, 150 A.D.2d 831, 540 N.Y.S.2d 382 (3d Dep't 1989).
6. Medical Society of the State of New York, Principles of Professional Conduct, ch. 3 (June 18, 2001).
7. 265 A.D.2d 695.
8. Chapter 15 of this manual discusses the physician disciplinary process.

James F. Horan is an Administrative Law Judge with the New York State Department of Health.

Gregory Naclerio is a member of the firm Ruskin, Moscou, Faltischek, P.C. in Uniondale. His practice areas include health law, white-collar crime and investigations, and corporate governance.

Medical Research and the Looming Lawsuit for "Breaching Dignity"

By Margaret A. Lourdes

A new trend in lawsuits is sweeping the country. Medical research programs have come under increasing legal fire following the 1999 death of 18-year-old Jesse Gelsinger. Gelsinger suffered from a debilitating genetic disorder, but was enjoying a period of remission when invited to participate in a University of Pennsylvania experimental gene therapy trial.[1] He died three days after the procedure commenced. The university, among others, was sued, and an undisclosed settlement was reached within one month.

On the heels of the Gelsinger tragedy, scores of other educational institutions and their affiliates fell under the cloud of litigation relating to medical experimentation.

One of the most startling lawsuits prompted the temporary closing of the research program at the renowned Johns Hopkins University. In 2001, a healthy 24-year-old lab technician working at Hopkins agreed to participate in an asthma study. The project exposed her to hexamethonium, which caused her death shortly thereafter.[2]

Many people, in and out of the research community, agree these occurrences reveal a severe shortcoming in research safety standards and practices. Others present a colder defense, submitting that volunteers knowingly offer themselves up as potential sacrifices for a greater good. Despite varying opinions, it is clear litigants are forcing the issue to be addressed by the judiciary, legislators, and federal regulators.

From the flood of litigation, an avant-garde claim has developed, entitled "Breach of the Right to be Treated with Dignity." The cause of action, which has no statutory or binding precedent, has prompted great fanfare and controversy. Any attempt such as this to extend or expand the law must be met with the question whether a true benefit will ensue if change is embraced, or whether merely creative lawyering is at work.

The Claim: "Breach of the Right to be Treated with Dignity"

In 1997, a clinical trial conducted at the University of Oklahoma-Tulsa subsequently led to litigation that included a prayer for relief pursuant to a "dignity claim." The suit against the University was settled in the fall of 2002 for an amount in excess of $300,000.[3]

The Oklahoma-Tulsa project focused on an experimental vaccine for sufferers of malignant melanoma. The plaintiffs, including one pregnant volunteer, allegedly experienced notable side effects from the vaccine, resulting in traumatic physical and emotional damage. A number of the trial's participants stated they were falsely promised miraculous outcomes and were grossly misled relating to the risks of receiving the vaccine.[4] Other volunteers for the study continued the vaccine and did not participate in the litigation.[5]

In support of the "dignity claim," the complaint quoted the Nuremberg Code and the World Health Organization's Helsinki Declaration. The plaintiffs suggested the two doctrines are "essentially world statutes," which set broad standards of care for medical experimentation. The portions of the doctrines quoted in the plaintiffs' complaint refer to the need for informed consent, minimal risk standards, adequate testing facilities, and qualified personnel.

Neither the Nuremberg Code nor the Helsinki Declaration creates a private cause of action under American law for plaintiffs. Moreover, neither could legitimately be interpreted as intending to create a new cause of action exclusively for dignity damages. Therefore, the following question arises: What would inventing a "dignity claim" achieve? Does the claim fulfill an honest social need or would setting such a precedent for recovery only spawn frivolous, inflammatory litigation?

Current Law Analogous to the "Dignity Claim"

Informed Consent

The Nuremberg Code, which was promulgated because of Nazi atrocities, provides for absolute, voluntary consent from any individual receiving experimental medicine. Furthermore, such consent from the participant must follow a complete and candid disclosure of all reasonably foreseeable hazards or inconveniences relative to the project.

The Helsinki Declaration reiterates the need for informed consent. It departs from the Nuremberg Code's absoluteness, however, by providing some exceptions to the requirement that informed consent be obtained.[6] In limited situations, an individual's consent may be waived or granted by third parties consistent with the Helsinki Declaration.

Under United States law, experimental projects involving human subjects are governed by various federal regulations, state statutes, and common law precedents, which implement the requirement for informed consent. For example, the Food and Drug Administration, the Department of Health and Human Services, and local Institutional Review Boards have adopted positions akin to the flexible approach of the Helsinki Declaration, as they have abandoned a rigid rule of volunteer consent and approve exceptions within certain confines.[7] Among the states, California and Nevada are examples of those that have reached beyond federal informed consent regulations by passing state legislation concerning genetic and human research.[8] Finally, in addition to federal and state regulations, a basic common law duty is grounded in long-standing judicial decisions and persuasive texts such as the Restatement of Torts.

