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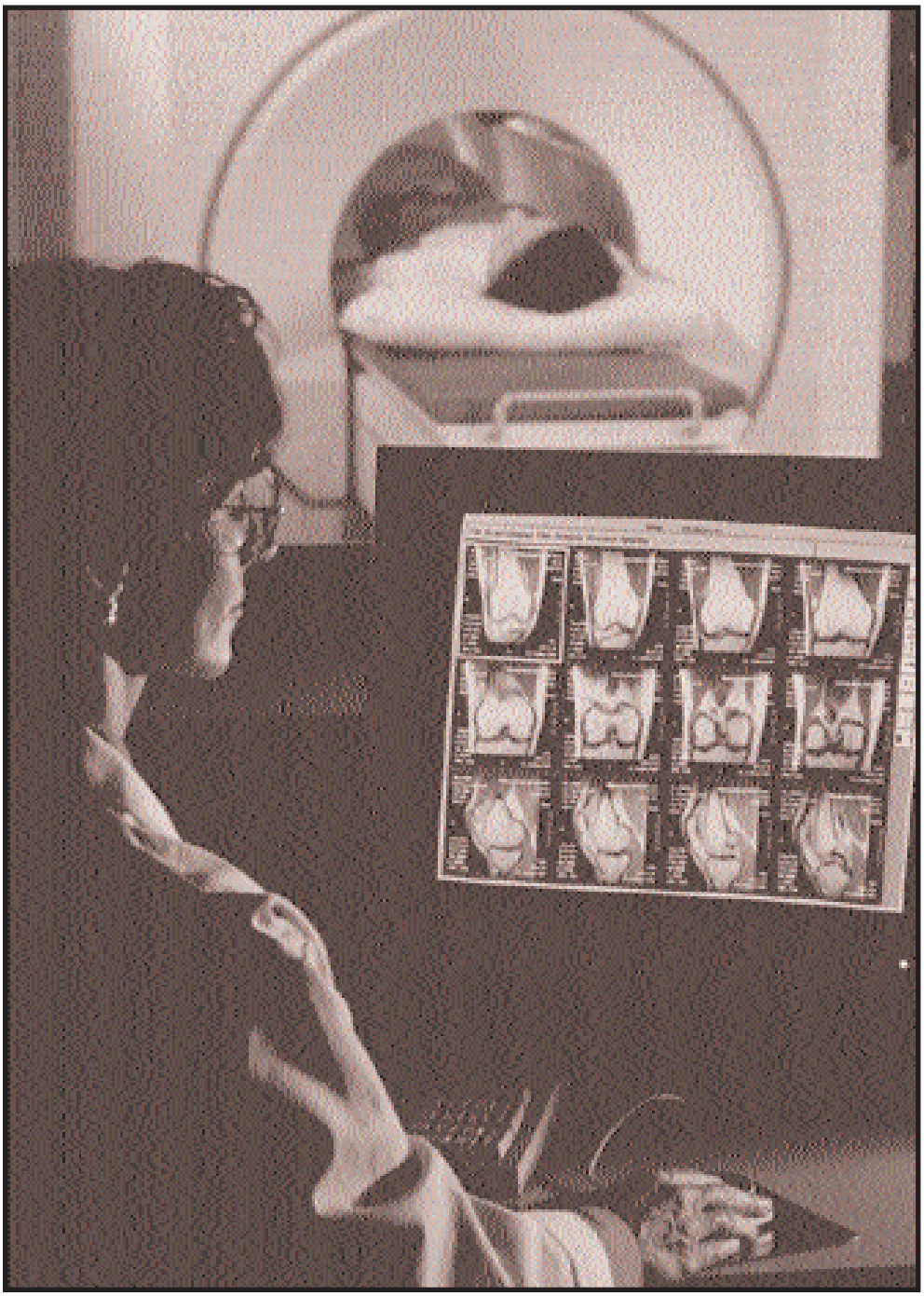
Health Law Journal

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

Published in cooperation with Pace University School of Law Health Law and Policy Program



Inside

HEALTH LAW JOURNAL

SUMMER/FALL 2001

Vol. 6, No. 3

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

in cooperation with

PACE UNIVERSITY SCHOOL OF LAW
HEALTH LAW AND POLICY PROGRAM

A Message from the Section Chair

Proud of Our Association. Proud of Our Section. Proud to Be an Attorney.

The attack on New York, the Pentagon and the rest of our country has deeply shocked and affected all of us. In varying degrees, we all share the pain, fear and concern that has resulted from this cowardly assault.

Just like you, I have experienced emotions since September 11, 2001, that I have never felt before. I worry about the safety and well-being of my wife, children and other family members and friends. I question how these terrorists could plan and implement such a heinous act. I fear that these savage cowards will try and attack us again. I think about the people who were murdered and the loved ones they left behind.

As a New Yorker, I feel a tremendous sense of loss—analogous to the loss of a close loved one—when I look up at the New York City skyline and am reminded of what is missing. I'm physically and emotionally sickened by the smoke that still emanates from where the Twin Towers used to be. The odor reminds us that there is now a holy resting ground for thousands of people—people of all ethnic and religious backgrounds—in lower Manhattan.

Such concerns, fears and emotions, however, are not all I am consumed with. I also think about the many heroes who gave of themselves—their time, their money, their expertise and/or their lives—to save victims of the attack. I take comfort in knowing that we—on an individual basis and as a society—share a bond and commitment to rebuild, while we begin the process to bring those responsible to justice.

And to my surprise, I have also been comforted and energized by our profession. The leaders of the New York State Bar Association (NYSBA), along with the Office of Court Administration and the leadership of The Association of the Bar of the City of New York, the New York County Lawyers' Association and other local bar associations, have all taken an active role in providing assistance to approximately 14,000 of our colleagues who have been displaced by the attack, offering legal assistance and support to victims and their families, and raising funds to support the relief efforts of other organizations.

NYSBA President Steven Krane and Executive Director Patricia Bucklin identified how our membership could help and then took steps to guide our members to provide such help and assistance. Following my message is an excerpt from President Krane's letter to the NYSBA membership which outlines the actions our Association has taken.

Our Section members responded to NYSBA's request to be accessible to answer legal questions victims and their family members may have, as well as provide helpful information on the NYSBA's Web site <www.nysba.org> which was established to ensure that pertinent information and resources were readily available to all those affected. A special Health Law Section task force was created to coordinate our assistance. Task force members included: Mark Barnes, Esq., of the law firm Ropes & Gray; Salvatore Russo, Esq., of the New York City Health and Hospitals Corporation; Frank Serbaroli, Esq., of the law firm Cadwalader, Wickersham & Taft; Robert Wild, Esq., of the law firm Garfunkel, Wild & Travis; and me.

Moreover, in my capacity as Chair of our Section, I was contacted by the Executive Board of the 9,000–member Health Law Section of the American Bar Association asking me how it can help. The following is an excerpt of its offer:

> We come to you in our capacities as officers of the Governing Council of the American Bar Association Health Law Section and also as friends. In those roles, we are seeking your thoughts and guidance about how best the Section might help meet the needs of your communities in the wake of this past week's events. We share the sadness and heartfelt pain that all Americans feel after the recent tragedy and also share a desire to do something to help. Our purpose in contacting the State and Local Bar Health Law Sections or Committees of the involved communities is to ask for your help in identifying a tangible project that the ABA Health Law Section might pursue or assist in pursuing with our state and local sister organizations. We have floated ideas among ourselves on Council and realize that so many organizations are doing so much that we are at risk of duplicating the good work of others. At the same time, we know that there may be as yet unidentified needs that health lawyers can meet. Would your leadership be willing to give our request some attention? We would greatly appreciate your insight

and your perspective. A project can relate to fund-raising, can be more concrete (i.e. replacing medical or health safety equipment) or can represent some other creative idea of which you may be aware due to your direct knowledge of your area and the local health bar. In any event, thank you in advance for your attention to this request.

I have asked John Williamson, NYSBA's Associate Executive Director, to respond to this request. In addition to the organized bar, countless attorneys have offered free legal services and assistance to victims and their families. For example, thousands of attorneys, far more than were needed, volunteered their time and expertise to help survivors commence estate proceedings and access needed assets. Many attorneys have offered free office space and/or other assistance to attorneys who have been displaced due to the destruction of their offices.

It is, indeed, true that in sad and challenging times, we also experience the best we all have to offer. I am proud of our Association, our Section, our profession. I'm proud to be an attorney.

Robert Abrams

President Krane's Letter to the NYSBA Membership:

"On September 11, 2001, this nation was the victim of a vicious and unprecedented attack. The images of colossal office towers collapsing in flames and acrid smoke will forever be etched in our minds. The virtually universal response of the American people is to demand and expect swift retaliatory action against the forces of evil responsible for these acts. In the meantime, we must all do whatever we can to help those countless thousands who have been affected, directly or indirectly, by these terrorists.

The New York State Bar Association expresses its deepest condolences and heartfelt sympathies to the families who have lost loved ones. Our thoughts and prayers are also with those who were injured and their families. We urge all our members to do what they can to assist, such as donating blood and/or making contributions to one of the numerous relief organizations.

We are ready to serve as a clearinghouse to match lawyers with victims and family members in need of legal assistance provided through pro bono programs offered jointly by The Association of the Bar of the City of New York and the New York County Lawyers' Association. We are also ready to assist lawyers whose offices were destroyed or are temporarily or permanently unfit for occupancy, along with the families of lawyers who worked in the WTC and adjacent areas. We are also available to assist the clients of both displaced and deceased lawyers.

Call our toll-free number (1-877-HELP-321) or e-mail us (help321@nysba.org), if you:

- *need emergency legal services as a result of the disaster;*
- *are a displaced lawyer who needs assistance to resume your practice;*
- *are a lawyer who is a victim or is displaced by the attack and would like to post basic contact information on our Web site for your clients to access;*
- *are a client looking to contact your lawyer who had/has an office in the affected area.*

In addition, we have developed a guide to Mass Disasters: Answers to Frequently Asked Legal Questions, *which is available on our Web site. Questions and answers will be updated as needed.*

To our members: we ask for your cooperation in helping us to serve the needs of the members of our profession who now find themselves without offices, files and the use of basic technologies. We will work to match lawyers willing to provide space, support staff, and equipment with colleagues in need. To lawyers who are opposing counsel, in a current or upcoming matter, to any attorney who had an office in the WTC and the surrounding area: we ask for your courtesy and cooperation in helping them to re-assemble files and to provide other information as may be necessary. Of course, all of us should be particularly mindful at this time of the anti-solicitation laws and rules in effect in New York.

We would also like to thank the scores of lawyers and bar associations throughout our state and across the country that have contacted us during the last several days to offer their support and assistance. We will need all the help we can get.

Our continued courage and respect for the rule of law is paramount as we prepare to meet the challenges in the days, weeks, and months ahead."

In the New York State Courts

Court Applies Title VII Shifting Burdens Analysis to Wrongful Termination Claim Under Public Health Law § 4406-d

Lewis v. Individual Practice Ass'n of Western New York, 723 N.Y.S.2d 845 (Sup. Ct., Erie Co. 2001). Section 4406-d of the Public Health Law (PHL), enacted in 1997, provides certain rights and protections for physicians who advocate on behalf of their patients. Among other things, the statute prohibits a health care plan from terminating or refusing to renew a health care provider's contract solely because the provider "advocated on behalf of an enrollee" (PHL § 4406-d(5)). In *Lewis*, the plaintiff is a physician who contracted with an individual practice association (IPA) to provide medical services to insureds of the defendant health maintenance organization (HMO).

After the IPA elected not to renew his contract, plaintiff commenced an action against the IPA and the HMO for violation of PHL § 4406-d, alleging that but for his patient advocacy, the IPA would have renewed his contract. The defendants argued that they could not have violated the statute because patient advocacy was not the "sole" reason for plaintiff's non-renewal. The court refused to accept this literal interpretation, finding that it would render the statute unenforceable, and that it was inconsistent with legislative intent.

Drawing on the shifting evidentiary burdens used in employment discrimination case law, the court adopted the following analysis to be applied to allegations of a PHL § 4406-d(5) violation:

1. Plaintiff must show that he engaged in the protected activity of patient advocacy and that his contract was not renewed.
2. The burden then shifts to the defendant to articulate other valid reasons for the non-renewal.
3. If defendant articulates a valid reason, the burden shifts back to plaintiff to show that the reasons given were pretense for not renewing the contract based on patient advocacy, and that the reasons given would not alone or in combination have led to non-renewal.

The third prong of the standard is satisfied if the plaintiff can demonstrate that others who are similarly situated, but did not engage in patient advocacy, had their contracts renewed. The court also ruled that an HMO's provider performance criteria established pursuant to PHL § 4406-d(4) is discoverable in cases concerning patient advocacy protections.

HMOs and Insurance Companies Cannot Avoid Compliance with the Prompt Payment Law by Delegating Payment Functions to an Intermediary

In re New York Health Plan Association, Inc. v. Levin, 723 N.Y.S.2d 819 (Sup. Ct., Albany Co. 2001). Petitioner health plans and their association sought an article 78 proceeding seeking to invalidate a letter issued by the New York State Insurance Department. The letter noted that "HMOs and insurance companies are required to pay undisputed claims and bills within 45 days of receipt," and that such obligation exists even if the HMO or insurance company delegated the responsibility of paying claims to outside entities. Thus, even if claims payment has been delegated, the HMOs and insurance companies are still liable to the provider for interest on late payments and to the Insurance Department for late payment penalties.

The Insurance Department's letter is based upon Insurance Law § 3224-a, known as the "prompt payment law." The prompt payment law provides that any insurer or organization licensed or certified under Public Health Law article 41 shall pay all undisputed bills or claims of a provider within 45 days of receipt. Petitioners argued that the Insurance Department exceeded its statutory authority in issuing the letter, because the obligation to pay within 45 days arose only if the insurer or HMO actually received the bill. Petitioners contended that this 45-day period never begins to run as to them when providers submit claims to IPAs, which act as intermediaries between the provider and the HMO / insurer.

The court rejected this argument, finding that the Insurance Department's position was consistent with the prompt payment law and the implementing regulations, which make clear that an HMO may not avoid its responsibility to pay providers in a timely fashion by subcontracting claims processing and payment functions.

Petitioners also argued unsuccessfully that the circular letter violated the State Administrative Procedure Act because the Insurance Department did not follow required procedures for the promulgation of a rule. The court ruled that the letter did not constitute a rule, but was simply a reminder of existing laws and regulations.

The court also rejected petitioner's contention that the HMOs and insurance companies would be required to make double payments—to the IPA and to the provider—because the contracts between the IPAs and the HMOs could address such issues. Instead, the court accepted the Insurance Department's argument that an inability to enforce the prompt payment law against

HMOs and insurance companies for violations by the IPAs would leave the state without a remedy, as the prompt payment law does not provide authority for sanctioning IPAs directly.

Appellate Division for the Second Department Affirms Dismissal of Peer Review Lawsuits on Ground of Health Care Quality Improvement Act Immunity

Sithian v. Spence 724 N.Y.S.2d 906 (2d Dep't 2001). Plaintiff in this case is a vascular surgeon whose privileges were suspended by a hospital upon the recommendation of its newly hired Chair of the Department of Surgery. After completion of an internal peer review process, including a hearing before a committee of the medical staff and appellate review before a committee of the hospital's Board of Trustees, the hospital upheld the summary suspension. Plaintiff filed suit in state court against the department Chair, members of the medical board, the President of the medical staff, the President of the hospital, and members of the Appellate Review Committee, seeking monetary damages for alleged defamation, breach of bylaws and other torts. Plaintiff also asserted similar claims against the independent expert retained by the hospital to review plaintiff's vascular surgery charts.

The trial court granted defendants' motion for summary judgment dismissal of all claims on the grounds that defendants were immune from liability under the federal Health Care Quality Improvement Act (HCQIA). The HCQIA, 42 U.S.C. § 11112, provides immunity from money damage claims under federal and state law for participation in the medical peer review process.

The Appellate Division for the Second Department affirmed summary judgment dismissal based on the HCQIA. The appellate court also ruled that the physician's damage claims were barred by statutory immunity under PHL § 2805.

This decision represents the first reported application of HCQIA immunity in the Second Department, which has now joined the First Department (see *Heimlich v. St. Luke's Roosevelt Hospital Center,* N.Y.L.J., Oct. 19, 1992 (Sup. Ct., New York Co. 1992), *aff'd*, 202 A.D.2d 361, 610 N.Y.S.2d 3 (1st Dep't 1994), and the Fourth Department (*Gelbard v. Genessee Hospital*, 680 N.Y.S.2d 358 (4th Dep't 1998); *Gelbard v. Genessee Hospital*, 706 N.Y.S.2d 861 (4th Dep't 2000)) in dismissing money damage lawsuits against participants in the medical peer review process. [Editor's note: Garfunkel, Wild & Travis, P.C. represented the hospital defendants in the *Sithian* action].

Court of Appeals Reaffirms Broad Discretion of Board of Regents in Matters of Professional Misconduct and Disciplinary Action

Nehorayoff v. Mills, 95 N.Y.2d 671, 723 N.Y.S.2d 114 (2001). Eighteen months after the Board of Regents revoked petitioner's license to practice medicine for negligently performing five abortions (one resulting in a patient's death), petitioner applied for restoration of his license. A Peer Review Committee found petitioner adequately rehabilitated and recommended that the revocation of petitioner's license be stayed, and after three years of probation, his license be restored. The Committee on the Professions, although "troubled" by the seriousness of petitioners's misconduct, voted 2-1 to recommend restoration, with ten years probation, the first five years limited to a hospital setting.

The Board of Regents rejected the Committee recommendation and denied petitioner's application. The Board based its decision on the gravity of the original offense, the size of petitioner's practice at the time, its view (contrary to that of the Committee) that petitioner failed to express appropriate remorse, and reservations expressed by the Committee on the Professions.

Petitioner challenged the Board's determination in an Article 78 proceeding on the grounds that the Board abused its discretion. The Supreme Court dismissed the petition, concluding that the Board's determination was neither arbitrary or capricious, and was supported by a rational basis. The Appellate Division reversed, holding that petitioner's acceptance of responsibility for his misconduct, as well as his continuing education, compelled the exercise of discretion in his favor.

The Court of Appeals reversed the Appellate Division, noting that Education Law §§ 6510 and 6511 vests the Board of Regents with considerable discretion concerning matters of professional misconduct, including the revocation and restoration of medical licenses. The Court also held that license restoration is granted only in rare cases, and the Board is not required to weigh or consider any particular factors. To prevail, an applicant must present evidence "so ineluctable in its implication that it would compel affirmative action from a Board which has 'discretion' to restore or to refuse."

The Court of Appeals held that the Appellate Division departed from that standard in this case and improperly substituted its judgment for that of the Board of Regents. Going even further, the Court ruled that the Appellate Division's consideration and acceptance of petitioner's asserted grounds for restoration was an "impermissible weighing of the evidence," based on an erroneous and unauthorized 'balanced evaluation of factors' standard. Because the Board's basis for denial of restoration was rational and not arbitrary, it could not be disturbed.

Appellate Division Upholds Five-Year Suspension of Physician's License Based on Sexual Relationship with a Patient

Barad v. State Board for Professional Medical Conduct, 724 N.Y.S.2d 87 (3d Dep't 2001). The petitioner, a physician specializing in obstetrics, gynecology and reproductive endocrinology, brought suit to challenge a determination by the State Board for Professional Medical Conduct (the "State Board") that found him guilty of physically abusing a patient in violation of Education Law § 6530(31), and engaging in conduct in the practice of medicine that evidences moral unfitness to practice in violation of Education Law § 6530(20). The findings were based on petitioner's sexual relationship with a female patient. Petitioner also challenged the penalty imposed by the State Board—a five-year suspension of his license to practice medicine, with a stay of the last three years if he were to complete medical education courses on patient abuse.

In reviewing the hearing record, the Appellate Division found sufficient evidence to support the finding that a physician-patient relationship existed between the petitioner and the patient at the time that they engaged in a sexual relationship. Petitioner treated the patient between February 1996 and August 1996. The patient testified that she believed petitioner to be her physician at the time of their three-month affair, from September 1996 to December 1996, because the petitioner neither informed her that she was no longer a patient, nor did she terminate her attempts to become pregnant. Petitioner also met with the patient in his office in December 1996 and made an entry in the patient's chart.

The court also rejected petitioner's argument that Education Law § 6530(44) only proscribes sexual contact between psychiatrists and their patients. The court noted its recent decisions addressing and rejecting that argument. (*In re Miller v. Commissioner of Health for State of New York*, 270 A.D.2d 584, 703 N.Y.S.2d 830 (3d Dep't 2000) and *In re Selkin v. State Board for Professional Medical Conduct*, 279 A.D.2d 720, 719 N.Y.S.2d 195 (3d Dep't 2001)).

Petitioner next argued that the State Board cannot apply a per se bar to sexual contact between a physician and patient, but must instead, in accordance with Education Law § 6530(20), find a lack of consent or other evidence showing exploitation of a vulnerable patient. The court did not address the per se issue, but found that petitioner exploited the patient in this case. The court relied upon the fact that the petitioner, as a fertility expert, was aware of the weakened mental state of patients after failed pregnancies, and that the hearing record supported the conclusion that the patient was mentally fragile and thus incapable of voluntary relationship with the petitioner.

Court Dismisses Disability Claim by Terminated Alcoholism Counselor

Woods v. Southside Hospital, 98 Civ. 2858 (E.D.N.Y. 2001). In this case, the court granted summary judgment dismissal of a disability discrimination suit brought by a substance abuse counselor discharged for misrepresenting the status of his state certification. The employee alleged that he was fired due to his disability (anxiety, hypertension and depression). The court ruled that the former employee would be unable to establish at trial that he met the definition of a person with a disability under Title I of the Americans with Disabilities Act (ADA).

Under the ADA, a plaintiff can establish that he is a person with a disability in one of three ways. First, that he has a "physical or mental impairment that substantially limits one or more . . . major life activities." Second, even though he doesn't presently have such an impairment, that he has "a record of such an impairment." Third, that his former employer regarded him as having such an impairment.

Plaintiff contended that he met the statutory definition of a person with a disability because he suffered from "anxiety, hypertension, and depression," that substantially limited one or more of his major life activities. The court ruled that although anxiety, hypertension, and depression were continuous impairments that possibly limited the major life activity of working, they did not impair plaintiff's ability to work at the time of the hospital's adverse employment decision. Thus, plaintiff could not, as a matter of law, meet the statutory definition of a person with a disability.

The court also ruled that records in the hospital's file, discussing the former employee's alleged excessive use of sick time, do not raise a triable issue of fact regarding the existence of a record of impairment. Further, because the hospital personnel who participated in the decision to terminate him had no knowledge of his medical condition, the court concluded that the former employee could not raise a triable issue of fact that the hospital regarding him as disabled. [Editor's note: Garfunkel, Wild & Travis, P.C. represented the hospital in *Woods*.]

Medical Records that Refer to Drug Treatment but Are Not the Records of Such Treatment, Are Not Covered by Federal Confidentiality Statute

Doe v. James M. Inman Construction Corp., 721 N.Y.S.2d 383 (2d Dep't 2001). The plaintiff sued his employer for personal injuries sustained while installing a roof. The discharge summary from the hospital where plaintiff was treated for his work injury, as well as the medical records from the physical rehabilitation facility to which he was transferred, referred to plaintiff's history of substance abuse and treatment.

Federal law (42 U.S.C. § 290dd-2(a)) provides that patient records maintained in connection with the treatment of substance abuse are confidential and may be disclosed only to medical or research personnel with the patient's written consent, or upon court order for good cause shown. Plaintiff resisted the employer's demand to produce his medical records, on the ground that they were confidential and not subject to disclosure because they made reference to his prior history of substance abuse and use of methadone.

The trial court granted the employer's motion to compel production and the Appellate Division affirmed. The court held that the treatment plaintiff received from the two subject health care facilities did not involve the treatment of a substance abuse problem, but related only to the treatment of injuries he sustained as a result the accident. The mere reference in those records to substance abuse treatment provided elsewhere did not render the records confidential under federal law.

Court Denies Medical Group's Preliminary Injunction Motion to Enforce Restrictive Covenant Against Terminated Physician

DeMaio v. Hudson Valley ENT Associates, P.C., Index No. 2297/01 (Sup. Ct., Orange Co.). Plaintiff's employment agreement provided that at the end of three years he could become shareholder upon payment of a $20,000 buy-in price. During the course of his employment, plaintiff rejected a series of overtures by the practice to increase the buy-in price, and the practice terminated his employment two months before he was due to become a shareholder. The physician also alleged that he learned, through his accountant's examination of the practice's records, that he had been undercompensated throughout his employment.

After the physician left the practice, he opened up a new practice within the geographic scope of a restrictive covenant contained in his employment agreement. The physician commenced a lawsuit seeking a declaration invalidating the restrictive covenant on the grounds that his employer's prior material breaches of their agreement—by undercompensating him and pressuring him to increase the buy-in amount—precluded the practice from enforcing the restrictive covenant. The practice counterclaimed to enforce the restrictive covenant, and moved for a preliminary injunction.

The court denied the employer's preliminary injunction motion, finding that there were sharply disputed issues of fact as to whether the practice had, in fact, materially breached the employment agreement. Citing a series of recent cases, the court held that these issues precluded enforcement of the restrictive covenant on a preliminary injunction motion. [Editor's note: Garfunkel, Wild & Travis, P.C. represented the plaintiff in *DeMaio*].

No Covenant of Good Faith and Fair Dealing Arises from an Employment Relationship that Is Terminable-at-Will

Spero v. Valhalla Anesthesia Associates, New York County Index No. 19791/99 (Sup. Ct., Westchester Co., 2001). Plaintiff signed an employment agreement to work as an anesthesiologist with defendant, a hospital-based anesthesia group. Shortly after starting work, plaintiff requested a leave of absence. When the defendant did not authorize the leave of absence, plaintiff resigned from employment, with the resignation to be effective in 90 days. Plaintiff commenced an action against the anesthesia group, alleging (among other claims) breach of the covenant of good faith and fair dealing with regard to his employment contract.

The defendant moved to dismiss the claim on the grounds that no covenant of good faith and fair dealing arises from an employment relationship that is terminable-at-will. Plaintiff argued that he was not an employee-at-will because his employment agreement was for a definite term of one year.

Plaintiff's employment agreement provided that it was in effect for a term of one year, but that either party may terminate the agreement without cause on 90-days written notice to the other. Plaintiff contended that because the agreement required a notice period prior to its termination and contemplated a one-year term, it did not create an at-will employment. The court ruled that because plaintiff's employment was terminable at any time "without cause," plaintiff was an at-will employee, notwithstanding the 90-day notice provision. As no claim for breach of the covenant of good faith and fair dealing ca be asserted where the underlying contract provides for at-will employment, the court dismissed the claim. [Editor's note: Garfunkel, Wild & Travis, P.C. represented the defendants in *Spero*].

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

In the New York State Legislature

In an unusually prolonged legislative session, bracketed by a budget stalemate at its front end and the terrorist attack at its close, just more than a dozen health care laws were enacted by press time. All but a handful of the new health-related laws signed into law so far this session were relatively minor in their impact—such as authorizing out-of-state health care professionals to provide services during special breast cancer events—or extended other previously enacted laws that would have otherwise expired. A number of important but controversial health care issues defied resolution, including proposals to enact women's health insurance benefits (including coverage for oral contraceptives), to establish liability on HMOs, to provide insurance "parity" in the coverage of mental health services and to define medical necessity for HMO and insurance coverage.

The prospects for any legislative action on health legislation following the September 11th terrorist attack appear remote, given the virtually exclusive focus of the Legislature on matters relating to the attack and its impact on the state's security and economy. An exception could be the long-standing proposal advanced by Empire Blue Cross and Blue Shield to convert from not-for-profit to for-profit status: the fact that Empire's headquarters were destroyed in the World Trade Center attack and the legislation's creation of a $1 billion charitable asset to meet health care or other public needs—at a time when the state will be critically short of tax revenue—may enhance its prospects.

On one contentious and important health care issue, the Court of Appeals showed a capacity to act where the Legislature has been stalemated: by its decision in *Aliessa v. Novello*, ___ N.Y.2d ___ (June 5, 2001), the Court ordered that the state's Medicaid program extend coverage to legal aliens who had been otherwise denied eligibility during the first five years of their residence in the United States. And, as a result of the terrorist attack, the Pataki administration took emergency action, albeit on a temporary basis, to revise and/or suspend the process by which eligibility and renewed enrollment in Medicaid and Child Health programs occur—an issue that continues to be debated in the Legislature.

Nevertheless, a handful of important health care bills have been signed into law by Governor Pataki during the course of 2001, including the following:

- ***Chapter 192, S.3230-A (Kuhl) / A.7520-A (Winner)***: Authorizes the Southern Tier Regional Health Care Plan, Inc. to operate a Medicaid managed-care plan in which residents of Chemung, Schuyler, Steuben and Allegany counties may enroll voluntarily;
- ***Chapter 225, A.1644 (Kaufman) / S.3341 (Hannon)***: Establishes the long-standing Statewide Planning and Research Cooperative System (SPARCS) in statute (Public Health Law § 2816) and requires reporting of inpatient hospitalization, ambulatory surgery and emergency data to be reported to the statewide data base;
- ***Chapter 237, A.7805-A (Gottfried) / S.4127-A (LaValle)***: Requires that at least two hours of acceptable formal continuing education for dentists include coursework and training regarding the chemical and related effects of the use of tobacco products;
- ***Chapter 342, S.5489 (LaValle) / A.8956-A (Rules, at request of Sweeney)***: Amends existing informed consent requirements for genetic testing for research purposes to permit persons to provide consent for use of their genetic material for general research purposes, without time limits or other limitations, provided that the samples are stripped of personally identifying information or a coding system is utilized to protect the identity of the individual; and
- ***Chapter 348, A.83-A (Morelle) / S.4592 (LaValle)***: Requires registration of non-resident pharmacies that ship, mail or deliver prescription drugs and/or devices to other registered pharmacies or patients in this state and requires these out-of-state firms to satisfy certain conditions of registration.

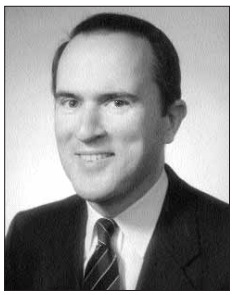
A number of other bills, which have passed both houses of the Legislature, still await action by the Governor and could be enacted before the close of 2001. And, with the Legislature expecting to return on a regular basis during the remaining weeks of 2001, new health care legislation could still see the light of day before the dawn of the 2002 legislative session.

Next year's legislative session may be expected to be dominated by concerns over the state's fiscal health, as a result of the terrorist attack and the economic downturn, with health care programs always likely candidates for budgetary reductions. At the same time, every member of the Legislature (in to-be-redrawn districts) and the Governor will be facing election next November—a phenomenon that often results in an unusually active legislative session.