Clearly, then, American law supports and imposes informed consent requirements in the field of medical research. The aspect of informed consent involved in a "dignity claim" premised on the Nuremberg Code or Helsinki Declaration presents nothing new.

Minimal Risks and Duties of Care

The language from the Nuremberg Code and Helsinki Declaration on which the plaintiffs rely make safety a cornerstone for medical research. No one would disagree with the proposition that researchers should be qualified professionals, that testing environments should be sterile and well maintained, and that trials should seek to minimize the risks to human subjects. Anything less would predictably engender a valid claim of common law negligence. Negligence claims encompass a duty and a breach of such duty, causally resulting in damages. Furthermore, to determine if one has breached any duty owed, the law requires that a "reasonable person standard" be applied. Hence, all medical researchers and practitioners have a duty to all patients and volunteers to act reasonably in conducting procedures.[9]

Allegations of damages stemming from unsanitary lab conditions, disregard of industry protocols, and concealment of potential risks of participation, describe conduct that is patently unreasonable. It is conceivable a jury would award substantial compensation based on a negligence theory if such accusations rang true. Therefore, the "dignity claim" clearly bears an overlap to a negligence claim and does not seem to create any new obligations concerning the standard of care required in medical research.

Fraud and Misrepresentation

If, as the recent litigation alleges, researchers are substantially misleading volunteers regarding the risks of experimental participation, a common law claim of fraud is born. A claim of fraud necessitates that a plaintiff prove a misrepresentation was made with the intent to induce reliance. In addition, the defrauded party must ultimately have relied on the misrepresentation to his or her detriment.[10]

Fraud supplies some unique weaponry to prevailing plaintiffs. Unlike British law, the "American Rule" holds all parties liable for their own legal expenditures, regardless of who is found liable. There are some exceptions to this rule, however. In incidences of bad faith, to wit, fraud cases, a court may assess attorney's fees against the defrauding party.[11] Moreover, medical practitioners may be subject to disciplinary action in the state in which they are licensed if fraudulent activity is discovered.[12]

Accordingly, it appears that provable fraud claims may arise under the same circumstances as the current "dignity" claims, leading to the conclusion that the dignity claim, again, fails to offer any practical, legal invention.

Battery

Battery is another claim that falls under the same ambit of elements as a dignity claim. It is defined as "the unprivileged, intentional touching of another." Interestingly, a battery case does not require any showing of physical damage to garner a money judgment. Through the battery claim, the law speaks directly to an individual's right to "dignity."[13] The importance of great physical harm is negated by the appreciation that any unwelcome touching invades one's personal dignity and therefore is per se actionable. Of course, the existence of palpable physical harm increases monetary awards, but the sheer offense to dignity pertinent to battery can stand on its own as a recoverable damage.

In cases of medical research, any touching beyond the scope of the individual's informed consent may be construed as battery. A volunteer, for instance, who comes into contact with a vaccine about which he was not informed of the relative risks may plead battery. Although the evolution of the law in many jurisdictions has shifted the basis for recovery in this situation from battery to negligence (informed consent) cases, battery still survives in some American courts relative to medical informed consent complaints.[14]

The dignity claim's elements, once again, merge with an existing cause of action.

Intentional Infliction of Emotional Distress (IIED)

Current claims against researchers also may resemble claims for intentional infliction of emotional distress. To prevail, an IIED plaintiff must show severe emotional suffering resulting from intentional or reck-

less conduct that was extreme or outrageous.[15] Allegations of dirty labs and researchers' lying to innocent volunteers undoubtedly create an image of reckless and extreme conduct.

Moreover, the claim of intentional infliction of emotional distress acknowledges the sanctity of individual dignity by providing a means of recovery without the need to prove any physical harm. It can be argued this claim accomplishes what the dignity claim professes to have as its goal. It grants a right to sue when human respect and dignity are ignored to the point that our consciences are shocked.

Where Is the Law Amiss?

After surveying a breadth of existing claims that apply to medical research blunders and misgivings, one can more intelligently formulate an opinion on the appropriateness of recognizing an action for "Breach of the Right to be Treated with Dignity."

The claim obviously does not break new ground by bestowing a vehicle for recovery where no other claim exists. Yet, in fairness, it is not uncommon for a single fact pattern to give rise to a number of different, applicable legal claims. New rights of recovery must be prudently evaluated, however, since fresh causes of action inevitably increase litigation, burden the legal system, and create the potential for great social cost.

A new claim is always tested and stretched by plaintiffs and lawyers. Interpretations as to when "one's dignity has been breached" will unleash a Pandora's box of subjectivity on the part of plaintiffs. The natural progression of such a claim could bridge a slippery slope from medical research to standard medical practitioners. The vision of dissatisfied or sensitive patients turned plaintiffs, suing for what they perceive as "dignity breaches" by doctors or nurses seems dauntingly plausible.

The crux of a good analysis is that "dignity claims" serve a philosophical rather than a pragmatic principle. They speak to people's emotions and distinguish untoward occurrences during medical research from the ordinary portrait of common civil litigation. They suggest that someone victimized by medical research is entitled to a special right, suggesting a medical calamity is more offensive to its victims than harm flowing from other types of tortious or fraudulent conduct.

To be sure, respecting an individual's dignity must be an essential component of all medical undertakings. Human specimens, after all, are not laboratory mice. Human volunteers deserve to be treated with dignity, particularly by a profession whose basic and most enduring ethical principle is "First, do no harm."

People turn in their darkest, most vulnerable hours to the medical community for aid. Any individual who, in the guise of practicing medicine, violates an individual's trust or betrays basic duties must be held accountable. Although the genuine spirit behind the dignity claim may be to improve safety and protect the vulnerable, it may also chill the medical community with ominous threats of subjective litigation, ironically hurting the very group it seeks to guard.

In the end, achieving deserved accountability through the creation of a new, elastic, and potentially duplicative cause of action seems to portend a greater social risk than benefit.

Endnotes

1. Gerard Magill, *The Ethics Weave in Human Genomics, Embryonic Stem Cell Research, and Therapeutic Cloning: Promoting and Protecting Society's Interests*, 65 Alb. L. Rev. 701 (2001)
2. *Supra* note 1.
3. Omer Gillham, *OU Settles Melanoma Research Suit*, Tulsa World, Aug. 28, 2002.
4. *See* Complaint, *Robertson v. McGee*, No. 01CV00G0H(M) (N.D. Okla. filed Jan. 29, (2001), available at http://www.sskrplaw.com/gene/robertson/complaint/complaint.html.
5. *Supra* note 3.
6. Norman Fost, *Waiver of Consent for Emergency Research*, 24 Am. J.L. & Med. 163 (1998).
7. Jennifer Kulynych & David Korn, *The Genetics Revolution: Conflicts, Challenges and Conundra*, 28 Am. J.L. & Med. 309 (2002).
8. *Supra* note 4.
9. Dan B. Dobbs, Torts and Compensation: Personal Accountability and Social Responsibility for Injury (2d ed. 1993).
10. *Supra* note 8.
11. *See* Hon. Jesse R. Walters, Jr., *A Primer for Awarding Attorney's Fees in Idaho*, 38 Idaho L. Rev. 1 (2001); Dana Schneider, *Tenth Circuit Survey: Attorney's Fees*, 75 Den. U. L. Rev. 711 (1998); Peter Schlechtriem, *Attorney's Fees as Part of Recoverable Damages*, 14 Pace Int'l. L. Rev. 205 (2002).
12. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in the Changing Healthcare System*, 21 Am. J.L.& Med. 241 (1995).
13. *Supra* note 6.
14. *Supra* note 4.
15. *Supra* note 6.

Margaret Lourdes, Esq., is a practicing attorney in Michigan and a faculty member of the law department of Cleary University in Ann Arbor, Michigan.

Lawyer Assistance Program Can Help Attorneys with Alcoholism and Substance Abuse Problems

Alcoholism and substance abuse are problems that can afflict any member of the bar at any time. Indeed, the percentage of lawyers and judges suffering from alcoholism and drug addiction is significantly greater than the general population. Because of the pervasiveness of the problem in the profession and the devastation suffered not only by the alcoholic or addict but also by their family members, partners and clients, the Bar Association formed the Committee on Lawyer Alcoholism and Drug Addiction in 1978, and to help the Committee address the problem, the Lawyer Assistance Program, headed by Ray Lopez, was created in 1990. Under Ray's direction, the State Bar program is on the cutting edge of alcoholism and drug addiction education, intervention, treatment and is nationally respected as one of the leading programs in the field. Despite the great success of the program, over 5,000 referrals in twelve years, there are thousands of lawyers and judges who do not know about the program and what it can do for them. Recently, Patricia K. Bucklin, Executive Director of the New York State Bar Association, asked all Section and Committee Chairs to tell their members about the Committee and what it can do for any of their members who are struggling with alcohol or substance abuse problems.

"[T]he percentage of lawyers and judges suffering from alcoholism and drug addiction is significantly greater than the general population."