Compiled by James W. Lytle. Mr. Lytle is the managing partner of the Albany office of Kalkines, Arky, Zall & Bernstein, and devotes much of his practice to regulatory and legislative representation of health care clients. He serves as the Second Vice-Chair of the Health Law Section.

In the New York State Agencies

Health Care Practitioner Referrals and Laboratory Business Practices



Notice of Continuation: Amendment renumbers existing Part 34 and divides the part into Subpart 34-1, entitled Health Practitioner Referrals, and Subpart 34-2, entitled Laboratory Business Practices. The purpose of the rule is to bring state regulation into compliance with federal rules and clarify state direct billing and anti-kick back laws. The notice of proposed rule was published in the N.Y. Register on December 6, 2000. Expiration Date: December 6, 2001. *See* N.Y. Register, May 9, 2001.

Case–Based Payments

Emergency Rule Making: Pursuant to Public Health Law §§ 2803(2), 2807(3) and 2807-c(3), the Department of Health repealed sections 86-1.62 and 86-1.63 and added new sections 86-1.62 and 86-1.63 to Title 10 N.Y.C.R.R. The Department found that the immediate adoption of this amendment is necessary to make current regulations consistent with changes made to the diagnosis related group (DRG) classification system used by the Medicare prospective payment system. In addition to establishing a basis for case classification for case–based rates of payment that is consistent with the system of diagnosis-related groups established pursuant to title XVIII of the federal Social Security Act, the amendments modify existing DRGs and add new DRGs to reflect medically appropriate patterns of health resource use. The current service intensity weights and trimpoints are also updated to be consistent with the proposed DRG modifications. Filing date: May 25, 2001. Effective date: May 25, 2001. *See* N.Y. Register, March 14, 2001, June 13, 2001.

Program of All-Inclusive Care for the Elderly (PACE)

The Department of Health proposed to amend the Title XIX (Medicaid) State Plan to include the Program of All-Inclusive Care for the Elderly (PACE) as a Medicaid State Plan option. PACE is a new benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing under a capitated payment arrangement. There would be no impact on the annual aggregate Medicaid expenditures with regard to this proposal. The state currently has four PACE programs already operating under federal waiver authority. Effective April 1, 2001. *See* N.Y. Register, March 28, 2001.

Title XIX (Medicaid) for Inpatient Services, Long–Term Care Services and NonInstitutional Services

The Department of Health proposed to amend the Title XIX (Medicaid) State Plan for hospital inpatient services, long–term care services and noninstitutional services to comply with the proposed state legislation. Amendments include: effective April 1, 2001 and annually thereafter, an amount of up to $13 million annually of additional disproportionate share payments are authorized for certain public general hospitals, other than those operated by the state of New York or the State University of New York; effective for state fiscal years beginning April 1, 2001 and April 1, 2002, specialty hospital adjustments are authorized to certain public general hospitals, other than those operated by the state of New York or the State University of New York, and located in a city with a population of over one million, of up to $296 million annually, based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment during any annual period; effective for the periods April 1, 2001 though June 30, 2003, the capital cost component of every proprietary residential health care facility rate of payment shall not include a payment factor to pay an annual rate of return on owner's equity or a payment factor to pay an annual rate of return on average equity capital. The estimated annual aggregate increase in Medicaid expenditures is approximately $60 million. *See* N.Y. Register, March 28, 2001.

Outpatient Services

The Department of Health gave notice of its proposal to amend the Title XIX (Medicaid) State Plan for hospital outpatient services. Upon clarification from the Health Care Financing Administration, the Department will make any modifications necessary to its payment methodology for outpatient services provided by Federally Qualified Health Centers and Rural Health Clinics. Modifications shall reflect amendments to the Social Security Act § 1902(a)(15) and (aa). An estimate of the aggregate annual increase in Medicaid expenditures will be provided when further analysis is completed. *See* N.Y. Register April 11, 2001.

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

Amendment of sections 80.46, 80.67, 80.68 and 80.71-80.75 of Title 10 N.Y.C.R.R. Pursuant to Public Health Law article, §§ 3308 and 3338,

the Department of Health amended these regulations in order to provide for the electronic transmission of prescription data by pharmacies, allow controlled substances to be prescribed on an official, single part, departmental form, and permit partial filling of some prescriptions. Filing date: March 26, 2001. Effective date: May 1, 2001. *See* N.Y. Register April 11, 2001.

Civil Penalties Against Noncompliant Adult Care Facilities

Emergency Rule Making: The Department of Health amended sections 486.5 and 486.7 of Title 18 N.Y.C.R.R. pursuant to the statutory authority of Social Services Law § 460-d(7)(b)(2)(iii). These regulations establish protections to assure the safety of residents of adult homes, residences for adults and enriched housing by permitting the department to expedite the enforcement process against facilities that endanger or cause harm to residents. The purpose of these regulations is to protect the life, health and safety of residents in adult care facilities by expanding the authority of the Department of Health to impose civil penalties against such facilities that endanger or cause harm to adult care facility residents. Filing date: June 5, 2001. Effective date: June 5, 2001. *See* N.Y. Register, June 20, 2001.

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For Your Information

By Claudia O. Torrey

As many of you already know, the standards for the final rule[1] on the privacy of individually identifiable health information (I^2HI) became effective on April 14, 2001.[2] The compliance date for the final rule is April 14, 2003, for health care providers, health care plans (that are not small health plans), and health care clearinghouses. Small health plans have until April 14, 2004, to be in compliance with the final rule.

"One topic of the final rule that has generated much discussion concerns the use and disclosure of PHI in marketing and fund-raising."

Under the final rule, I^2HI is defined[3] as a subset of health information,[4] including demographic information collected from an individual that is created or received by a health care provider, health care clearinghouse, health plan or employer. The I^2HI must identify an individual or provide a reasonable basis for identification. The I^2HI must relate to the past, present or future physical or mental health of an individual, or to payment for the provision of health care to an individual. I^2HI also pertains to the provision of health care to an individual.

The final rule states that protected health information (PHI) is a subset of I^2HI that is transmitted by electronic media, maintained in any medium described in 45 C.F.R. § 162.103, or transmitted or maintained in any other form or medium. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g, or records described within 20 U.S.C. § 1232g(a)(4)(B)(iv). Thus, the final rule concerns itself with the use and disclosure of PHI.

One topic of the final rule that has generated much discussion concerns the use and disclosure of PHI in marketing[5] and fund-raising.[6] Marketing is defined as a communication about a product or service wherein the purpose is to encourage recipients of the communication to purchase or use the product or service. A communication *is not* marketing if it is made orally, or is in writing and the covered entity (CE)—health care provider, health care clearinghouse or health plan—does not receive direct or indirect remuneration from a third party for making the communication. Further, marketing does not include communications that fall into the above stated exceptions AND are made:

(i) by a CE for the purpose of describing the entities participating in a health care provider network, or health plan network or for describing a product or service that is provided by a CE or included in a plan of benefits; or

(ii) for a particular individual wherein the communications are made by a health care provider to an individual concerning treatment of and for the individual, or are made by a health care provider or health plan to an individual in the course of managing treatment for the individual, or for the purpose of directing or recommending alternative treatments, therapies, providers, or health care settings to the individual.

As a general rule, if PHI is used or disclosed for marketing purposes, an authorization form[7] is needed. An authorization form is *not* needed for the use or disclosure of PHI in a marketing communication to an individual if the communication:

(i) is face-to-face; or

(ii) concerns products or services of nominal value; or

(iii) concerns the health related products and services of the CE or of a third party; AND

(a) identifies the CE as the party making the communication,

(b) prominently states whether the CE has received or will receive direct or indirect remuneration for making the communication, and

(c) contains instructions describing how the individual may opt-out of receiving such communications. *Exception*: the PHI communication is contained in a newsletter or similar general communiqué, that the CE distributes to a broad group of patients, enrollees, or other individuals; *or*

(iv) is for the purpose of communicating to a business associate that assists the CE with such communi-

cations (needless to say, such would be covered in a contract between the CE and the business associate); *or*

(v) is to target individuals based on their health status or condition. The communication must explain why the individual has been targeted and how the product or service relates to the health of the individual, and the CE must determine prior to making the communication that the product or service being marketed may be beneficial to the health status or condition of the group being targeted.

The communication in the first three above stated exceptions must identify all three subsets.

While an authorization form is usually not needed for treatment, payment, or health care operations, the activity list within the definition of health care operations[8] clearly states that *only* the aforementioned items for which an authorization form is not needed in a marketing communication come within the rubric of health care operations.

There is not a separate definition for fund-raising in the final rule like there is for marketing, but one of the activities listed under the definition of health care operations is fund-raising for the benefit of the CE. This definition read in conjunction with 45 C.F.R. § 164.514(f), further states that a CE may use or disclose PHI without an authorization form to a business associate or to an institutionally related foundation.[9] Thus, regarding fund-raising, the only type of PHI that can be utilized without an authorization form between a CE (for its own benefit) and a business associate or an institutionally related foundation, is demographic information related to an individual and dates of health care provided to an individual. Any other use or disclosure of PHI for fund-raising presumes the use of an authorization form, though such is not stated.

The final rule does state that any other use or disclosure of PHI for fund-raising must be set forth in the *mandatory* notice of privacy practices that a CE must develop for the use and disclosure of PHI.[10] The fund-raising materials must contain an opt-out provision, and the CE must make reasonable efforts to ensure that opt-out requests are honored.

"As we become a more global society with multinational corporations, CEs will have to keep in mind the Safe Harbor Privacy Principles negotiated between the U.S. Commerce Department and the European Commission . . ."

Although there are exceptions to the use of an authorization form, in the marketing and fund-raising context, a health care provider (which is a CE) may still need to have on file a consent form from an individual for the use or disclosure of PHI in the context of marketing and/or fund-raising. A consent form is needed *prior* to the use or disclosure of PHI in order to carry out treatment, payment, or health care operations.[11] A consent form is *not* needed if the health care provider has an indirect treatment relationship with the individual, or the health care provider created or received PHI in the course of providing health care to an inmate.[12]

There are three situations[13] that do not require *prior* consent, but where subsequent consent should be attempted:

(a) in an emergency, if the provider attempts to obtain consent as reasonably practicable; or

(b) where the provider is required by law to treat an individual, and is unable to obtain consent; or

(c) where the provider attempts to obtain consent, but substantial barriers to communication exist. However, based upon professional judgment, an individual's consent to receive treatment is clearly inferred from the circumstances.

These three PHI consent form exceptions require the health care provider to document consent attempts, and the reason why consent was not obtained.[14]

As we become a more global society with multinational corporations, CEs will have to keep in mind the Safe Harbor Privacy Principles negotiated between the U.S. Commerce Department and the European Commission (creator of the European Union Directive on Data Protection; Some of the principles are notice, consent, data integrity and enforcement.). While adherence to the principles is voluntary for American companies, adherence may make the exchange of personal data with European Union countries easier. Marketing and fund-raising can still be done under the final rule, but CEs will have to be careful when such involves the use or disclosure of PHI.[15]

Endnotes

1. Standards for Privacy of Individually Identifiable Health Information; Final Rule, 65 Fed. Reg. 82, 461 (2000) (to be codified at 45 C.F.R. pts. 160, 164; hereinafter, when applicable, the C.F.R. sections will be used for the final rule).
2. Final rule; correction of effective and compliance dates, 66 Fed. Reg. 12,434 (2001).
3. 45 C.F.R. § 164.501.

4. 45 C.F.R. § 160.103.
5. 45 C.F.R. § 164.514(e).
6. 45 C.F.R. § 164.514(f).
7. 45 C.F.R. § 164.508.
8. 45 C.F.R. § 164.501.
9. According to the final rule preamble, an institutionally related foundation qualifies as a nonprofit charitable foundation under Internal Revenue Code § 501(c)(3) and has in its charter statement of charitable purposes an explicit linkage to the CE. The term does not include an organization with a general charitable purpose, because its charitable purpose is not specific to the CE.
10. 45 C.F.R. § 164.514(f)(2); *see* 45 C.F.R. § 164.520 generally; and *see also* C.F.R. § 164.520(b)(1)(iii)(B).
11. 45 C.F.R. § 164.506(a)(1).
12. 45 C.F.R. § 164.506(a)(2)(i)(ii).
13. 45 C.F.R. § 164.506(a)(3)(i)(A), (B), (C).
14. 45 C.F.R. § 164.506(a)(3)(ii).
15. Given the lack of explanation in the final rule regarding such words and phrases as remuneration and product or service, a CE may want to clarify whether their marketing team is a part of the CE workplace (yielding sanctions under the final rule), or whether such team is a business associate (not necessarily under the direct purview of the Department of Health and Human Services / Office of Civil Rights, and therefore not necessarily yielding sanctions).

The reader should be aware that the Office of Civil Rights within the U.S. Department of Health and Human Services issued guidance statements on July 6, 200l, regarding the final rule. The guidance statements address several topics including consent, marketing and medical research. They are electronically available at <http: / / www.hhs.gov / ocr / hipaa / finalmaster.html>.

The guidance statements reiterate what this author alluded to above—the overlap between "treatment," "healthcare operations" and "marketing" is unavoidable. CEs will have to look carefully at how their specific marketing activities are conducted, in order to determine whether or not such activities are excluded from the definition of marketing.

The reader should also know that a suit was filed in the federal district court of South Carolina challenging the constitutionality of the final rule, as well as the final rule's scope of authority (*See South Carolina Medical Association v. United States Department of Health and Human Services* (D.S.C., Columbia Div. filed July 16, 2001)). The plaintiffs seek declaratory judgments, as well as any other relief the federal court may deem appropriate. The author believes this suit may be the first, formal, legal challenge of the final rule.

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Conflicts Between Health Care Agents and Personal Needs Guardians: Can They Be Avoided?

By Richard Gabriele

New York has enacted several comprehensive and well-considered statutes in the last decade to facilitate the making of important health care decisions on behalf of elderly and incapacitated persons. These include the adoption in 1992 of Article 81 of the Mental Hygiene Law regarding guardianships and the adoption in 1990 of Article 29-C of the Public Health Law regarding health care proxies.[1] However, real life usually outruns the foresight of legislators, and the problems that clients actually face in the real world often present factual circumstances which even the most comprehensive statute fails to address directly. Thus ensues litigation. Over the last few years, my office has represented clients in numerous cases involving health care proxies and guardianships. While there are issues that need to be addressed regarding each of these statutes individually, I thought it might be useful to address some interesting questions that arose in one recent case, which involved the interplay of *both* the statutes mentioned above and which highlighted some fruitful areas for further possible legislation.

This particular case began with a very typical fact pattern. The incapacitated person was an elderly woman suffering from dementia. There were two family factions—a sole surviving son, on one side, and on the other side, the wife and children of a deceased son. Needless to say, the two family groups disagreed about what was the best treatment for the elderly woman and whether there was any need for court intervention. However, at the son's request, the court did intervene, and it made an attempt at a Solomonic compromise, i.e., it recognized the validity of the health care proxy under PHL Article 29-C which the elderly woman had given to her son, and it also appointed the woman's grandchildren as her personal needs guardians under MHL Article 81. Something for everyone. Unfortunately, despite its arduous efforts and good intent, the court almost certainly made a bad situation worse by giving the adversarial positions of each of the opposed family factions some stamp of legitimacy. Although this particular case has not yet reached its conclusion, it has nevertheless brought three interesting issues to the fore.

First: When the time came to decide whether the elderly woman should be placed in a nursing home, who was the proper person to make that decision—the health care agent or the personal needs guardian? Such a decision implicates medical issues as well as residential issues, health care concerns as well as social concerns. MHL § 81.22(a)(9) authorizes the personal needs guardian "to choose the place of abode" for the incapacitated person. But PHL § 2980 authorizes the health care agent to make "health care decisions" for the incapacitated persons which encompass "any . . . service . . . to treat an individual's physical or mental condition." In addition, PHL § 2982(4) gives the decisions of the health care agent "priority over decisions by any other person." The difficulty which the court has faced in threading this needle suggests that perhaps more attention needs to be given by the Legislature to the procedures that govern decisions by surrogates to place an incapacitated person in a nursing home.[2]

"[R]eal life usually outruns the foresight of legislators, and the problems that clients actually face in the real world often present factual circumstances which even the most comprehensive statute fails to address directly. Thus ensues litigation."

Second: What weight, if any, should the court give, when choosing a personal needs guardian, to the fact that there already exists a valid health care proxy issued to a person from a different family "faction"? As noted above, there are many decisions, such as placement in a nursing home, that fall within the gray area between the duties of a health care agent and the duties of personal needs guardian. It must also be recognized that much litigation arises in these kinds of situation because of the contention and dispute between various family members. However, although MHL § 81.02(2) directs a court to consider "available resources" in deciding whether to appoint a guardian and although MHL § 81.19(d) lists various factors that a court must consider in choosing a guardian, a court is *not* directed by the statute to evaluate potential family conflicts as a factor to weigh when choosing a personal needs guardian. MHL § 81.19(d)(8) lists "conflicts of interest between the person proposed as guardian and the incapacitated person" as a factor to be considered when choosing a guardian. Perhaps an additional subsection should be added to that statutory provision referring to "potential conflicts between the person proposed as guardian and other surrogates of the incapacitated person."

Third: Should any preference be given to a child over other family members in deciding who should serve as a personal needs guardian? In other words, *all other things being equal,* does a child have a presumptive right to care for his or her parent in the parent's old age? Does this issue implicate constitutional issues of privacy relating to the family unit? Although, admittedly, "all other things" are rarely equal in the real world, the case I am discussing came pretty close. The son of the incapacitated woman was a caring son, who had a long-standing and loving relationship with his mother, who never abused her, who visited her frequently, and who even had professional (medical) qualifications that were of particular benefit to his mother. Yet the court appointed as personal needs guardian not the son, but the grandchildren. By what authority? The court based its decision on a very questionable ground, i.e., the ambiguous, confused and uncertain "choice" of the incapacitated person. MHL § 81.19(a)(1) allows anyone who is "suitable" to be appointed as guardian, and lists by way of example several family relationships—i.e., spouse, adult child, parent or sibling (but not grandchildren)—yet it does not prioritize among these persons or establish any preference or presumptions.[3] This is a personal situation that many of us now face or will soon confront as our parents age. Should we, as children, be presumed able to care for our parents as they grow old and have the presumptive right to do so? Or should a court be able to intervene and appoint someone else in our stead?

The Legislature cannot address every eventuality. But the questions discussed above are very fundamental and very common: Where is the line of demarcation of duties between a health care agent and a personal needs guardian? Who between them should decide whether or not to place an incapacitated person in a nursing home? Should a court consider potential and actual family conflicts in deciding whom to appoint as a guardian? What right does a responsible adult child have to care for a parent in his or her old age? I suggest that these issues are important and merit some further legislative consideration. Failure to do so will continue to invite long, costly and bitter lawsuits for many clients.

"Should we, as children, be presumed able to care for our parents as they grow old and have the presumptive right to do so? Or should a court be able to intervene and appoint someone else in our stead?"

Endnotes

1. MHL § 1.01ff and PHL § 2980ff.
2. MHL § 81.22(a)(9) requires consent of the incapacitated person before such placement but, in most such cases, the incapacitated person is incapable of giving such consent.
3. Other statutes do establish an order of preference. For example, in PHL Art. 29-B, the Legislature has established a list of priority surrogates to sign Do-Not-Resuscitate Orders. *See* PHL § 2965(2)(a). In this priority list, an adult child would be a preferred surrogate to a grandchild.

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The Legal Remedies of Medical Providers Against Insurance Companies for Nonpayment of Services Rendered

By Nathan M. Barotz

Introduction

The U.S. health care system is in disarray because the economic behaviors that drive the system are not only irrational, but are often contrary and counterproductive. While a free market requires rational consumers who demand better products at better prices and providers who are rewarded for supplying both, the unique tripartite system of patient, medical provider, and third-party insurance company not only frustrates rational behavior by both consumers and physicians but oftentimes penalizes it.[1]

At the most basic level, each of the three parties in this unique system has its own set of driving priorities: First, while the consumer is receiving the service and is therefore interested in receiving the highest quality service available, the consumer is not the purchaser of that service, and, as a result, has no motive to determine the real value of the service. Compare this with the provider of service, who is generally paid for providing the service and, therefore, has no motive to reduce the amount of services provided and generally no objective, nationwide fee schedule on which to base his or her fees.

Finally, the third-party insurance company receives income for premiums paid and, in accordance with its duty to its shareholders, has a responsibility to make sure that those premium dollars are not wrongly spent on services that are unnecessary, billed above market rates, or not covered under the contracts of insurance or the provider agreement. Specifically, market forces dictate that insurance companies are under an obligation to their shareholders to limit payment (and increase profits) unless these contracts clearly mandate payment and there is an economic incentive on the part of the insurer to comply with the terms of the contracts. This economic incentive may be effected through judgments as the result of civil litigation or fines imposed by regulatory agencies.[2]

Stemming from these three different sets of priorities is a conflict that has been receiving greater attention in the legislative and judicial forums at the state and federal levels: Under the law as it stands today, how can a medical provider, whether the provider is a physician, a hospital, a nursing home, a diagnostic facility, or any one of a number of other medical service providers, as an assignee to rights of payment for services provided, enforce its rights against a third-party insurance company with respect to claims for payment for medical
services provided that the payer has denied or unilaterally decreased? To phrase the same issue differently, under the law as it stands today, how can a medical provider, as an assignee to rights of payment for services provided, enforce his or her rights against an insurance company with respect to claims for payment for medical services provided that the insurance company has denied or unilaterally decreased?

As we analyze the common law and statutory tools available to a medical provider under the current law, there are three elements which we will include in our analysis: (1) Who is the party that has standing under the cause of action (i.e., the medical provider or the state regulatory authority)?; (2) the cause of action; and, possibly the most important; (3) the damages available if the plaintiff is successful (i.e., contract damages or punitive/treble damages).

Our review will include an analysis of common law causes of action available to the medical provider which include: breach of contract (breach of the contract of insurance; breach of the implied covenant of good faith and fair dealing and unjust enrichment); tort (breach of fiduciary duty and intentional infliction of emotional harm); and fraud. Possible statutory causes of action include N.Y. General Business Law § 349 and N.Y. Insurance Law §§ 2601 and 3224-a.

Breach of Contract

First and foremost, the common law cause of action of breach of contract, specifically the contract of insurance or the provider agreement, allows a medical provider to pursue reimbursement from the insurance company for services rendered. The issue that arises under this simplest of common law causes of action is one of damages. Can the plaintiff recover anything more than reimbursement for the services provided and possibly interest at the statutory rate?

The Court of Appeals answered this question in *Garrity v. Lyle Stuart, Inc.*,[3] when the plaintiffs asserted that the defendant insurance company delayed, denied or decreased claims in an abusive manner. The Court stated that "it has always been held that punitive damages are not available for a mere breach of contract, for

in such a case, only a private wrong and not a public right, is involved."[4]

The courts have upheld this rule in a number of cases, including *Samovar of Russia Jewelry Antique Corp. v. Generali*.[5] "It is plain that a mere breach of a private contract in the nature of a policy of insurance simply does not support a claim for punitive damages [citations omitted] even where the acts complained of are alleged to be willful and unjustified [citations omitted]."

If the plaintiff could establish a showing of morally reprehensible conduct directed at the general public, then the plaintiff might establish a claim for punitive damages. This standard was established in the leading case of *Walker v. Sheldon*,[6] where the Court established the standard of wanton dishonesty as to imply a criminal indifference to a civil obligation and morally culpable conduct directed at the general public as opposed to a mere private wrong. This will be a high standard for a plaintiff medical provider to overcome.

In the recent case of *Logan v. Empire Blue Cross and Shield*,[7] the court, relying on the two landmark cases *Rocanova v. Equitable Life Assurance Society*[8] and *New York University v. Continental Insurance Co.*,[9] dismissed a claim for punitive damages for alleged bad faith claims practices because it found no tortuous conduct. But see *White v. Blue Cross and Blue Shield of Greater N.Y.*,[10] which allowed a claim for punitive damages and attorneys' fees to stand upon a showing of particularly egregious conduct by the defendant insurer toward the single mother plaintiff who was reduced to dire circumstances by such conduct. This lower court case, cited only once in 11 years, stands in stark contrast to the weight of authority. *White* was distinguished in the case of *Novogroder v. Morgan Stanley Mortgage Capital, Inc.*[11]

Unjust Enrichment

Another cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered is unjust enrichment. Under the theory of unjust enrichment, a plaintiff medical provider can argue that insured patients have paid premiums to the insurance companies, said premiums to be used to pay claims, specifically claims for medical services provided. If the insurance company unilaterally decides not to pay the claims or unilaterally decreases reimbursement amounts, the insurance company should not be entitled to keep the premiums. While this cause of action allows for damages for an individual plaintiff, the damages available to the physician are probably limited to the premiums paid by the insured to the insurance company, which will probably be a relatively small amount.

Few medical providers have attempted to incorporate this theory in actions against insurance companies. The plaintiffs pleaded the theory in *Greenspan v. Allstate Insurance Co.*,[12] and on the motion to dismiss, the court construed the cause of action to require a finding of a fiduciary relationship. Perhaps this is because plaintiffs also asked that a constructive trust be imposed on defendants. The *Greenspan* court dismissed the claim.[13]

Implied Covenant of Good Faith and Fair Dealing

A third cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered is breach of the covenant of good faith and fair dealing which arises out of the contractual relationship of the parties. In New York, this is elucidated in many cases, such as *M/A Com Security Corp. v. Gales.*[14] While certainly less than a fiduciary relationship, an insurer's duty under an insurance contract requires that it must not do anything that would deprive the insured or her assignees (i.e., the medical providers) of her rights under the contract.

In the Court of Appeals decision in *New York University v. Continental Insurance Co.*,[15] although the Court denied the claim for punitive damages, the Court did state that if the insurance company investigates and refuses to pay a covered claim in bad faith, this action on the part of the insurance company would amount to a breach of the insurance contract's implied covenant of good faith and fair dealing.

This case does not stand for the proposition that an insurer should make payment on all claims that it receives, or that it should not make good faith, reasonable investigations into the medical necessity and validity of the underlying medical services. On the contrary, the insurer has a duty to its shareholders to confirm that the payments it makes for claims submitted are for *bona fide* claims billed at contracted rates or, in the absence of contracted rates, at usual and customary rates.

The limitation is the same one that we have noted so far: the damages available to the medical provider would be limited to contract damages and will not support a claim for punitive damages. "Rocanova cannot maintain a claim for punitive damages based on his undismissed cause of action for breach of the implied covenant of good faith and fair dealing."[16]

Breach of Fiduciary Duty

A fourth cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered and the first that may lead to punitive damages is the breach of fiduciary

duty. An important distinction in a claim of breach of fiduciary duty and a claim for breach of contract is the ability for the plaintiff to seek punitive damages without having to show an impact on the public at large.[17]

The plaintiff does have a higher hurdle to overcome as a claim for breach of fiduciary duty does not arise from a simple breach of contract.[18] "No wrongful purpose except failure to pay a claim under the contract is alleged."[19] Where the courts have allowed punitive damages based on a finding of breach of fiduciary relationship between an insurer and an insured, however the plaintiff has established the existence of a fiduciary relationship apart from, or in addition to, the insurance contract. An example of this is *Dornberger v. Metropolitan Life Ins. Co.*,[20] where the breach of fiduciary duty arose out of misrepresentation and omissions that induced the insured to enter into the insurance contract.[21] Plaintiffs often plead the allegations of misrepresentation and deception, usually in connection with the sale of the insurance contract, which could make out a claim for breach of fiduciary duty, as a separate action under General Business Law § 349.

Intentional Infliction of Emotional Harm

A fifth cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered and the second that may lead to punitive damages is the intentional infliction of emotional harm. The author is unable to find any cases in which plaintiffs have been successful in actions against third-party payers based on the intentional infliction of emotional harm. One of the cases in this area is *Korona v. Statewide Insurance Co.*,[22] in which the court found that the insurance payer was not liable for intentional infliction of emotional harm in its denial of no-fault benefits. *Warhoftig v. Allstate Insurance Co.*[23] also holds that an insurance contract alone does create a relationship that could support a claim for such tortuous conduct. However, in that case, the Second Department did allow the breach of insurance contract to stand and stated that if the plaintiff ultimately prevailed "he may recover such consequential damages as resulted from the breach of the insurance contract."[24]

Fraud

A sixth cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered, and the third that may lead to damages beyond contract damages, is fraud.

While a medical provider can plead fraud, it is extremely difficult to accomplish the leap from a contract claim to a fraud claim although plaintiffs often try to "up the ante." One of the reasons for the difficulty is that the plaintiff must plead his or her fraud claim with particularity. An element of a well-pleaded claim would require stating who, where and when the alleged misrepresentation was made.[25]

Plaintiffs have attempted to make this leap in actions against insurers by pleading that the insurer represented it would honor its obligations under the insurance contract and promptly pay valid claims. In *New York University v. Continental Insurance Co.*, the court rejected this claim and held that this is simply a restatement of the action under the insurance contract.[26]

Where, as is often the case, a physician brings a claim against an insurer on a claim assigned to the plaintiff by a patient treated by the plaintiff, another barrier to a fraud claim arises. This is illustrated, again by *Greenspan v. Allstate Ins. Co.*,[27] where the plaintiffs alleged that the defendant carrier had made fraudulent misrepresentations to them concerning processing of the claims assigned to the plaintiff by their patients and submitted for payment to the carrier (such as having lost the claims or making requests for excessive or unnecessary information). Plaintiffs claimed that they had rendered treatment in reliance on these fraudulent misrepresentations. The court refused to credit the claim, finding that the alleged misrepresentations were all made after services had been rendered and the claims had been submitted, thus obviating any reliance.

N.Y. General Business Law § 349 ("Deceptive Trade Practices")

A seventh cause of action available to a medical provider to pursue reimbursement from the insurance company for services rendered and the first that is based on a statutory cause of action is a violation of Gen. Bus. Law § 349. Section 349 is a "consumer protection" act. It provides in relevant part:

> (a) Deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful.
>
> * * *
>
> (h) In addition to the right of action granted to the attorney general pursuant to this section, any person who has been injured by reason of any violation of this section may bring an action in his own name to enjoin such unlawful act or practice, an action to recover his actual damages or fifty dollars, whichever is greater, or both such actions. The court may, in its discretion, increase the award of damages to an amount not to exceed three times the

> actual damages up to one thousand dollars, if the court finds the defendant willfully or knowingly violated this section. The court may award reasonable attorney's fees to a prevailing plaintiff. N.Y. Gen. Bus. Law § 349. *See generally*, Moldovan Note, *New York Creates a Private Right of Action To Combat Consumer Fraud: Caveat Venditor*, 48 Brook, L. Rev. 509 (1982).