Currently there are 68 Committee members and a vast network of volunteers. Most are attorneys and judges of Supreme Court, County Court, Family Court, and Civil Court. The Committee is aided by professional counselors, like Ray Lopez in Albany, and Eileen Travis in New York City, and many others serving local bar associations.

The primary functions of the Committee, with Ray Lopez's guidance and direction, are twofold: 1) to assist attorneys, judges, and law school students and their families who are suffering from alcoholism, drug abuse, depression and stress-related issues through abuse interventions and planning, sobriety monitoring for appellate courts and disciplinary committees, and participation in treatment programs and twelve step groups with attorneys on a local level; and 2) to educate the profession as a whole to detect the warning signs by participation in presentations at law schools, judiciary conferences, disciplinary committees and bar association committees on a statewide and local basis.

"Committee members would welcome the opportunity to speak at Committee or Section events regarding stress management issues, substance abuse, alcoholism and depression among attorneys."

One year ago, Chief Justice Judith S. Kaye formed the Lawyer Assistance Trust to study the problems of alcoholism and substance abuse in the legal profession and to provide assistance to groups addressing these problems. Eight of the Committee's 68 members serve as Trustees.

Information on outreach concerning attorneys' personal problems with alcohol and drug abuse and possible grants for efforts related to attorney wellness, in the areas of substance abuse, stress management and depression is available to all NYSBA Sections and Committees. Committee members would welcome the opportunity to speak at Committee or Section events regarding stress management issues, substance abuse, alcoholism and depression among attorneys.

All services provided by the LAP or Committee members are confidential and protected by Section 499 of the Judiciary Law.

For more information about the Committee, to arrange for a presentation by Committee members or for a confidential referral of an attorney who you believe has a problem with alcohol, substance abuse, stress management or depression, contact the Lawyer Assistance Program at 1-800-255-0569.

In re Grand Jury Investigation in New York County

In re Grand Jury Investigation in New York County, 111 (2002)

New York City Health and Hospital Corporation, Respondent,

v.

Robert M. Morgenthau, et al., Appellant

Court of Appeals of the State of New York.

Decided October 15, 2002.

David M. Cohn, for appellant.
Timothy J. O'Shaughnessy, for respondent.

Before: Chief Judge Kaye and Judges Smith, Levine, Ciparick, Wesley and Graffeo concur.

Opinion by Judge Rosenblatt.

Hospitals may assert a physician-patient privilege under CPLR 4504 to maintain the confidentiality of patient medical records. The case before us involves the extent to which Grand Juries may, compatibly with CPLR 4504, acquire medical records for the purpose of identifying criminal assailants.

On May 25, 1998, an unidentified assailant stabbed a man to death in Manhattan. Police could determine only that the assailant was a Caucasian male in his 30s or early 40s and that he may have been bleeding when he fled the scene. Over two and a half years later, still unable to identify him, the District Attorney of New York County conjectured that the assailant may have sought medical treatment at a local hospital shortly after the homicide. In early 2001, the District Attorney served Grand Jury subpoenas duces tecum on 23 hospitals, including four facilities operated by the New York City Health and Hospitals Corporation (HHC). Those subpoenas sought:

> "[a]ny and all records pertaining to any male Caucasian patient between the ages of 30 to 45 years, who was treated or who sought treatment on May 25th, 1998 through May 26th, 1998 for a laceration, puncture wound or slash, or other injury caused by or possibly caused by a cutting instrument and/or sharp object, said injury being plainly observable to a lay person without expert or professional knowledge; said records including but not limited to said patient's name, date of birth, address, telephone number, social security number and other identifying information, except any and all information acquired by a physician, registered nurse or licensed practical nurse in attending said patient in a professional capacity and which was necessary to enable said doctor and/or nurse to act in that capacity."

Citing CPLR 4504,[1] HHC invoked the physician-patient privilege and refused to turn over emergency room triage logs potentially responsive to these subpoenas, claiming that compliance would necessarily breach patient confidentiality in violation of the statute. After the District Attorney moved to hold HHC in contempt, HHC cross-moved for an order quashing the subpoenas. Supreme Court denied both motions but ordered HHC to submit the records for in camera inspection. The Appellate Division unanimously reversed and granted the motion to quash, holding that compliance with the subpoenas would violate the physician-patient privilege because "the assessment of the nature and causes of the injuries triggering production of the relevant documents involves an inherently medical evaluation" (287 A.D.2d 287, 288 [2001]). This Court granted the District Attorney leave to appeal, and we now affirm.