Individual medical providers can bring a claim under Gen. Bus. Law § 349 and section 349 does apply to insurance companies as defendants.[28] In addition, plaintiffs are using this cause of action as the basis for a number of class actions against insurers for bad faith claims settlement procedures.[29]

An important element that the medical provider must plead and prove in a case under section 349 is the impact on consumers. In *Negrin v. Norwest Mortgage, Inc.*,[30] a class action was brought charging a violation of Gen. Bus. Law § 349 arising out of improper mortgage recording fees. The court stated that an essential element of the claim was a consumer who is victimized by an entity that has a "disparity of bargaining power."[31] Failure to allege this element of the cause of action under section 349 will result in dismissal of the claim.

This was the case in *Greenspan*,[32] mentioned above, where a detailed and extensive compilation of "practices designed to deny or delay reimbursement for properly submitted and documented claims for medically necessary services" was alleged.[33] Plaintiffs in that case were health care providers who rendered services to accident victims who then assigned their right to receive reimbursement from defendant insurance company to plaintiffs.

Defendant, in its motion to dismiss, argued that section 349 was purposed to protect consumers and not health care providers or other business, such as plaintiffs, citing *Azby Brokerage Inc. v. Allstate Insurance Co.*[34] The court was constrained to dismiss the complaint because there was no allegation of injury to the public. The court noted, however:

> Here, although Allstate's deceptive acts allegedly impeded plaintiffs' ability to earn a living, they may also affect the public interest. The purpose of the no-fault insurance law was to institute an inexpensive, efficient method of compensating accident victims.
>
> * * *
>
> Deliberately erecting barriers to reimbursement and imposing additional social costs may frustrate that objective and harm the public. Allstate's conduct may also affect the ability of accident victims to obtain medical treatment. See also *Riordan, 977 F.2d at 53* ("The Riordans presented ample evidence to prove that Nationwide engaged in similar deceptive settlement practices against other policyholders, thus satisfying the GBL § 349 requirement that the conduct be recurring or have ramifications for the general public.") 937 F. Supp. at 294 (citations omitted).

To the same effect, see *Abraham v. The Penn Mutual Life Insurance Co.*[35] quoting *Greenspan* at 5. By contrast in *Gaidon, Guardian Life Insurance, Co., supra*, the section 349 claim survived a motion to dismiss, since it included the allegation that the deceptive acts or practices were likely to, and did, mislead a reasonable consumer. It should be noted that the common law fraud claims were dismissed in that case as they required a higher standard of pleading and proof than a section 349 claim based on the same facts.[36]

While section 349 seems to be the class action charge of choice for those who would break a lance against the champions of the insurance citadel, it has its limitations. As discussed earlier in this article, the damages that may or may not be available to the medical provider are an important consideration. There is no provision for punitive damages in section 349. As the *Greenspan* court noted: "Even if plaintiffs replead their Section 349 claims, that statute does not authorize an award of punitive damages. See N.Y. Gen. Bus. L. Sect. 349(h) (authorizing recovery of actual damages and giving court discretion to increase damage award to an amount not exceeding treble actual damages or $1000).[37]" The statute does, however, provide for attorney's fees.[38]

N.Y. Insurance Law § 2601

As a general rule, the regulation of insurance companies is left to the individual states. The New York State Insurance Department has comprehensive regulatory powers over all insurance companies doing business in the state. Insurance Law § 2601 enumerates those regulatory powers relevant to the scope of this article. The relevant portions of that statute are as follows:

> (a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business

practice, shall constitute unfair claim settlement practices:

(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverage at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear . . .; or

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts eventually recovered in suits brought by them.

While a first read of the statute encourages the medical provider that he or she has found a powerful cause of action, further study highlights one of the most troublesome problems that medical provider seeking reimbursement from insurance companies for services rendered face in New York: There is no private right of action under section 2601.[39]

The Superintendent of Insurance is empowered to hold hearings and conduct investigations to determine whether an insurer has violated this section.[40] The Superintendent is further empowered to impose monetary penalties for violation of sections of the Insurance Law, including section 2601.[41]

The Insurance Department has imposed a number of monetary penalties on insurance companies in the past, but these penalties have been largely limited to penalties for violation of the "prompt payment" laws. While the penalties imposed by the superintendent may not seem to be a significant deterrent given the size of the offenders, more recently there was a penalty in excess of $1 million imposed on Kaiser Health Plans for a variety of violations, including some which were described as bad faith claims practices.

To soften the blow to the private litigant, the courts have held that this section of the Insurance Law does not preempt the common law remedies against insurers even if such claims include allegations of unfair settlement practices.[42]

The apparent comprehensive sweep of the Department's disciplinary powers over abusive claims settlement activities has led many courts to conclude that an insured's right to anything other than strict contractual relief is preempted by state regulatory power and remedies.[43]

N.Y. Insurance Law § 3224-a ("Prompt Payment Law")

In September 1997 the New York State Legislature enacted Insurance Law § 3224-a that required insurers, effective January 1998, to pay providers within 45 days of the receipt of a claim or bill for services unless the claim was disputed. Under the law, if the insurer has a good faith dispute regarding the validity of a claim or that a claim was not clear, the insurer has to notify the health care provider within 30 days that the insurer is not obligated to pay the claim, state the specific reasons why the insurer is not liable, or request additional information needed to determine liability to pay the claim. Under the law, the insurer is required to pay an undisputed amount within 45 days of the receipt of the claim. If the insurer fails to make timely payment, it is required to add interest to the outstanding bill.[44]

While this statute also appears to be a powerful weapon for the medical provider seeking reimbursement from insurance companies for services rendered in New York, as with section 2601, there appears to be no private cause of action under section 3224.

Racketeer Influenced and Corrupt Organizations Act of 1989 (RICO)

Plaintiffs around the country have tried to employ RICO against insurance companies. There have been few decisions, with those that have been handed down presenting mixed results.

In January of 1999, the U.S. Supreme Court allowed Humana enrollees to pursue a class action against Humana. The suit alleged that Humana had excluded the plaintiff class from hospital discounts that the managed care plan had secretly negotiated. The Court dismissed the defense that the McCarran-Ferguson Act, which gives the states primary regulatory authority over insurance companies, barred any suits against the insured defendant under RICO. There were a number of other lawsuits against Blue Cross and Blue Shield plans on the same issue, most of which were settled.[44] The *Humana* case was remanded to the lower courts for further action.

Numerous other RICO suits are pending in other states. In the U.S. District Court for the Northern District of Alabama, an action is pending against CIGNA, AETNA and Humana.[46] The same law firm, the Law

Offices of Archie C. Lamb, Jr., in Birmingham, Alabama, is representing the plaintiffs in an action against Blue Cross of California, Pacific Care Health Systems, Inc. and Foundation Health Systems, Inc. in the District Court of the Northern District of California.[47] Additional RICO actions by health care providers against insurers include *Clay v. Pacific Care Health Systems, Inc.*, (complaint filed May 24, 2000)[48] and *Shain v. Humana*, (filed January 28 in the U.S. District Court for the Western District of Kentucky and transferred August 1 to the Southern District of Florida.) On June 8, 2000, the U.S. District Court for the Southern District of Florida consolidated 13 proposed RICO class actions against Humana into *Price v. Humana*.

Some of these cases allege abusive claims practices, for example, in the *California Medical Association* case and the *Mangiere* case, allegations are that the defendant plans provided inadequate payments, withheld payments and threatened to withhold payments. However, many of the allegations range far more widely and attack some of the basic premises of managed care such as allegations that physicians are offered non-negotiable contracts, incentives are provided to limit patient care and that the insurers give priority to cost considerations and profits over patient care and unnecessarily and improperly interfere in patient care.

Antitrust

This is an interesting and potentially far-reaching theory that, as yet, has not reached very far. Thus far this cause of action has only been used in a "battle between giants." This was a case between two large corporate parties represented by large corporate law firms. The case is *PepsiCo, Inc. v. Continental Casualty Co.*,[49] This was an action under the corporate plaintiff's, directors' and officers' liability policy wherein, among other things, it was alleged that the defendant insurance company had threatened to terminate the policy and actually canceled other policies and that such behavior was part of a "conspiracy among Continental and other insurance companies, underwriters and their agents directed against PepsiCo and other policyholders."[50] The court found that this constituted an illegal boycott under the antitrust laws where the target was "a customer or some or all of the conspirators."[51]

New York No-Fault Personal Injury "No-Fault" Law

One class of cases, those brought under the New York No-Fault and also the Workers' Compensation Acts, is a good example of the damages limitation available to medical providers. If a medical provider, as assignee of an insured patient, is successful on action under the contract of insurance, the medical provider is entitled to the amount of the services according to the published fee schedule. The only economic disincentive for the insurance company not to abusively deny or unilaterally decrease reimbursements is the fact that the court or arbitrator is empowered by the statute to award attorney's fees (subject, however, to arguably low caps) as well as interest, at the rate of 2 percent per month compounded until the claim is paid.

Employee Retirement Income Security Act of 1974 (ERISA)

Any work addressing legal causes of the action in New York State against insurance companies for denial of payment for medical services rendered must also address the role of ERISA, the doctrine of federal preemption, and recent court opinions on the applicability of ERISA.

ERISA governs the provision of health care benefits not provided through Medicare, Medicaid, government employers, church plans, and some other exceptions. Preemption is the legal principle that certain matters are of such a national, as opposed to local, character, "that a federal law can supersede or supplant any inconsistent state law or regulation."[52]

The general rule of ERISA preemption is that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."[53] The exception to the general rule is that "nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities."[54] Any exception to the exception prevents states from regulating ERISA plans under the guise of the above exception by stating that:

> [n]either an employee benefit plan (other than a plan established primarily for the purpose of providing death benefits), nor any trusts established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business or insurance of banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trusts companies, or investment companies.[55]

The issue for the purposes of this article is: How does ERISA's preemption rule prevent medical providers from suing to enforce their claims for nonpayment for services rendered against health insurance

companies? First, there is the scope of ERISA. ERISA governs the provision of health care benefits provided through Medicare, Medicaid, government employers, church plans, and some other exceptions.[56] The issue of ERISA preemption will generally arise where the patient received medical benefits through employment or through a spouse or parent who received it through employment.

In order to determine if ERISA preemption may become an issue in a medical provider's suit against an insurer for non-payment for services rendered, the plaintiff should address the following questions: Are the underlying health care benefits provided to the patient through her employment? If so, was it provided through a qualified ERISA plan?[57]

The purchase of insurance by an employer on behalf of the employee does not create a *de facto* finding of existence of an ERISA plan.[58] In order to qualify as an ERISA plan, the defendant has to prove that the employer did more than purchase insurance for its employees (e.g., such as collecting premiums or administering the plan or the claims deriving from it.)[59] The defendant HMO would probably have to argue that it was more than just a service provider.[60]

If ERISA does apply and the defendant raises the issue, the defendant will have the burden of proving it is an ERISA plan and seeking one of the two types of preemption.[61] If the defendant succeeds, then the case will be removed to federal court and the court will dismiss the state law claims.

If the court deems the underlying claims to arise from a breach of an ERISA plan, then the medical provider has to exhaust its administrative remedies as outlined by the Department of Labor on November 21, 2000, at 65 Fed. Reg. 70246. Only after exhausting all administrative remedies can the provider pursue other remedies. The only sanctions for the ERISA plan not complying with the rules is $100 a day if the plan does not provide information requested by the claimant.[62]

If the underlying claims do not arise from a breach of an ERISA claim, then the plaintiff can pursue the state common or statutory law claims in state court.

Class Action

There have been an increasing number of attempts to bring class action cases against insurers for bad faith first-party claim settlement procedures. Most of these cases have been brought outside New York and few have so far yielded reported decisions. Despite the large defense resources of most insurance companies, some large law firms have evidenced an interest in developing a practice in this area. Because of the small dollar amounts in controversy in the typical health insurance claim and the corresponding availability of anything but contract damages, it is economically impractical to bring these claims on an individual practitioner basis. This is one of the more important factors driving the development of class action certification in this area.

Plaintiffs seeking class certification pursuant to Rule 23(b)(3) must meet a two-tier test.[63] Plaintiffs should meet the requirements of that test by showing more than just the allegations in the pleadings.[64]

First, the plaintiffs must satisfy the definitional requirements for a class as contained in Rule 23(a): (1) the class is so numerous that joinder is impracticable; (2) questions of law or fact are common to the class; (3) the interests of the named parties are typical of the class; and (4) the class representatives will provide fair and adequate representation for absent class members.[65] Second, the plaintiffs must show (1) that the question of law or fact common to the class predominates and (2) that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.[66]

Other States

A word about the world outside of New York. The laws and the kind of lawsuits vary widely from state to state.[67] At the time the Goldberg survey was written, cases in 16 states had allowed punitive damages in first-party bad faith claims settlement actions. They were Alabama, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Montana, North Dakota, Ohio, Oklahoma, Rhode Island and South Carolina.[68] A few states have statutorily defined and permitted causes of action by aggrieved insureds against insurers for bad faith.[69]

No one has ever tried to survey and calculate whether there is any effect on the cost of insurance in those states where punitive damages are allowed. To be sure, there are many other factors that influence strongly the cost of insurance and it cannot be expected that this would be a major one. More interesting, and ever harder to measure, is whether the effectiveness and aggressiveness of a state's insurance department regulation of abusive claims practices by insurance companies has any correlation with the state court's receptivity to claims for punitive damages against those insurers, especially if brought as class actions.

Conclusion

Under the current law in New York State, a medical provider in the state of New York who is seeking reimbursement from an insurance carrier for services ren-

dered does not have many economically practical avenues to pursue. While the physician, hospital, nursing facility, diagnostic center, or other provider may have some common law and statutory causes of action that it may pursue, the economic reality of contract damages often make such a suit impractical. In the absence of legislative change or new rulings from the courts, most providers will have to continue to rely on the state to oversee and enforce their rights for payment for services rendered.

Endnotes

1. J.D. Kleinke, Bleeding Edge: The Business of Health Care in the New Century (1988).
2. David Stires, *Debunking Oxford*, Fortune, Mar. 19, 2001, at 94. A figure used by industry analysts to assess the success or failure of an HMO is its "medical-loss ration" which is the amount of money that an HMO pays out in medical care divided by the premiums it receives. A lower ratio translates into better profits and earnings with general industry trends being between 82% and 86%.
3. 40 N.Y.2d 394, 386 N.Y.S.2d 831.
4. *Id.* at 398.
5. 476 N.Y.S.2d 869 (1st Dep't 1984).
6. 10 N.Y.2d 401, 723 N.Y.S.2d 488.
7. 714 N.Y.S.2d 119 (2d Dep't 2000).
8. 83 N.Y.2d 603, 612 N.Y.S.2d 339 (1994).
9. 87 N.Y.2d 308, 639 N.Y.S.2d 283 (1995).
10. 549 N.Y.S.2d 598 (Sup. Ct., N.Y. Co. 1989).
11. 2000 U.S. Dist. LEXIS 6098 at 8 N.D. Ill. 2000.
12. 937 F. Supp. 288 (S.D.N.Y. 1996).
13. *Id.* at 295 (relying on *Liebowitz v. Elsevier Science, Ltd.*, 927 F. Supp. 688, 711 (S.D.N.Y. 1996) and *Citytrust v. Atlas Capital Corp.*, 570 N.Y.S.2d 275, 279 (1st Dep't 1991)).
14. 904 F.2d 134, 136 (2d Cir. 1990).
15. 87 N.Y.2d 308, 639 N.Y.S.2d 283, 289 (1995).
16. *Rocanova*, 83 N.Y.2d at 614.
17. *See, e.g., Sherry Associates v. The Sherry Netherland, Inc.*, 708 N.Y.S.2d 105 (1st Dep't 2000). *See generally* Robert H. Shaw III, *Increasing Liability for Refusal to Pay First Party Claims: Bad Fault and Punitive Damages*, 13 Wake Forest L. Rev. 685 (1977). Chris Michael Kallianos, *Bad Fault Refusal to Pay First Party Insurance Claims: A Growing Recognition of Extra Contract Damages*, 64 N.C. L. Rev. 1421 (1986).
18. *See, e.g., Tyson v. Aetna & Life, Cas. Co.*, 429 N.Y.S.2d 120 (4th Dep't 1980).
19. *Rochester Radiology Assocs., P.C. v. Aetna Life Ins. Co.*, 616 F. Supp. 985 (N.D.N.Y. 1985). William T. Barber *et al.*, *Is An Insurer A Fiduciary To Its Insureds*? 25 Tort & Ins. L.J. 1 (1989).
20. 967 F. Supp. 506 1997 (S.D.N.Y. 1997).
21. *See United States v. Brennen*, 958 F. Supp. 1111, 1121 (E.D.N.Y. 1996) ("existence of a fiduciary relationship [between the insurer and the insured] presents a jury question").
22. 504 N.Y.S.2d 514 (2d Dep't 1986).
23. 604 N.Y.S.2d 245 (2d Dep't 1993).
24. *Id.*; *see Harary v. Allstate Ins. Co.*, 983 F. Supp. 95, 100 (E.D.N.Y. 1997).
25. *See* F.R.C.P. 9(b); CPLR 3016(a).
26. 639 N.Y.S.2d at 288-89. *But see PepsiCo, Inc. v. Continental Casualty Co.*, 640 F. Supp. 656 (S.D.N.Y. 1986) (dismissing a claim for fraud against the same defendant but with leave to replead with sufficient particularity).
27. *Greenspan v. Allstate Ins. Co.*, 937 F. Supp. 288, 291 (S.D.N.Y. 1996).
28. *See, e.g., Riordan v. Nationwide Mut. Fire Ins. Co.*, 756 F. Supp. 732 (S.D.N.Y. 1990); *Sulner v. General Accident Fire & Life Assurance Corp.*, 471 N.Y.S.2d 794 (Sup. Ct., N.Y. Co. 1984).
29. *See, e.g., Gaidon v. Guardian Life Ins., Inc.*, 94 N.Y.2d 330, 704 N.Y.S.2d 177 (1999); *McKinnion v. Int'l Fidelity Ins. Co.*, 704 N.Y.S.2d 774 (Sup. Ct., N.Y. Co. 1999).
30. 700 N.Y.S.2d 184 (2d Dep't 1999).
31. *Id.* at 192 citing *Teller v. Hayes*, 630 N.Y.S.2d 769 (2d Dep't 1995).
32. *See* note 27, *supra.*
33. *Id.* at 290.
34. 681 F. Supp. 1084 (S.D.N.Y. 1988).
35. 200 U.S. Dist. LEXIS 10645 (S.D.N.Y. 2000).
36. *See Wender v. Gilberg Agency*, 711 N.Y.S.2d 399 (1st Dep't 2000) (action by a doctor against an insurance agency under section 349 for selling the wrong insurance policy).
37. 937 F. Supp. at 295 n.2.
38. *But see Hart v. Moore and the Home Ins. Co.*, N.Y.S.2d 477 (Sup. Ct., Westchester Co. 1992), where plaintiff was found to have a cause of action against defendant insurance company and the court held that punitive damages could be awarded under Gen. Bus. Law § 349 but only where the total award, including the punitive damages, did not exceed $1,000.
39. *See, e.g., Rocanova v. Equitable Life Assurance Soc'y*, 83 N.Y.2d 603, 612 N.Y.S.2d 339, 343 (1994); *Klinger v. Allstate*, 702 N.Y.S.2d 853 (2d Dep't 2000); *Gen. Accident Ins. Co. v. Cicchetti*, 708 N.Y.S.2d 883 (2d Dep't 2000).
40. *See* Insurance Law §§ 2404-2405.
41. *See* Insurance Law §§ 109, 2402(b).
42. Government Memorandum, 1970 N.Y. Legislative Annual 489. See *Greenspan*, 937 F. Supp. 288, 293 (S.D.N.Y. 1996), quoting the Governor's memorandum about the bill as follows: "While the bill would leave to the courts the settlement of individual disputes, it would give the Insurance Department a strong tool to prevent misuse of the legal process and to deal with claims practices that are harmful to the public."
43. *See, e.g., Roldan v. Allstate Ins. Co.*, 544 N.Y.S.2d 359 (2d Dep't 1989). "The availability of punitive damages in private lawsuits premised on unfair claims practice has been preempted by the administrative remedies available to the Superintendent of Insurance pursuant to Insurance Law § 2602. *Id.* at 373-74." *But see Riordan v. Nationwide Mutual Fire Ins. Co.*, 756 F. Supp 732 (S.D.N.Y. 1990), *aff'd*, 977 F.2d 47 (2d Cir. 1992), *certified question to the N.Y. State Court of Appeals withdrawn because of mootness*, 984 F.2d 69 (2d Cir. 1993), where the federal court denied a motion to dismiss an action for punitive damages on a first-party bad faith claims settlement case, finding the requisite impact on the general public and refusing to follow the *Roldan* case. *Id.* at 741. To the same effect, see *Belco Petroleum Corp. v. A.I. G. Oil Rig, Inc.*, 565 N.Y.S.2d 776 (1st Dep't 1991) and *Greenspan*, *supra*.

44. Insurance Law § 3224-a.
45. *See* Modern Health Care, Aug. 24, 1998, p. 22.
46. *Mangiere v. Cigna Corp*, No. 99 C.V. 3254 (N.D. Ala. complaint filed Dec. 7, 1999).
47. *California Medical Association v. Blue Cross of California, Inc.*, N.D. Cal. No. C-00-1894 (Complaint Filed May 25, 2000).
48. *Id.*
49. 640 F. Supp. 656 (S.D.N.Y. 1986).
50. *Id.* at 663.
51. *Id.* citing the leading Supreme Court case of *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1977).
52. Black's Law Dictionary 1197 (7th ed. 1999).
53. ERISA § 514(a), 29 U.S.C. § 1144(a).
54. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).
55. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).
56. 29 U.S.C. § 1003(b).
57. *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 975-78 (5th Cir. 1991); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 491-92 (9th Cir. 1998); *Donovan v. Dillingham*, 688 F.2d 167, 1369-70 (11th Cir. 1982); *Frappier v. Wishnov*, 678 So.2d 884, 885-86 (Fla. App. 4th Dist. 1996).
58. *Kanne*, 867 F.2d at 492; *Donovan*, 688 F.2d at 1375; *Fortune v. Medical Assoc.'s of Woodhull, P.C.*, 803 F. Supp. 635, 640 (E.D.N.Y. 1992).
59. *Hansen*, 940 F.2d at 978; *Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991).
60. *Nealy v. US Healthcare*, 93 N.Y.2d 209 n.3, 689 N.Y.S.2d 406 n.3 (1999).
61. Thomas A. Moore & Matthew Gaier, *HMO Liability—Part III: Erisa Preemption*, N.Y.L.J. 3, Sept. 2, 1997, col. 1.
62. Medical Lie Update, Vol. 2, No. 11 (Nov. 2000).
63. *See Amchem Prods. v. Windsor*, 521 U.S. 591, 613-15 (1997); *Morel v. Giuliani*, 927 F. Supp. 622, 633 (S.D.N.Y. 1995).
64. *See Sirota v. Solitron Devices*, 673 F.2d 566, 571 (2d Cir. 1982).
65. *See* Fed. R. Civ. P. 23(a).
66. *See* Fed. R. Civ. P. 23(b)(3).
67. For a comprehensive survey of state laws in this area and related litigation, see *Goldberg, et al., Can the Puzzle Be Solved: Are Punitive Damages Awardable in New York for First-Party Bad Faith,* 44 Syracuse L. Rev. 723 (1993).
68. *Id.* at n.37.
69. *Id.* at nn.34 & 35.

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Physicians' Responsibility for Physician Assistants and Nurse Practitioners

By Robert A. Wild and Lara Jean Ancona

I. Introduction

This purpose of this article is to describe certain obligations of a physician under New York State law and the federal Medicare program with respect to countersigning medical orders and similar documents when medical services are provided by physician extenders, such as physician assistants and nurse practitioners.

II. Scope of Practice

A. Physician Assistants

New York State Education Law § 6542 ("Education Law") allows a physician assistant to perform medical services, but only where the physician assistant is under the supervision of a physician and the duties assigned to the physician assistant are within the scope of the practice of the supervising physician.[1] The physician assistant must be "continuously" supervised by the supervising physician (discussed later).

B. Nurse Practitioners

Education Law § 6902 defines the scope of practice of a nurse practitioner and requires a nurse practitioner to have a written practice agreement to collaborate with a physician qualified in the same specialty before practicing in New York State.[2] Services provided by a nurse practitioner must be in accordance with the practice agreement and written practice protocols and must be supervised by the collaborating physician. N.Y. Comp. Codes R. & Regs. § 64.5 (N.Y.C.R.R.) further requires that the practice agreement include a provision for physician review of the nurse practitioner's patient records (a random sample is sufficient) no less than every three months.

III. Supervision of Physician Extenders

A. Requirements for Supervision

1. Physician Assistants

The supervision rules with respect to a physician assistant require that supervision be continuous, but do not necessarily require that the supervising physician be physically present when the physician assistant is rendering services. The supervising physician must, however, be immediately available to the physician assistant. A physician practice must, therefore, have procedures in place to ensure the supervising physician is immediately available to consult with the physician assistant by, at a minimum, telephone or other effective, reliable means of communication whenever the physician assistant is rendering patient services.[3] Moreover, 10 N.Y.C.R.R. § 405.4 requires any hospital which includes physician assistants on its medical staff to adopt bylaws, rules and regulations which set forth in writing the mechanism or mechanisms by which the supervising physician will exercise continuous supervision of the physician assistant for which he or she is responsible.[4]

2. Nurse Practitioners

The collaborating physician's responsibility for patients under the nurse practitioner's care is controlled by the applicable law discussed above and the required practice agreement and written practice protocols. If a nurse practitioner is working independently or employed by a physician practice, the practice agreement and written protocols will, within the confines of the applicable law, determine the scope of the supervision provided by the collaborating physician. The practice agreement must, at a minimum, provide for referrals and consultation with the collaborating physician, coverage for emergency absence of either the nurse practitioner or the collaborating physician, resolution of disagreements between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment and review of patient records by the collaborating physician.

Alternatively, where a nurse practitioner is employed by a hospital, the hospital, through its rules and regulations and those of its medical staff, may further limit the scope of a nurse practitioner's practice if such limitations are reasonable and related to the hospital's objectives or, alternatively, impose greater responsibilities upon a collaborating physician than are imposed by the practice agreement and applicable law.

B. Countersignature Requirements

1. Physician Assistants

With respect to writing medical orders, section 1.1.6 of the Medicare Carriers Manual provides that a physician assistant may provide the dispensing order and write and sign the detailed written order if he or she meets certain criteria (which include being permitted to do so under the applicable state law). Where a physician assistant is employed by a hospital, 10 N.Y.C.R.R. § 94.2 allows the physician assistant to write medical

orders within the hospital, but requires that any such medical orders written for an inpatient be countersigned by the supervising physician within 24 hours, although not necessarily prior to the execution of the medical order. The medical orders a physician assistant employed by a hospital may write include orders for controlled substances for which physician assistants cannot generally write prescriptions (see Prescriptions below).

Since 10 N.Y.C.R.R. § 94.2 refers specifically to *inpatients*, one could argue that New York State law allows a physician assistant employed by a hospital to write medical orders for outpatients without the countersignature of the supervising physician. With respect to both inpatients and outpatients of a hospital, however, a physician assistant must be given the authority to write medical orders by the bylaws, rules and regulations of a hospital. Moreover, as a matter of practice and to reduce liability risks, hospitals often require countersignatures for both inpatients and outpatients.

Alternatively, where a physician assistant is employed by a physician practice, New York State law does not specifically require the countersignature of the supervising physician on medical orders. The physician assistant must, however, continue to perform only the medical services which are assigned to him or her by, and within the scope of the practice of, the supervising physician.

2. Nurse Practitioners

With respect to writing medical orders, section 2158 of the Medicare Carriers Manual allows a nurse practitioner to perform those services he or she is legally authorized to perform under the applicable state law and New York State law does not specifically require a collaborating physician to countersign a nurse practitioner's medical order. Under New York State law, a nurse practitioner employed or extended privileges by a hospital may admit his or her own patients, write medical orders for inpatients under the nurse practitioner's care, and perform such other procedures for which the nurse practitioner is credentialed, if permitted by the hospital's bylaws, rules and regulations. The degree to which hospitals actually permit such activities apparently varies considerably from institution to institution.

Alternatively, a hospital may require the countersigning of all medical orders of a nurse practitioner even though New York State law does not have such a requirement. With respect to a nurse practitioner employed by a physician practice, New York State law (as with physician assistants), allows the nurse practitioner to write medical orders and does not require the countersignature of the collaborating physician. Once again, issues of quality of care and liability may suggest to a physician a more stringent approach, but that is an individual matter and may vary a great deal from practice to practice.

C. Prescriptions

1. Physician Assistants

New York State law, 8 N.Y.C.R.R. § 94.2, allows a physician assistant to write prescriptions (with exceptions for certain controlled substances), but only when he or she is assigned to do so by the supervising physician. Although prescriptions written by a physician assistant do not have to be countersigned by the supervising physician, they must be written on the supervising physician's blank prescription pad and contain (1) the supervising physician's name, address and telephone number; (2) the name, address and age of the patient; and (3) the date on which the prescription was written. The physician assistant must sign the prescription by printing the name of the supervising physician, printing his or her own name, and signing the prescription followed by the letters "RPA" and the physician assistant's registration number.

2. Nurse Practitioners

A nurse practitioner who satisfies the education requirements under New York State law, is authorized to write prescriptions. The nurse practitioner must obtain a certificate from the New York State Department of Education after successfully completing a program which includes a pharmacology component or its equivalent. Such prescriptions must be issued on the nurse practitioner's prescriptions forms which have printed on them the name, certificate number, office address and office telephone number of the nurse practitioner. The collaborating physician is not required to countersign the prescription nor is the collaborate physician's name or registration number required to be stated on the prescription.

IV. Electronic Signatures

In addition to the countersignature requirements, other issues regarding signatures and countersignatures come to the fore. Our increasingly "electronic" society has forced physicians and hospitals to address issues such as the use of electronic signatures for medical orders. New York State law allows a hospital, in certain circumstances, to accept electronic signatures of a physician.

The hospital must, however, have policies and procedures in place to ensure that the author of each medical order is properly identified and that only properly authorized practitioners and personnel are utilizing electronic systems. The hospital's policies should include an ongoing verification process to ensure that electronic communications and entries are accurate and complete.

Under 10 N.Y.C.R.R. § 405.10, a hospital must create a system to identify the author of all medical orders. The system should identify the categories of practitioners and personnel who are authorized to utilize electronic or computer authentication systems. Whenever a medical order is given, it should be promptly and completely recorded in the patient's medical record in a legible manner and must be authenticated by the ordering practitioner.