Our analysis begins with the history and purpose of the physician-patient privilege. Common law did not recognize any confidentiality in communications between patients and medical professionals. New York was the first state to enact a physician-patient privilege statute (see 2 R.S., pt III, ch 7, tit 3, § 73 [1828]; *see also Dillenbeck v. Hess*, 73 N.Y.2d 278, 284 [1989]; Fisch, N.Y. Evid § 541, at 356 [2d ed. 1977]). The modern codification of the privilege, CPLR 4504, serves three core policy objectives implicated on this appeal (*see generally* Prince, Richardson on Evidence, §§ 5-301, 5-302, at 248-249 [Farrell 11th ed.]). First, the physician-patient privilege seeks to maximize unfettered patient communication with medical professionals, so that any potential embarrassment of public disclosure will not "deter people from seeking medical help and securing adequate diagnosis and treatment" (*Dillenbeck*, at 285, *quoting Williams v. Roosevelt Hosp.*, 66 N.Y.2d 391, 395 [1985]; *see also Matter of Grand Jury Proceedings [Doe]*, 56 N.Y.2d 348, 352 [1982]). Second, the privilege encourages medical professionals to be candid in recording confidential information in patient medical records, and thereby averts a choice "between their legal duty to testify and their professional obligation to honor their patients' confidences" (*Dillenbeck*, at 285, *citing* Fisch, § 541; *see also* 3 Cmsrs on Rev'n of the Statutes of NY, at 737 [1836]). Third, the privilege protects patients' reason-

able privacy expectations against disclosure of sensitive personal information (*see* Martin, Capra & Rossi, New York Evidence Handbook, § 5.3.1, at 367 [1997]; Developments in the Law: Medical and Counseling Privileges, 98 Harv. L Rev 1530, 1544–1548 [1985]).

Though in derogation of the common law, the physician-patient privilege is to be given a "broad and liberal construction to carry out its policy" (*Matter of Grand Jury Investigation in Onondaga County*, 59 N.Y.2d 130, 134 [1983]; *Matter of City Council of the City of N.Y. v. Goldwater*, 284 N.Y. 296, 300 [1940]).[2]

On this appeal, the District Attorney contends that enforcement of the subpoenas would not offend these policies or violate CPLR 4504. The prosecutor argues that the subpoenas do not seek information acquired by means of medical diagnosis, treatment or expertise, and should be enforced because they purport to seek records only of injuries "plainly observable to a lay person without expert or professional knowledge." We disagree.

We agree that the physician-patient privilege generally does not extend to information obtained outside the realms of medical diagnosis and treatment. Indeed, because the policies underlying the physician-patient privilege implicate confidential patient relationships with medical professionals as medical professionals, we have generally limited the privilege to information acquired by the medical professional "through the application of professional skill or knowledge" (*Dillenbeck*, 73 N.Y.2d at 284 n 4). Accordingly, notwithstanding CPLR 4504, medical professionals have been authorized to disclose observations of a heroin packet falling from a patient's sock (*see People v. Capra*, 17 N.Y.2d 670 [1966]), injuries on a patient's cheek and lip (*see People v. Giordano*, 274 A.D.2d 748 [2000]), and a patient's slurred speech and alcohol-laced breath incident to intoxication (*see People v. Hedges*, 98 A.D.2d 950 [1983]). Likewise, photographs of methadone-treatment patients taken to prevent unauthorized individuals from obtaining the drug (*see People v. Newman*, 32 N.Y.2d 379, 384 [1973], *cert. denied* 414 U.S. 1163 [1974]) and the names and addresses of a medical professional's patients (*see Matter of Albert Lindley Lee Mem. Hosp.*, 115 F. Supp. 643 [ND N.Y. 1953], *aff'd* 209 F.2d 122 [2d Cir], *cert. denied sub nom. Cincotta v. United States*, 347 U.S. 960 [1954]) are outside the ambit of CPLR 4504 and must be surrendered pursuant to a valid subpoena.

We conclude, however, that *Onondaga County* controls this appeal and directs that the challenged subpoenas be quashed. In *Onondaga County*, as in the instant case, the victim was stabbed to death under circumstances that led investigators to conclude that the assailant may have left the scene bleeding. Endeavoring to identify the assailant, the District Attorney of Onondaga County issued a Grand Jury subpoena on a hospital, seeking "all medical records pertaining to treatment of any person with stab wounds or other wounds caused by a knife" (*Onondaga County*, 59 N.Y.2d at 133). In quashing the subpoena, the Court held that compliance might have "require[d] the hospital to which it is addressed to divulge information protected by the physician-patient privilege" (*id.* at 132). The Court concluded that under those circumstances, it was "not * * * possible to comply with a demand for names and addresses of all persons treated for a knife wound without disclosing privileged information concerning diagnosis and treatment" (*id.* at 135).