The hospital system may allow the use of both written and electronic signatures or computer generated signatures to authenticate medical orders. Any electronic order or authorization must be recorded in the medical record, including the date, time, category of practitioner, mode of transmission and point of origin. Medical orders may also be made by facsimile if they are legible and signed.

V. Conclusion

The supervising physician of a physician assistant or nurse practitioner may be required to countersign the medical orders of the physician extender as part of his or her supervisory duties. Even where the supervising physician is not legally required to countersign the medical orders of a physician assistant or nurse practitioner, the supervising physician should consider periodically reviewing and countersigning the physician extender's orders and chart notes to create evidence of his or her supervision. These countersignatures and documentation may be the best evidence to support a claim of appropriate supervision.

The supervising physician should consider that under the doctrine of *respondeat superior*, negligent failure to properly supervise a physician extender exposes him or her to vicarious liability for the wrongful acts of the physician extender. The physician extender's negligent failure in treating supervising physician's patient resulting in an injury, which is within his or her scope of practice, allows the patient to sue the supervising physician as well for any injury incurred. The supervising physician should also consider that failure to properly supervise the physician extender could affect his or her New York State medical license.

Endnotes

1. The practice of a physician assistant may generally include the performance of medical services. It will be limited in the type of medical services the physician assistant may perform by the duties assigned and the scope of practice of the physician assistant's supervising physician. Moreover, the duties assigned must be appropriate to the training and experience of the physician assistant.
2. The practice of a nurse practitioner may include the diagnosis of illness and physical condition and the performance of therapeutic and corrective measures within the nurse practitioner's specialty area of practice and must be performed in collaboration with a licensed physician qualified to practice in the specialty involved.
3. Medicare billing regulations may require the physician assistant and supervising physician to meet more stringent supervision provisions.
4. A hospital may adopt more stringent rules and regulations regarding the scope of supervision required from a supervising physician in connection with a physician assistant employed by the hospital.

"All Right, Mr. DeMille, I am Ready for my Close-up"[1]

(A Health Care Lawyer's Practical Guide to Considerations in Negotiating a Film/TV Contract[2])

By Salvatore J. Russo

In today's health care environment competition for patients among health care facilities and health care systems is acute.[3] Health care providers are expending significant resources in creating and fostering positive images within the community. Merely focusing upon the communications and marketing budgets for health care institutions over the past couple of decades will provide a glimpse at growth of the interest in this area over time.[4] In the late '70s, health care facilities' public affairs department activities were largely related to news article placements, working with auxiliaries, preparing annual reports, and designing in-house facility brochures.[5] In contrast, departments of communications and marketing at health care facilities presently have comparatively large budgets which are used to hire advertising consultants, purchase multimedia advertisements, and sponsor local radio and television programs.[6]

"You think that as a health care lawyer you must be acquainted with a broad variety of legal disciplines, from hazardous waste disposal to anti-referral laws, with safe harbors. When did entertainment law slip into the cadre of subjects that a health care lawyer must know?"

Therefore, the idea of getting "free" positive publicity associated with the making of a movie or television program is very appealing. So the possibility of your client requesting that you represent it in the negotiations with a media organization for the development of a film or television program is not so remote.

How will you advise your client? You first reaction may be, "Oh no, you must be kidding." You think that as a health care lawyer you must be acquainted with a broad variety of legal disciplines, from hazardous waste disposal to anti-referral laws, with safe harbors. When did entertainment law slip into the cadre of subjects that a health care lawyer must know? You step back, take a deep breath, as your client has visions of the "miracle medical center" on television equipped with budding George Clooneys as physicians.[7] You are hoping that the film proposal is for a scripted show with actors portraying patients and doctors at your client's institution. In that instant, you realize that even that scenario is not perfect. You think of the television series "Felicity," and New York University's decision not to allow the show to use its name as the college that Felicity attends, and serves as the setting for the show.[8] According to news reports, the primary reason for NYU not permitting the producers to use its name in the show was the problem of script control, i.e., the inability to control how NYU and its students would be portrayed each week.[9] Have no fear, your client's proposal will be for reality programming, since such programming is the vogue today.[10] There has been a proliferation of reality type medical shows.[11]

Once you have embarked upon the process of advising your client on this project, you will quickly appreciate the institutional tensions created by the proposal and the interplay among the different, divergent interests involved in this enterprise. The lawyer/risk management types have as their central focus the protection of the institution from potential liability, the marketing types are interested in securing good publicity, the department chiefs are concerned with demonstrating what a fine service they run, and the providers are interested in showing what exemplary professionals they are.[12] In advising your client, you ought to keep the various perspectives in mind.

I. Assemble a Multidisciplinary Team

In your role as lawyer/counselor, you should advise your client to create a small multidisciplinary team to assist in providing guidance and input on the development of the media project. The team should be comprised of senior management individuals from the institution, as well as legal counsel. The senior management representatives should be from the department(s) that will principally be involved with the shooting of the film/TV program—hospital administration, a physician, a nurse, the communications/marketing department, a patient advocate and an individual from risk management/legal counsel. This group ought to be senior enough to get cooperation from staff, get questions answered regarding the media undertaking, and be trusted and relied upon to make sound business recommendations to the chief executive officer (CEO). In recognition of the potential fallout from the decision to undertake this enterprise, the CEO is the final decision-maker.

II. Conduct a "Due Diligence" Background Investigation

Ascertaining whether you wish to do business with the film/TV production company, the director and the camera crew, is the first critical step. Are these people experienced, professional and reputable? Are they involved with sensational and shocking film/TV shows? Who is backing the production? Even with the most tightly drafted agreement, the confidence and trust that the institution has in these various players involved with the production is pivotal, and is your best insurance against an unsatisfactory outcome. The multidisciplinary team should conduct a "due diligence" background investigation on the various players involved in the film production. The team should seek out the following:

1. Identify the persons and business entities that will be involved in the film's production and airing of the final product.
2. Obtain the curriculum vitae of the persons involved in the film, and conduct background checks on each of the business organizations that will be part of the production.
3. Request copies of works from the director, the production crew, executive producer and anyone else who has such work exemplars and will be participating in this project.
4. Ask for a list of references from people with whom the various players have worked on similar films.
5. Request a copy of the "treatment," "concept piece" or proposal, with the draft budget that was presented to the financial backers of this enterprise. This document will also give you a realistic idea of the level of commitment your institution will need to play in this film.
6. Ask for a copy of the contracts between the several business entities and persons involved in the project. They may wish to redact or eliminate certain attachments from those documents.
7. Identify all the lawyers representing the different people involved with the undertaking.
8. Schedule a meeting with the multidisciplinary team and the director, producer, production crew and the other major players in this film production.

Armed with information collected from the above-outlined steps, the interdisciplinary team should be able to make a reasonable response to the question, "Are these people with whom the facility should partner in this media venture?" Assuming that the answer is "yes," then you will need to discuss and negotiate understandings on the subjects identified in the next section.

III. Subjects to Be Discussed and Negotiated in a Film/TV Agreement

After conducting the "due diligence" background investigation you will have learned a great deal about your potential business partners and the way in which your project is conceptualized. Now is the time for you to go over the subjects set forth below with your client, and then later with the lawyers for your potential business associates.

1. The nature of the commitment (pilot, series or full-length film).
2. Protections for patient involved in the film.
3. Reduction of risk management/medical malpractice liability exposure in film.
4. Types and amounts of insurance, and indemnification.
5. Mechanisms for limiting potential for playing to the cameras.
6. Rights of review and editing.
7. Access to facility and utilization of facility resources.
8. Compensation/reimbursement/contribution to facility.
9. Opening and closing credits.
10. Security/parking lot spots and other miscellaneous items.

A. The Nature of the Commitment (Pilot, Series or Full-Length Film)

It is obvious that with various degrees of commitment by the health care client there are concomitantly different levels of risk for an unsatisfactory outcome. The longer the commitment, the greater the risk that the business partners will grow displeased with the venture. The dissatisfaction could emanate from a variety of sources. The production does not quite portray the facility in a manner in which the facility's trustees and administration desire. The film is not artistically or commercially successful. Too many of the facilities resources are being expended in production. There is pressure to outdo last week's show. Some untoward event was captured for an audience of millions by the film crew. Hospital personnel are developing unfavorable star qualities. Well, I could go on and on. You get the picture.

Ideally, you should seek to limit the institution's risks by limiting its commitment to a one-shot film with a duration of no greater than 50 minutes of airtime. A longer commitment may be like entering the institution of marriage, easy to get into, difficult to get out of.[13] However, if your client seeks to dominate the Nielsen Rating[14] with a weekly television series, then you should negotiate a pilot episode, with the right to withdraw thereafter, as well as that right to be exercised at other pivotal junctures in subsequent television seasons.[15] In any event, you should put a limit on the number of hours or days that the production crew is entitled to film at your facility as part of the agreement. You may have to include a right to request additional shooting time, subject to the facility's consent. The production crew may want to have a clause that states that such consent may not be unreasonably withheld.

"Paramount among the interests at play for the health care institution is the protection of its patients."

B. Protections for Patients Involved in the Film

Paramount among the interests at play for the health care institution is the protection of its patients. In the end, for both ethical and pragmatic reasons, this interest should trump all others. What type of image is depicted to the viewing public, if an excellent medical center obviously compromises the interests of the infirm patients entrusted to it for health care? Patients who believe that their interests have been jeopardized, may institute legal action and express their outrage to the news media.

Ideally, you should attempt to steer the production to filming elective scheduled procedures. Those situations afford the facility with the greatest opportunity to ensure that the interests of the patients involved are safeguarded. Additionally, you should seek to exclude certain vulnerable populations, such as minors, prisoners and those individuals seeking treatment for mental illness or substance abuse, from participation in the film. Moreover, no patient ought to be solicited for participation in the movie without a physician's preliminary determination that such participation would not interfere with medical treatment, nor where participation may adversely affect the patient's recovery and subsequent well-being. Also, in order to minimize the intrusiveness of the filming, the film crew should be small (at most three), and try to limit the amount and size of the filming equipment to be used (ideally one handheld small camera.) Finally, the film crew must follow "House Rules," (which will be explained in more detail later in the article) which will also seek to reduce the potentially overwhelming effect of filming by controlling the environment somewhat.

All patients and others appearing in the film must execute a specific written consent. Sometimes, because of the nature of the film being shot, such as an emergency room type program, the director wants the film crew to have access to patients prior to formally executing a written consent. This poses some particular challenges, because you want to minimize the risk of regulatory violations, as well as any claims by individual patients. If the institution is willing to bear some risk, you may want to consider the following precautions.

- Conduct an educational in-service for members of the crew and film editing staff on patient rights and patient confidentiality.
- Those individuals involved with the filming and editing the film must execute a "Covenant of Confidentiality." Breach of such covenants can result in personal liability, as well as corporate liability for those entities involved in the production (there needs to be some teeth in the covenant.)
- The film crew must abide by the House Rules for Filming. (described later)
- As stated above, there must be a preliminary determination by a physician that the patient's participation will not interfere will medical care, or adversely affect the patient's recovery and subsequent well-being.
- Verbal consent from the patient or a patient's surrogate should be obtained prior to filming.
- Where written consent is subsequently not obtained, the film footage cannot be used, and must be destroyed.
- Film footage not used in the movie/TV program or its promotion cannot be used for other purposes, and is to be destroyed. The production crew must attest to the destruction of the excess footage.

In addition to the above safeguards, prior to executing a consent to filming, a physician should conduct an assessment of whether the patient has capacity to make such a decision. Furthermore, the consent should contain a provision that allows the patient to withdraw consent for some time period after executing it, such as 90 days.

C. Reduction of Risk Management/Medical Malpractice Liability Exposure from the Film

Upon agreeing to engage in an undertaking of this sort, there is always some degree of risk that cannot be eliminated. However, there is some risk in everything

we do. We do not live in a risk-free environment. Some key elements in limiting risk in these situations are: taking the steps outlined in this article, such as background investigation; adequate patient consent process; securing the proper insurance and indemnification protection (to be discussed later); and establishing House Rules for Filming ("House Rules.") The House Rules should be an attachment to the agreement.

"Even the most impeccably drafted agreement is not worth the paper it is written upon unless it is supported with adequate financial resources to fulfill the contractual obligations of your client's business partners, as well as to compensate the health care facility for any damages that can arise out of a breach by the other party(ies) to the agreement."

The House Rules are pivotal in managing or controlling the access granted to the filmmakers. What should be in the House Rules? They should include, at least, the following:

1. No filming without prior verbal consent.
2. All members of the production crew must be accompanied by hospital staff.
3. Prior approval is required to enter certain areas of the hospital.
4. If requested by hospital staff to leave, you must do so immediately.
5. If asked to stop filming, you must do so at once.
6. Proper identification badges must be worn at all times.
7. Should you be permitted to follow a patient into the operating room, you must adhere to instructions regarding proper dress and decorum.
8. Equipment must not block any hallways, entrances, exits, elevators, or in any way interfere with the activities necessary for the care of patients.
9. All members of the production crew must observe infection control protocols, and obey the medical and clinical staff's instructions regarding any matter relating to health risks.
10. There shall be no more than one film crew shooting at the facility at a time. In no event shall that crew, including the director, exceed three people.

In addition to undertaking the above precautions, it is time to discuss the insurance and indemnification considerations to handle situations that can arise.

D. Types and Amounts of Insurance and Indemnification

Even the most impeccably drafted agreement is not worth the paper it is written upon unless it is supported with adequate financial resources to fulfill the contractual obligations of your client's business partners, as well as to compensate the health care facility for any damages that can arise out of a breach by the other party(ies) to the agreement. Many times production companies are relatively modest sized, assetless corporations. Insurance coverage and having "indemnification" obligations guaranteed by a "deep pocket"[16] entity is a way you can further reduce your client's potential liability exposure.

With regard to insurance coverage, ideally you will seek coverage that is specific to the film/TV production your client is involved with. Moreover, you should also seek to have your client as either a "named insured," or alternatively, as an "additional insured," on the policy. Additionally, you will want to request that the insurance carrier be either a New York corporation, or a carrier licensed to do business in New York State, in order to have access to New York State's Insolvency Fund.

There are various types of events for which your client will need the security that will result from the production company possessing insurance. The occurrences include, among other things: (1) inadvertent damage caused by the film crew to an expensive piece of hospital equipment, such as an MRI; (2) injury occasioned upon a visitor by a piece of filming equipment; (3) injury that a crew member sustains while filming; (4) damage resulting from a violation of a patient's right to privacy/confidentiality; and (5) injuries sustained to one's character as a result of slander or libel. You will seek to have the production company obtain the following types of insurance to cover such events: general liability insurance with a property damage rider; workers' compensation insurance; an errors and omission's policy covering acts of libel, slander, invasion of privacy and rights of publicity; and automobile insurance for any vehicle which will be on the campus of the health care facility. You should seek to get coverage in the amounts of at least $1 million per incident, and $3 million cumulatively, unless otherwise advised by the institution's insurance consultant. In the contract you will require that "certificates of insurance," will

need to be presented at least ten days prior to filming. You ought also to have a provision which requires at least ten days' notification of any changes or cancellation of any insurance.

You should also seek a broad indemnification provision to cover any gaps or shortfalls which may result from the types of insurance coverage, as well as the level of insurance coverage. The indemnification should include reimbursement for all legal fees, or even reasonable legal fees. The indemnification will also need to be an obligation undertaken by the "deep pocket" entity.