We perceive no difference of any actual substance between the subpoena quashed in *Onondaga County* and the ones challenged here. The records potentially responsive to the HHC subpoenas are precisely the same as those sought in *Onondaga County*. Though the District Attorney crafted the instant subpoenas with *Onondaga County* in mind by broadening their scope (to include most bleeding wounds rather than only knife wounds) and narrowing their reach (to include only wounds "plainly observable to a lay person"), the subpoenas still run afoul of *Onondaga County*.

Here, much as in *Onondaga County*, the challenged subpoenas define the class of records sought by the "cause or potential cause" of injury. Thus, the subpoenas inevitably call for a medical determination as to *causation* "through the application of professional skill or knowledge" (*Dillenbeck*, 73 N.Y.2d at 284 n. 4). It is precisely this intrusion into the physician-patient relationship that CPLR 4504 seeks to prevent. The inherently medical nature of this judgment is not obviated by attempting to qualify it in terms of what a layperson might plainly observe.

By merely reviewing hospital records after patients obtain emergency medical treatment, hospitals cannot reasonably determine whether particular injuries and their causes would have been obvious to a layperson. Medical records are not organized on the basis of what laypersons—as opposed to medical professionals—might discern. Even if a particular medical record does state the cause of injury, the record may not indicate reliably how the hospital ascertained the cause. Medical professionals may have learned the cause from the patient, or discovered it based on their medical expertise. Hospitals should not face contempt proceedings merely because they cannot distinguish the indistinguishable.

This result is further justified by the policy objectives of the physician-patient privilege and the broad construction of CPLR 4504 required to achieve them.

Patients should not fear that merely by obtaining emergency medical care they may lose the confidentiality of their medical records and their physicians' medical determinations. A contrary result would discourage critical emergency care, intrude on patients' confidential medical relationships and undermine patients' reasonable expectations of privacy.

Finally, we note that none of the Legislature's many statutory exceptions to the physician-patient privilege apply here. For example, notwithstanding CPLR 4504, Public Health Law § 2101(1) obliges physicians to immediately disclose cases of communicable disease (*see Thomas v. Morris*, 286 N.Y. 266, 268-270 [1941]), and Social Services Law § 413(1) requires all medical professionals to report actual or suspected cases of child abuse (*see People v. Trester*, 190 Misc. 2d 46, 48 [Jan. 15, 2002]). CPLR 4504(b) exempts from the privilege "information indicating that a patient who is under the age of sixteen years has been the victim of a crime." Likewise, Penal Law § 265.26 requires hospitals and medical professionals to report to law enforcement authorities certain cases of serious burns (*see Rea v. Pardo*, 132 A.D.2d 442, 446 [1987]), and Penal Law § 265.25 obliges hospitals and medical professionals to report every case of a bullet wound, gunshot wound, powder burn and "every case of a wound *which is likely to or may result in death* and is actually or apparently inflicted by a knife, icepick or other sharp or pointed instrument" (*see also Onondaga County*, 59 N.Y.2d at 133, 135–136; Donnino, Prac Comm, McKinney's Cons Laws of NY, Book 39, Penal Law art 265, at 220, 222).

Inasmuch as the Legislature enacted an exception to CPLR 4504 directing the reporting of potentially life-threatening stab wounds (*see* Penal Law § 265.25), we reaffirm our conclusion that the Legislature intended CPLR 4504 to protect against disclosure those medical records of patients whose stab wounds are less severe (*see Onondaga County*, 59 N.Y.2d at 136). Thus, because none of the Legislature's other exceptions to the privilege apply, the records the District Attorney seeks remain privileged under CPLR 4504, and the subpoenas seeking their disclosure must be quashed.

Accordingly, the order of the Appellate Division should be affirmed, without costs.

Order affirmed, without costs.

Endnotes

1. CPLR 4504 provides, in pertinent part: "Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing [or] licensed practical nursing * * * shall not be allowed to disclose any information which [s]he acquired in attending a patient in a professional capacity, and which was necessary to enable him [or her] to act in that capacity. The relationship of a physician and patient shall exist between a medical corporation * * * and the patients to whom [it] render[s] professional medical services."

2. We recognize that courts may properly decline to enforce the physician-patient privilege where its invocation does not serve its policy objectives. Thus, for example, "a person or entity subject to proceedings for having committed crimes against an individual should not be permitted to assert the victim's physician-patient privilege as a bar to production of relevant medical records or testimony" (*Grand Jury Proceedings [Doe]*, 56 N.Y.2d at 352; *see also People v. Lay*, 254 A.D. 372 [1938], *aff'd* 279 N.Y. 737 [1939]).