E. Mechanisms for Limiting Potential for Playing to the Camera

Depending on how conspicuous and distracting the film crew is, its presence may affect the provision of health care services. Staff may react to the film crew in many different ways. They may act like deer in the headlights of a car, play to the camera, or ignore it. In order to minimize the adverse effects that the camera can have upon the delivery of health care, your client should conduct a preliminary meeting with staff to orient them to the purpose of the enterprise, as well as point out the dangers that result from diverting attention from patient care to other tangential issues. Staff should be reminded that they are health care professionals and not professional actors, nor is the film intended to serve as their personal "bully pulpit."[17] The House Rules, and your client's rights of review and editing the "rough cut" of the film/TV program can assist in downplaying the negative outcomes of playing to the camera.

F. Rights of Review and Editing

Generally no production company will surrender artistic control over a film/TV program. Artistic freedom is a fundamental philosophical principle much like freedom of the press. Therefore, you may not be able to negotiate as many substantial rights as you desire for your client in this area. You should attempt to get veto power over the final product, but do not hold out great hopes of achieving this result. Here are some rights that you may be more likely to secure for your client:

- The production crew will undertake reasonable efforts to accurately and evenhandedly portray the facility and its staff.
- The film/TV program cannot purposely select and focus upon patients and situations that are likely to have adverse outcomes.
- The institution will be granted up to three opportunities, at different reasonable times and dates to view a "rough cut" of the final product, and be provided a complete printed script.
- Subsequent to viewing the "rough cut," the health care facility shall provide written comments describing any portions of the film that in good faith appears to inaccurately or unevenly portray the facility, or purposely cast the institution in a disparaging light, or depict the medical treatment provided at the facility in a medically inaccurate manner.
- The producer shall respond to the facility's written comments.

"Artistic freedom is a fundamental philosophical principle much like freedom of the press."

- The facility shall have a right to appeal to a mutually agreed upon independent medical expert to resolve questions of medical accuracy.
- The facility shall have a right to review all promotional materials prior to release, and comment.

G. Access to Facility and Utilization of Facility Resources

The health care facility's contribution to the film/TV program is access to its space, patients and staff. Generally, camera crews and the director will desire unfettered access to your institution. As the House Rules provide, access to the institution shall be controlled. However, managing access will require that film crews be escorted at all times. Such activities and staffing related to those activities have a financial cost to the institution. Also, the time spent by the production crew, doctors, nurses, patients and administrators, has a cost to the institution.

H. Compensation/Reimbursement/Contribution to the Health Care Facility

The facility's in-kind contribution to the production of the film/TV program can be substantial. While the health care facility is anticipating its benefit deriving from a good public relations image, the institution should seek to obtain some compensation, reimbursement or contribution to offset its costs. You should also advise your client to roughly calculate the amount of in-kind contribution it will provide to this enterprise. You should use those calculations when negotiating with the production company.

I. Opening and Closing Credits

The opening and closing credits do not alter the substance of the film/TV program, however, they are important. There is something about this modern ver-

sion of "having your name in lights," which can stroke some significant egos within and outside of the health care facility. You should negotiate the language very carefully. You should have your client be clear as to who it wishes to acknowledge and what precisely it wants to appear in the credits. Who knows, your client may wish to acknowledge you and your firm as the facility's legal counsel in the credits, speaking about good public relations.

J. Security/Parking Lot Spots and Other Miscellaneous Items

There are a host of other items you will need to discuss and come to closure on. They may relate to some seemingly minor but important matters, such as who provides security for production equipment, how many parking spaces can the crew have access to during the filming, how many copies of the film does the institution receive. There are some other miscellaneous items of great impact, such as, what is the term of the agreement, what provisions of the agreement survive the expiration of the contract (hint—indemnification), which you will also have to negotiate.

"Who knows, your client may wish to acknowledge you and your firm as the facility's legal counsel in the credits . . ."

Now your client can go off to Hollywood and be prepared for its close-up, Mr. Spielberg. See you at the premiere.

Endnotes

1. This is a quote from the character Norma Desmond in the movie "Sunset Boulevard" (1950-Paramount Movie Studios). She was portrayed by Gloria Swanson (1897-1983), originally a silent movie actress. Cecil Blount DeMille (1881-1959) played himself in the movie. Mr. DeMille was a director, producer and actor. Among his many directing credits is the epic film, "The Ten Commandments" (1956-Paramount Movie Studios.)
2. This article concerns negotiating contracts where the health care entity and its patients are the subject of the film/TV program, and not where the facility is merely the site for a film shoot. The article is written from the perspective of an attorney representing a health care institution or health care system.
3. Jennifer Steinhauer, *In A Competitive Market, City Runs Ads For Its Hospitals*, N.Y. Times, March 28, 2000, p. 7.
4. Marketing Health Services Staff, *Trends In Health Care Marketing*, Marketing Health Services, Fall 1999, p. 42.
5. Bruce Japsen, *Ad Budget Drop: Hospital Marketing Budgets Up, and Budgets Down*, Modern Healthcare, p. 70, Feb. 17, 1997; Mary C. Gilly & Mary Finley Wolfinbarger, *Does Advertising Affect Your Nurses*, Journal of Health Care Marketing, p. 24, September 1992.
6. Mary Chris Jaklevic, *Hospitals' Advertising Spending Up 11.4%*, Modern Healthcare, p. 56, April 3, 1995; *see* Marketing Health Services Staff, *supra* note 5 at 42.
7. George Clooney is an actor who played Dr. Douglas Ross, an emergency room physician in a television show entitled, "ER," which began airing on Thursday nights at 10 p.m. EST on NBC.
8. "Felicity" is a television weekly fictional program in which the title character attend college in New York City. It airs on Wednesdays at 9 p.m. EST on the WB Network.
9. Anita Gates, *NYU, Says 'No Thanks' For Star Role in Sitcom*, N.Y. Times (Metropolitan Section), Sept. 2, 1998.
10. James Poniewozik, *Reality TV: NBC Get Cojones, Critics Get the Willies*, Your Weekend Guide for the Whole Week (July 30, 2001) <http://www.time.com>.
11. University of New Jersey Medical & Dental Center, "48 Hours" on CBS, January 1995; "Hopkins 24/7," ABC, Fall 2000; "Trauma: Life in the E. R.," "Labor and Delivery," "Code Blue" and "A Baby's Story" on the Learning Channel, 2001; "Women DOCS" and "Strong Medicine" on the Lifetime Channel, 2001.
12. These are gross generalizations, however there is some degree of these interests at play.
13. This expression is not original. I first heard this expression used in the context of analogizing it to tax loopholes at Hofstra Law School. Thanks to Professor Daniel Posin.
14. Nielsen TV ratings are a service of Nielsen Media Research. The company was founded in 1923 by Arthur C. Nielsen, Sr. It was one of the first research companies to measure the audience for a rapidly developing radio broadcasting and advertising industry. Nielsen Media Research was there again in 1950 at the birth of the TV broadcasting and advertising business, and has remained the official national measurement service of the television industry for over 40 years. *See* <http://www.nielsenmedia.com>.
15. The television season begins in September and continues through the following May, see <http://www.tvguide.com>.
16. Deep pocket is "a person or organization having substantial financial resources." Merriam-Webster's Collegiate® Dictionary On-Line, <http://www.m-w.com/cgi-bin/dictionary>.
17. This term stems from President Theodore Roosevelt's reference to the White House as a "bully pulpit," meaning a terrific platform from which to persuasively advocate an agenda. Roosevelt often used the word "bully" as an adjective meaning superb/wonderful <http://www.c-span.org/guide/congress/glossary/bullpul.html>.

Salvatore J. Russo is an Executive Senior Counsel for Medical/Legal Affairs with the New York City Health and Hospitals Corporation, and is Chair-Elect of the Health Law Section of the New York State Bar Association. The views and advice expressed in this article are purely those of the author, and do not constitute legal advice and do not substitute for individualized legal advice for particular clients and circumstances.

Executive Committee

On October 12, 2001, the Executive Committee of the Health Law Section held its meeting for the first time in Section history at the home of the Association in Albany. Members of the Committee were able meet with Association staff and learn more about the resources that the Association provides the Section and its members.

There were many items on the meeting's agenda, including but not limited to: joint programs and projects with the Medical Society of the State of New York, the Annual Meeting Program, update on the *Health Law Journal*, and reports from Committee Chairs and Section Officers. In addition to the foregoing business items, the Committee had a special guest in attendance at the meeting, Donald P. Berens, Jr., General Counsel of the New York State Department of Health. Robert Abrams, Section Chair, and Berens discussed the generally collegial relationship that the Section and Counsel's Office have enjoyed over the years. They explored avenues to further enhance the relationship. Mr. Berens was invited to share some remarks at the luncheon at the Annual Meeting. The meeting was very productive.

Biotechnology and the Law Committee

October 2001

The Health Law Section's Biotechnology and the Law Committee met on September 28, 2001, at the offices of Kalkines, Arky, Zall & Bernstein in New York City. Joining the Committee was Ann Carroll from the New York State Task Force on Life and the Law to assist the Committee in its consideration of the many public policy recommendations made by the Task Force in its recent report on genetic testing and screening.

Given the Committee's long-standing interest in the field, it was decided that the Committee would devote the bulk of its work this fall to considering the recommendations of the Task Force and to drafting the necessary implementing legislation to enact its recommendations into law. The Committee expects to focus on the issues of informed consent, confidentiality, the use of genetic testing for insurance and employment purposes and the licensure/certification of genetic counselors. It is anticipated that the existing laws governing genetic testing and confidentiality will be generally revised and clarified and that more explicit responsibility will be vested in the Department of Health to oversee compliance with the applicable informed consent and confidentiality requirements.

Ms. Carroll indicated an interest on the part of the Task Force to work closely with the Committee in this process and provided very useful insights to Committee members on the Task Force's work. The Committee anticipates undertaking this work during the course of the fall, initially through conference calls and subsequently a face-to-face meeting, scheduled for November.

Attendees also discussed other issues to which the Committee may wish to devote attention that may bear special relevance to the terrorist attack. Among other suggestions, the Committee discussed the issue of bioterrorism and considered whether the topic may be an appropriate one for a future CLE or Annual Meeting presentation. The Chair also noted the necessity of identifying a replacement and urged Committee members to consider making nominations for the position.

Past, Present and Future Activities of the Committee on Health Care Providers

The Committee on Health Care Providers (the "Committee"), headed by Committee Chair Mark Barnes, decided in 2001 to focus its efforts on the following three main projects: (1) to provide comments on the proposed New York State privacy legislation; (2) to coordinate a roundtable discussion on relevant corporate practice of medicine issues, to be addressed by representatives of the New York State departments of Health, Insurance and Education; and (3) to request that the New York State Department of Health post its letter rulings on its Web site and provide a search engine for those rulings. The Committee has also begun efforts to work with other committees of the Health Law Section, including the Committee on In-House Counsel, to prepare a report on suggested reforms of some basic aspects of professional medical conduct procedures and rules. The working group is Co-Chaired by Greg Naclerio and Karen Gallinari, and will be producing a White Paper to be shared and discussed with the Committee on Professional Responsibility and ultimately with the Executive Committee of the Section.

The Committee has organized a Corporate Practice of Medicine Roundtable Discussion which is being sponsored by the Committee and the Association's Health Law Section. This program will be held on June 28 from 11 a.m. to 1 p.m. at Proskauer Rose LLP, 1585 Broadway, New York, NY. The purpose of the program

will be to allow members of the health care bar in New York State to interact, in an informal, off-the-record, moderated discussion, with several representatives of the various New York State offices and departments on issues related to the corporate practice of medicine and legal restraints on the contracting and administration of services for physician practices. The departments will be represented at the discussion session by: (1) Tom Zyra, Esq. (Insurance Department); (2) Judy Doesschate, Esq. (Department of Health); and (3) Doug Lentivech, Esq. (Education Department).

Committee on Securing Health Care for the Uninsured

At this time, the Committee is embarking on the preparation of a White Paper on ways to secure health coverage for uninsured New Yorkers. The White Paper will include a survey of the public and private studies undertaken to identify the population comprising the uninsured, as well as analyze the legislative and private programs currently in place that seek to reduce the number of uninsured individuals. It is intended to educate the legal community and Legislature regarding the uninsured and under-insured population in New York and will propose approaches to be considered in order to address the problem.

In the past, the Committee reviewed the regulations proposed to implement Healthy New York insurance coverage, and reviewed the provisions of HCRA related to expanding coverage to those traditionally without health insurance.

If interested in serving on the Committee, please contact Ross P. Lanzafame, Esq. at (716) 231-1203.

Special Committee on Medical Information

During the last year, our Committee has been busy with bill analysis. A Subcommittee composed of Jim Horan, James Fouassier, John Cody and Anne Maltz wrote an analysis of the Health Information Privacy Act of 2000 (HIPAA). This bill was being considered for introduction by Assemblyman Gottfried. The analysis was not submitted because its completion coincided with the issuance of the HIPAA regulations. We believed that any bill should be drafted and analyzed with an eye to the newly enacted regulations.

One area that we continued to be concerned about was the interplay between the Gramm-Leach-Bliley Act and HIPAA. G-L-B also deals with the transmission of medical information but is less protective than HIPAA. An early draft of the New York enactment of G-L-B did not contain language that protected medical information to the degree that HIPAA does. We had conversations with the then Superintendent and Assistant Superintendent of the Insurance Department, Mr. Levin and Mr. Serio respectively. We learned that this issue had been of concern to others as well. Ultimately, the final regulations evolved to contain additional protection.

Currently a Subcommittee composed of James Fouassier, John Cody, Melinda Hogan, Martha Robinson, Adam Shaw, Stanley Russell and Anne Maltz is working on a comment to Assembly bill A.04230, the Personal Privacy Act of 2002.

In addition to these activities, the Health Law Section together with the NYSBA held a full day CLE program on HIPAA, entitled: “Confidentiality: the Newest Challenge.” The program was well attended and well received. In the coming year, we plan to serve as a forum to address the HIPAA questions of our colleagues, monitor and comment on state legislative activity on privacy of medical information, and develop an educational program for our Section.

We are also participating in the development of a joint MSNY-NYSBA educational program on HIPAA. We are planning a program for our members and would welcome your thoughts on topics. If you have a HIPAA question, feel free to contact Anne Maltz at amalt@herrick.com. She will be happy to field the questions.

Report of the Professional Discipline Committee

The Committee co-sponsored a well-received spring CLE program on discipline of Health Professionals by the Education and Health departments. The program dealt not only with licensing hearings involving the Office for Professional Medical Conduct and the Office for Professional Discipline, but also with other hearings involving the Medicaid Program, the Bureau of Controlled Substances and the Patient Protection Program for nursing home residents.

Welcome New Section Members:

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Steven R. Antico
Robert D. Bergida
Jonathan J. Braverman
Andrew Bressner
Ann Marie M. Buerkle
Christopher Cabalu
Erin K. Calicchia
Meredith Canniff
Linda Caputo-Friedmann
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Ellen M. Yacknin
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Tova E. Zifzider
Cheryl Zimmerli

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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Preparing For and Trying the Civil Lawsuit

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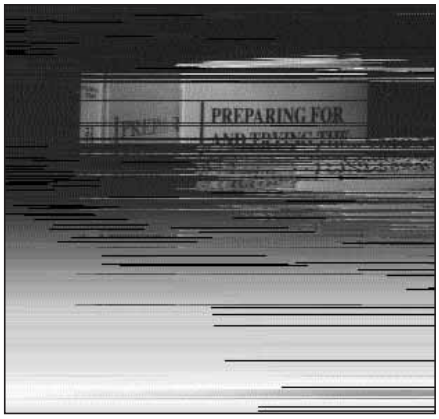

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