NEWS flash

What's Happening in the Section

Section Web Site Now Posts Job Listings

The Health Law Section Web site now lists positions available for health lawyers, and positions sought by lawyers. To post an announcement, go to nysba.org/health.

Fraud, Abuse and Compliance Committee Conducts Program on "Enforcement of Federal Health Care Laws: The Government Perspective"

On September 23, the Fraud, Abuse and Compliance Committee sponsored a conference at the Harvard Club in New York City entitled "Enforcement of Federal Health Laws: The Government Perspective." The well-attended and well-received program included presentations by four federal health care fraud coordinators from the U.S. Attorneys' offices in the Southern and Eastern Districts of New York. The program was organized by Tom D'Antonio of Ward Norris Heller and Reidy, LLP (Rochester) and Robert P. Borsody of the Law Office of Robert P. Borsody (New York City).

Student Writing Competition Named for Barry Gold

Prizes Increased

The writing competition announced previously in this *Journal* has become the "Barry A. Gold Memorial Student Health Law Writing Competition." Named after the founder of the Health Law Section, the prize will be awarded to the best articles submitted by law students to the *Journal*.

The first prize is $1,000; the second prize is $500. Funds for these prizes were generously provided by Manatt, Phelps & Phillips—the law firm which has merged with Kalkines, Arky, Zall and Bernstein, LLP.

Articles must be submitted by May 15, 2003. More information about the prize and the judging process and criteria can be found on the Section's Web site, www.nysba.org/health.

Vice-Chair James Lytle, Secretary Lynn Stansel and Section Chair Salvatore Russo at the State Capitol on Lobbying Day.

Section Sponsors Cocktail Reception for Health Law Professors

On October 10, the Section sponsored a cocktail reception for health law professors at the offices of Cadwalader, Wickersham & Taft in lower Manhattan. The reception is part of an ongoing effort by the Section Chair, Sal Russo, to strengthen relations between health law academia and the practicing health law bar.

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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Ross P. Lanzafame (Chair)
Harter Secrest & Emery LLP
1600 Bausch & Lomb Pl.
Rochester, NY 14604
(585) 232-6500
Fax: (585) 232-2152
e-mail: rlanzafame@hselaw.com

Biotechnology and the Law
Douglas R. Sansted (Co-Chair)
Kalkines Arky Zall & Bernstein, LLP
1675 Broadway, Suite 2700
New York, NY 10019
(212) 541-9090
Fax: (212) 541-9250
e-mail: dsansted@kazb.com

Sally T. True (Co-Chair)
True Walsh & Miller
202 East State Street, 7th Floor
Ithaca, NY 14850
(607) 272-4234
Fax: (607) 272-6694
e-mail: stt@twmlaw.com

Consumer/Patient Rights
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United Cerebral Palsy Associations of NYS, Inc.
330 West 34th Street, 13th Floor
New York, NY 10001
(212) 947-5770, x224
Fax: (212) 356-0746
e-mail: sm66@nyu.edu

Randye S. Retkin (Co-Chair)
NY Legal Assistance Group
130 East 59th Street
New York, NY 10023
(212) 750-0800, x187
Fax: (212) 750-0820
e-mail: rretkin@nylag.org

Ethical Issues in the Provision of Health Care
Kathleen M. Burke (Co-Chair)
New York Presbyterian Hospital
525 East 68th Street, Room W-109
New York, NY 10021
(212) 746-4075
Fax: (212) 746-8994
e-mail: kburke@nyp.org

Carl H. Coleman (Co-Chair)
Seton Hall Law School
One Newark Center
Newark, NJ 07102
(973) 642-8586
Fax: (973) 642-8194
e-mail: colemaca@shu.edu

Vincent F. Maher (Co-Chair)
Gair Gair & Conason
80 Pine Street, 34th Floor
New York, NY 10005
(212) 943-1090
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e-mail: vmaher@iona.edu

Fraud, Abuse and Compliance
Thomas S. D'Antonio (Chair)
Ward Norris Heller & Reidy LLP
300 State Street
Rochester, NY 14614
(585) 454-0700
Fax: (585) 423-5910
e-mail: tsd@wnhr.com

Health Care Finance
Joseph V. Willey (Chair)
Katten Muchin Zavis Rosenman
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e-mail: joseph.willey@kmzr.com

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Herrick Feinstein, LLP
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Fax: (212) 592-1500
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Charles A. Mele (Co-Chair)
Web MD
669 River Drive, Center II
Elmwood Park, NJ 07407
(201) 703-3426
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Health Care Providers
Edward S. Kornreich (Chair)
Proskauer Rose LLP
1585 Broadway
New York, NY 10036
(212) 969-3395
Fax: (212) 969-2900
e-mail: ekornreich@proskauer.com

In-house Counsel
Karen I. Gallinari (Chair)
Staten Island University Hospital
Legal and Regulatory Affairs Dept.
475 Seaview Avenue
Staten Island, NY 10305
(718) 226-8188
Fax: (718) 226-8692
e-mail: kgallinari@siuh.edu

Managed Care
Paul F. Macielak (Chair)
New York Health Plan Association
90 State Street
Albany, NY 12207
(518) 462-2293
Fax: (518) 462-2150
e-mail: pmacielak@nyhpa.org

Membership
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Abrams Fensterman et al.
5 Dakota Drive, Suite 206
Lake Success, NY 11042
(516) 328-2300
Fax: (516) 328-6638
e-mail: pformato@abramslaw.com

James F. Horan (Co-Chair)
NYS Health Department
433 River Street, 5th Floor
Troy, NY 12180
(518) 402-0748
Fax: (518) 402-0751
e-mail: jfh01@health.state.ny.us

Nominating
Francis J. Serbaroli (Chair)
Cadwalader Wickersham & Taft
100 Maiden Lane, Room 703
New York, NY 10038
(212) 504-6001
Fax: (212) 504-6666
e-mail: francis.serbaroli@cwt.com

Professional Discipline
Hermes Fernandez (Co-Chair)
Bond Schoeneck & King
111 Washington Avenue
Albany, NY 12210
(518) 462-7421
Fax: (518) 462-7441
e-mail: fernanh@bsk.com

Kenneth R. Larywon (Co-Chair)
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220 East 42nd Street
New York, NY 10017
(212) 916-0918
Fax: (212) 949-7054
e-mail: larywk@mcblaw.com

Special Committee on By-Laws
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555 West 57th Street
New York, NY 10019
(212) 523-2162
Fax: (212) 523-3935
e-mail: kmeyer@bethisraelny.org

Peter J. Millock (Co-Chair)
Nixon Peabody, LLP
30 S. Pearl Street, 9th Floor
Albany, NY 12207
(518) 427-2650
Fax: (518) 427-2666
e-mail: pmillock@nixonpeabody.com

Special Committee on Medical Information
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Phillips Nizer LLP
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New York, NY 10103
(212) 841-0552
Fax: (212) 262-5152
e-mail: kfisher@phillipsnizer.com

James G. Fouassier (Co-Chair)
NYS Dept. of Law
2100 Middle Country Road
Room 108
Centereach, NY 11720
(631) 468-4400
Fax: (631) 737-6050
e-mail: james.fouassier@
oag.state.ny.us

Special Committee on Mental Health Issues
Henry A. Dlugacz (Co-Chair)
740 Broadway, 5th Floor
New York, NY 10003
(212) 254-6470
Fax: (212) 674-4614
e-mail: hdlugacz@gis.net

J. David Seay (Co-Chair)
National Alliance of the Mentally Ill of NYS
260 Washington Avenue
Albany, NY 12210
(518) 462-2000, x207
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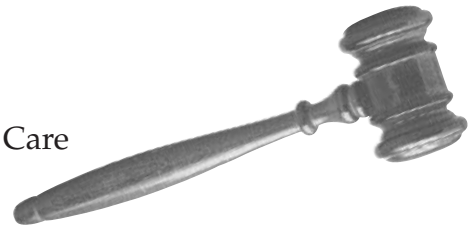

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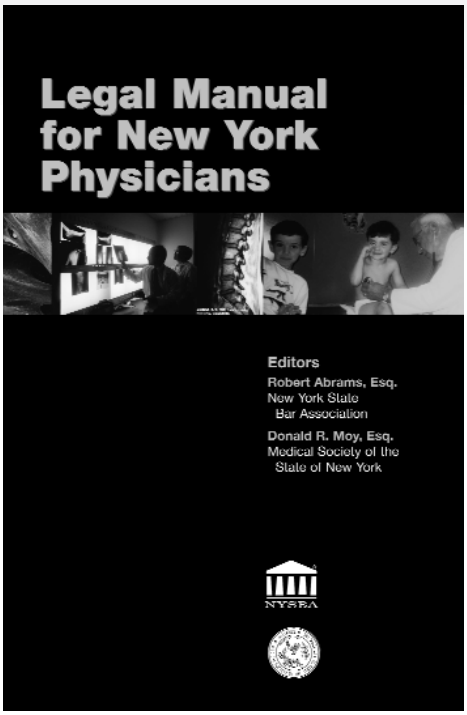

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ISSN 1530-3926

Health Law Section
New York State Bar Association
One Elk Street
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